

Agent Liability & Kentucky Law

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ERRORS & OMISSIONS

Errors and omissions and professional liability insurance provides important liability protection to professionals. It covers claims for damages that are not covered by other liability forms. Through the purchase of errors and omissions insurance, the professional is protected from the risk of financial loss due to errors, acts, omissions or negligence in the rendering of professional services. The liability insurance environment is rooted in our litigation system. The agent who offers this insurance must be familiar with the legal concepts, legal terms and court decisions affecting liability insurance. The agent must also understand the elements of the insurance forms which are used to provide liability coverage.

Agents offering errors and omissions and professional liability insurance provide a true service to their customers. Without this coverage, a professional is in danger of serious economic loss.

The Liability Environment

There may be no other time when the need for protection against liability litigation has been greater. Newspapers and the television news discuss high profile lawsuits almost daily. Employers, businesses, municipalities, the media, professionals, and common citizens are all targets. It appears that one can sue or be sued for just about anything. The number of liability suits filed has grown tremendously in recent years.

Why Lawsuits Have Increased

Legal observers cite several reasons for the dramatic increase in lawsuits. One of these reasons is a change in the attitude of society toward bringing a legal action against another party. Individuals today, it is said, tend to look for someone to blame, for a party to "pay for" negative circumstances that occur. The vendor must pay when a customer spills coffee and is burned because the vendor kept the coffee too hot. The employer must pay when an employee is not promoted because the employer was discriminatory or failed to notice the excellent work of the employee. The municipality must pay when an auto, which veered off into a ditch, is damaged because the municipality did not appropriately care for the roadway. Harm which befalls an individual is not seen as happenstance - it could have been avoided if some party had not failed to do the right thing.

Another reason pointed to for the proliferation of lawsuits is the complexity of services and products, which are offered today. The knowledge and technology revolutions have placed some occupations in the position of being able to offer services and products which are new and innovative, but which result in unexpected ramifications. The medical and pharmaceutical industries have created products intended to provide great advances in birth control, weight loss, or as remedies for other health concerns, but have instead resulted in harming the user. Innovative manufactured products have also brought with them some unexpected outcomes, causing skin irritations, fires, toxic fumes, and other harm. Because society's technological prowess is outpacing its ability to foresee harmful consequences, some say, an increase in litigation is not only to be expected, but is necessary in order to protect society from services and products which are insufficiently tested before being brought to market.

A third reason given for the increase in litigation is the result of increased competition in the marketplace. Professionals and businesses are under pressure to perform. They often have large customer bases, and trying to take care of so many customers' needs can lead to mistakes, delays in response times, or carelessness. This lack of care or negligence results in lawsuits.

But the primary reason most experts give for the increase in lawsuits has to do with changes in the legal environment. Several important developments in the legal arena have occurred over the last few decades. These developments, discussed below, include the ability of lawyers to advertise, the amount of money to be made by litigation, the application of joint and several liability in the awarding of damages, and a shift in the application of contract law by the courts.

Lawyers and Advertising

Today, statutes and the legal profession allow lawyers to freely advertise their availability. Prior to the late 1970's, lawyers were generally forbidden by the bar and in some cases by state law, to solicit business. In 1977, however, a Supreme Court decision stated that a lawyer's right to advertise was protected by the Constitution (*Bates v. State Bar of Arizona*, 97 S. Ct. 2691 (1977)). One of the outcomes of this decision is that lawyers now make it their business to inform the public of the many circumstances under which a lawsuit may be made and regularly and openly declare their willingness to assist in such matters.

The Amount of Money in Litigation

A criticism that is sometimes made of today's litigation system is that the lawyers involved are able to earn significant amounts of money from it. In some cases, lawyers earn income even when a suit is unsuccessful. This situation is believed to encourage the practice of bringing suits that do not have a sound basis, or are frivolous. Another concern is that because there is so much money to be made through litigation, some lawyers may encourage bringing suits rather than finding some other, less expensive, solution.

Joint and Several Liability

Joint and several liability is the practice of assigning liability for damages based on an ability to pay. For example, if a corporation or municipality is brought into a lawsuit along with an individual, and both parties are found liable, under joint and several liability rules, the corporation or municipality would likely pay the greatest amount of a damage award. Under joint and several liability rules, even if the individual was the party with the greatest fault, the corporation or municipality may pay the bulk of the damages because they are able to do so. This practice is thought to encourage bringing suits, which would normally not have been undertaken, because the plaintiff would have little chance of actually collecting damages. It is also thought that joint and several liability rules may encourage bringing parties into lawsuits who previously would have been excluded because their liability was negligible.

Application of Contract Law

The change in the legal environment, which is thought to have had the biggest impact on the number of liability suits, is the view courts take today regarding transactions based on a contract. Up until this century, courts would rarely overrule the terms of a contract if the contract was legal and both parties had agreed to the terms of the contract freely. If both parties had agreed to the terms of a legal contract, liability laws, which apply when a wrong is committed against another party, would not apply. The legal phrase in Latin that was applied to this concept was *volenti non fit injuria* - "to one who is willing, no wrong is done." If there is no wrong, there is no legal liability. Under traditional contract law, it does not matter whether the consumer or the vendor might suffer harm. If both had agreed to the contract, both parties must stick to the agreement.

As insurance agents know, a contract must follow certain rules in order to be legal: it must have two or more competent parties, a legal subject matter, consideration and assent by the parties. Agents are also taught that the written contract is assumed to include all oral agreements - if something is not written into the contract, unless fraud or misrepresentation is present, courts will uphold the terms of the written contract and exclude or ignore prior oral agreements or negotiations (the parol evidence rule).

Recently, liability courts have begun to listen to arguments involving oral negotiations and oral promises and, in some cases, have held parties liable for words spoken, even if a legal contract exists which would in the past have exonerated the parties. (This is one reason agents are often required today by the employer to use a specific telephone script or to follow a specific sales track or use a memorized answer regarding certain policy features. The employer is trying to limit exposure to lawsuits due to the communication of oral information that contradicts a written contract). Since liability courts will now listen to suits related to oral negotiations prior to a contract, which would have traditionally been under the jurisdiction and remedy of contract law, more liability suits occur.

Another change in the legal environment related to contract law has to do with the premise of consent of the parties involved in a contract. As mentioned, it was commonly held that if both parties consented to a legal contract, neither party could be charged with a wrong in a liability court. Contract law would apply. However, some liability courts now hear cases involving contracts if it can be successfully argued that a party did not consent because they did not know what they were consenting to. In today's complex climate, contractual transactions can involve complicated clauses concerning items the average consumer knows little about. Courts have sympathy for the consumer, and may award damages against a business due to harm to the consumer resulting from a product sold or service done, even if no violation of contract occurred.

One of the outcomes of this point of view is the creation of the legal concept that some contracts are contracts of adhesion. A contract of adhesion is one where one party creates the terms of the contract, and the other party adheres to them. There is no real negotiation process, it is believed, under a contract of adhesion. Many business transactions are based on contracts of adhesion - one does not normally negotiate the terms of a furnace warranty, or the purchase of an airline ticket, or the price of a mail-order doll. An insurance policy is an example of a contract of adhesion. Since it is so deemed, a court of law is freer to dismiss certain clauses, provisions and terms in a policy if it feels they are damaging to the purchaser than if the contract were considered negotiated one. Because of the concept of contracts of adhesion, liability courts now hear many cases, which previously were under the jurisdiction of contract law.

Reducing the Consequences of Liability Exposure

All of these circumstances - the attitude of society, an increasingly complex and pressure filled marketplace, and the legal environment - have led to an increase in liability suits. Businesses and professionals are both more susceptible to the risk that a suit will be filed against them. However, there are steps that can be taken to reduce the consequences of this liability exposure. One of the most important is the purchase of liability insurance.

Liability insurance is available to provide protection against various types of liability. This course focuses on Errors and Omission and Professional Liability insurance. Both these forms of insurance protect professionals, such as doctors, nurses, dentists, veterinarians, accountants, engineers, and more, from the financial consequences of alleged and actual claims of negligence, errors and omissions in the carrying out of professional duties. Protection against these claims can mean that a professional will not lose his or her business and ongoing financial security because of mistakes in professional conduct.

Liability and the Law

When discussing errors and omissions and other liability insurance, the legal concepts applied to liability are important. Liability insurance provisions spring from statutes relating to legal liability and from insurance contract law.

Common Law

Common law relies strongly on past court decisions, or precedents. Centuries ago in England, all law was based on the customs and traditions of the local people. When rule in England became united under Norman kings, judges appointed by the king would go from hire to shire to hold court and administer local law. Over time, the rulings of these judges built on and replaced popular customs. As the rulings made by these judges were used and modified by other judges, these judgments were applied throughout the land, resulting in "common law."

The United States, as a former colony of Great Britain, generally adopted common law as the basis for civil law in most states. (The State of Louisiana is the only exception, its French roots resulting in the application of the Code Napoleon in the formation of its civil laws). Common law is developed based on previous court rulings. Once a court makes a decision, other courts can use the decision and the arguments behind it when ruling on cases they hear. Because of this, common law is rooted in tradition and past decisions and yet can change and evolve over time.

Tort Law

Common law governs the remedies for tortious acts. A tort is an act that is committed by one party, which causes injury or damage to another party or to another's property. The difference between an act, which is a tort and one which is a crime, is that a tort is a private wrong against a party or property, and a crime violates a public right. It is possible for an act to be both a tort and a crime, and therefore for the guilty party to be required to pay damages under tort law and also be punished under criminal laws.

A tort is not a breach of contract. Contract law provides the remedy for acts, which are considered to be a breach of contract. As has been mentioned, in recent years, some acts, which were traditionally the subject of contract law, have become the subject of tort law.

A tort is remedied by an action for damages. A plaintiff brings suit against the tortfeasor - the party who is alleged to have committed the tort. The tortfeasor is the defendant in the suit. The plaintiff seeks to be awarded damages, an amount of money, for the injury or damage caused by the defendant.

Torts may be either against a person or against property. Personal torts are actions such as false arrest, false imprisonment, malicious prosecution, assault, battery, libel, slander, or other forms of defamation. Property torts include the unauthorized use and assumption of control of another's property, unlawful entry on another's land (trespass), unreasonable and improper use by an individual of his or her own property that causes damage to the adjoining property (nuisance), and any act of negligence that causes damage to the property of others.

In order for a defendant to be required to pay damages, he or she must be found legally liable for the damages. Liability is generally based on establishing negligence on the part of the alleged tortfeasor. However, courts also award damages on the basis of absolute liability, strict liability, and imputed or vicarious liability. Before these other forms of liability are examined, negligence will be discussed.

Negligence

Negligence is the failure to use due and reasonable care. The standards for determining what reasonable and due care are can vary based on the tort and the parties involved. Professionals are generally held to a high standard of care by the courts. Many professionals are in a position of trust - they may be responsible for a customer's financial, health, housing, or family welfare. If those within a profession are generally expected to be expert, capable, thorough and competent, a court hearing a case against such a professional will judge that conduct that is less than expert, capable, thorough, or competent, as less than reasonable and due care.

In order to establish the presence of negligence, four elements must exist:

- A legal duty to act or to not act
- A breach of duty
- Proximate cause between the breach of duty and the damage or injury
- Actual loss or damage

Legal Duty

The law recognizes various duties owed. There is a legal duty to protect one another's rights and property. Reasonable and due care is another legal duty owed.

Breach of Legal Duty

Besides establishing that a legal duty is owed, a breach of that duty must be found in order for negligence to be present.

Proximate Cause

To establish negligence, there must be proximate cause between the breach of duty and damage and injury. Proximate cause is the legal doctrine that states that the breach of duty must launch an unbroken chain of events that results in the damage or injury in order for liability to be found.

Damage or Injury

A court must find that actual damage or injury occurred. A breach of legal duty may occur that does not cause harm. A fiduciary may make an unreasonable financial decision, but that decision may result in greater net worth for a customer. In such a situation, a court might determine that the fiduciary should be removed, but because no loss occurred, the maximum damages awarded may be expenses related to replacing the fiduciary.

Defenses Against Negligence

The courts recognize several different defenses against a claim of negligence. These include intervening cause, last clear chance, contributory negligence, comparative negligence, and assumption of risk.

Intervening Cause

Intervening cause is used to defend a case of negligence by eliminating the necessary element of proximate cause. An intervening cause breaks the chain of events leading to the injury or damage. If an intervening cause creates a new chain of events that led to the injury or damage, proximate cause between the breach of duty and the damage may not exist, and therefore, negligence may not exist.

Last Clear Chance

Another defense against negligence argues that the plaintiff had the last clear chance, or the final opportunity, to avoid the loss or damage. The plaintiff's failure to act, it is argued, caused the loss or damage, not the breach of duty on the part of the defendant.

Contributory Negligence

Contributory negligence was once a defense used in most states. It has been replaced in most of them by the concept of comparative negligence, but a few jurisdictions still recognize this defense. Under contributory negligence, if the plaintiff is found to have in any way contributed to the damage or loss, no damage award will be made.

Comparative Negligence

Comparative negligence rules weigh the proportionate amounts of negligence contributed by all parties in the damage suit. If the plaintiff is found to have contributed to the damage or injury, damages are not dismissed. Instead, the award to the plaintiff is reduced by the amount of his or her responsibility for the loss.

Assumption of Risk

Under the assumption of risk defense, the defendant must prove that the plaintiff understood the risks involved, including the possibility of the damage and injury in question, and yet allowed the act to occur.

Under such a scenario, the plaintiff is said to have assumed the risk of the activity, and so cannot hold another liable for resulting harm.

Liability without Negligence

As mentioned, there are forms of liability recognized by the courts without the necessity of establishing negligence in the manner discussed above. A court may award damages based on absolute, strict or imputed liability.

Absolute Liability

Negligence does not have to be proven when an activity is considered indisputably hazardous. A party conducting an indisputably hazardous activity is considered to have absolute liability for any damage or injury that arises from the activity. Examples of indisputably hazardous activities are keeping wild animals or handling dangerous materials.

Strict Liability

Strict liability is a term first used by the courts in 1962. In that year, the California Supreme Court found a power tool manufacturer strictly liable for an injury caused by a piece of wood that flew out of the tool and hit the operator in the head (*Greenman v. Yuba Power Products, Inc.*, 59 Cal. 2d 57, 27 Cal Rptr. 697, 377 P 2d 897 (1963)). Strict liability was applied because a defect in the product was found to have allowed the piece of wood to fly out of the machine. This inaugurated the precedent that a product defect, which causes damage or injury, can establish liability without requiring negligence on the part of the manufacturer.

Imputed or Vicarious Liability

Imputed or vicarious liability occurs when another party is held responsible for a negligent party's actions. Employers are generally held to be liable for the actions of their employees under the concept of imputed liability.

Types of Damages Awarded in Liability Suits

If the defendant is found to be legally liable, the court will require the defendant to pay damages to the plaintiff. These damages can include compensatory or actual damages, general damages, nominal damages, and punitive damages.

Compensatory Damages

Compensatory or actual damages are moneys paid to compensate for the financial loss for which the defendant is liable. These are also sometimes referred to as special damages.

General Damages

General damages are charged to the defendant to pay for a loss or injury that is a direct consequence of the tort committed, but not for financial loss. An example of general damages is an award for pain and suffering.

Nominal Damages

Nominal damages may be charged in a situation where loss or injury was negligible. They are small awards made in order to show that the liable party was responsible.

Punitive Damages

As the name suggests, punitive damages are awarded in order to punish the liable party. They are generally awarded if the court determines the responsible party acted in a malicious, vicious, or willful manner. Besides punishing the liable party, punitive damages also may have the purpose of acting as a deterrent to others, making an example of the defendant, or to teach the defendant a lesson.

The Professional and Liability Insurance

Professionals have special concerns and issues related to liability exposure. The services performed by professionals are considered very significant to their customers. The customer's finances, health, housing, or other items of critical importance can be seriously impacted by a professional's work. If a

money manager fails to purchase a new investment on a timely basis, if an accountant overlooks an important tax due, if a real estate agent does not submit a timely bid, the customer can suffer financial loss. If a doctor does not prescribe the right medication, if an engineer miscalculates the amount of stress a structure can bear, or if an architect is ignorant of an important municipal code, the customer can suffer both monetary harm and general loss. A mistake made by a professional that causes damage or injury to a customer can, of course, lead to a lawsuit. Because of the vital nature of services provided by professionals and the potentially serious consequences of an error or omission, they need liability insurance protection.

State Regulation

Another reason professionals may need liability insurance is that they may be required by state regulations to carry such coverage. Those who practice medicine are normally required to carry liability insurance in order to carry a state medical license. In many states, directors and officers of charitable organizations must carry liability coverage. Government entities may require that professionals doing business with them carry liability insurance. For example, in Florida, anyone providing legal, architectural, engineering or any other professional services must carry an amount of liability insurance determined by the state department for whom services are performed. Specific business owners may be required to carry liability insurance as well. Oregon recently established a rule that new Tavern Owners and those who offer liquor at public events must carry \$300,000 of liquor liability insurance.

Customer Requirements

Professionals may also be required to carry liability insurance by non-government customers or contractors who use their services. Businesses may require professionals who are working on an independent contractor basis to carry liability insurance. Contractors may require subcontractors to carry liability insurance. Consumer groups often advise individuals who plan to hire professionals, whether architects, lawyers or plumbers, to engage only those who have liability insurance.

Professional Association Requirements

Some professional associations encourage or require their members to purchase liability insurance. If the association is a legal entity, e.g. a group of dentists, lawyers or accountants who establish a partnership, the firm may require each member to carry liability insurance.

High Standard of Care

Generally, occupations, which require a specific degree or accreditation and a license in order to practice, are viewed as professional occupations. As mentioned, professionals are expected by the courts and the general public to exercise the greatest care, diligence, judgment and skill in their work because the services they provide are often critical to the welfare of those for whom they are provided. Because of this high standard of care and the critical nature of work done, liability suits are a significant risk for professionals, making liability insurance coverage a prudent purchase. Because a mistake can cause significant harm to a customer, damage awards against a professional can be very high. Without insurance, a professional's business could be financially ruined.

Fiduciary Responsibilities

If the professional is a fiduciary, such as a lawyer, accountant, trustee, real estate broker, retirement plan administrator, or money manager, special liability concerns apply. Fiduciaries are in positions of

trust. They must act in the best interests of the client at all times. The law expects the fiduciary to fulfill six specific duties, regardless of the type of occupation the fiduciary is in. These are loyalty, obedience, disclosure, confidentiality, reasonable care and diligence, and accounting.

Loyalty

A fiduciary is to act solely in the best interests of his or her principal, the party whom he or she is representing. The fiduciary must put all other interests aside, even his or her own, on behalf of the interests of the principal.

Obedience

The fiduciary must follow the instructions given by the principal. For example, if a trust is involved, a fiduciary must abide by all the terms of the trust; if a real estate deal is involved, a fiduciary must offer the terms of purchase set out by the principal.

Disclosure

The fiduciary must disclose all relevant and material information pertaining to the fiduciary relationship. A money manager must disclose risks involved in an investment; a real estate broker must disclose all potential buyers and so on.

Introduction to Liability Insurance

Liability insurance is used to reduce loss exposures related to the risk that a claim for damages will be brought by a third party against the insured. These loss exposures include the possibility of loss due to investigating, negotiating, settling, defending and paying damages to the party bringing the suit. Anytime a claim or suit is brought, expenses related to these activities are likely to occur. Liability insurance pays for these expenses, up to the limits of the coverage.

Coverages and Exclusions in Liability Insurance

Negligence - Professional liability and E&O policies cover some forms of negligence in the course of rendering professional duties. They do not cover criminal negligence, however, because criminal acts cannot be covered by insurance contracts.

Strict Liability - Strict liability may be covered by liability policies. Strict liability is a form of liability, which arises from product defect. It is not considered criminal liability.

Imputed Liability - Imputed liability is covered in employer liability insurance forms and in some professional liability forms where the insured has risks as an employer. A business owners policy form, the Employment-Related Practices form, is also available for this type of coverage. General liability forms provide some employer liability coverage, although liability for bodily injury and liability that is covered by Workers Compensation laws are excluded.

Legal Obligation for Damages - Liability policies pay only amounts to which the insurance applies and that the insured is legally obligated to pay. This obligation is determined through a court, or, under most policies, the insurer may settle a claim and establish outside a court of law the amount that the insured must pay.

Claims Expenses - Liability insurance also covers expenses related to liability claims such as defense expenses, payment of bail bonds and bonds to release attachments, loss of earnings, and interest on any judgment amount. These expenses all arise from the liability claim and are considered within the scope of the coverage. In some cases, these expenses are paid in addition to damages paid under the policy and are included as supplementary payments.

Damages - Liability insurance may cover compensatory or actual damages, nominal damages, general damages and possibly even punitive damages up to the limits of liability in the policy. If the policy does not cover certain types of damages, these damages will be listed as an exclusion within the policy terms.

In some cases, punitive damages may not be covered even if they are not specifically excluded in the contract. The reason for this is that the basis for punitive damages may be fraud, malice (which is by definition a willful act) or the commission of certain criminal acts. Insurance policies will not pay benefits for any act, which is fraudulent, willful or criminal. In certain states, punitive damages can be awarded without the plaintiff establishing fraudulent, willful or criminal conduct on the part of the defendant. If punitive damages are awarded in such a state and the damages are not based on fraud, or on a willful or criminal act; the insurer may pay them (up to the limits of the insurance and as long as the policy does not specifically exclude coverage of punitive damages). However, in states that require that fraud, malice or the commission of a criminal act be present in order for punitive damages to be applied, punitive damages would not be paid by the insurer, even if the policy terms do not specifically exclude punitive damages.

In some cases, courts have excluded punitive damages from insurance coverage because punitive damages are not for the benefit of the third party. They are awarded to punish the defendant. Since liability insurance is purchased for the benefit of the third party victim, and premiums are paid in order to compensate that victim, having insurers pay for them is against the purpose of the insurance. And, some courts have determined, if insurers are required to pay for punitive damages, premiums will rise for all, in effect causing innocent insureds to take the punishment for the guilty defendant. Punitive damages, then, may or may not be covered by a policy. If a client has questions regarding whether punitive damages are covered, the insurance company's legal department may be the best place to find an answer. However, there may not be a definitive answer until a claim is decided by a court of law.

Intentional Wrongs

Under the law, insurance is considered an instrument intended to pay for loss, which is fortuitous, or beyond the control of the insured. Therefore, generally, intentional wrongs are not covered by any insurance policy. However, in some cases, intentional acts are covered by liability insurance. For example, an insured dentist may intentionally remove a tooth from the mouth of a patient because she thought it was the correct tooth, when in fact she was mistaken. Or, an insured doctor may prescribe medicine intentionally, but make an error in doing so because the patient has an allergy to the medication. Wrongs such as these, which are intentional but are also mistakes, are generally covered by Professional Liability and Errors and Omissions insurance. In order to be excluded from coverage under these policies, courts generally have to find intent to cause harm. Intent to act is not alone sufficient reason to exclude a wrong from coverage.

Types of Liability Forms

There are three broad types of liability forms for businesses or professionals, other than automobile liability forms: General Liability, Business owners Liability and Professional Liability or Errors and Omissions forms.

Commercial General Liability Forms

Commercial General Liability forms cover bodily injury and property damage liability, personal and advertising injury liability and medical expenses incurred for bodily injury caused by an accident on or by the premises owned or rented by the insured, or that arise from the insured's operations. The definitions of bodily injury, property damage, personal injury and advertising injury provide an explanation of the coverage provided:

Bodily Injury

Under the Insurance Services Office, Inc., Commercial General Liability form, bodily injury means bodily injury, sickness or disease sustained by a person. Bodily injury includes death resulting from any of these at any time.

Property Damage

Under this same form, property damage means physical injury to tangible property, including all resulting loss of use of that property. Property damage also means loss of use of tangible property that is not physically injured.

Personal Injury

Personal injury is defined in this form as injury, other than bodily injury, that arises out of one or more of the following:

- False arrest, detention or imprisonment; • Malicious prosecution
- 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 that disparages a person's or organization's goods, products or services
- Oral or written publication of material that violates a person's right of privacy

Advertising Injury

Advertising injury is defined in the commercial general liability form as injury arising out of one or more of the following offenses:

1. 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
2. Oral or written publication of material that violates a person's right of privacy
3. Misappropriation of advertising ideas or style of doing business
4. Infringement of copyright, title or slogan

Notice that none of these injury definitions deal with economic damage.

Business owners Liability Form

The Business owners Liability form includes these same coverages, and defines them very similarly. This form also does not recognize coverage for economic damages. Both the Commercial General Liability and Business owners Liability forms can be endorsed to add other liability coverages. Commercial liability forms are available for pollution liability, liquor liability, railroad liability, and many other specific types of liability. Business owner Liability forms can also be endorsed to extend pollution liability coverage, covered tenants liability and many other types of liability coverage.

Professional Liability and Errors and Omissions Forms

The third type of liability insurance is Errors and Omissions and Professional Liability. As has been discussed this is the only type of liability form that meets the special liability needs of professionals.

Occupation Specific Coverage

Each professional liability form includes definitions and terms that are related specifically to the occupation of the professional insured. For example, the form may define professional services to mean "the services for which the insured is licensed, trained and qualified to perform in the insured's capacity as a [name of occupation]." The definition of the named insured will also typically refer to the specific occupation being covered, e.g. a lawyer's professional liability form might declare that "named insured means the lawyer named in the declarations."

Consent of the Insured

The terms Professional Liability and Errors and Omissions (E&O) are often used interchangeably to discuss liability insurance for professionals. There is a slight difference between the technical definitions of Professional Liability and E&O insurance, however. Under the strict definition of E&O insurance, an E&O's contract's provisions must state that the insurer is not required to have the insured's consent in order to settle a claim. Under a strictly defined professional liability insurance contract the insurer would have to have the insured's consent in order to settle any claim. In every other way, the two types of insurance are virtually indistinguishable from one another. The distinction regarding the insured's consent is not generally recognized by insurers today; many, if not most, "professional liability" policies allow the insurer to settle a claim without the insured's consent. (Because the two terms are commonly used interchangeably within the industry today, and because many policies, whether called Professional Liability or Errors & Omissions, allow the insurer to settle without the insured's consent, this course also uses either term to describe insurance that covers the liability risks of professionals).

Some policy forms give the insurer the right to remove itself from a claim if the insured will not accept a settlement to which the insurer and the plaintiff both agree. In such a situation, the insured will likely continue to defend himself or herself against the claim, but the insurer will pay no more to the insured once a damage award is set or a new settlement is agreed to than the settlement amount which the insurer had originally offered. This provision basically allows the insurer to change the limit of liability from the limits in the policy to the amount offered to settle the claim in question. Such a provision does give the insured a way to block the insurer from settling a claim without his or her consent and includes protection for the insurer because the insurer can limit its liability payments related to the claim.

Damages

Professional liability forms generally pay "damages" which the insured is legally obligated to pay because of a claim. Damages under a general liability form includes: damages arising from bodily injury, personal injury, advertising injury and property damage. The definition of damages under an E&O policy is broader and generally means monetary amounts for which the insured is legally liable, and includes amounts paid as judgments, awards or settlements.

Other Injury

If a professional liability form does not include a broad definition of damages, it will generally include a broad definition of injury in order to cover professional liability risks. General liability forms specifically cover liability for certain harms that are defined in the policy. These are bodily injury, property damage, personal injury and advertising injury. E&O forms that are based on general liability policies, or which are used as endorsements to general liability policies cover these four harms and cover liability for other injury that arises out of the rendering or failure to render professional services.

Occurrence

The definition of "occurrence" in a general liability form is normally similar to the following: an accident, including continuous or repeated exposure to substantially the same general harmful conditions. Under a professional liability form, any act or omission arising out of the rendering or failure to render professional services is included in the definition of occurrence.

Premises Liability

Regarding property damage, the general liability forms exclude liability for property damage arising out of property owned, rented or occupied by the insured, out of premises sold, given away or abandoned by the insured, out of property loaned to the insured, out of personal property in the care, custody or control of the insured, out of the part of real property on which the insured or any contractor or subcontractor working on the insured's behalf or out of part of any property that must be restored, repaired or replaced because the insured's "work" was incorrectly performed on it. Many professional liability forms do not exclude any of these forms of property damage, or offer it at an additional charge since a possible area of liability for a professional can occur when a customer is harmed on the insured's property, or on property the insured is occupying. This type of property damage liability coverage is known as premise liability.

Employee Liability

Bodily injury or personal injury that arises out of an employee's failure to provide professional services is excluded under general liability forms. Under an E&O form, bodily injury, personal injury, property damage, advertising injury or other injury is covered that arises out of an employee's rendering or failing to render professional services in connection with the insured's business.

Employment Practices Liability

Most professional liability forms exclude employment practices liability such as liability that arises out of actual or alleged termination or discrimination. In order to be covered for such liability the professional must purchase additional employment practices liability coverage.

Contractual Liability

Most contractual liability is excluded from liability forms for professionals. However, contractual liability protection can generally be added to coverage for additional premium.

License Protection Coverage

Some coverages of E&O insurance are applicable only to certain occupations. For example, some professionals are responsible to a board or commission that oversees the professional's actions. For example, a securities representative may be responsible to the SEC or the NASD. A doctor may be responsible to a medical board. A lawyer may be responsible to a state bar association. These professionals may be subject to discipline from these entities. Within professional liability forms for professions such as these, definitions related to disciplinary proceedings or hearings will be included. Some policies provide license protection or licensing board coverage, which includes reimbursement for expenses related to such disciplinary hearings, including defense expenses. In order for licensing board coverages to apply, the insured is generally required to notify the insurer in writing about the proceeding and to provide documentation of all expenses. The licensing board coverage may be indemnity coverage, meaning that the insured must pay the defense costs and be reimbursed by the insurer.

Insurability Under Professional Liability Forms

Liability insurance is different from other forms of insurance because the ability to forecast frequency and severity of claims is difficult. Life insurance issuers can use mortality tables along with health risk factors to establish insurability and premium charges. Property insurers have statistics regarding fires and other perils they can base their rates upon. Automobile property damage insurance relies on accident statistics by make and model of automobile to help establish rates. Liability risks are much more difficult to plot on a graph or include in a calculation. They do not establish a frequency distribution pattern like the other types of risks mentioned.

In order to determine insurability, professional liability underwriters look at 3 basic issues: (1) whether the applicant has a prior history of claims, (2) whether the applicant has a prior history of licensing board complaints or other disciplinary actions and (3) whether the applicant has ever been cancelled or been denied coverage. Coverage will not necessarily be denied if any of these factors are found to exist, but premium rates may be increased or exclusions added to the policy. Whether or not coverage is denied or premiums are increased depends upon the circumstances surrounding the complaint, claim or coverage denial. A complaint regarding the late filing of an advertisement to the NASD will be less significant to an insurer underwriting a securities rep than would a complaint regarding misrepresentation.

Claims Made vs. Occurrence Based Policies

Liability policies are offered as either "claims made" or "occurrence" based policies. These two terms refer to the conditions under which a policy will pay a claim, or what "triggers" the payment of benefits under the policy.

Occurrence Based Policies

Under an occurrence based policy, in order for the coverage to apply, the injury or damage must occur during the policy period. As long as the policy applies to the injury or damage, if the injury or damage occurs during the policy period, the policy will pay, even if the claim is made after the policy period ends.

All professional liability policies at one time were occurrence-based policies. However, not only have lawsuits become more prevalent since that time, resulting in more claims, but the subject of lawsuits has become more often about damage or injury that occurred years ago. Courts ruled that even though damage and injury occurred years ago, if damage was only just discovered, the occurrence-based insurance policies that were in force when the injury was discovered provided coverage. The increase in lawsuits and the fact that current occurrence based policies had to cover risks from years ago made occurrence based policies very expensive to purchase.

Claims Made Policies

Because of this, most professional liability policies issued today are claims made policies. Under a claims-made policy, both the damage or injury and the claim must be made during the policy period. Claims made policies help limit the insurer's exposure to injury and damage that occurred in the distant past because the claim must also be made during the policy period. An insurer has a fair degree of certainty that claims to which the coverage applies will be known while the policy is in force. The insurer can then review the risk annually and make premium adjustments based on the experience of the risk over the coverage year.

Claims made policies can have provisions for expanding the coverage period. They can be written with a retroactive date and/or an extended reporting period, or ERP. A retroactive date, typically a date no more than six months before the policy inception date, moves the policy coverage to that earlier date. Injury or damage that occurs before the retroactive date is not covered. Any injury or damage that occurs from the retroactive date until the policy coverage ends is covered, assuming the claim is made during the policy period. The retroactive date is sometimes referred to as a nose. An ERP extends the amount of time under which a claim may be made. ERPs may include two coverages: a relatively short mini tail and a longer midi tail. The mini tail provides an extended period of time, for example sixty days, to report claims that arise out of covered injury or damage that had not been reported during the policy period. The midi tail, which may be for a period of up to five years, gives an additional period to make claims that arise out of an occurrence that was reported during the policy period or during the mini tail period. ERPs may also provide just one tail coverage - one period of time to report claims for injury or damage that occurred during the policy period.

A Supplemental ERP can be purchased for some insurance that provides an unlimited period of time to report claims for an occurrence reported during the policy period. This is known as full tail coverage.

There are two ways to purchase full tail coverage. One way is known as a pre-paid tail. The charge for the tail is part of the annual premiums paid. The other way is to purchase the coverage purchases at the end of the policy period. Such coverage must normally be purchased while the policy is in force or within a limited time frame after the policy period ends. The price of full tail coverage varies.

Generally, however, the cost of a tail is from 175% to 250% of the last premium. The cost is higher for a tail because the likelihood of a claim is greater as time goes on. A benefit of many claims made policies is free full tail coverage upon death, permanent disability or permanent retirement.

Retroactive dates and extended reporting periods are generally purchased in order to remove any gaps in coverage when one policy replaces another. An ERP provides coverage on a policy which will be replaced if the new claims made coverage has an inception date or retroactive date later than the prior coverage's policy period ends. A retroactive date provides coverage from the new policy to cover the gap if the old policy ends prior to the new policy's inception date.

Group Professional Liability Insurance

Professional liability insurance can be provided on a group basis. Group policies are normally issued to a group of people in the similar or same business type who are subject to the same loss exposures. The advantages of buying a group policy are that premiums are likely to be lower than purchasing an individual policy and persons who may not be insurable under an individual policy may be insurable under a group policy. The reason for these two advantages: lower premium expense and insurability - can also be seen as a disadvantage. The reason group policies may provide lower premium and insure otherwise uninsurable risks is that the coverage under a group policy is normally more limited than that of an individual policy. Group policies also often have lower limits of liability than are found in individual policies. However, policy benefits vary, and a group policy may be equivalent to available individual forms.

Liability Insurance for a Legal Group

Professional insurance may be issued to a legally formed group, such as a corporation or a partnership of doctors, lawyers or other professionals. There are provisions in such policies which are not necessarily applicable to individual policies.

Severability

Severability means that each insured under the policy has his or her own liability limits. If several lawyers are covered under a policy with severability of limits, for example, and the policy has a five million per occurrence and twenty million total liability limits, each lawyer would be covered for \$5 million /\$20 million in liability.

Conditions for Coverage

In some cases, legal group coverage applies only if all members of the group carry their own individual liability policies as well. For example, a policy covering a partnership of doctors may require that each doctor carry malpractice insurance. If so, the policy issued to the group will normally apply as excess insurance over each doctor's own policy.

Premiums

Premiums for a legal group are generally calculated based on the number of professionals, independent contractors and staff to be covered by the policy. A policy may require that additional premium be paid immediately if an additional insured is added during the policy period. Other policies calculate the extra premium required at the end of the policy period.

Umbrella Liability Insurance and Excess Policies

Umbrella liability insurance is purchased to provide additional, high limit insurance that applies to liability for damages that arise from a suit or claim. These liability policies are called "umbrella liability

policies" because they provide broad coverage that encompasses many forms of liability and provide additional insurance over other insurance policies the insured owns.

In order to purchase an umbrella liability policy, the insured must already have general liability insurance. The insurer may also require other forms of liability insurance as well, such as automobile liability insurance. The requirements for underlying coverages depend upon the coverages the umbrella liability policy provides. This requirement is known as required underlying limits. The reason for this requirement is that umbrella insurance is structured to pay for damages as excess over underlying policies.

Premiums are calculated and provisions written based on this assumption. Umbrella policies generally include some coverage that is not found in underlying policies. For such coverage, the insured is required to pay for damages up to a certain amount, for example \$100,000, before the umbrella insurance will pay. This practice of requiring the insured to pay for damages related to coverages not provided by underlying policies is called self-insured retention. Self-insured retention acts as a sort of deductible on the policy.

Excess policies are similar to umbrella liability policies, but do not generally provide broader coverage than the underlying liability policies. Excess policies that offer additional coverage for the same kind of coverage as the underlying policy or policies are called following form policies. Since a following form policy does not provide any coverage not found in the underlying policy, no self-insured retention requirement is involved. Excess policies are also available which do not require underlying insurance, but include other insurance provisions that apply the coverage as excess over any other applicable coverage the insured owns.

Two types of payment clauses are found in umbrella liability policies. One is an indemnity clause, which states that the insurer will reimburse or indemnify the insured for amounts, which the insured becomes legally liable to pay or which are assumed under contract. The other is a pay on behalf clause, which states that the insurer will make direct payment on behalf of the insured for amounts, which the insured becomes legally liable to pay or which are assumed under contract. An umbrella policy or excess insurance policy can be an excellent complement to a professional liability policy if the professional is subject to high damage awards. Purchasing an umbrella or excess policy can be less expensive than purchasing an E&O policy with a high liability limit.

Summary

Liability insurance provides coverage against the risk that a lawsuit will be brought against the insured. Generally, the coverage protects against liability for acts resulting from the insured's negligence, but types of liability that do not require the presence of negligence, such as strict and imputed liability, may be covered. The basic types of liability forms available for businesses and business owners are commercial general liability forms, business owners liability forms and professional liability forms. Professional liability forms differ from the other type of business liability forms because they cover liability arising from rendering or failing to render professional services.

They are occupation specific forms and may include premises liability coverage, license protection coverage and coverages that apply only to the professional's occupation. Liability forms may be claims made or occurrence-based policies. Most E&O policies are claims made policies today. However, the ability to file claims after the policy period can be provided through adding an extended reporting period to the policy. The extended reporting period can be purchased with a length of several weeks, several years, or for an unlimited time period.

E&O & Professional Liability Forms

There are a wide variety of liability forms available for the professional. Some provide limited coverage provisions and others have broad coverage provisions. Generally, all professional liability and E&O forms include the following items:

- Coverage or Insuring Agreement
- Definitions
- Conditions
- Exclusions
- Limits of Liability
- Policy Period
- Coverage Extensions, if any
- Endorsements, if any

Insurance Services Office, Inc., which is a service organization to Property/Casualty insurers, creates and files many property/casualty insurance forms with the state Insurance Departments. Many insurers use the forms as created, or customize them for their own use. ISO's professional liability forms are generally endorsements to their Commercial General Liability policies or their Business owners Liability policies. Because the ISO forms are widely used, this course will refer to them from time to time, particularly the Business owners Liability Coverage Form along with various Professional Liability endorsements from ISO. The Business owners Liability form is very similar to the Commercial General Liability form from ISO. Professional liability forms are generally available in two ways - as an endorsement to a commercial general liability or business owners liability form or as policies, which stand alone or are not an endorsement to any other liability form.

Coverage or Insuring Agreement

Basically, the insuring agreement of a professional liability form states that the insurer will pay the sums that the insured becomes legally obligated to pay because of damages" or "claims" that arise out of acts, errors, omissions or negligence of the insured. Some forms state that the insurer will pay for damages because of "bodily injury," "property damage," "personal injury," "advertising injury" or "other injury," that arise out of the rendering or failure to render professional services in connection with [occupation description].

If the policy is a claims made policy, as many professional liability forms are, the insuring agreement will normally include stipulations that the coverage applies only if the damage or injury results from a claim that is first made against the insured during the policy period and based on any injury or damage that occurred during the policy period, including any applicable retroactive date. If any ERP is provided in the coverage, the form will state that the claim cannot be made later than the time period the ERP encompasses in order for coverage to apply.

Another important part of the insuring agreement or the conditions of a policy is that the insured must have had no prior knowledge before the effective date of the policy that any act, omission or error could result in the claim in order for the coverage to apply. Some policies include language to the effect that the insured could not have foreseen that any act, omission or error could result in a claim in order for coverage to apply. Such language places a serious responsibility upon the insured to disclose, at the time of policy application, any acts, omissions or errors he or she is aware of that

could result in a claim. If this information is not disclosed, the insurer may not cover damages that result from such acts, errors or omissions. Depending on the circumstances, the insurer may cancel coverage if the insured did not properly disclose such information.

Definitions

The definitions within the policy vary depending on the type of occupation the form covers. Some of these occupation-specific definitions will be discussed later in the chapter when types of professional liability and E&O forms are covered. Definitions, which are commonly found in professional liability forms, regardless of what occupation is being covered, are discussed below:

Claim

Generally, a claim is defined to mean a notice that is received by an insured from a person or entity that advises that the person's or entity's intention is to hold the insured liable for damages or injury covered by the insurance. A claim can include a demand for money or services and the serving of a suit. Some forms include the institution of arbitration proceedings in the definition of a claim.

Claim or Suit Expenses

Liability forms for professionals generally pay for various expenses related to claims or suits. The expenses included in policy coverage normally are:

- All reasonable expenses related to investigating and defending the suit or claim
- All costs taxed against the insured in any suit to which the insurance applies
- Interest that accrues on the full amount of any judgment after the entry of any judgment and before the insurer has paid, or offered, or deposited in court the amount of judgment that is within the policy's limits of liability or limits of insurance
- Premiums on appeal bonds and premiums on bonds needed to release attachments, up to the specified limit in the policy
- Reasonable and necessary expenses the insurer asked the insured to incur related to the investigation or defense of a claim or suit. Some policies include loss of earnings as a reasonable and necessary expense and other policies exclude from payment loss of earnings.

Damages

Damages are generally defined to mean a monetary judgment determined by a court of law or due under a settlement. They may include an arbitration awards as well. Exclusions from damages commonly included in the policy are:

- Punitive damages
- Fines
- Penalties
- Restitution of fees, profits or charges for services rendered
- Any judgments of damages that are not insurable

Advertising Injury

Forms, such as Business owners Liability Forms with Professional Liability endorsements from Insurance Services Offices, which include a definition of advertising injury, generally define it to mean injury that arises out of one or more of the following:

- Oral or written publication of material that slanders or libels a person or entity or disparages goods, products or services of a person or organization
- Oral or written publication of material that is in violation of a person's right to privacy
- Infringement of copyright, title or slogan

Bodily Injury

Bodily injury is defined in the business owners professional liability forms to mean bodily injury, sickness or disease, including death that is sustained by a person.

Personal Injury

Personal injury is defined to mean injury other than bodily injury that arises out of:

- False arrest, detention, or imprisonment
- Malicious prosecution
- 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 that disparages a person's or organization's goods, products or services
- Oral or written publication of material that violates the right to privacy of a person

Property Damage

Property damage is defined in the business owners liability forms to mean physical injury to tangible property, including all loss of use of the property or loss of use of tangible property that is not physically injured.

Insured

The insured is generally defined to include the named insured; the spouse of the named insured in certain cases; principals, partners, executive officers, directors, stockholders, or trustees if acting on behalf of the named insured within the scope of their respective duties; the executor or legal representative of the insured; and any predecessor in interest. Employees may also be covered for rendering or failure to render professional services in connection with the insured's business.

Coverage Territory

Some professional liability forms provide worldwide coverage. Others limit the coverage territory to the United States, Puerto Rico and Canada. Still others provide some form of limited worldwide coverage in addition to coverage in the US. Worldwide coverage is often available as an additional coverage to professional liability policies if the insured desires to purchase it.

Consent of the Insured

If the policy requires the consent of the insured to settle a claim, the language usually includes a condition that the consent may not be unreasonably withheld. The policy may also state that if the insured does not give consent to a settlement approved by both the insurer and the plaintiff or claimant, the insurer's liability related to the claim or suit will not exceed the amount the insurer would have been liable for should the insured have approved the settlement. If the form does not require the consent of the insured, the policy language will give the insurer the right to settle any claim or suit.

Professional Services

The definition of professional services is the definition which limits the coverage to services related to the occupation covered. For example, a form covering a lawyer would include in professional services items such as acting as an attorney, a notary public, a conservator, a trustee, and so on. A form covering an architect would include services as an architect, and might specifically include landscape architecture or other types of architecture. An accountant's form might include services such as bookkeeping, tax preparation, and similar services in addition to accounting services.

Occurrence

Liability forms may use the definition of occurrence to describe the trigger for a claim or suit, or may use the term "wrongful act" or use "incident," as in "medical incident." An occurrence in professional liability or E&O form is defined to mean an accident, including continuous or repeated exposure to substantially the same general harmful conditions and will include acts or omissions that arise out of the rendering of or failure to render services as a [name of occupation.]

If the term wrongful act is used it will be defined using terms such as any error, act, omission, neglect, or breach of duty actually or alleged to have been committed or attempted by an insured. Such acts, of course, must be in the course of performing professional services. Forms using the definition of an incident commonly use language similar to those used in the wrongful act definition - any act, error, or omission in the insured's rendering or failure to render professional services.

Complaint

If a form includes licensing board coverage or similar coverage, terms related to this coverage will also be defined. A complaint may be defined as the official documentation that is required by the licensing board or other entity that regulates the insured's professional activities and conduct.

Hearing, Professional Review or Proceeding

Also related to licensing board coverage, the form may need to define the various types of proceedings that the board may undertake and for which the insurer will pay defense expenses.

Premises

If premises liability coverage is provided, the form will include a definition of premises. Premises are generally defined to be the location that is stated on the declarations or certificate of insurance, approaches that adjoin the premises, and may include additional locations that are used by the insured for professional purposes as long as the insurer is notified of the additional locations at application or within a specified time frame stated in the form.

Product

Not all E&O forms include a product definition, since many professions do not include a product in any way, but rather are services only. In those forms which include coverage for liability related to an insured's product, product is defined to mean any good or product, other than real property, that is manufactured by the insured, those trading under the insured's name or a person or organization whose business or assets the insured had acquired. Containers, materials, parts or equipment that are furnished in connection with the product are also included in the product definition.

Policies vary as to whether they also cover products sold and distributed by the insured. If selling and distribution of product is excluded, it is normally because the professional covered would normally provide the product as part of his or her professional services, not as a retailer or wholesaler. If included, it is normally because selling or distributing the product is a minor part of the professional's occupation, again, not because the professional is a retailer or wholesaler.

True retail and wholesale risks are covered by other types of liability forms. The product definition often includes any warranty or representation made by the insured regarding the fitness, quality, durability, performance or use of the product and the providing of or failure to provide warnings or instructions related to the product.

Work

Work means work or operations performed by the insured, or on behalf of the insured and materials, parts or equipment that is furnished in connection with the work. It also generally includes warranties or representations regarding the fitness, quality, durability, performance or use of the product and the providing of or failure to provide warnings or instructions related to the product.

Employee

An employee is generally defined to exclude temporary workers.

Policy Conditions

Bankruptcy

Bankruptcy or insolvency on the part of the insured does not relieve the insurer of its responsibilities under the policy. Bankruptcy generally relieves an insured of debts. Under bankruptcy rules, an insured would therefore not be responsible for damages awarded under a lawsuit. However, several years ago many state legislatures decided that a liability insurer should pay harmed third parties even if an insured declared bankruptcy.

State legislatures felt the third party should be able to collect damages and believed that since the insurance was paid for, the insurer should pay regardless of the bankruptcy. As more and more states adopted such legislation, insurers began making this bankruptcy condition a part of their liability policies, and today this clause is standard.

No Action Against the Insurer

The no action against the insurer condition provides the terms under which an insured can be paid by the insurer. If the policy states that no action can be made against the insurer until the insured has

paid a third party an amount fixed by a final judgment or an agreement between the insured, the third party and the insurer, the policy is actually an indemnity policy, not a liability policy.

Indemnity policies pay back the insured after the insured pays for the damages. If the no action against the insured clause states that no action can be made against the insurer until the amount of the insured's obligation to pay has been determined by a judgment after a trial or by an agreement between the insured, the third party and the insurer, the policy is a liability policy. It pays once the amount of liability is established.

Duties in the Event of A Claim

The duties of the insured in the event of a claim are generally quite extensive. This is understandable since an insurer normally will be defending the insured and/or working on a settlement, so needs a lot of information as early as possible in order to do so. Common duties included under professional liability policies include notifying the insurer as soon as possible in writing of any claim or if the insured has reason to believe there will be a claim. The written notice should include:

- The names and addresses of any injured persons or witnesses
- The nature and location of any injury or damage arising out of the occurrence or offense
- The act, error, omission, injury or circumstances that caused the claim or likelihood of claim
- How, when and where the occurrence, act or incident took place
- The injury or damage that occurred and/or may occur from the act

The insured must also immediately send the insurer copies of any demands, notices, summonses or other legal papers that are received regarding the claim or suit. Additionally, the insured generally must authorize the insurer to obtain records and other information related to the claim, cooperate with the insurer in the investigation, settlement or defense against the suit, and assist the insurer in the enforcement of any right against any person or organization that may be liable to the insured because of injury or damage to which the insurance applies.

Subrogation

Subrogation is the legal term for the process through which an insurer is able to recover damages from the party liable for damages once the insurer has paid an insured or other claimant. A typical subrogation clause states that the insurer will be subrogated to the insured's right of recovery related to any payment the insurer has made. To subrogate means "to substitute." The insurer's right to recover damages is substituted for the insured's right to the damages since the insurer paid damages on behalf of the insured.

There are five legal elements to the concept of subrogation:

1. The party, e.g. the insurer, who claims the right of subrogation must first pay the debt
2. The party who claims the right of subrogation is not a volunteer, but has a legal obligation to pay the debt
3. The party who claims the right of subrogation is secondarily liable for the debt - in the case of liability insurance, the insurer is secondarily responsible
4. A third party is primarily liable for the debt
5. No injustice may result by allowing the right of subrogation to the party

Regarding point 4, the third party who is primarily liable is the person or entity from whom the insurer seeks to recover payment. For example, in the case of a suit involving contributory negligence, the insurer may seek to recover damages from a third party who contributed to the loss or damage for which the insurer paid.

Subrogation is important because of the service it performs for all parties involved in a claim or suit:

- The process results in the party who is liable for damages or loss to be held responsible
- By being able to recapture certain losses, an insurer is able to keep premiums lower than if such recovery was not possible
- Since the insurer recovers the payment, not the insured or the plaintiff in the suit, payment is made to the rightful party

Cancellation

Cancellation rules vary by state - some states mandate the number of days of notice the insurer must give the insured and vice-versa in order for a policy to be cancelled. The period of time between notice and actual cancellation may also be regulated by state law. A standard cancellation condition will generally state that the named insured can cancel the policy at any time. In order to cancel the policy, the insured must return the policy to the insurer or its representative and mail the insurer a written notice of the cancellation and when it will be effective. In order for the insurer to cancel the policy, the insurer must mail the insured a notice at the address shown in the declarations not less than a certain number of days, normally 30 or 60, before the cancellation becomes effective. If the policy is being cancelled for non-payment of premium, the notice can normally be mailed 10 days before the cancellation becomes effective.

If the policy is cancelled, any premium refund due is paid on a pro-rata basis. If the policy is cancelled by the insured, the policy may state that the premium refund will be calculated on a short rate basis. Calculating premium under the short rate basis allows the company to recoup some expenses related to the issue and administration of the policy.

Other Insurance

The condition related to other insurance explains how the insurance will be applied if other insurance is in force regarding the same occurrence or incident. Generally, liability policies state that the coverage will apply as excess, unless other insurance is written as specific insurance over the limits of liability in the policy, as an excess or umbrella policy may be.

Concealment or Fraud

If the insured intentionally conceals or misrepresents any material fact or circumstance relating to the insurance, the insurer will cancel the policy or it will be voided. This includes knowingly notifying the insurer of any fraudulent or false claim against the policy.

Assignment

No assignment of a policy can be made without the insurer's consent. Assignment does not include an executor or other legal representative acting as the named insured if the named insured dies. An executor or other legal representative will be treated as the named insured in such a circumstance.

Inspection and Audit

Under some policies, the insurer has the right to inspect the insured's property and operations at any time. If such an inspection is done, the insurer does not warrant that the property or operations inspected are safe or healthful, or are in compliance with any law, rule or regulation.

A policy may also give the insurer the right to examine and audit the insured's books and records at any time while the policy is in force. The insurer may also have the right to perform such an audit regarding the insurance up to a specified time frame after the policy has terminated.

Liberalization Clause

Some policies include a liberalization clause. Under a liberalization clause, if the insurer submits to a state insurance department a filing that results in extending or broadening the insurance either by endorsement or by substituting a policy form, and the broader coverage does not require additional premium, and the filing is approved while the policy has been in force, or within a specified number of days, e.g. 45, prior to its inception, the benefit of the extended or broadened insurance will apply to the insured as though the endorsement or substitution were a part of the policy.

Separation of Insureds

If the policy includes a separation of insured provision, the insurance applies as if each named insured were the only named insured and separately to each insured against whom a claim or suit is brought, up to the limits of insurance in the policy. A separation of insureds provision is important in a situation where there are covered employees, partners or executives in addition to the named insured.

Changes

Policies state that the terms of the insurance may not be waived, changed or modified except by endorsement issued or as otherwise agreed to in writing by the insurer.

Premium

A variety of premium programs are available for professional liability policies. Some policies charge an annual premium, which is adjusted based on experience each policy period. Others use a stepped-up premium program. Under such a program, premium increases incrementally over a specified period of time, for example five years. After the end of the specified period, the annual premium amount remains relatively stable, unless a change of risk occurs.

Exclusions

Some liability forms include many exclusions and some include only a few. The number of exclusions depends on the insuring agreement and conditions - if the insuring agreement is broad, there will generally be many exclusions. If a policy's insuring agreement and conditions provide a more narrow scope of coverage, there tend to be few exclusions.

Expected or Intended Injury

Expected or intended injury is excluded from E&O and professional liability forms.

Dishonest Acts

Also excluded, either by a stated exclusion or because of accepted insurance law, are acts, errors, omissions and personal injuries that arise out of dishonest, fraudulent, criminal or malicious intent.

Contractual Liability

Contractual liability is liability assumed under a contract. Contractual liability is generally excluded under professional liability forms, although additional coverage or endorsements can be used to provide contractual liability under a professional liability policy; this coverage is being included as standard coverage in more and more forms. Under some forms, certain types of contractual liability are not excluded. The business owners form covers bodily injury and property damage arising from contractual liability assumed under an insured contract. An insured contract is defined to mean items such as a contract for a lease of premises, a sidetrack agreement, any easement or license agreement, any elevator maintenance and other specifically mentioned contracts.

Other forms do not include liability assumed under an insured contract. Generally all forms include liability, which would have existed even if the insured had not assumed the liability under a contractual agreement. A professional may need contractual liability coverage. For example, if a doctor or other medical professional works for a managed care organization or other health care organization, the organization often includes in its contract with the doctor that the doctor must assume liability for any claims against the doctor which also result in a claim against the health care organization.

Workers Compensation and Similar Laws

E&O and professional liability forms generally exclude liability which the insured has under any workers' compensation, unemployment compensation, employers liability, disability benefits or other similar law. Businesses can purchase workers compensation insurance to cover such liability.

Employer's Liability

Employer's liability protects an employer against claims arising out of acts of an employee while acting within the employee's scope of duties. Employer's liability is sometimes also called vicarious liability when used to describe coverage under a liability form. Vicarious liability actually encompasses the insured's liability for acts of any other party, not just for employees. Under some forms, employer's liability for bodily injury to an employee while in the employ of the insured and carrying out duties related to the conduct of the insured's business is excluded. Other forms include such coverage. Employer's liability or vicarious liability is based on the legal principle of Respondent Superior. This principle is based on the idea that the employer, or under the original principle, the "Master," is responsible for damages arising out of the actions of the employee, or under older laws, the "Servant." Under this principle, if injury or damage arises out of the employee's scope of duties, the employer is generally liable. This is the case even if an employee seeks to conceal damage or injury or the actions leading up to such damage or injury from the employer, because the employer should have oversight processes in place.

A professional may need vicarious liability coverage for claims arising from acts of employees and other professionals within a group. When professionals establish a group, the law recognizes an association between the parties within the group and may hold one party liable for another party's

action. If a professional needs employer's liability coverage for such items and it is not included in a liability form, additional coverage can generally be purchased to cover this risk.

Employment Practices Liability

Employment practices liability coverage protects against liability for actions arising from activities as an employer. Specifically, it covers damage and injury that arise out of discrimination, wrongful termination, failure to promote, sexual harassment or out of a complaint filed with the EEOC. In order to file a complaint with the EEOC, an employee must be employed by an employer with 15 or more employees. The employee files the complaint directly with the EEOC; the employee does not need an attorney to file the complaint. The EEOC will attempt to resolve the situation with the employer. If it cannot be resolved to the EEOC's satisfaction, the EEOC will sue the employer in federal court, or provide the employee with a "right to sue" letter, which allows the employee to sue the employer in federal court. Typically, an attorney representing the employee will work on a contingency basis, because the plaintiff, if found liable, will be responsible for the employee's attorney costs. Like other optional coverages, employment practices liability is generally available with the payment of additional premium if such coverage is not part of the basic professional liability form purchased by the insured.

Fiduciary Liability

Also excluded from some E&O and professional liability forms is fiduciary liability. The responsibilities of fiduciaries were discussed earlier in this course. Because of the special exposures of fiduciaries, liability for acts as a fiduciary may be excluded under a form. There are special E&O forms for fiduciaries which may be purchased. If fiduciary liability is excluded, the exclusion will generally be worded similarly to the following:

"This insurance does not apply to claims arising from the insured's capacity as a fiduciary or representative capacity."

Claims by Insureds against another Insured

Liability forms do not cover claims by an insured against another insured. This is one reason why many firms require each professional to carry his or her own liability policy.

Certain Damages

Fines, penalties, punitive or exemplary damages are excluded from coverage under many E&O forms. Damages, which are a multiple of compensatory damages, may be excluded as well. Some forms allow the paying of damages which are multiples of compensatory damages if the claim is for libel or slander.

Securities Transactions

Some forms, such as those for lawyers or accountants, exclude coverage for claims that arise out of giving advice regarding the purchase or sale of securities or other investments. Other exclusions related to securities transactions exclude claims that arise out of acts, errors, omissions or personal injury involving any security or any transactions subject to the Securities Act of 1933, the Securities Exchange Act of 1934, the Public Utility Holding Company Act of 1935, the Trust Indenture Act of 1939, the Investment Company Act of 1940, or the Investment Advisors Act of 1940. All these Acts regulate various types of securities transactions and securities advisors. Any purchase, sale or

offering of a security subject to any state Blue Sky or Securities law may also be excluded. "Blue Sky" rules require state registration and in some cases, licensing, for securities representatives.

Sexual Impropriety Allegations

Some professional liability forms, such as those for doctors or psychologists, include an exclusion for claims that involve sexual impropriety allegations. Some actual cases of such impropriety have been highly publicized and have resulted in large damage awards, so some insurers are unwilling to assume this risk.

Certain Personal or Advertising Injury

Certain types of personal and advertising injury are excluded under the business owners forms. In other forms, similar exclusions are generally included, although they may be stated as exclusions to covered claims. These common exclusions include personal injury or advertising injury:

- That arises out of oral or written publication of material which publication the insured directed or did with knowledge that it was false
- That arises out of oral or written publication of material that was first published before the beginning of the policy period
- That arises out of the willful violation of a penal statute or ordinance committed by or with the consent of the insured

Regarding personal injury or advertising injury that arises out of oral or written publication of material that was first published before the beginning of the policy period: prior acts may or may not be covered by professional liability policies. Generally, if included, prior acts coverage would also exclude those acts that the insured knew or could reasonably have known could result in a claim, or simply exclude those that the insured knew could result in a claim. Prior acts coverage can often be added to a policy's coverage if it is excluded.

Advertising injury is excluded from the business owners forms if it arises out of:

- Breach of contract, other than the misappropriation of advertising ideas under an implied contract
- The failure of goods, products or services to meet advertised quality or performance
- The wrong description of the price of goods, products or services

Certain Bodily Injury

Bodily injury to any insured is not covered by a professional liability policy. Such coverage is generally provided through workers compensation insurance. Bodily injury to a person while taking part in athletics is also generally excluded. Finally, bodily injury due to war is excluded. War is generally defined to include civil war, insurrection, rebellion or revolution.

Limits of Liability

The limits of liability clause of a policy generally includes four parts - an each occurrence or each claim limit, an aggregate limit of liability, a deductible amount and the application of the liability limits to multiple insureds, occurrences or claims. The limit for each occurrence or claim is the most the policy will pay for covered damages and injury related to one claim or one occurrence.

The aggregate limit of liability is the most the policy will pay for all claims or occurrences made in one policy period, plus any extended reporting period if applicable. The deductible amount is generally applicable to each claim or occurrence. If more than one insured is involved in the making of a claim, or if more than one claim or suit is brought, or there are multiple persons or entities involved in making the claim, the limits of liability of the policy will not be increased.

Policy Period

The policy period is generally annual. However, the policy period may be extended through the use of a retroactive date under a claims made policy. The policy period will appear in the declarations of the policy. If a retroactive date applies, both the retroactive date and the policy period will be stated.

Coverage Extensions

Coverage extensions are coverages which are added to a policy which may have different limits of liability from the other coverages in the policy. A wide variety of extensions to liability coverages are available. Coverage extensions can be made to add worldwide coverage, additional locations, additional insureds, pollution liability, licensing board coverage and more.

Endorsements

Many endorsements may be made to professional liability policies. Endorsements may be used to add contractual liability coverage, premises liability coverage, employers liability coverage, a deductible, additional insureds, additional locations and many other coverages. Endorsements can also be used to exclude certain risks. For example, an insurer may exclude a specific coverage or may exclude claims related to certain activities, which are seen as too risky to insure.

Premium Discounts

Professional liability and E&O forms offer premium discounts in various forms. Some of the discount programs available offer significant premium savings.

Prepayment Discount

Some insurers offer a premium discount if premiums are prepaid. For example, if an insured pays for two years of premium, a 10% discount may apply.

New Business Discount

A new business may qualify for a discount for the first few years of coverage. The likelihood of claims grows as time goes on, so the insurer can charge lower rates in the early years. An insurer may offer a 75% discount for the first year, a 50% discount for the second year, a 25% discount in the third, and thereafter charge the professional the normal premium rate.

Continuing Education Discount

Some professionals are required to take or have available to them continuing education courses. Some insurers reduce premium if a certain number of continuing education courses are taken.

Use of Contractual Liability Language

Insurers may reduce premium for certain loss control measures. One loss control method that may reduce premium is the use of language in contracts, which limits liability. The insurer provides sample language to the professional to be used in contracts, and/or the insured provides the insurer with proof that contractual language limits liability.

Peer Review

Some professions are subject to peer review boards. As another incentive to institute loss control measures, some insurers will reimburse the insured the cost of a peer review. At least one insurer reimburses 50% for the cost of the review upon receiving verification of the peer review and the other 50% at policy renewal.

Alternative Dispute Resolution Methods

If an insured uses alternative dispute resolution methods, such as mediation, some insurers will reimburse premium. Since alternative dispute resolution can provide substantial savings over the cost of defending a case in court, the premium reimbursement can be substantial, as much as 50% of the annual premium.

Temporary Disability

Some policies will reduce premium if the professional is temporarily disabled. For example, if a professional is disabled for thirty days or more, premium will be reduced for up to six months, or as long as the disability lasts, whichever is shorter.

Risk Management

Besides offering premium discounts for loss control measures, some insurers who specialize in professional liability for certain occupations offer risk management tools, which will help insureds control losses. For example, the insurer may have self-assessment tools, which provide a method for the insured to evaluate exposures. These tools often include suggested procedures to implement to help reduce any exposures found.

In addition to self-assessment tools, some insurers give presentations and seminars which educate insureds on important loss exposures found in their occupation and also provide information to reduce such exposure. Insurers may offer these seminars as a benefit to their customers at no charge. Some insurers require attendance at these presentations and hold them all over the US.

Retirement Benefits

Some claims made policies include retirement benefits. These can include no-cost tail coverage if the insured has been covered by the insurer for a specified period, for example for five years. Some policies also offer continuous coverage on an occurrence basis upon retirement.

Insured's Duties in the Event of Occurrence, Claim or Suit

In the event of an "occurrence:"

- The insured must notify the insurer as soon as practicable of an "occurrence" or an offense which may result in a claim. The notice should include:
 - How, when and where the "occurrence" or offense took place;
 - The names and addresses of any injured persons and witnesses; and
 - The nature and location of any injury or damage arising out of the "occurrence" or offense.
- If a claim is made or "suit" is brought against any insured, the insured must immediately record the specifics of the claim or "suit" and the date received and notify the insurer of the claim or suit as soon as practicable.
- The insured must see to it that the insurer receives written notice of the claim or "suit" as soon as practicable.
- The named insured and any other involved insured must immediately send the insurer copies of any demands, notices, summonses or legal papers received in connection with the "suit," authorize the insurer to obtain records and other information and cooperate with the insurer in the investigation or settlement of the claim or defense against the "suit." The insured(s) must assist the insurer in the enforcement of any right against any person or organization which may be liable to the insured because of injury or damage covered by the insurance.
- The insured, except at that insured's own cost, is not to voluntarily make a payment, assume any obligation, or incur any expense, other than for first aid, without the insurer's consent.

Separation of Insureds

The insurance applies as if each named insured were the only named insured and separately to each insured against whom a claim or suit is brought, up to the limits of insurance in the policy.

Summary

E&O and Professional Liability policies all include an insuring agreement, definitions, conditions, and exclusions. They may also provide extended coverages or be attached by endorsements. The policies may offer many coverages, including employer liability, licensing board protection, contractual liability and more, or they may provide more limited coverages. Some insurers offer many additional benefits, such as premium discounts and special risk management tools.

Agents & Brokers E&O Insurance

Insurance agents perform many duties, which can expose them to lawsuits for acts, errors, omissions or negligence in performing professional services. Agents advise clients on types and amounts of coverages needed, provide explanations regarding policy features, benefits and contractual terms, respond to client communications, process requests for changes in coverage, and process renewals among other duties. Each of these functions can result in a liability claim. Insurance Agents and Brokers Errors & Omissions insurance generally covers the activities of insurance agents, insurance brokers, insurance consultants, managing general agents and notaries public. Most available forms are claims made. A common each-claim limit of liability for these policies is \$1,000,000. Some forms base limits of liability on the amount of annual revenue the agent earns.

Exclusions, which may be included in Insurance Agents and Brokers E&O, are:

- Insurer insolvency, receivership, bankruptcy, liquidation or financial inability to pay
- Promises or guarantees as to interest rates or fluctuation of interest rates, the market value of any product sold, economic forecasts, or the level of future premium payments
- Acting as a fiduciary as defined under ERISA

- Acting as a trustee
- Violation of rules and regulation of securities regulators
- Violation of the provisions of COBRA
- Discrimination or unfair competition
- Licensing board coverage
- Violations of RICO
- Structured settlement placements

Coverages, which may be important to an agent to add to an E&O policy, are prior-acts coverage, licensing board coverage, carrier solvency coverage and first dollar defense coverage (which pays for the attorney's fees from the first dollar, after any applicable deductible). Another important feature to consider is whether the insurance covers defense expenses within the limits of the policy liability, or if defense is paid for in addition to the limits of liability, as a supplementary payment.

If defense is paid for as a supplementary payment, the limit of liability on the policy can be used for paying damage awards. If not, the amount available for paying damage awards may be significantly eroded by the paying for defense costs. Another important feature of the form is whether the insurer has the "right and duty to defend" the insured under the policy, or has the "option to defend" the insured. If the policy states that the insurer has the "right and duty to defend," the insurer will defend insured against any covered claim.

Agent Liability Risks

Lawsuits against agents generally involve inadequate coverage and accusations of agent misrepresentation. These areas represent the two greatest liability risks for the agent. Other related risks include errors or omissions during the application process, slow response time, mishandling of customer complaints, lack of documentation, and insolvency on the part of the insurer.

Application Errors and Omissions

The application provides the basis for the insurer to decide to accept or deny a case and to determine the amount of premium to charge for the policy. The agent can cause gaps in coverage or inappropriate coverage to be issued by not taking care to obtain complete information on the application. For example, suppose a psychologist performed services once a month at a free clinic and was not fully covered by the liability insurance purchased by the clinic.

The psychologist mentions to the agent that she works at the free clinic, the agent jots down a note to remind herself to pull and fill out the appropriate attachments to the application, but forgets to do so and omits this information from the application package. Later, the psychologist is sued by a patient from the clinic and sues the agent because the agent sold her inadequate coverage. Whenever the application is not completed to disclose the risk associated with the applicant appropriately, the potential for a lawsuit exists.

Lack of Documentation

If a claim is made or suit is filed against an agent, the agent will need documentation to make a defense against the claim. Information in a customer file may show that the client was offered adequate coverage, was properly informed of policy features and was responded to promptly. If such documentation is not kept, the agent may not be able to demonstrate his or her lack of liability.

Mishandling Customer Complaints

No customer call or communication can be ignored or not responded to without incurring a liability risk. Not returning calls from a time-consuming, "pesky" customer can cause problems for the agent, and may result in the agent not taking care of a legitimate need or concern of the customer. Each call, whether a complaint or inquiry, must be handled in a professional, timely manner.

Other mistakes in handling customer complaints may be not taking them seriously, not taking steps to remedy them, not informing the managing agent and insurer of the problem, or promising to follow-up with the customer and not doing so. Complaints can escalate into lawsuits if not handled carefully.

Slow Response Time

In addition to providing a timely response to complaints, the agent must respond to other customer needs such as change requests, additions to coverage and claims, in a timely fashion. Slow responses can cause an agent to be susceptible to liability for harm that comes from the delay. For example, assume a customer is going to take an extended trip around the world and requires special property insurance for certain valuables that will be going with him.

If the agent delays in processing required forms, the customer may leave the country without the needed coverage. If anything happens to the property and it is not covered, the customer would have reason to sue the agent.

Insurer Insolvency

The agent may be waited against if an insurer he or she represents becomes insolvent. The customer may argue the agent should have performed more due diligence regarding the insurer's solvency before placing business with it, or should have been aware that the insurer was having financial problems and should have replaced the client's coverage before the insolvency occurred.

Inadequate Coverage

As mentioned, inadequate coverage is the basis of many of the lawsuits filed against agents. Inadequate coverage can occur due to omissions in the application or not responding to or being slow to respond to customer communications. Lack of knowledge and expertise on the part of the agent can also result in inadequate coverage. If the agent cannot recognize risks and loss exposures, the agent will not be able to offer appropriate insurance products to cover them.

If the agent does not fully understand the coverages in the insurance offered, the agent cannot be sure the customer has all the protection the customer needs. Lack of follow-up and insurance reviews can also cause inadequate coverage. Agents must regularly review their customer's coverages to make sure appropriate types and amounts of insurance are in force.

Misrepresentation

Misrepresentation of a policy's coverage is the other leading cause of liability suits brought against agents. Misrepresentations can occur during prospecting, during a sales presentation, during the application process, while responding to questions over the phone - virtually any time there is communication between the client and the agent. Remember that courts are recognizing oral statements made, not just the written contract, as grounds for tort action.

Reducing Liability Risks

By concentrating on reducing liability risks, the agent not only protects himself or herself, but also can increase customer satisfaction and develop positive organizational and professional skills. Purchasing insurance will transfer risk to the insurer, but reducing exposure is the best approach to liability risks.

Client Information Forms

One of the methods used to reduce liability exposure is the use of client information forms. Such a form includes a thorough questionnaire, which can be used to determine insurance needs. Agents can complete the forms for each new customer and for existing clients at policy renewal. Client information forms are available through software programs, some of which do not allow for altering information, which can be helpful when creating a document trail for each customer.

Using standardized client information forms rather than just taking notes about the customer can help to ensure that all important questions are asked before any coverage is suggested. By using the form with every customer, the agent may be able to establish that reasonable care was taken should a claim or suit arise. A benefit to using a client information form at policy renewal is that changes in coverage are usually made by the insurer at renewal. The insured may be subject to more limited coverage terms at this time and may need to purchase additional coverage. Or, new coverages may have been added. Faithfully reviewing coverage at policy renewal will help keep a customer from being surprised and angry when a claim arises that the customer thought would be covered.

Documentation

Implementing and maintaining procedures for compiling and keeping critical documentation can also reduce liability risks. One type of documentation, which should be kept is that surrounding coverage discussions. In addition to any completed client information forms, the agent should make notes regarding coverage inquiries made by an insured or applicant, coverage suggestions made by the agent and notes regarding any action taken or to be taken as a result of the discussion. If any decisions were reached during the conversation, the agent should follow up with written correspondence confirming the decision.

Another documentation-related safeguard is the requiring of clients to sign a statement if they opt to decline suggested coverage. These declination statements should be kept on file. By having the signed statement on hand, the agent will be able to demonstrate that the insurance was offered to the client if the client alleges inadequate coverage was the fault of the agent. Documentation of client communications should also be kept. Customer mail, telephone calls, faxes, e-mail and voice mail should all be documented and kept in the customer file. E-mails should be printed from the computer and placed in the file. Written correspondence should follow verbal or digital client communications.

Education and Training

Education and training regarding liability risks of the agent as well as on products and programs offered is critical in reducing exposure to lawsuits. Misrepresentation can be significantly reduced when agents understand all features of the products they sell. Misrepresentation also declines when agents understand the importance of clear communication, both in terms of providing the best service to a client and from the perspective of reducing liability exposure. Following office procedures and taking special care to complete and keep all important documentation is also more likely to occur when agents understand the potential negative repercussions of not doing so.

Complaint Resolution

Complaint resolution is an especially important area on which to focus in order to reduce liability exposure. Typically, a customer will complain to the agent, agency or insurer before taking a complaint to the state insurance department or procuring an attorney. By resolving the complaint at the agency or insurer level, the agent may be protected from further action on the part of the client.

Responding to Liability Claims

If a claim or lawsuit against the agent or agency is made or is likely, the E&O insurer should be notified immediately. The agent should not speak to the plaintiff's attorney, but should funnel all communication through the defense attorney and the E&O insurer.

Other important tips for anyone who is facing legal action include:

- Discuss the claim with the defense attorney only. Any other conversations are not considered privileged information
- Follow the attorney's advice
- Do not destroy any documents related to the case and provide all documents the defense attorney requests
- Keep calm and keep doing a good job. Remember that many claims are frivolous or without merit

Response Times

The agent should respond to client requests and communications within a reasonable time frame. Maximum time frames to respond to correspondence, phone calls and other customer communications should be established and followed. For example, an agency may establish a maximum time frame of 48 hours to process mail and require same day or next morning response to phone calls, e-mails and voice mail.

Due Diligence

The agent should investigate all insurers he or she will represent in terms of financial stability and reliability and keep documentation related to that investigation. The agent should also pay attention to the memorandums and press releases issued by the insurer since they may deal with the financial ratings and other financial information related to the insurer's solvency. If the insurer does encounter financial problems that may be significant to clients, the agent should inform the clients and allow them the choice to replace coverage if the client so desires.

Professionalism

As a professional, the agent is required to act in the best interest of clients and appropriately represent the insurer. One of the important responsibilities of the agent is to provide information and offer products, which he or she is competent to offer. If a client has a need for a program or product that the agent is unfamiliar with, the agent should seek the assistance of an agent with experience in that product, or refer the client to that agent. Sometimes a customer should be referred to a tax or legal advisor. The agent should never try to offer products whose features he or she does not have sufficient experience or knowledge to communicate to customers.

Another mark of the professional is to serve the customer well. The agent can best do so by being careful in the explanations and information provided to them. Misrepresentations can be avoided by taking care to make sure, to the best of the agent's ability, that the customer understands the explanations given by the agent. The agent should avoid overly technical terms that are likely to be misunderstood by the customer. The agent should also avoid generalities. The agent should not make statements such as "this policy provides all the property coverage you'll need," or "the insurer will never increase premiums by more than 3%." "Never" and "always" are two terms an agent should take care in using. Such general phrases have formed the basis of more than one lawsuit against an agent.

A Lawsuit When E&O Insurance Is In Force

Insured is served with a lawsuit. Insured contacts claim representative at the insurer and mails the summons and complaint to the insurer. Claims representative at the insurer takes down the claim details, verifies coverage, refers insured to an attorney or asks insured to contact an attorney in the area. Insurer pays fees to the attorney selected or assigned, less the policy's deductible. Insurer also pays damage award or settlement, if any.

Employer Purchased E&O Insurance

Sometimes, an agent will be covered by an E&O insurance policy purchased by the agency or insurer. The agent may question whether a personal E&O policy is necessary. In order to answer this question, the agent should review the features of the policy in force. What are the limits of liability covering the agent? Does the policy cover defense expenses as a part of the limit of liability, or in addition to the limit of liability? Does the policy include insurer solvency coverage or other coverages important to the agent? Even if all the answers to such questions indicate that the coverage is sufficient, the agent may still want to purchase a personal policy, for the following reasons: First, a policy purchased by the employer is not portable; the agent cannot take the policy along if the agent moves to another agency or insurer. The agent may have a gap in coverage if the move to the other agency is sudden or unplanned, or if the current employer goes out of business. Secondly, the agent may be sued by the employer who purchased the policy. The employer paid policy will not cover the agent in such a circumstance. Finally, the agent may want additional coverage to make sure that he or she will not suffer economic loss should a lawsuit occur. By having additional coverage, the agent is less likely to be the subject of a damage award that exceeds the limits of liability of the policies.

Summary

Insurance agents and brokers have significant liability exposures. The greatest exposure is to the risk of a lawsuit based on misrepresentation or inadequate coverage. The agent can purchase E&O coverage to help protect against the financial loss, which may arise if a lawsuit occurs. The agent can also reduce the risk of liability exposure by the use of client information forms, keeping accurate documentation and records, taking ongoing training in both E&O exposures and products and programs sold, appropriately handling complaints, establishing and keeping reasonable response times, performing due diligence on the insurers represented, and acting as a professional by offering only those products and advice that the agent is competent to provide and by being careful in all explanations and information provided.

TRENDS IN E&O AND PROFESSIONAL LIABILITY INSURANCE

The liability insurance industry continues to change. Change occurs in part because liability insurers creatively respond to customer needs by adding innovative coverage options and developing products for emerging professions and occupations. Liability insurance also exists within the ever-evolving legal environment and insurers must quickly react to new legal trends and decisions. It also is subject to regulation by the various states with the result that insurers must add and delete coverages as new regulation is enacted. The agent offering liability insurance can expect that changes within this industry will go on occurring.

Emphasis on Risk Management

Because liability risk is high and insurance premiums expensive for many professions, more and more professionals will focus on risk management to reduce liability loss exposures. Many professionals are already relying on risk management as a key element of their liability risk response. Evidence of the emphasis on risk management is the now common practice of hiring a risk manager for an office or designating one of the professionals in a practice as the firm's risk manager, insurers will continue to focus on risk management as well. Insurers will go on providing education on risk management to policyholders and rewarding policyholders with premium reductions and credits for participation in education, loss control programs and peer reviews. Policyholders will look for insurers who provide these benefits, not just because of the reductions in premium that go with them, but also because they want the risk management services the insurers provide.

New Coverages and Limitations

Professional liability policies will continue to include coverages, which were traditionally optional as standard coverages. For example, as alternative dispute resolution is used more and more commonly, more policy forms are covering the expenses related to the processes under ADR. Some coverages, like pollution liability coverage, have become more available as the professionals within industries affected by pollution liability have taken steps to reduce potential losses.

Exclusions and limitations will also be added. Some risks will be determined to be uninsurable or to be so expensive to insure that coverage for the risk will be limited to the few professionals who need it. An example of a limitation in coverage that is appearing in more and more policies is the change from offering defense expenses as an addition to damage award liability limits to making defense expenses part of the limits of liability. By changing this element of coverage, insurers are in effect reducing the limits of liability for many professionals. Unfortunately, because of the high damage awards and legal expenses involved in suits, insurers are under economic pressure to reduce coverage and/or increase premiums for professionals in the legal, CPA, medical and other high liability risk professions.

Tort Reform

One of the most important issues affecting liability insurance is tort reform. This course began by discussing the many changes in the legal liability environment in the past several decades. Since the 1980's, a call has been made for reform in tort law. Members of the legal profession and education system, state legislatures, federal politicians and many of the general citizenry have sought to enact

laws to remove some of the most troubling or controversial applications of current tort law. Tort reform legislation which many states have passed include:

- Placing a cap on punitive damages
- Eliminating the use of joint and several liability
- Requiring the filing of certificates of merit by expert witnesses
- Limiting non-economic damages
- Disallowing the use of "deceptive trade practices" as a basis for a suit toward certain professionals
- Shortening statutes of repose and limitations so that suits regarding certain acts from long ago cannot be brought
- Enacting standards regarding who can be considered an "expert" witness
- Mandating the use of alternative dispute resolution for certain cases
- Reinstating the doctrines of comparative negligence and assumption of risk

Changes to Punitive Damages Rules

Approximately thirty-one states have enacted legislation regarding punitive damages. Legislation that has been passed in some states places caps on the amount of punitive damages, which may be awarded. For example in Texas, the cap on the maximum punitive damages which can be awarded for "non-criminal" acts is \$200,000 or twice the amount of economic damages plus non-economic damages not to exceed \$750,000. In North Carolina, a cap of three times compensatory damages or \$250,000, whichever is greater, and in Wisconsin, a cap of \$350,000 was placed on non-economic damages in medical malpractice cases. Alaska, which passed many pieces of tort reform legislation in 1997, limits punitive damages to the greater of three times compensatory damages or \$500,000 in most cases and non-economic damages to the greater of \$400,000 or the injured person's life expectancy in years multiplied by \$8000.

Some states have also passed legislation to require certain standards of evidence in order for punitive damages to be awarded. In Wisconsin, punitive damages may only be awarded if the defendant is judged to have acted "maliciously or in intentional disregard of the rights of the plaintiff." In Texas, there must be "clear and convincing evidence" that malice was involved. In Montana, a unanimous jury must determine liability and establish the amount of punitive damages. In Pennsylvania, legislation affecting medical liability states that there must be willful or wanton misconduct or reckless indifference to the rights of others in order for punitive damages to be awarded.

Joint and Several Liability

Another area of reform legislation has been the elimination of joint and several liability, although an exception for medical malpractice cases has been made by some states. Approximately thirty-four states have made some modifications to joint and several liability laws. One method used to limit its use is to set standards regarding the amount of responsibility a defendant must have in order to be held as liable under joint and several liability rules. For example a defendant's liability may be limited to the percentage of the defendant's responsibility for damages for certain types of cases. A plaintiff's ability to recover damages was barred in some states if the plaintiff was found to be more than 50 percent at fault for the injury or damage. In some states, for example, Louisiana, joint liability has been abolished and proportionate liability is now used.

Frivolous Lawsuits

States also enacted statutes to limit the bringing of frivolous lawsuits. In some states, penalties may be charged against a plaintiff if a frivolous suit is brought. The party who brought the frivolous suit may also be required to pay the other party's reasonable expenses.

Expert Witnesses

In some states, in order to be considered an "expert" witness in a medical malpractice case against a board-certified physician, the witness must now be certified in the same specialty and have practiced or taught in that specialty for at least one year before the incident. Another statute requires that a medical expert witness is not eligible to testify after ten years of retirement, and if the witness is retired when testifying must provide proof of completion of continuing medical education. In Alaska, an expert witness must be licensed and trained in the profession of the defendant and must be certified by a board recognized by the state.

Venue

States have passed legislation regarding venue. Recall from an earlier discussion that venue is important because states laws and court interpretations differ regarding its establishment. If a plaintiff can choose from many possible venues, it is likely that the venue, which is likely to be of most benefit to the plaintiff, will be chosen. States have enacted legislation to limit possible venues for torts occurring within that state. There has also been a call by some for a federal reform measure regarding venue. Currently, if a company does business in all states, the plaintiff could potentially select venue from one of many within those states. A suggested federal reform measure limits the venue of a wrong involving a multi-state business to the state in which the firm has the largest employment or the state through which the product is imported.

Statutes of Repose and Limitations

Statutes of repose and statutes of limitations limit the ability to bring suit regarding alleged wrongs after specified periods of time. Several statutes have been passed in recent years, which place limits on the time period suits may be brought for different types of wrongs. Some parties involved in tort reform favor a uniform statute of limitations, and are working to bring legislation in all states to enact a single statute of limitations for all types of alleged wrongs. Examples of statutes of repose and statutes of limitations, which have been enacted include, in Iowa, a 15 year statute of repose for product liability cases, unless fraud, concealment, latent diseases caused by harmful products is established or certain specified products are involved, in Mississippi, a 7 year statute of repose for medical malpractice actions, with exceptions for cases involving fraudulent concealment and foreign objects, and in Alabama, a statute of limitations for certain actions against public officials and municipalities.

Alternative Dispute Resolution

Another way states have chosen to reform tort law is to require that alternative dispute resolution (ADR) methods be used to settle certain cases. Alternative dispute resolution techniques include negotiation, mediation and arbitration.

Other State Legislation Regarding Tort Reform

Texas has been a state, which has enacted some of the most aggressive legislation regarding tort reform. In addition to passing several tort reform laws, Texas also required that insurers doing business in the state reduce rates on liability insurance. The reasoning behind this was that the tort legislation should reduce the number and size of liability damage awards, and so the insurers will experience reduced costs. However, the Texas regulators reasoned, the insurers cannot be trusted to reduce premium charges immediately to reflect the reduction in losses, so the Insurance Commissioner should mandate rate reductions. The rate reductions that were mandated beginning in April 1, 1995, and which are subject to change annually are listed in the table on the following page.

Many states have also enacted statutes to protect employers from liability arising from providing employee references. In Idaho, for example, liability against an employer can be found only if there is clear and convincing evidence that actual malice or a deliberate intent to mislead is present. Maryland has enacted a similar statute, requiring clear and convincing evidence that actual malice or false information was intentionally or recklessly disclosed.

Mandated Liability Insurance Rate Reductions in Texas

LINE or SUBLINE PERCENTAGE REDUCTION

1. Professional liability insurance for physician, other health care provider, or hospital: 30%
2. Commercial liability insurance for damages arising out of the manufacture, design, importation, distribution, packaging, labeling, lease, or sale of a product or for completed operations coverage: 25%
3. Private passenger automobile liability insurance for bodily injury: 15%
4. Commercial automobile liability insurance for bodily injury: 20%
5. Private umbrella and excess liability insurance: 20%
6. The liability portion of commercial multi-peril insurance: 10%
7. The liability portion of homeowner's, farm and ranch owner's, and renter's insurance: 5%
8. The employer's liability portion of workers' compensation insurance: 10%
9. All lines and sublines of other commercial liability insurance: 15%

Challenges to Tort Reform

The legislation enacted by the states has not occurred without opposition. In several states, the legislation was referred to the courts to determine their legality under the respective state's constitution. In some cases, legislation has been overturned or interpreted by the courts so as to undo essential elements related to reform. It is generally expected that tort reform legislation will continue to be enacted throughout the nation, and that court challenges will also continue. Agents who sell liability insurance should try to keep current on any tort reform rules in their state.

Summary

Agents offering professional liability insurance are part of a dynamic field. Laws are changing and the professional marketplace is sophisticated and demanding. Currently, there are many insurance companies providing exciting, comprehensive liability coverages for professionals. Coverage for emerging professional fields becomes available regularly and coverage for existing professions is evolving as competition and customer demand require. Agents in this field have the challenge of staying on top of new product features and new laws that can affect their customer base. They also have the privilege of knowing they are providing a true service to their customers by giving them the

information and products they need to manage the risk of liability in their businesses. Errors and omissions and professional liability insurance are important business tools and will continue to be into the future.

Glossary

Absolute Liability: A form of liability, which does not require the establishment of negligence. A party conducting an indisputably hazardous activity is considered to have absolute liability for any damage or injury that arises from the activity.

Assumption Of Risk: A defense against negligence. Under the assumption of risk defense, the defendant must prove that the plaintiff understood the risks involved, including the possibility of the damage and injury in question, and yet allowed the act to occur.

Boilers and Machinery Insurance: A form of insurance that provides coverage for property damage from boilers, electric machinery and other higher risk types of machinery that are excluded by the commercial property and business owners property forms.

Broad Insurance Form: An insurance form, which has an insuring agreement that describes expansive coverage. The form will typically include many policy exclusions.

Contracts of Adhesion: A contract of adhesion is one where one party creates the terms of the contract, and the other party adheres to them.

Contributory Negligence: A defense in a liability suit that is based on the argument that if the plaintiff is found to have in any way contributed to the damage or loss, no damage award will be made.

Commercial General Liability Form: A liability insurance form for commercial risks which covers bodily injury and property damage liability, personal and advertising injury liability and medical expenses incurred for bodily injury caused by an accident on or by the premises owned or rented by the insured, or that arise from the insured's operations and excludes professional liability risks.

Comparative Negligence: A legal defense against the finding of total liability. Under comparative negligence rules, the proportionate amounts of negligence contributed by all parties in the damage suit are considered. If the plaintiff is found to have contributed to the damage or injury, the award to the plaintiff is reduced by the amount of his or her responsibility for the loss.

Crime Insurance: A form of insurance that protects a business against certain types of crimes. Forms include but are not limited to Employee Dishonesty, Theft, Disappearance and Destruction, Premises Burglary, Robbery and Safe Burglary and Computer Fraud.

Damages: A monetary judgment determined by a court of law or due under a settlement.

Extended Reporting Period: An optional benefit of claims made forms, which extends the amount of time under which a claim may be made.

Excess Policy: A policy specifically designed to provide coverage on an excess basis over other insurance the insured owns.

Following Form Policies: Excess policies that offer additional coverage for the same kind of coverage as the underlying policies owned by the insured.

Hazard: An insurance term used to describe conditions that increase risk.

Indemnity Policy: An insurance policy, which pays benefits to reimburse the insured for payments made for covered claims.

Inland Marine Insurance: Insurance that covers a wide variety of transportation risks.

Insurable Loss: A loss which is considered to be insurable has five elements: (1) the loss must arise from a pure risk, (2) the loss must be definable, (3) the loss must be calculable, (4) the loss must not occur to many people simultaneously, and (5) the loss may not be intentional.

Intervening Cause: A defense against negligence that is based on the argument that an intervening cause breaks the chain of events leading to the injury or damage. If an intervening cause creates a new chain of events that led to the injury or damage, proximate cause between the breach of duty and the damage may not exist, and therefore, negligence may not exist.

Joint and Several Liability: A method of assigning liability damages in a negligence case based on an ability to pay.

Licensing Board Coverage: A professional liability coverage, which pays for the reimbursement of expenses related to disciplinary hearings, including defense expenses by a licensing board.

Loss Exposure: An insurance term, which refers to conditions that include the possibility of loss.

Last Clear Chance: A defense against negligence that is based on the argument that the plaintiff had the last clear chance, or the final opportunity, to avoid the loss or damage. The plaintiff's failure to act, it is argued, caused the loss or damage, not the breach of duty on the part of the defendant.

Moral Hazard: A condition or conditions that increase the likelihood that an insured or a person in a position to be paid by an insurer will intentionally cause, overstate or increase a loss.

Morale Hazard: A condition or conditions that increase the likelihood that the attitude of the insured or a person who will be paid by the insurer will cause a loss.

Negligence: The failure to use due and reasonable care.

Notary Public: A public officer who is licensed and authorized to administer oaths and attest and certify documents. Includes copyrighted material of Insurance Services Office, Inc. with its permission.

Occurrence: As defined in professional liability or E&O form, an occurrence means an accident, including continuous or repeated exposure to substantially the same general harmful conditions and will include acts or omissions that arise out of the rendering of or failure to render services as a professional.

Parol Evidence Rule: A legal principle that states that a written contract is assumed to include all oral agreements.

Peril: An insurance term meaning a cause of loss.

Physical Hazard: A condition or conditions of property, people, or operations that can increase loss.

Property Coverage: Insurance which provides protection against the risk of financial loss due to property damage.

Proximate Cause: A legal doctrine that states that a breach of duty must launch an unbroken chain of events that result in the damage or injury in order for liability to be found.

Pure Risk: A risk, which cannot result in the possibility of gain.

Retroactive Date: An optional feature of a claims-made policy, which applies the policy coverage to an earlier date. Injury or damage that occurs before the retroactive date is not covered. Any injury or damage that occurs from the retroactive date until the policy coverage ends is covered, assuming the claim is made during the policy period. The retroactive date is sometimes referred to as a nose.

Risk: The chance of loss.

Risk Management Process: A process with the objective of reducing loss. The process includes identifying risks, evaluating each risk for frequency, severity and type, determining the best risk response, implementing the response, monitoring the results and making changes as necessary.

Speculative Risk: A risk that includes the possibility of gain. Insurance policies do not cover speculative risks.

Severability: An insurance condition, which provides each insured under the policy with his or her own liability limits.

Statute of Limitations: A legal principle that requires that certain lawsuits must be instituted within a stated period of time after the action, which forms the basis of the lawsuit occurred. The applicable period of time can vary by state and by the type of lawsuit involved.

Strict Liability: A form of liability, which does not require the establishment of negligence. Strict liability applies to manufacturers who make a product with a defect, which causes damage or injury. Includes copyrighted material of Insurance Services Office, Inc. with its permission.

Subrogation: A legal term for the process through which an insurer is able to recover damages from the party liable for damages once the insurer has paid an insured or other claimant. To subrogate means "to substitute." The insurer's right to recover damages are substituted for the insured's right to the damages since the insurer paid damages on behalf of the insured.

Supplemental ERP: A form of an extended reporting period benefit that provides an unlimited period of time to report claims for an occurrence reported during the policy period. A supplemental ERP is also known as full tail coverage.

Tort: An act that is committed by one party, which causes injury or damage to another party or to another's property. The word "tort" means wrong.

Umbrella Liability Insurance: Insurance, which provides additional, high limit insurance that applies to liability for damages that arise from a suit. Umbrella liability policies generally provide broad coverage that encompasses many forms of liability and also provide additional insurance over other insurance policies the insured owns.

Venue: The location of the court that has proper jurisdiction over a trial or litigation.

Vicarious Liability: A form of liability that occurs when another party is held responsible for a negligent party's actions. Employers are generally held to be liable for the actions of their employees under the concept of vicarious liability. Vicarious liability is also known as imputed liability.

Workers Compensation Insurance: A form of insurance that covers employer risks such as injury, disability or death that occurs to employees while on the job.

Confidentiality

A fiduciary also owes a client, confidentiality. It is considered a breach of fiduciary duty if a client's affairs are discussed on the golf course or in the break room. Of course, providing information about one client's affairs to assist another client is also a breach of confidentiality.

Reasonable Care and Diligence

A fiduciary must act with the care and diligence of a reasonable and prudent fiduciary. Regarding retirement plan fiduciaries, Section 404(a)(1)(B) of ERISA states that a fiduciary must discharge his or her investment duties with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims. (Emphasis added.)

Another standard that may be applied to fiduciaries is the prudent investor rule. This rule is used currently applied to fiduciaries in approximately seventeen states. It is sort of an updated version of the prudent man rule. Under the prudent man rule, a trustee emphasized conservation of principle. Under the prudent investor rule, a trustee is to emphasize total returns. The prudent investor rule looks at the overall return of an investment portfolio. If some of the investments within the portfolio are risky, perhaps even too risky for the portfolio, as long as the overall portfolio has an appropriate level of risk and return, under the prudent investor rule, a trustee will generally be considered to be acting prudently. Under the prudent man rule, one imprudent investment could be the basis of a trustee's liability for loss.

When the courts hear a liability case against a fiduciary, in order to determine if the fiduciary acted reasonably and prudently, they apply the standard that the fiduciary is to be knowledgeable about his or her field of expertise. They also expect that the fiduciary will act as a fiduciary who has had experience in the profession, that the fiduciary will appropriately investigate any matter under consideration within his or her duties, and that the fiduciary will get outside help if a matter is beyond the scope of his or her experience or knowledge.

Accounting

Finally, a fiduciary owes the principal accurate and complete records regarding the transactions and other matters handled for the principal. All money or property handled by the fiduciary for the principal is to be accounted for and appropriately safeguarded. Because of the important duties owed by

fiduciaries and the significant consequences of the services provided, they are a likely target of lawsuits, and so need liability insurance.

Summary

For those in business, the liability environment today poses a significant risk. Lawsuits are frequent and damage awards can be high. The courts are hearing new and different types of liability suits. The many innovations in products and services offer new opportunities for financial gain and new areas of litigation. Businesses need liability protection more than ever.

Professionals have special risks that require liability protection. The services they provide are often critical to their customers. These critical responsibilities along with the high standards of conduct customers and the courts apply can make a professional very vulnerable to lawsuits with significant damage awards. In the liability climate today, professionals need the protection provided by Errors and Omissions and Professional Liability insurance.

AGENT LIABILITY

Introduction

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

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

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

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

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

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

Are there individuals who might settle (much easier than a big insurer) to avoid a long and protracted trial? If you haven't guessed by now, it's you. You could be the next victim of a clever attorney looking to cash-in on a quick settlement when something goes slightly astray with your client's coverage. You can protect yourself through education. When you know what is expected of you, proper legal and sales conduct legal and sales conduct can be followed and conflicts minimized. The end result is less liability risk to you and your practice.

Agent/Broker Liability

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

Furthermore, the consumer of our time has lost all respect for the status of the professional, any professional. This includes doctors, lawyers, teachers, clergy, real estate brokers, stockbrokers and insurance agents. Few would think twice about suing any one of these professionals to receive satisfaction for an honest mistake, let alone one leading to a financial loss or injury.

Understanding this, it is easy to see that the selling of insurance can lead to conflicts and legal disputes. When an insurance agent and his client cannot resolve differences, agent liability can result, even when the agent is right.

Claims against you may surface as a result of events that occur before or after a policy is issued, and they may involve you and a client, your insurer or a third party who is an intended beneficiary. Cases can be built around issues of legal conduct as well as sales conduct. They can be as basic as failure to secure the type or amount of coverage requested by the client to more complex and seemingly "blue sky" claims where clients demand to recoup losses and damages simply because of a relationship that existed between agent and client.

Other claims span the gamut from client losses due to an insurance company failure to refusal to pay a claim. Sometimes, an agent's liability is the result of simply being too busy to witness a signature or too rushed when entering a policy premium payment - small mistakes. Of course, a single incorrect digit or a blank you forgot to complete can mean the difference between a policy being "in force" and a policy being cancelled or a claim being denied

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

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

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

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

Agent Liability - Duties & Status

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

- Basic agent duties
- The law of agency
- Producer's status (relationship to the client/insurer)
- The classification of the producer as agent/broker or agent/professional

Basic Agent Duties

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

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

Duty also does not require the broker/agent to secure complete insurance protection against any conceivable loss the insured might incur, but there may be a duty to explain policy options that are widely available at a reasonable cost. An agent's duty to provide correct coverage is not triggered by a client's request for "full coverage" because that request is not a specific inquiry about a specific type of coverage. In other words, just because a client asks for full coverage an agent may not be liable to provide it. However, if a client requests a specific type of coverage, the agent is responsible to see if it is available and determine if the client qualifies.

An insured is also entitled to rely on an agent/broker's advice on the meaning of policy provisions. However, a client's reliance may be unjustified when the advice given by the agent "is in patent conflict with the terms of the policy". It is a clear legal responsibility of agents to understand the difference between two products that he is attempting to sell. Whether an agent has an affirmative duty to inform a client of possible gaps in coverage depends on the relationship of the parties, specific requests of the client and the professional judgment of the agent.

Once a policy is issued, traditionally theories of legal conduct provide that an agent does not have the duty to ferret out, at regular intervals, information which brings the policyholder within provisions of a policy. In essence, it seems the courts have been more concerned about general agent duties to inform clients of appropriate coverage at the time of sale. Recent departures from this theory includes a case where an agent was found liable for failing to determine that the insurance policy was no longer needed by the client. In another example, an agent assured his client that the limits of the policy continued to meet his needs when they actually fell short (i.e., agent duties may also include informing clients their coverage is appropriate after the sale).

Although each case stands on its own, the underlying determinant of "after sale" duty may be the "special relationship" that exists between client and agent (e.g. an agent handling the client's business for an extended period of time may assume a higher standard of care). These are the basic agent responsibilities. Agents are not precluded from assuming additional responsibility, which they normally do in most client transactions. When a lawsuit arises, however, it is the client's burden to show that greater duty is the result of an express or implied agreement between agent and client where the agent has taken more responsibility. In most instances, the facts of the particular case determine whether the court finds a greater duty has been assumed.

The Law of Agency

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

An agency relationship begins when agents are granted authority to operate by expressed, implied or apparent agreement. This can be created by contract or agreement or it can take the form of casual mutual consent. What is interesting about the business of insurance is that most agents start out as an agent for the client, when coverage is requested, and then become an agent for the company, when business is placed. As you will see later, the exact status you occupy when a problem occurs affects your liability exposure. A person who markets insurance is typically referred to as a producer. The insurance market and many state laws describe different kinds of producer: - general agents, local agents, brokers, surplus or excess general agents, local agents, brokers, surplus or excess-line brokers or agents and solicitors.

General Agents

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

Local Agents

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

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

Brokers

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

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

Surplus Brokers / Agents

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

Solicitors

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

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

Insurance companies always attempt to tightly define or narrow the authority of agents to limit their exposure to agent wrongdoing. In practice, however, the law generally considers the agent and the insurer as one and the same, even though the agent works as an independent contractor. So, the insurer is most often legally responsible for the acts of the agent and is regularly sued by third parties (clients of the agent) who feel they have been wronged. Of course, when a policy owner sues his insurance company, agents are often named for various breaches of duty between client and agent. Agent liability may also exist where insurance companies sue their own agents. Insurance companies and errors and omission carriers alike exercise their right to sue an agent under various legal theories, typically for indemnity of any judgment losses they may have incurred through a policy owner claim.

Insurance Producer Status

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

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

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

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

A huge problem for agents occurs when they act as principals, when, in fact they are not, or when they have neglected to identify the principal (i.e. an undisclosed principal). An agent who advises a client that he is covered, with knowledge that the intended insurance company has not yet agreed to accept such coverage acts as the insurance company until coverage is accepted (i.e., the client has full recourse against the agent for any uncovered loss).

If it can be proven that it was reasonable for the client to assume that the agent actually had real authority to act for the principal, the client can hold the insurer to the contract, even when one did not exist. The client who incurs coverage shortfalls is in a much better position to recover from the agent where a principal (insurance company) is not disclosed.

Of course, a written disclosure agreement indicating that the agent was a representative of the insurance company, acting as principal or not disclosing the principal for a specific reason would go a long way to clarify that the status between the agent and client, or agent and company. In commercial insurance transactions, agents go to great lengths to "clear the air" concerning agent status by using a broker of record letter. These letters authorize or terminate agency and stand as proof of evidence that an agent is representing the client/principal or "out of the loop".

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

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

Agent vs. Broker

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

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

Basically, an insurance broker is an independent business or business person that procures insurance coverage for clients. Brokers generally receive commissions from the insurer once coverage is actually placed, and except when collecting premiums or delivering the policy, is the agent of the insured for all matters connected with obtaining insurance coverage, including negotiation and placement of the insurance. Typically, brokers are insurance professionals who maintain relationships with several insurers but are not appointed agents of any of them. The purpose of determining whether the insurance producer was acting as a broker or as the insurer's agent when an insurance contract was placed, helps establish the theories of liability that the client may plead and what defenses the agent or his insurer may raise. In many court cases, it is not clear whether the producer was acting as a broker or an agent. So, attorneys typically plead their case under the banner of each status thereby plucking the feathers of the agent and the "deep pockets" of the insurance company at the same time.

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

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

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

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

Agent vs. Professional

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

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

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

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

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

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

Conflicts Through Contract Disputes

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

1. The existence of an insurance contract or principal-agent agreement or an implied agreement
2. The breach of contract or non-fulfillment. A violation of contract terms is fairly clear-cut

Primary breach of contract, however, can surface under any of the following headings:

Failure to Act/Procure Coverage

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

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

Failure To Notify Lack of Coverage

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

Failure To Place Coverage At Best Available Terms

As part of the duty to exercise good faith, reasonable skill, and ordinary due diligence in procuring insurance, a broker has a higher duty than agents to be informed of the different insurers and policy terms and to place coverage at the best available terms. If other brokers working in the same market knew that better terms were readily available, the broker who failed to obtain these terms for the client could be liable for the client's loss. In one case, the broker failed to obtain "coinsurance" clauses that were commonly available and carried a lower premium. This must be distinguished from cases proving that the broker does not have an absolute duty to obtain the lowest possible rate.

Failure To Renew

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

Policy Promises & Provisions

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

Many lawsuits have been pursued on misunderstood policy time limits that restricted the client's ability to perform or file a claim. Agents can easily become a focus of these disputes. Another misinterpretation might be in defining policy terms (e.g. what is an "accident" defined to be?). Some agents might be taught not to volunteer information on an issue such as this. But, insurers and agents have a fiduciary duty to their insured clients to disclose full and complete information. Failure to do so may result in a claim of fraud.

Agent Promises

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

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

Advertising Promises

Advertising violations are among the most costly mistakes. Regulators have been known to levy stiff fines of \$1,000 or more per violation. In other words, 1,000 non-compliant flyers distributed in the mail or otherwise could amount to a fine of \$1 million or more (\$1,000 X 1,000 flyers). By contract, agents are required to secure company approval of all advertising. Few agents, however, would think twice about scrutinizing company provided ads. However, it is suggested that agents carefully review advertising provided by the insurer to make sure it honestly reflects the promises of the policy.

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

What Policies Say versus What They Mean

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

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

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

Client Understanding and Reading of Policies

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

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

Minimum Standards

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

Conflicts Created By Agent Torts

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

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

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

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

Negligence & Misrepresentation

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

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

Bad Faith

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

Agent liability may accrue due to unfair conduct by agents or allegations of fraud, deceit, misrepresentation or the statutes dealing with unfair settlement practices (where the agent is acting as a claims representative for the insurance company or in his individual capacity, independent of the agency).

Agents must remember that the number one reason that people purchase insurance policies through agents is for service. When an insured makes a request to procure coverage or turns in a claim, he is not bargaining for promises, but rather action.

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

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

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

Conflicts Created By Client/Agent Relationships

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

1. Contributory and
2. Agents as Fiduciary

Contributory Liability

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

exposure, since he is considered, in the eyes of the law, to be subject to a higher standard of knowledge and responsibility.

Yet, faced with stiffer competition, agents are somewhat compelled to upgrade their image by creating marketing "niche" expertise with titles, credentials and job descriptions like: financial planner, estate planner, retirement planner, "one-stop" insurance agency, loss control consultant, etc. Contributory liability relationships have also been cast simply because an agent has always handled a client's business over the years, so much so, that clients have blindly depended on their advice. The result of these "titles" and "agent trust" is a higher level of culpability. In fact, plaintiff attorneys have and continue to develop legal strategies that establish contributory liability of agents by multiple approaches, including:

Lack of Client Knowledge

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

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

Improper Advertising

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

Dual Agency

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

Errors & Omissions Insurance

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

Client / Agent Interaction

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

Agents as Fiduciaries

New legal theories are continually attempting to establish an agent selling an insurance contract as a principal fiduciary and therefore a probable "deep pocket". A fiduciary is defined as someone who is held in trust or complete confidence. Compared to an agent's contractual duty, which requires negligence or tort action, fiduciary duty is intrinsic to his business. In other words, an agent's liability as a fiduciary simply comes with the territory.

In recent years, cases of fiduciary duty are more prevalent. The most obvious fiduciary responsibility of agents is to protect and safeguard client monies. Other fiduciary related liabilities relate to an agent's duty of care. These cases even rear-up in a one-time business transaction (e.g. you don't have to be a longstanding advisor to be liable).

More often than not, the issue of fiduciary exposure surfaces where an agent proposes a "full coverage" policy but failed to describe a certain provision or exclusion that existed in the written policy. In addition, fiduciary problems are launched by special agent relationships where the insurance contract is established as a collateral issue of some greater purpose such as an insurance agent claim to have special "expertise" where the client is unsophisticated, or when an agent promises to provide "complete coverage."

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

Employment Retirement Income Security Act (ERISA)

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

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

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

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

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

from which choose, and as a member of a team of plan consultants, he is less likely to be classed as a fiduciary.

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

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

Medicaid Planning

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

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

Insurer Claims Against Agents

When most agents ponder professional liability, they think client lawsuits. But agents and brokers also face exposure from the insurers they represent. When agents are sued by their insurer, it is most likely for a violation of the law of agency. Most agents are familiar with the term fiduciary duty. Between agent and principal, (the insurer), fiduciary duty of the agent prevents him from competing with the principal concerning the subject matter of the agency or from making a "secret profit" other than what is stipulated or agreed as commissions. Fiduciary responsibility is especially pronounced when the agent writes insurance for himself.

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

They include:

- Duty of care and skill, using standard care and skill
- Duty of good conduct
- Duty to give information by communicating with the principle and clients
- Duty to keep accounts by keeping track of money
- Duty to act as authorized
- Duty to be practical not attempt the impossible
- Duty to obey or comply with the principal's directions

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

Basic Agency Violations

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

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

Misappropriating Premiums

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

Failure to Disclose Risk Factors

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

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

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

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

Failure To Cancel or Notify of Cancellation

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

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

Authority To Bind

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

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

Premium Financing Activities

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

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

Liability Created By Insurer Failures

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Misrepresentation & Insurer Failures

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

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

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

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

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

Claims of Regulation by the State Insurance Department

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

Claims of Minimum Capital and Surplus Requirements

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

Claims of Minimum Reserve Requirements

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

Claims of Annual Statements

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

Claims of Periodic Examinations

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

Claims of Statutory Accounting

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

Claims of Investment Restrictions

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

Guaranty Fund Claims

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

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

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

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

Agent Relationships & Insurer Failures

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

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

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

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

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

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

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

"When one considers all of the factors of tort recognition, including the social policy aspects, the argument for the establishment of a tort duty on the part of the collateral parties (agents, broker brokers, re-insurers, etc) to the insurance relationship is compelling. Placing a duty on the collateral parties to investigate and monitor reasonably the solvency of insurers with which they deal yields a much more socially advantageous result. This duty logically extends the duty already existing for brokers to exercise care in the placement of insurance with solvent insurers.

The proposed duty, however, requires affirmative investigation and monitoring. This investigation and monitoring should, at least, include an evaluation of National Association of Insurance Commissioners' data, Insurance Regulatory Information System data, ratings service data, and any other public information and general information circulating within the industry. Thus, the duty requires a more thorough investigation than present law apparently requires brokers to make. In addition, the duty continues past the placement of the insurance or the commencement of the insurance relationship."

Congress has also chimed in by suggesting that:

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

Agent Sales Conduct

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

- It might keep you from being sued by a client or your insurer.
- The cleaner your record, the less involved underwriters will be in the sales process (i.e. you have more control over the sales process and less compliance).
- Sales conduct violations drive up the cost of doing business which could affect your commissions, or, completely replace the current system of incentive pay with a salary or other form of measured compensation.
- Sales conduct problems erode the public trust and that can cut into your sales.
- Sales conduct lawsuits are now part of how companies are rated. More suits mean a lower rating and a harder sale for you.
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There are many industry groups and agent associations who feel that the movement toward sales ethics is way behind schedule. Too much emphasis and money has been spent on grooming sophisticated "salesmen", they say, when there is a greater need for agent diligence and fair dealing. The cornerstone of this agent diligence movement is now called agent due care or sales conduct sales conduct. Roughly translated, the meaning of sales conduct is an agent's professional and

ethical handling and choice of company, product and sales presentation to best serve a client's financial planning.

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

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

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

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

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

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

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

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

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

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

Agents must realize, that doing "too little" concerning how and where they place client business can be hazardous to their financial health and moral responsibility to the people they serve. This takes on special meaning to agents when they discover that lawyers want to prove that a pocket rating card and other company supplied financial condition brochures may not be enough to demonstrate that an agent did his best in selecting a carrier who, after purchase, declined to unsafe or liquidated status. The significance is that the courts in just about every state have made it absolutely clear that insurance agents are lot more than a mere contract of insurance. They are selling security, peace of mind, and freedom from financial worry in the event of a catastrophic claim.

Sales Conduct In Choosing A Company

Agent legal conduct in choosing a company centers on the ability to direct a client to an insurer that is solvent at the time of purchase and able to meet its contractual obligations. Sales conduct considers diversification (spreading risks among carriers) and ongoing monitoring by private rating services. Policy owners must depend on agents for choosing insurers because they are generally unsophisticated in analyzing the financial complexities of solvency. Agents help businesses and individuals purchase property and liability insurance to minimize current financial losses. Life, health and annuity policies cover losses of future economic potential. In both cases, the purpose is to shift the financial consequences of loss.

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

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

Regulators of insurance companies, like regulators of financial institutions such as banks and thrifts, do not make public announcements of pending problems. This could cause a "run on the bank" or a "run on the insurance company". Severe disintermediation, withdrawal of policyholder funds or policy cancellations, could initiate a complete collapse similar to what happened with Mutual Benefit Life. By stepping in without public warning or fanfare, regulators hope to avoid the severity of a takeover and minimize consumer panic. That is why an agent will not receive advance warning from regulators. Unless the agent is tracking solvency by demanding full disclosure from an insurer before and after involving a client, he may experience the unpleasant experience of dealing with a disgruntled client or his attorney who just read about an insurer's demise, complaints filed with the insurance commissioner, or worse, a surprise visit from the "60 Minutes" investigative team.

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

Using the Rating Services

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

Even the rumor of a downgrade may precipitate a "run on the bank", as in the case of Mutual Benefit, and seriously exacerbate an insurer's financial problems. There is little doubt that rating organizations play a significant role in the insurance marketplace. Some have expressed concerns about the potential adverse effect of ratings on particular insurers and consumer confidence in the insurance industry in general. Once the province of only one organization, A.M. Best; a number of new raters emerged during the 1980s.

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

On Going Monitoring & Policy Replacement

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

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

Company Deals

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

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

Conflicts of Interest

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

State Admission

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

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

Sales Conduct in Choosing Product

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

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

Regardless of the sequence of policy decisions, agents must recognize that the choice of a policy is viewed differently between agent and client. An agent seeks coverage as a means of transferring pure risk. A client views policies in terms of obtaining reduced uncertainty (e.g. in most cases, your customers can only hope that the policy they purchase is appropriate). That is why agents are vital players in any insurance purchase.

The greater agent due care exercised, the more valuable the service. It is also why, when viewed from an agent's liability, all options should be disclosed.

Sales Conduct - Life/Health

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

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

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

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

Life Insurance

Before determining the amount of life insurance needed by a client, due care would involve the agent and client in a discussion concerning the various types of life insurance available (e.g. annual renewable term, deposit term, decreasing term, level term, whole life, modified whole life, single premium whole life, universal life, variable life, etc.).

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

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

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

Capital needs for family income

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

Capital needs for debt repayment

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

Other Capital Needs

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

Estate Settlement Costs

Final expenses can be expensive. Uninsured medical costs and funeral expenses are one aspect. In addition, there are federal and state death taxes. Although the Economic Recovery Tax Act of 1981 eliminates the federal estate tax on property passed to a surviving spouse, the estate of the survivor may face a large death tax liability.

Current Assets Available for Income Production

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

Net Capital Needs

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

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

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

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

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

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

Essential Life Insurance Due Care Questions

- What existing death benefit sources does the client have? Group life, survivor's income, individual plans, association group life plans, pension plan death benefits.
- Who is insured?
- Is someone contributing economically who must be added?
- Do all death benefits, along with available assets, meet client objectives?
- Are there other needs to consider such as dependents with special problems? Business debts? Personal debts?
- Are there existing life policies that can be cash surrendered or tax exchanged to more efficient plans?
- Is waiver of premium available? Is this a desirable benefit for this client?
- Is there accidental death benefit or double indemnity? If so, is this desirable or can it be dropped in favor a lower premium?
- Is coverage guaranteed renewable? To what age? Is the client's health stable enough to change policies?
- Is coverage decreasing term? Is the balance sufficient? Is there a substandard rating that can be removed?
- Are there policy dividends? Is the client making the best use of these dividends? Or, would reduced premiums be recommended?
- What are the settlement options available at death? (Lump sum, payment options, insurance trust, etc.)
- Is there a plan for the "common disaster" involving both husband and wife?

Disability Insurance

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

Essential Disability Due Care Questions

- How much monthly protection is needed? Is an individual policy needed to supplement work plans?
- When does protection need to start? (30, 60, 90 days etc - the elimination period), i.e., can the client "self-insure" for a period of time?
- Does the client have discretionary income to buy needed protection?
- Is the coverage non -cancellable or guaranteed renewable? Can a block of insureds, including your client, be canceled?
- If multiple policies are owned (employer, association, individual), will the benefits of one be reduced by the other? Is there a case for eliminating a policy?
- Is there an employer supported uninsured sick-pay plan available?
- What is the definition of a disability in the client's policy? How severe? How long?
- Does the policy include occupational and non-occupational coverage?

- Is there a substandard rating or waiver of condition? Will the company remove it? Will another company write without a waiver?
- Is there a waiver of premium benefit? Would this be necessary for the client?

Similar to life insurance, due care analysis by the agent involves "need analysis". Through inquiries and available financial papers the agent should determine the current after-tax income needs of the client. This amount could be reduced by expenses that might be eliminated due to the disability. For example, if the client is homebound, he will not need to cover transportation costs of commuting to work or other work related expenses. Next, an adjustment for possible government benefits can be made using amounts that might be available from Social Security. Minimum employment history and limitations on the term of protection covered should also be considered. Other adjustments that an agent should investigate include earned income continuing from other family members, investment income that might be derived from current assets and inflation to keep pace with cost of living increases.

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

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

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

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

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

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

Health Insurance

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

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

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

Basic Eligibility

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

Total Maximum Coverage

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

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

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

Deductibles

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

Stop Loss & Co-Payments

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

Pre-Existing Conditions & Waivers

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

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

Exclusions

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

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

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

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

Guaranteed Renewability & Rate Changes

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

Important Dates & Notification

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

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

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

It would not be considered due care for an agent who handles different product lines to market a \$250 per month whole life insurance plan to a financially limited client when there was no health insurance in place. A more prudent approach would combine a "basic hospital plan" for major medical emergencies at \$150 per month and a term life plan for \$100 per month. Even the agent who specializes in a specific product line should exercise due care to inquire that clients have health coverage in place or at least budget for same before selling other forms of insurance.

Essential Health Coverage due Care Questions

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

Annuity Analysis

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

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

Fixed rate annuities might be an alternative for CDS, GNMA's (Ginnie Maes), T-Bills or other similar obligations. Variable annuities are better geared to individuals who seek tax deferral, yet willing to ride with the ups and downs that accompany stock and mutual fund investments.

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

Immediate Annuity vs. Deferred Annuity

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

Single Premium vs. Flexible Premium

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

Fixed Rate vs. Variable Rate

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

Yield vs. Guarantees

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

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

Yield vs. Liquidity

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

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

Maturity options

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

Pre-1981 Annuities deliver principal first, then tax interest or appreciation. Post 1981 annuities tax interest or appreciation first then deliver principal. Also to be considered is annuitization of the contract where a systematic withdrawal and payoff of the contract over time delivers some principal and taxes interest and appreciation with each payment.

Withdrawals & IRS Penalties

Where the client is withdrawing all or part of an annuity contract PRIOR to age 59½, he should be apprised of the 10% IRS penalty for early withdrawals. At present, this can only be avoided where the annuitant dies, becomes substantially disabled, or where annuitization is chosen over a minimum five year period.

Guaranteed Death Benefits

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

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

The tax liability is the difference between the amount invested subtracted from the value of the annuity contract, multiplied by the beneficiary's tax bracket. Options to mitigate this include five year or lifetime annuitization of the contract.

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

State Guaranty Fund Coverage

Rules governing state guaranty coverage should be disclosed to the client. If the State does not permit advanced disclosure concerning guaranty fund protection, the agent should privately exercise diligence in planning annuity purchases.

The primary concern is whether the full amount of the annuity is covered against insurer failure. Perhaps due care is served by diversifying among several insurers and/or between fixed and variable contracts to take full advantage of guaranty protection.

Titling Options

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

As a general rule, the death of an owner or annuitant triggers a death benefit that carries tax liability. Unless the survivor beneficiary is the spouse, the beneficiary must take a lump sum and pay the tax or annuitize over a minimum five-year period. An important area for agents to investigate is whether the annuity contract enforces or waives surrender charges where a death of the annuitant or owner has occurred. In some contracts, the surrender charge can be deferred where an owner dies and a contingent owner is allowed.

Essential Annuity due Care Questions

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

Business Insurance

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

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

Sole Proprietorships

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

Partnerships

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

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

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

Corporations

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

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

Essential Business Insurance Due Care Questions

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

Sales Conduct - Property/Casualty

Risk management in the property/casualty arena is extremely complicated, yet the primary goal is the same as other forms of insurance: the transfer of risk. However, a higher standard of due care and agent liability exist in property/casualty because of binders, indemnity disputes and redlining. A binder can be written or oral. At the point when the client says "I want it" and the agent says "You're covered", a binder has occurred. Immediately upon creating any oral binder, the agent should make note of the terms of coverage, when the binder was made and the parties involved. Further, to reduce the possibility of disputes, the agreement should be reduced to writing as soon as possible. Abuses occur where agents do not have binding authority, yet lead clients to believe they do. Likewise, clients may use binders as a means of obtaining free insurance for limited periods.

Property and casualty insurance contracts are contracts of indemnity in that they provide for compensating the insured for the amount of loss or damage. Due care is accomplished when an adequate amount of compensation is provided that will avoid profit or loss from a peril or hazard. Elementary insurance defines a peril as the cause of a loss. Fire, lightning and collision are all examples of perils. A hazard is anything that increases the chance of loss. A loose gas connection to a main heater system is an example of a hazard. Hazards, however, can also take shape in "morale" form. Reckless driving is one such example of a morale hazard.

Compared to life and health contracts, it can be said, that fewer property/casualty policies are read by clients. There is generally less understanding of liability or casualty matters, and therefore, a greater reliance is placed on agent advice and counsel. That is why proper sales conduct would encourage clients to read their policies and help them review the fine print to fully understand exact limits of coverage, define perils, clarify what constitutes a hazard and recognize policy owner duties. Having specimen policies available for this purpose should be standard procedure. Areas where agents should exercise additional due care involve the "agent as counselor". Insurance is the first line of defense in asset protection. The role of the property/casualty agent in preserving what clients have already accumulated is vital.

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

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

Essential Liability Due Care Questions

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

Risk

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

- Many in the industry, however, feel it is extremely important to reassess societal views on risk by assuming more responsibility for risk consequences. An example would be clients who continue to build in flood plains or high-risk fire areas, despite knowledge of their existence.
- When disaster strikes, should these individuals receive subsidies through taxpayer financed state and federal disaster aid, government flood control projects and mandatory shared-market insurance programs?

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

Loss Control

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

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

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

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

Valuation

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

In addition, companies are directing it encouraging agents to re-evaluate coverage levels. In many cases, this involves inspections of properties to account for recent improvements, such as finished basements, patio covers, garage conversions; deterioration; code compliance to rebuild; i.e., new hurricane or earthquake standards; and illegal uses, e.g., a business run out of the home. Bringing inadequately covered premises to full coverage levels increases underwriting income, which may allow a carrier to lower rates within a class of policy owners. Equally important is the liability protection afforded carriers and agents.

Homeowners Insurance

Agents should exercise due care in several important capacities:

Selection of Policy

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

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

Value

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

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

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

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

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

Eligibility

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

Deductibles

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

Policy Exclusions

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

Liability & Liability Exclusions

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

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

Auto Insurance

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

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

Policy Limits

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

Policy Eligibility

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

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

Policy Conditions

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

Policy Endorsements

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

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

Policy Exclusions

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

Policy Effective Date

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

Named Insured

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

Auto User

Is everyone who uses the auto a named insured?

Associated Named Entities

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

Commercial & Professional Lines

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

Policy Limits

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

Eligibility

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

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

Policy Endorsements

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

Scheduled Losses

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

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

Policy Exclusions

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

Sales Conduct - Illustrations/Quotes

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

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

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

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

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

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

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

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

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

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

Agent Business & Marketing Practices

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

Concealment

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

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

Presentations, Illustrations & Quotes

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

Misrepresentations

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

Twisting & Churning

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

Redlining

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

False Claims

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

Unfair Business Practices

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

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

Policy Replacement

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

Additional requirements typically include the completion of specific sections of the insurance application where the agent must acknowledge that he or she is aware of the replacement.

Privacy

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

Client Disclosure

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

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

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

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

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

For example, an agent proposal included the following disclosure:

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

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

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

CASE LAW

AGENCY LIABILITY

Lyming v. Farm and Citv Insurance Company

Court of Appeals of Kansas - Feb. 18, 2005.

I. Background

In February 2002, Lyming contacted Roquet Insurance Agency concerning car insurance. Roquet Insurance Agency is an independent agent that contracts with several insurance companies, including F & C. David Roquet, who is Gail Roquet's son, shopped Lyming's insurance needs with several different companies, and F & C was ultimately chosen. David Roquet took an application with Lyming and submitted it to F & C.

Based on Lyming's application, the estimated premium was \$322.40. Lyming paid to Roquet Insurance Agency a required premium deposit of \$161.20, and coverage was bound. Thereafter, Lyming was required to pay a total of \$180.80 before April 14, 2002, in order to get a policy issued. Lyming paid the balance before the due date.

In an invoice dated May 2, 2002, F & C notified Lyming that her policy would expire on May 26, 2002, and informed her that the premium for May 26, 2002, to November 26, 2002, was \$684. The minimum amount due on the renewal policy was \$142. Only three payment options were set forth in the invoice: (1) pay the entire policy balance; (2) pay the minimum due; or (3) pay any amount between the minimum due and the policy balance.

Lyming was instructed that if she wished to apply for renewal of her policy, her payment must be received by the due date, which was May 26, 2002. On the invoice, Lyming was informed that if she had coverage questions or policy changes, she should contact her agent, Roquet Insurance. Lyming was further informed that if she had questions about the bill, she should contact the listed number for F & C.

On Wednesday, May 22, 2002, Lyming paid \$75 to Roquet as a partial payment on her renewal policy. According to Roquet, when Lyming came in on May 22 and paid the \$75, she told him that she would pay the balance on Friday. Roquet told her that would be okay because the due date was May 26. According to Lyming, however, she told Roquet that she would not be in until the following Friday to pay the remaining balance, and Roquet told her that would be fine.

On May 30, 2002, Lyming was involved in a car accident. The next day, Lyming paid to Roquet the remaining \$67 of the minimum amount due. When F & C received the \$142 payment, they returned it along with a letter stating that the policy had expired on May 26, 2002. The letter stated that Lyming should contact her agent to complete a new application if she desired coverage.

In July 2002, Lyming sued Roquet and F & C. Although it is difficult to discern the exact claims that Lyming asserted, it appears that she raised breach of contract, agency, KCPA violations, and other professional liability claims. In August 2002, both F & C and Roquet moved to dismiss the KCPA claims, arguing that the purchase of insurance is not a consumer transaction under the KCPA. Later, F & C also moved for summary judgment on the insurance contract and agency claims against it. F & C contended that because Lyming did not accept F & C's offer to renew her contract by making the payment as required, no contract of insurance was in force at the time of Lyming's accident. F & C maintained that Lyming's partial payment and late payment of the balance constituted a counteroffer which F & C rejected. In addition, F & C argued that as a matter of law, Roquet

Insurance Agency was an independent insurance agent and, therefore, the agent of Lyming and not the agent of F & C.

Lyming responded to Roquet's motion for summary judgment by arguing that Roquet was F & C's agent for purposes of accepting periodic payments, binding F & C. Lyming submitted an affidavit in which she maintained that she had made periodic payments in the past to Roquet. Lyming further asserted that Roquet had accepted and cashed her \$75 periodic payment as he had done in the past, without reservation, and had failed to tell her that her periodic payments would no longer be acceptable.

The trial court ruled on these motions in March 2003. Determining that Lyming's claim involved the direct purchase and administration of an insurance contract and that the purchase of insurance is not a consumer transaction under the KCPA, the trial court dismissed the KCPA claims. In addition, the trial court denied F & C's summary judgment motion. The trial court determined that, based on the discovery up to that point, Roquet might be seen as the apparent agent of F & C when, as Lyming maintained, Roquet agreed or acquiesced in her late payment.

In June 2003, after further discovery, F & C again moved for summary judgment. F & C argued that Lyming had failed to set forth any facts that would make them liable to her under an apparent agency theory. The trial court granted F & C's second summary judgment motion. Stating that Lyming had proffered no facts showing that F & C held Roquet out as its apparent agent to extend the premium due date, the trial court determined that Lyming did not have a claim against F & C under any insurance policy.

The trial court noted that although Lyming had previously paid installments on her initial policy with F & C, she had paid the total premium outstanding by the due date. After F & C moved for costs, the trial court also assessed deposition expenses in the amount of \$379.75 against Lyming. In March 2004, Lyming accepted Roquet's offer of judgment under K.S.A. 60-2002(b) for \$1,500, plus court costs incurred to date. Subsequently, Lyming moved for costs, including advanced expenses and attorney fees, against Roquet. The trial court denied Lyming all costs in the action.

II. Analysis & Decision

A. F&C Liability

Ordinarily a broker or agent who is employed to procure insurance becomes the agent of the person for whom the insurance is procured.

There are many exceptions to the rule, however, and the question cannot be answered absolutely, but depends upon the circumstances of the particular case. For some purposes and under certain circumstances, a broker may represent either the insured or insurer, or both.

An examination of the many cases in this jurisdiction dealing with the subject reveals that the nature of an agency, its scope and authority, and the question whether an agreement between agent or broker and the insured is enforceable against the insurer, are matters to be determined from the powers expressly or impliedly conferred by insurer in the light of other relevant facts and circumstances shown to exist in a particular case.

It is undisputed in this case that Roquet Insurance Agency was an independent agent that held contracts through several insurance companies whereby it could submit applications to them. The agreement between F&C and Roquet set forth Roquet's authority as follows:

"A. The Agent is an independent contractor, not an employee of the Company and, subject to requirements of and prohibitions imposed by law, the terms of this Agreement, and the underwriting rules and regulations of the Company, is authorized to:

1. Solicit, receive and transmit to the Company proposals for Insurance contracts, including fidelity and surety bonds, which the agent is authorized to write.
2. Bind and execute insurance contracts as provided in the then Current Instructions to Agents.
3. Provide all usual and customary services of an insurance agent on all insurance contracts placed by the Agent with the Company.
4. Collect and receipt for premiums, except as to direct bill business or premium finance payments, and to retain commissions as full compensation out of premiums so collected as specified in the commission schedule. The Agent agrees to refund return commissions on policy cancellations or reductions, in each case at the same rate at which such commissions were originally retained.
5. Exercise his authority personally or through his authorized employees.
6. Represent other companies.
7. Exercise exclusive and independent control of his time and the conduct of his agency.

There is nothing contained within the language of this agreement that conferred upon Roquet the authority to waive or to extend the insured's premium due date. Agents' powers and duties are limited to that specifically conferred upon them in writing by the insurance company.

Nevertheless, Lyming's argument seems to center around whether Roquet had the apparent authority to renew coverage when only a partial premium payment was received by the premium due date. Lyming cites to the following rule: "An ostensible or apparent agency may exist if a principal has intentionally or by want of ordinary care induced and permitted third persons to believe a person is his or her agent even though no authority, either express or implied, has been actually conferred upon the agent."

In order to avoid summary judgment, Lyming must have presented evidence that F & C either intentionally or by lack of ordinary care induced and permitted her to believe that Roquet had the authority to extend or to waive her premium due date.

Turning our attention to the current issue, Lyming points to several acts and circumstances that she believes shows that Roquet had the apparent authority to extend or to waive her premium due date. First, Lyming maintains that F & C did nothing to cure the impression that Roquet could act upon the matter of premiums as he did with the initial policy. There is no evidence in the record, however, that Roquet previously extended or waived the premium due date. When Lyming initially applied for insurance with F & C, she paid to Roquet a required premium deposit.

Later, Lyming paid the premium balance by the April 14, 2002, due date. Moreover, F & C did inform Lyming that in order to apply for renewal coverage, a minimum of \$142 must be received by May 26, 2002. Lyming was further instructed to send her payment to F & C. As a result, the evidence fails to support Lyming's statement.

Second, Lyming asserts that she was told by F & C to deal with Roquet concerning payment of her premium and other day-to-day matters. In making this assertion, Lyming fails to cite to a place in the record where such statements have been made. In her statement of facts, however, Lyming does

point to her deposition testimony where she stated that a representative of F & C told her to contact Roquet regarding her May 30, 2002, accident.

In addition, Lyming testified: "I assumed because Roquet Insurance's name and number was on here that I could make my payments to them because that's how I had started. It was an assumption." Lyming's assumption, however, does not establish that she was told by F & C to deal with Roquet concerning premium payments. In fact, Lyming was instructed to send her payment on her renewal policy to F & C. She was also instructed to contact the number for F & C if she had questions about her bill.

Third, Lyming points out that Roquet testified that he was authorized to accept renewal premiums on behalf of F & C. In considering this fact in its February 2004 memorandum opinion and order, the trial court stated:

"While it is true that Roquet was authorized or permitted to accept premium payments, notwithstanding Farm & City had designated the place of payment of premiums due to be at its office directly ... nevertheless, such permitted or condoned authority in Roquet to accept payments cannot be extended and transformed into an authority in Roquet to alter Plaintiffs contract with Farm & City as to the date premiums must be paid, the date for which Plaintiff had been clearly advised by Farm & City."

We agree with the trial court. The fact that Roquet was permitted to accept renewal premium payments cannot reasonably be translated into an authority to alter the payment terms on a renewal policy.

Fourth, Lyming points out that she had a prior F & C claim denied by Roquet. The claim referred to by Lyming was made in February 2002, the day after she applied for insurance coverage. F & C maintains that, without even notifying them, Roquet determined that Lyming's car had been damaged before she applied for insurance. F & C points out that once Lyming disputed Roquet's finding, the claim was submitted to F & C and then paid.

The record on appeal shows that the claim was paid. The evidence fails to establish whether F & C gave Roquet the authority to deny claims. Because it appears that F & C paid the claim after Roquet's initial denial, the evidence tends to establish that Roquet did not have the apparent authority to deny claims.

Finally, Lyming asserts that she was given an F & C receipt when she made her payment to Roquet. F & C contends, however, that this receipt is not their document. Instead, F & C maintains that it is an internal accounting document used by Roquet.

Apparently, Lyming attempts to establish that F & C, by giving Roquet either the express or apparent authority to perform these functions on behalf of the company, led her to believe that Roquet had the authority to extend or to waive her premium due date. As we have pointed out, however, some of Lyming's asserted facts are fatally flawed. Moreover, even if these asserted facts were true, they fail to show that Roquet had the apparent authority to extend Lyming's premium due date. Lyming could not have reasonably relied on these facts to establish that Roquet had the authority to extend or to waive the premium due date on her renewal policy.

In finding that Lyming had failed to set forth facts establishing that Roquet had the apparent authority to extend a premium due date, the trial court stated:

"Here, [Lyming] can point to no fact emanating from any conduct or practice of Farm & City upon which she could ground, being 'a person of ordinary prudence, conversant with business usage[s], and the nature of the particular business', an assumption that Roquet was authorized to extend the premium due date of which she had been clearly advised by Farm & City."

Here, Lyming has failed to bring forth evidence that establishes F & C either intentionally or through lack of ordinary care induced and permitted her to believe that Roquet was authorized to waive or extend her premium due date. In fact, Lyming's deposition testimony indicated that no one at F & C ever told her that Roquet had the authority to extend her premium due date. We find that Lyming has failed to meet her burden to present evidence of a genuine issue of material fact concerning Roquet's apparent authority in extending or waiving her premium due date.

B. Agent - Roquet Liability

The present case involves a failure to renew insurance rather than a failure to procure insurance. Roquet's failure to renew Lyming's insurance when he accepted her partial premium payment did not make him an insured.

An agent who fails to procure insurance may be sued for breach of contract or negligent default in the performance of a duty imposed by contract.

Here, Roquet's liability could have been based on his negligence or on the theory that he breached a contract with Lyming. Nevertheless, Roquet was not an insurer.

NOTE: This claim was settled at the district level for \$1,500.

E&O COVERAGE

Employers Reinsurance Corporation v. Anthony L. Muro, Jr., et al.

Appellate Court of Connecticut - Dec. 21, 2004.

I. Background

In 1997, 1998 and 1999, Muro was licensed to sell life insurance in Connecticut. During that time, Muro advised the defendant clients to sell all or part of their existing annuities and insurance policies (insurance products), and to purchase promissory notes from World Vision Entertainment, Inc., and Sebastian International Enterprises, Inc., with the proceeds from the sales. Shortly thereafter, the notes became valueless due to the insolvency, liquidation or bankruptcy of World Vision Entertainment, Inc., and Sebastian International Enterprises, Inc.

The defendant clients initiated separate lawsuits against Muro in which they claimed that they incurred losses from the sale of their insurance products and the purchase of promissory notes that later became worthless. Muro sought coverage under the professional liability policy he had purchased from the plaintiff through Midland National Life Insurance Company, he. The plaintiff initially defended the actions under a reservation of rights.

On May 31, 2002, the plaintiff initiated an action for a declaratory judgment and requested the court to rule that Muro's alleged acts were not covered under the policy. The defendant clients, along with Robert Pitruzzello and Virginia C. Pitruzzello, joined the declaratory judgment action as party

defendants. With the action pending, the parties negotiated a partial settlement of their claims against Muro in which they liquidated the amount of the defendant clients' damages, and they agreed that the plaintiff would pay damages to the defendant clients if the court found that Muro's negligent conduct that caused the defendant clients' losses was covered under the terms of Muro's professional liability insurance policy with the plaintiff.

As part of their stipulation, the defendant clients agreed not to pursue liability against Muro in his personal capacity. The plaintiff thereafter filed a motion for summary judgment in which it asserted that the claims made against Muro by the defendant clients were not covered under the professional liability policy or, in the alternative, that Muro's actions were specifically excluded from coverage under several policy exclusions. The court granted the plaintiffs motion on June 2, 2003, and rendered judgment for the plaintiff. This appeal followed.

II. Analysis & Decision

On appeal, the defendant clients claim that the court improperly concluded that Muro's advice to sell the insurance products did not cause them to suffer any loss or damage. In its declaratory judgment complaint, the plaintiff asked the court for, inter alia, a "declaration that [the plaintiff] has no obligation to defend or indemnify Anthony Muro, Jr. for the underlying suits." In rendering judgment in favor of the plaintiff, the court ruled that Muro's advice to the defendant clients to sell their insurance products was not covered by the policy because any loss resulting from the sales was superseded by Muro's advice to purchase the promissory notes.

In its memorandum of decision, the court ruled: "The court construes the express inclusion of 'licensed' services to evidence the contracting parties' intent to restrict coverage to damages which flow directly from deficient performance of a licensable act rather than to allow coverage for consequential damages which occur because of the doing of subsequent unlicensed acts, such as the purchase of worthless promissory notes."

In our assessment of whether the court correctly held that Muro's advice to the defendant clients to sell their insurance products was not covered under the policy, we look first to the policy itself. If the language of an insurance policy is unambiguous, the interpretation of the terms of the policy is a question of law over which we exercise plenary review. Here, the operative language is plain. By the terms of the policy, the plaintiff agreed to insure against any of Muro's negligent acts arising out of the conduct of his business as a licensed life, accident and health insurance agent.

It is undisputed that Muro's advice to the defendant clients to sell insurance products they owned occurred in the course of his business as a licensed insurance agent. In their actions against Muro, the defendant clients alleged that Muro's advice to sell insurance products caused them financial losses. In response to the plaintiffs declaratory judgment action, the defendant clients produced evidence that they had submitted claims for losses they incurred, including surrender charges, that were based solely on Muro's advice to sell.

This claim patently falls within the coverage provisions of Muro's policy with the plaintiff. In rendering summary judgment on the ground that all of the defendant clients' losses were caused by their subsequent purchase of worthless promissory notes, the court improperly decided the factual question regarding the allocation of the defendant clients' losses. In short, whether the defendant clients suffered damage as a result of selling valuable insurance products or, in the alternative, whether their losses were caused solely by having followed Muro's advice to purchase worthless promissory notes presents a question of fact that is not appropriate for disposition by summary judgment.

Because it is apparent that the plaintiff owed a duty of coverage for any of the defendant clients' damages that flowed from their sale of insurance products, the court should not have rendered summary judgment. The judgment is reversed and the case is remanded for further proceedings in accordance with law.

AGENT MISREPRESENTATION

Pan-American Life Insurance Company v. Roethke

Supreme Court of Kentucky - Nov. 22, 2000.

I. Background

D & B Roofing, Inc., is owned and operated by Stephan Roethke, and his wife Karen. Stephan is the president and Karen is the secretary/treasurer. In January 1992, Karen, on behalf of D & B, purchased individual health insurance coverage for one of D & B's employees through Joe Maresca. In April 1992, Karen, on behalf of D & B, purchased two more individual health insurance policies through Maresca. Physician's Mutual was the insurer on these three policies and Maresca, at the time, was an agent for Physician's Mutual. These three policies covered work-related injuries and illnesses, which was important to the Roethkes because both of them had previously rejected coverage under the Kentucky Worker's Compensation Act.

In July 1992, Karen and Maresca began discussing the possibility of obtaining group coverage for D & B's employees. Maresca told Karen that D & B could get better benefits, more coverage, and lower premiums with a group health policy. Karen testified that it was Maresca's urgings that better coverage could be obtained more cheaply that led her to consider switching to group health coverage.

On August 17, 1992, Maresca completed an "Application and Subscription Agreement" for group health coverage with Appellant, Pan-American Life Insurance Company ("PALIC"). Karen signed the application and was present when Maresca filled it out.

The PALIC group policy did not automatically cover work-related injuries and illnesses, while the individual policies with Physician's Mutual did. Rather, this coverage was optional under the PALIC policy. Section V, entitled "Benefits Desired," of the application that Maresca filled out and Karen signed, included the following paragraph:

"Occupational Coverage: Available if Worker's Compensation coverage not required by state law.

_____We elect 24-hour Occupational Coverage and agree to pay additional premiums required for the following individuals:

Rates based on Industry Code_____ "

The blank following this optional coverage was marked "None."

Karen testified that during her meeting with Maresca in regard to the application, she was not notified that coverage for work-related injuries was optional and obtainable only by purchasing a rider. She

also testified that the list of quotes for group coverage did not have any separate notation for occupational or work-related coverage.

She stated that the prior, Physician's Mutual policy did not require a rider, and that she believed the new policy "gave me exactly what the other policy did because he (Maresca) told me this is gonna be better."

Karen also testified that "I did not know what occupational coverage was." Because the existing policies provided coverage for work-related injuries and illnesses and she believed that "he was just trying to sell me another gimmick," Karen admits that she interrupted Maresca when he asked her if she wanted occupational coverage.

The agreement that Maresca had with National Insurances Services, Inc., specifically provided as follows:

"If this application is approved and I receive a license to represent any insurance company on whose behalf... (NIS) markets or administers business ... I understand that I will act as an independent contractor, not an employee or agent of NIS or any insurance company NIS represents.... As acknowledgment of my responsibility to each person to be insured through any coverage marketed or administered by NIS, I agree to fully explain to such persons all benefits, limitations and exclusions that pertain to any coverage I solicit. This explanation will occur prior to or concurrently with the solicitation and completion of any required individual enrollment material."

Also of importance in the decision of this case is language found in the application signed by Karen and completed by Maresca:

"The licensed broker who solicited this Application and Subscription Agreement... was acting as an Independent Contractor and not as a Broker of PALIC or NIS. Furthermore, the person who solicited this Agreement or upon whose explanation of coverages and benefits we relied is in fact our Broker for purposes of this Agreement. We understand as an Independent Contractor and as our Broker that person has no right to bind this coverage, or to alter terms or conditions of any Policies or any Enrollment Card or to waive any requirements of PALIC or NIS, or to adjust any claims for benefits under this insurance for which we are applying."

On December 28, 1992, Stephan was rendered a quadriplegic when he fell through a roof during an onsite inspection at a D & B Roofing Company job. PALIC denied Stephan medical benefits because his injuries were work-related.

Stephan filed suit against PALIC, NIS, and Maresca. In the suit, he alleged:

1. That PALIC and NIS are in breach of contract for denying payment of medical expenses incurred due to the fall;
2. That PALIC and NIS were negligent in their training and selection of Maresca as their agent;
3. That Maresca "made misrepresentations" and "fraudulently concealed facts" from D & B which induced D & B to obtain group health coverage from PALIC;
4. That PALIC and NIS are vicariously liable for Maresca's negligent acts; and
5. That PALIC and NIS have violated the Consumer Protection Act and the Unfair Claims Settlement Practices Act.

The trial court granted summary judgment to PALIC and NIS, finding that even if Maresca misrepresented the terms of the new policy, he had no authority to bind PALIC or NIS or impose

liability upon those entities for any risk not covered by the terms of the policy, based upon his limited liability.

The Court of Appeals reversed, holding that because the circuit court correctly held that Maresca's authority was that of an agent, liability for his acts could be imputed to PALIC if the jury found sufficient evidence that the agent made affirmative misrepresentations about the coverage. The Court of Appeals further held, however, that there was no cause of action against the two companies for failure to properly train Maresca, or for negligence in selecting Maresca as an agent.

II. Analysis & Decision

The basic question to be answered here is whether Maresca acted as agent for PALIC in the transaction with Karen, and, if he was PALIC's agent, whether he acted within the authority granted to him by his principal. If he did both, then the question becomes whether there is sufficient evidence to present the jury with the question of whether he misrepresented the coverage he offered and thus misled the Roethkes to their detriment.

An agent is defined under Kentucky law as follows:

"An agent" is an individual, firm, ... [or] corporation ... appointed by an insurer to solicit applications for insurance or annuity contracts or to negotiate insurance or annuity contracts on its behalf, and if authorized to do so by the insurer, to effectuate and countersign insurance contracts.

The liability of a company for the acts of its agent is set forth in KRS 304.9-035, which provides as follows:

"Any insurance company shall be liable for the acts of its agents when the agents are acting in their capacity as representatives of the insurance company and are acting within the scope of their authority."

The previously-quoted agency agreement NIS had with Maresca, as well as the aforementioned statement in the application for insurance executed by Karen, are relied upon by PALIC to avoid the effect of the above statutes, which have never been authoritatively construed by this Court. Kentucky statutory and case law have historically provided that anyone who solicited and received applications for insurance on behalf of an insurance company was an agent of the company "anything in the policy or application to the contrary notwithstanding."

Many jurisdictions have likewise enacted laws making an insurance intermediary the agent of an insurance company for whom it solicits business. The general purpose of the statutes is to prevent an insurer from denying responsibility for the representations and actions of an agent from whom applications are voluntarily accepted and to protect an applicant who relies on such representations or actions.

In Motorists Mut. Ins. Co. v. Richmond, KV.ADP.. 676 S.W.2d 478 (1984), the Court of Appeals expressed similar sentiments regarding the need to protect consumers from insurers who, in drafting contracts of adhesion, attempt to exculpate themselves from liability for the mistakes of those who market their product. Therein, the court stated:

"Few persons understand insurance who have not made it a special study. The agent who comes to get the insurance is the only person they deal with or know in the transaction. The

rule that he represents the company and not the insured in taking the application is just and is generally recognized."

The trial court determined that Maresca was an agent for PALIC in soliciting D & B's application for the group health insurance contract. The plain language of KRS 304.9-020 and the concern expressed in our case law for the need to protect insureds from overreaching supports this finding. PALIC's attempts to avoid the principal-agent relationship by providing otherwise in its agreement with Maresca and in the application for insurance are of no avail as the statute overrides any conflicting provisions. We agree with Roethke and the trial court that, for the purpose of the transaction at issue, Maresca was the agent of PALIC.

KRS 304.9-035 and settled principles of agency law provide that an insurer, as principal, is liable for the acts of its agents acting within the scope of their authority. While we agree with the trial court's observation that the agency statutes do not determine the scope of an agent's authority, we believe the trial court erred in concluding Maresca was not acting within the scope of his authority when he allegedly misrepresented the coverage of the group policy to Karen.

It is abundantly clear to us that Maresca was acting within the scope of his authority when he allegedly induced Karen to change her health insurance coverage from Physician's Mutual to PALIC, by misrepresenting the extent of coverage contained in the latter's policy. The NIS contract appointing Maresca to transact business gave him actual authority to "fully explain" to all potential customers the "benefits, limitations and exclusions" pertaining to coverage in the plans marketed. Indeed without such authority it would be difficult to sell the product.

It is not necessary for Roethke to show that PALIC instructed Maresca to misrepresent the coverage in order to establish that Maresca was acting within the scope of his authority. The proper question is not whether the principal authorized the specific wrongful act; if that were the case, principals would seldom be liable for their agents' misconduct. Rather, the proper inquiry is whether the agent was acting within the scope of the agency relationship.

This holding does not make the insurer absolutely liable for the agent, relieving the agent of responsibility. It is only liable when the agent acts within the scope of his authority, the insured reasonably relies upon that act, and the reliance constitutes the cause of the insured's damage. Additionally, Maresca remains liable for his own tortious conduct, and there is nothing in the record that would prevent PALIC from seeking indemnity from its agent.

This is a case in which affirmative misrepresentations about coverage are alleged, not simply the failure to advise a potential insured about optional coverages. PALIC assumed the risk that its appointed agent might misrepresent the coverages it offered - the provision of written material that pointed out the policy's exclusion of work-related events does not discharge the agent's duty. In other words, the insured's failure to read and comprehend the policy has no legal effect: it may not serve as a sword for the insured nor as a shield for the agency. This is true whether the underlying claim is for contract reformation or recovery based upon negligence of the agency.

Maresca was not only authorized but agreed "to fully explain to [Karen] all benefits, limitations and exclusions that pertain to [the] coverage [he] solicited." According to Karen, he attempted to accomplish this by representing to her that the new group coverage was "gonna be better" than the existing individual coverage that provided coverage for work-related injuries and illnesses. Whether Maresca was prevented by Karen from fully explaining the coverage of the group policy is a factual issue for the jury to resolve in determining if he misrepresented the coverage to her.

Finally, we can find no authority which requires an insurer to train its soliciting agents. Although it would greatly benefit insurers to train their agents well so as to avoid the type of claim presented here, no such legal duty to train exists. Furthermore, we agree that NIS cannot be held liable for the negligent selection of Maresca, because Maresca was duly licensed by the state. Any liability owed to Roethke by PALIC would be imposed vicariously.

APPLICATION PROCESSING

The Doctors Company v. Vincent

Supreme Court of Nevada - Oct. 13, 2004.

NOTE: The underlying claim is what is noteworthy in this case.

I. Background

In February 1998, Woods sought short-term medical coverage through Vincent, an independent insurance agent. After some inquiries, Vincent assisted Woods in completing a TDC form application for coverage. Woods claimed that he paid the initial premium to TDC by delivering a check to Vincent on February 7, 1998.

Vincent claimed that he or his assistant mailed the check with the TDC application form to TDC's insurance administrator, NMA, shortly before midnight on February 9, 1998. The forwarding envelope bore Vincent's private meter postage mark of that date.

Because Vincent was not a formally designated agent of TDC at that time, he included his own written application to act as a TDC agent with Woods' insurance application. Either Vincent or Woods checked a box on the TDC application form indicating that the effective date of coverage was to be "the date after postmark."

Notwithstanding Vincent's representations concerning the date of mailing, the United States Postal Service (USPS) did not place its postmark on the envelope until February 12, 1998.

NMA received the envelope on February 17, 1998, and processed the application. Evidence indicated that NMA initially accepted the coverage as of February 10, 1998, apparently based upon Vincent's postage meter mark of the previous day. However, based upon the USPS postmark, coupled with the request that the effective date of the coverage commence "the date after postmark," NMA changed the effective date of the policy to February 13, 1998.

Ironically, Woods was seriously injured in an accident at his home on February 11, 1998, between the two possible starting dates for coverage, February 10 and 13, 1998. Based upon the USPS postmark date of February 12, 1998, TDC ultimately denied Woods' claims for approximately \$350,000 in medical expenses. In this, TDC relied on a preexisting-condition exclusion in its policy. Woods filed his complaint in district court against Vincent and the TDC defendants seeking special, general and punitive damages. The suit against Vincent included claims of negligence, breach of fiduciary duty and intentional infliction of emotional distress. The claims against the TDC defendants included: (1) negligence, (2) breach of contract, (3) estoppel, (4) breach of the implied covenant of good faith and fair dealing, (5) unfair trade practices, (6) breach of fiduciary duty, and (7) infliction of emotional distress. Woods also alleged that TDC was vicariously liable for Vincent's actions on an agent/principal theory.

The question of which postage mark triggered coverage became central to the controversy during discovery. On one hand, the decisions to change the effective date of coverage and reject Woods'

claim for benefits could reasonably be justified by the questionable circumstances under which Vincent forwarded the application and Woods' coincidental accident within the disputed coverage window.

In this, testimony from postal service witnesses implied that Vincent backdated his postage meter to conceal his failure to timely submit the application. On the other hand, several NMA employees gave conflicting deposition testimony as to what constituted a postmark for purposes of establishing effective dates for such policies, and TDC apparently lacked policies and procedures governing which postmark triggered the effective date of coverage under such circumstances.

In its totality, evidence against TDC supported Woods' claims that (1) TDC originally accepted coverage as of February 10, 1998, thus initially recognizing Vincent's postage meter mark as stimulating commencement of coverage; (2) TDC only rejected coverage upon learning of Woods' claim for medical benefits; (3) TDC's separate conduct led to its contractual and extra-contractual exposure; and (4) given the initial acceptance of coverage as of February 10, 1998, and given that the TDC application form seemingly empowered Vincent to set the coverage commencement date, TDC treated Vincent as its agent for the purpose of placing coverage.

TDC moved for summary judgment on the coverage and vicarious liability issues. After the district court denied the motion in its entirety, TDC evaluated the potential risk of a substantial compensatory and punitive damages verdict. Shortly before trial, based upon the potentially negative evidence that surfaced during discovery, TDC settled with Woods for \$2.75 million. The TDC settlement did not, by its terms, extinguish Vincent's liability.

All parties stipulated in open court to the statutory good faith of the settlement between Woods and the TDC defendants. At the hearing memorializing the TDC settlement, Vincent's counsel reported that he too had settled with Woods, but for the relatively nominal sum of \$25,000. After TDC refused to agree to the good faith of Vincent's settlement, Vincent moved for its approval. Briefs for and against approval comprehensively summarized the history of the case. Although noting the disparity between the two settlements, Vincent argued that he had done nothing wrong, and that his liability was only tangential in relation to TDC's mishandling of the claim, i.e.,

TDC's wrongful refusal to pay benefits in connection with Woods' accident; TDC argued that the Vincent/Woods' settlement was not an arm's-length arrangement, that the settlement was improperly calculated to cut off its vested contribution and indemnity rights, that its exposure was entirely related to Vincent's failure to timely forward Woods' insurance application, and that Vincent's nominal settlement was grossly disproportionate to the relative degree of his exposure to Woods. TDC underscored its arguments that Vincent's settlement was entered into in bad faith with the fact that Vincent's errors-and-omissions insurance provided liability coverage with policy limits of \$500,000. Thereafter, without a hearing, the district court determined that Vincent settled with Woods in good faith:

"Woods has determined that settlement with Vincent is in his economic best interest. Therefore, Woods is willing to settle this matter for the amount of \$25,000. Based upon the record or the lack thereof at this point, TDC has failed to show that the \$25,000 settlement agreed to by Woods is disproportionately lower than Vincent's fair share of the damages."

Accordingly, the district court approved Vincent's settlement and entered a final judgment. On appeal, TDC challenges the order of approval because it effectively barred TDC's claims for contribution or implied indemnity against Vincent. TDC filed a separate contribution and indemnity action in the district court against Vincent, which the district court stayed pending our resolution of TDC's appeal in this case.

II. Analysis & Decision

The district court apparently failed to assess the good faith of Vincent's settlement as it related to TDC's potential claims for implied indemnity. Thus, the matter is reversed in part and remanded for the district court to determine whether the settlement was in good faith for the purpose of extinguishing TDC's potential implied indemnity rights.

MISREPRESENTATION

Floras v. Green

District Court of Appeal of Florida - June 16, 2004.

I. Background

Rachel Green obtained supplemental cancer insurance from Alfredo Flores via Capital Insurance Agency during her open enrollment period. At the time, she was covered under a supplemental cancer insurance with Colonial Life & Accident Insurance Company ("Colonial Life"). After consulting with Flores and a Colonial Life representative, Ms. Green cancelled her Colonial Life coverage, believing that the cancellation would not take effect until the end of the insurance year. It is undisputed that Ms. Green's pay stub reflected a "post-tax" supplemental policy. Ms. Green testified that she was assured by Flores and Nelson Fabel, a Colonial Life representative that the Colonial Life policy would remain in effect until January 1st, 1998.

The distinction between a "post-tax" policy and a "pre-tax" policy was explained at trial. If an employee with a "post-tax" policy elects to cancel the policy, the cancellation is effective immediately upon notification to the insurer. On the other hand, if an employee with a "pre-tax" policy elects to cancel, the cancellation does not take effect, and coverage continues, until the end of the existing policy period.

Approximately one month after cancelling the Colonial Life policy, Ms. Green was diagnosed with cancer. Ms. Green testified that she called Colonial Life when she returned home and was advised that her policy was cancelled effective October, 1997. Nevertheless, Ms. Green filed an application for payment of benefits under the Colonial Life policy and was denied benefits. As a result, Ms. Green filed a three count Complaint against Flores, Capital Insurance Agency, and Colonial Life. Specifically, Ms. Green brought:

- A negligent misrepresentation claim against Flores, alleging that Flores made a false statement regarding the coverage period of Ms. Green's cancer policy;
- A negligent misrepresentation claim against Capital Insurance for the acts of its agent, Flores; and
- A claim for wrongful cancellation of Insurance Policy against Colonial Life, alleging that she was told her policy would remain in effect through the end of 1997.

Ms. Green sought damages for payment of medical bills, attorney fees and costs. Ms. Green subsequently settled with Colonial Life for \$1,000. Flores and Capital Insurance served Ms. Green with a formal Offer of Judgment/Proposal for Settlement in the amount of \$5,000. Ms. Green did not accept the offer and the matter proceeded to trial.

Flores and Capital Insurance filed a Motion in Limine to restrict the presentation of any evidence relating to pain and suffering, mental anguish, and unpaid medical bills. Flores and Capital Insurance argued that any state of mind claim was barred by Florida's Impact Rule; and that Green did not plead Fraudulent Misrepresentation or Punitive Damages. Flores and Capital Insurance argued that Green's damages were limited to the policy benefits that would have been provided by the Colonial Life policy. The trial court denied the Motion in Limine and the matter proceeded to trial.

At trial, Flores and Capital Insurance renewed the Motion in Limine after Green's counsel questioned Green about her mental anguish and distress. The trial court allowed the testimony, reasoning that she could set aside any award for mental anguish. Flores and Capital Insurance renewed the Motion again after Ms. Green's counsel introduced evidence of the medical bills. Flores and Capital Insurance argued that introduction of the medical bills would confuse the purpose of the supplemental policy, to wit, that Ms. Green's HMO covers the bills and the Colonial Life policy was only a supplemental insurance policy. The court allowed the bills into evidence, explaining to counsel that she could later enter a Directed Verdict.

The jury subsequently returned its verdict in favor of Ms. Green, and awarded her \$20,000 for medical expenses and \$105,000 for pain and suffering. The jury also found that Ms. Green herself was 15% negligent. Flores and Capital Insurance filed a Motion for Judgment Notwithstanding the Verdict, for New Trial, or for Remittitur. As it had previously ruled during trial, the trial court struck the \$105,000 pain and suffering award, finding that it was contrary to Florida law, and that no claim to support was pled or demanded in the Complaint.

With respect to the \$20,000 award for medical expenses, Flores and Capital Insurance argued that the award should be reduced to \$3,480, which is the maximum benefits that Ms. Green was entitled to during the period for which she would have been covered by Colonial, from October of 1997 (when she was diagnosed) through December of 1997 (the end of the policy period). The court denied the remittitur.

On rehearing, remittitur was denied again. Final Judgment was entered for Green in the amount of \$16,000-the \$20,000 verdict amount, less 15% for her own negligence, less \$1,000 to set off Colonials settlement. We agree with Flores and Capital Insurance.

II. Analysis & Holding

Generally, an insurance agent's liability for negligence leading to the cancellation of an insurance policy cannot exceed the amount of the insurance obtained.

In the instant case, Ms. Green brought suit for Negligent Misrepresentation against Flores and Capital Insurance, and her damages are a result of the cancellation of a supplemental insurance policy. Consequently, her recovery is limited to the policy limits of the Colonial Life policy. Accordingly, we conclude that the trial court erred in denying Flores and Capital Insurance's Motion for Remittitur, and remand the matter for calculation of the Colonial policy limits.

MISPRESENTATION

AGENT INDEMNIFICATION

Farmers Mutual of TN v. Athens Insurance

Court of Appeals of TN - Oct. 4, 2004.

I. Background

In this declaratory judgment action filed by Farmers Mutual of Tennessee ("Farmers"), against Athens Insurance Agency ("Agency"), and Charles and Carolyn Spurling, ("Insureds"), the Trial Court ordered Farmers to pay insureds for their house under the policy and dismissed Farmers' claim against the agency.

Farmers alleged that insureds purchased homeowners insurance from Farmers through the agency and that the application for insurance contained several material misrepresentations of material fact. The insured house was destroyed by fire on June 29, 1999, and Farmers became aware of the misrepresentations during its investigation of the fire loss. Plaintiff also asserted that if the agency was responsible for the misrepresentation, then it should indemnify Farmers.

Following an evidentiary hearing, the Trial Court ruled that the insured, Charles Spurling, did not sign the application for the insurance policy, and that the insureds were not guilty of any fault or material representations relating to the taking of the application for insurance or the issuance of the policy. He declared the insureds were entitled to full policy benefits of \$75,000.00 plus pre-judgment interest in the amount of \$13,722.00.

He ultimately denied recovery by Farmers against the agency, and also awarded a bad faith penalty to the insureds for their attorney's fees.

On appeal, Farmers has raised these issues:

- Did the Trial Court err in holding that Farmers was not entitled to indemnification from the agency?
- Did the Trial Court err in granting pre-judgment interest to the insureds?
- Did the Trial Court err in assessing a bad faith penalty against Farmers?

Farmers insists the Trial Court erred in denying indemnification against the agency, because the Trial Court found that the insureds were not guilty of any fault or misrepresentation with regard to the application or issuance of the policy, and the Court further found that the signature on the application was not Spurling's. Thus, the argument goes that the agency was guilty of the misrepresentation and should indemnify Farmers in this action.

II. Analysis & Decision

No contract for indemnification was offered in evidence, however, indemnification can result from an express contract between the parties, or an obligation to indemnify can "arise by implication from the relationship of the parties".

The Trial Court decided this issue on the basis of comparative fault, however, the issue for consideration is whether there is an implied right of indemnification based upon the principal/agent relationship between Farmers and Athens.

An insurance agent who fails to make a full disclosure of all matters concerning the risks and hazards of a prospective insurable interest, or to report the issuance of a policy as directed in his contract of agency, may incur liability to the insurer for exposing the insurer to liability for claims of loss under policies, where such claims naturally result from the agent's wrongful conduct.

It must be proved, however, that the agent's conduct was the proximate cause of the loss to the insurer, and where the insurer was not prejudiced by the failure to report the policy issuance or to fully assess the risk involved, and would have done nothing differently or incurred no greater loss with or without such knowledge, the agent may escape liability for his wrongful conduct.

As a rule, the cases demonstrate an agent may be held liable to an insurance company when his conduct causes the insurance company to suffer a loss that it otherwise would not have suffered. In this case, the only proof from Farmers on this issue was from Rufus Watson, the marketing manager for Farmers. He stated that he felt Farmers would not have issued the policy if they had seen the "before" photos of the house. However, Farmers did issue the policy without having seen any photos, based upon the application, which clearly contained misrepresentations about the property.

Watson admitted, however, that he could not say Farmers would not have issued the policy if the roof was not listed as new, or if the application did not say the house had vinyl siding. He further testified that he assumed from the application that the \$75,000.00 value was the purchase price plus the cost of renovations, as the coverage sought was \$75,000.00.

There was no proof introduced at trial that Farmers would not have issued the policy if the application had been correct. Watson admitted that the application represented the house was being completely gutted, yet Farmers still issued the policy with no photos of the house and having done no inspection. Moreover, at the time of the loss, the information contained on the application was then substantially correct, as all of the renovations had been completed by that time. The insured testified that everything in the house had been renovated and that he had, in fact, put on a new roof, installed new wiring, a breaker box, and new vinyl siding. He gave the opinion that the house was worth at least \$75,000.00. The evidence shows that Farmers failed to establish that its loss was solely attributable to the misconduct of the agent.

While Farmers initiated the declaratory judgment action, the insureds had to wait nearly four years to be paid for the loss of their home, through no fault of their own. Prejudgment interest is an element of damages to be awarded in accordance with principles of equity.

MISREPRESENTATION

Schurmann v. Neau

I. Background

Schurmann attempted to purchase disability insurance that would provide \$4,000 per month of income continuation in the event of his total disability. To do so, he met with Neau, an insurance agent, to discuss his insurance needs.

Schurmann, who was self-employed as a dental appliance technician, stated his interest in obtaining an increase in the disability insurance coverage he currently had. According to Schurmann, after Neau reviewed a financial statement Schurmann provided from his accountant, Neau said that Schurmann should qualify for \$4,000 to \$6,000 per month disability insurance, which would be in excess of any social security and other payments Schurmann might be entitled to receive in the event of his total disability.

Neau completed an application to Franklin for disability insurance coverage in the amount of \$4,000 per month to age sixty-five, and Schurmann signed it. At the time of the application, Schurmann gave Neau a check for the first premium payment.

Later, again according to Schurmann, Neau told him that his application had been approved by Franklin and he would receive a policy which would provide \$4,000 per month income for total disability. Franklin did issue a policy, effective January 1, 1995, that stated that the monthly payment for total disability was \$4,000.

On January 18, 1995, Schurmann slipped on an icy driveway, hit his head and suffered a severe injury resulting in his total disability. Following his injury, Schurmann applied to Franklin for disability payments. Franklin made five monthly payments of \$4,000 each; then it stopped all payments because it had concluded that Schurmann's past income was insufficient to qualify him for \$4,000 per month payments and that any benefits due must first be reduced by other payments Schurmann was entitled to receive.

Schurmann sued Franklin to perform under the policy. Franklin calculated that Schurmann would not be entitled to receive more than \$1,500 per month. However, as a settlement, Franklin agreed to pay Schurmann \$2,044 per month to age sixty-five, net of social security benefits Schurmann was receiving, rather than the \$4,000 per month which Schurmann believed he had purchased. Franklin also made a lump sum payment of \$47,452 as a net sum for those months in which no payment of \$2,044 had been made, after crediting amounts paid in excess of \$2,044 during the first five months. The settlement with Franklin specifically reserved any claim Schurmann had against Neau.

Schurmann then sued Neau and his errors and omissions insurer, Employers Reinsurance Corporation, alleging claims for strict responsibility and intentional misrepresentation in the sale of the insurance policy. Neau responded with a general denial and raised one affirmative defense, the failure to mitigate damages. Neau moved for summary judgment asserting that even if he made the representations Schurmann claimed, they were not actionable. The circuit court agreed with Neau and granted his motion for summary judgment dismissing Schurmann's complaint. Schurmann appealed.

II. Analysis & Holding

Schurmann claims for misrepresentation under 2 theories, strict responsibility and intentional deceit, based on the Franklin policy which afforded him less than the \$4,000 per month that he requested and Neau told him had been approved.

Neau contends that: (1) even if he made the representations which Schurmann alleges in regard to the coverage that would be afforded, the representations were made during the course of an application process. Therefore, his statements related to facts which were not then in existence or were only statements of his opinion and not actionable; (2) Schurmann did not rely on Neau's representations to his detriment; and (3) Schurmann's settlement with Franklin precludes his claim against Neau.

Agency law in Wisconsin does not insulate an agent from liability for the agent's torts. It has long been the rule that an insured whose insurer denies him benefits that he had requested his agent to secure may bring a tort action against his insurance agent for failing to procure the requested coverage. Therefore, even when an insured has settled with and released the insurer for payment of less than would have resulted if the sought-after insurance had been provided, the agent may remain personally liable in tort to the insured for failing to procure the insurance that was requested, as the agent's liability is not dependent on his relationship to the principal but is attributable to the agent's own misconduct.

However, when the insurer provides the same coverage through settlement with the insured as was requested, no action against the agent exists because he has not failed to produce what was promised.

Here, the amended complaint alleges that Neau advised Schurmann that he could apply for \$4,000 to \$6,000 per month of income continuation coverage in the event of total disability, which payments would be in addition to any social security or other benefits available to him. It also alleges that Neau completed an application, which Schurmann signed and for which he made the first premium payment, that Neau told Schurmann that his application had been approved by Franklin in the amount of \$4,000 per month and that Schurmann believed all Neau's representations to be true and relied on them to his detriment, causing him injury. And finally, it alleges that Neau had an economic interest in the sale of insurance to Schurmann and that Neau made the representations recklessly without caring whether they were true, but with the intent to deceive Schurmann.

Schurmann's settlement with Franklin was not for the full amount for which he had bargained. It was for approximately fifty-one percent of that amount. Therefore, his claim was not fully satisfied. "Even where an insured has settled and released an insurer, the agent may remain personally liable in tort to the insured for failing to procure the proper insurance."

Reversed and remanded to try the issue of Neau's liability.

FAILURE TO OBTAIN COVERAGE / NEGLIGENCE

Appleton Chinese Food Service v. Murken Insurance Inc.

Court of Appeals of Wisconsin - June 7, 1994

I. Background

Murken Insurance, Inc., and its errors and omissions carrier, Utica Mutual Insurance Company, appeal a judgment awarding damages to Appleton Chinese Food Service, Inc. (ACFS) and Shyh Fann Tyan and Bin Ti Tyan, for their damages arising from Murken's negligent failure to procure requested insurance coverage.

A fire destroyed the Tyans' building and shut down the Dragon Gate Restaurant on December 5, 1990. The building was insured by United Fire under a policy procured by Murken, an independent insurance agency. The policy provided \$140,000 in actual cash value coverage, and it did not provide any type of business interruption coverage. Following the fire, United Fire appraised the building at an actual cash value of \$52,200 and paid that sum, less deductible, to the Tyans.

The Tyans and ACFS filed suit against Murken and United Fire. The complaint alleged that the Tyans had requested a policy with replacement cost coverage and lost business income coverage. It alleged that Murken was liable in contract and tort for failing to procure the requested coverage. It further alleged that United Fire was jointly liable with Murken for the failure to procure. It also alleged grounds for reformation of the insurance policy. Prior to trial, the Tyans and ACFS settled with United Fire for \$2,000 and stipulated to a release, releasing United Fire from liability for all of plaintiffs' or remaining defendants' claims.

After a six-day bench trial, the court issued extensive findings of fact and conclusions of law. It found that Tyan had met with a Murken insurance agent, Sue Priewe, and sufficiently communicated his request for \$140,000 replacement cost coverage on the property. He also requested lost business income coverage for ACFS. Consistent with this request, Priewe prepared seven applications to various insurers seeking quotes or price estimates for \$140,000 replacement cost coverage on Dragon Gate.

Due to Murken's clerical error, the applications did not request lost business income coverage and, consequently, none of the quotes Priewe received contemplated such coverage. This fact was never discovered because the quotes were never thoroughly reviewed. On Priewe's recommendation, the Tyans eventually selected United Fire. The court concluded that coverage was initially bound at replacement cost coverage. However, before the policy was issued, United Fire informed Priewe it could not issue replacement cost coverage and instead proposed writing the policy at actual cash value.

Priewe agreed to this proposal without consulting the Tyans. The policy was ultimately issued at actual cash value and, due to the earlier error, did not include lost business income coverage. The court concluded that Priewe had breached her duty to the Tyans to exercise reasonable skill, care and diligence in obtaining the requested coverage. It concluded that she was negligent in preparing the United Fire application for coverage and by failing to adequately review the quote and the policy to determine that they included the coverage for which she intended to apply. The court also concluded that Priewe negligently failed to notify the Tyans that the United Fire policy was issued at actual cash value coverage. The court found United Fire and the Tyans were negligent to a lesser extent. It awarded the Tyans damages of \$140,000 minus the deductible and actual cash value settlement they had already received. It awarded ACFS lost business income in the amount of \$21,364.

II. Analysis & Holding

At the time Priewe met with Tyan, the property was insured through a different company for \$140,000 under an actual cash value policy, though Tyan believed he was covered at replacement cost. The court could reasonably infer Priewe was motivated to ask Tyan why he wanted \$140,000 coverage because she knew the building was currently insured at \$140,000 actual cash value and believed such coverage far exceeded the property's value. The property's actual cash value turned out to be \$52,200, and its replacement cost exceeded \$140,000. This disparity, coupled with Priewe's knowledge that only \$85,000 had been invested in the property, reinforces the inference that Priewe would have been aware that \$140,000 in actual cash value coverage was excessive.

The court could also infer that when Tyan explained to Priewe that he needed \$140,000 in coverage because it was an old structure, he was expressing his belief that the building's actual cash value was well below its replacement cost, and therefore he needed replacement cost coverage. The court could further reasonably infer that Priewe understood this expression, as is evidenced by her request for replacement cost coverage. The court's finding that Tyan sufficiently expressed his request for replacement cost coverage is not clearly erroneous.

Murken's liability is premised upon its failure to procure coverage that the Tyans actually requested. As our supreme court has noted, "[a]n insurance broker is bound to exercise reasonable skill and diligence in the transaction of the business entrusted to him and he will be responsible to his principal for any loss from his failure to do so...."

An insurance agent, such as (defendant), must use the degree of care, skill, and judgment which is usually exercised under the same or similar circumstances by insurance agents licensed to sell insurance in Wisconsin.

While there is no duty to advise the policy holder of coverages available, the agent must use reasonable skill and diligence to put into effect the insurance coverage requested by his or her policy holder, act in good faith towards that policy holder, and inform him or her of the minimum statutory requirements. A failure on the agent's part to use that skill or diligence constitutes negligence. As a general rule, agency law does not insulate an agent from liability for the agent's torts. Thus, even where an insured has settled and released an insurer, the agent may remain personally liable in tort to the insured for failing to procure the proper insurance.

An agent who does an act otherwise a tort is not relieved from liability by the fact that he acted at the command of the principal or on account of the principal, except where he is exercising a privilege of the principal, or a privilege held by him for the protection of the principal's interests, or where the principal owes no duty or less than the normal duty of care to the person harmed.

More importantly, while Murken was United Fire's agent in some respects, it acted as the Tyans' agent in seeking to procure for them the requested coverage. As the court noted: "We, therefore, do not look to Murken merely as United Fire's agent for contract purposes;" Rather, Murken can be considered as having separate duties to the plaintiff." This conclusion is supported by the evidence. Murken did not represent any one insurer. Well before the Tyans chose United Fire, Murken was acting on their behalf in seeking coverage from different companies. Murken's negligence in completing applications for estimates occurred before the Tyans were bound to United Fire.

Wisconsin cases suggest that "separate duties" Murken owed to the Tyans spring in part from a principal-agent relationship created when an agent agrees to procure insurance for a client. The principal-agent relationship may not rise to the level of a duty to advise, but it certainly extends to an independent duty to act with reasonable care, skill and diligence in procuring the agreed upon coverage.

As a dual agent, Murken is independently liable to the Tyans for its negligence while acting as their agent. Consequently, the Tyans' settlement and release of United Fire does not preclude Murken's independent liability.

Damages arising out of a broker's failure to procure insurance are commonly determined by the terms of the policy the agent failed to procure. Here, Murken failed to procure lost business income coverage from United Fire. Thus the terms of that policy control. Where the terms of the policy are unambiguous, we will simply apply those terms instead of engaging in construction.

NEGLIGENCE

Gurkin v. Wood

Tenn. Court of Appeals, 2004

I. Background

In 1997, Gurkin sought personal insurance coverage on his Ford F-250 pickup truck (the "Vehicle"). He contacted Cross-Defendant/Appellee Roy Wood ("Wood"), a casualty and property insurance agent who had done extensive business with Gurkin and his family in the past. Wood had written insurance policies for Gurkin & Son for five to seven years, car insurance for Gurkin's family members, life insurance for Gurkin and his brothers, and homeowners insurance for Gurkin's parents. Based on his personal knowledge of Gurkin and his family's business, Wood filled out the application form and, after Gurkin's approval, submitted the application to Defendants/Appellants Tennessee Insurance Company, a member of the Ingram Industries Insurance Group, Permanent General Assurance Corporation, Permanent General Companies, and Ingram Industries Group (collectively "Tennessee Insurance").

The automobile insurance application filled out by Wood included sections to indicate ownership of the Vehicle and whether the Vehicle would be used for business purposes. Tennessee Insurance's underwriting guidelines provided that vehicles owned in a company name could not be insured. In addition, the underwriting guidelines outlined whether and to what extent vehicles used in the course of business could be covered. The guidelines separated business uses into acceptable and unacceptable uses. Acceptable business uses could be covered, so long as a twenty-five percent surcharge was applied, but unacceptable uses were uninsurable. Under the guidelines, an acceptable business use of a vehicle would be the "transportation of tools and/or materials incidental to the insured's business to a job site where the vehicle will remain parked for most of the work day." Unacceptable business uses were defined as:

- Any wholesale or retail delivery such as food (e.g. Pizza, etc.) newspapers, magazines, mail, packages, retail merchandise, etc.
- Any business involving frequent stops, whether on a regular route or not, such as courier or messenger services, exterminators, debit life insurance, sales
- Vehicles displaying advertising or transporting passengers
- Autos with permanently installed mobile equipment such as hoists, air compressors, pumps, generators, spraying, welding, building cleaning, lighting, and well servicing equipment
- Employer use of a vehicle

Gurkin's application indicated that he and his wife owned the Vehicle and that the Vehicle did not have a business use.

During Tennessee Insurance's review of the application, its underwriter sent both Gurkin and Wood a diary letter inquiring whether the Vehicle displayed any signs or logos and whether the Vehicle was used for business. The insurance agent responded on Gurkin's behalf by writing "no" next to both inquiries. Tennessee Insurance accepted Gurkin's application and issued a personal vehicle insurance policy with no additional premium for business use, effective August 18, 1997.

Once insured, Gurkin used the Vehicle for 100% of his transportation needs. This included recreational activities such as hunting, fishing, and golfing. It also included driving from his home in Collierville to the Grand Junction Gurkin's Grocery, Gas and Bait, regularly driving to the bank to conduct transactions for the Grand Junction store, and occasionally bringing merchandise from one Gurkin's store to another when a store ran low on merchandise. Gurkin infrequently made bank deposits for the other stores if one of his brothers was unable to do so. Gurkin also drove from the Grand Junction store to the Moscow Gurkin's Grocery, Gas and Bait two to four times per week for business meetings with his brothers, to drop off store receipts and bills, and to distribute cash. In addition, Gurkin owned a farm that produced revenue, and he drove his truck to the farm, though he did not use it while working on the farm. When applicable, Gurkin claimed mileage for business uses on his income tax return.

On November 30, 1998, Gurkin was involved in a vehicular accident with an uninsured motorist. Gurkin suffered personal injuries and property damage in the accident, and because the uninsured motorist was at fault, Gurkin filed a claim with Tennessee Insurance. After investigating the claim, Tennessee Insurance sent Gurkin a letter indicating that it had learned that the Vehicle had commercial license plates and was used for business purposes. The letter essentially told Gurkin that Tennessee Insurance might rescind his insurance on grounds of material misrepresentations in his application. Later, after further investigation, Tennessee Insurance rescinded Gurkin's insurance coverage, back to the effective date of the policy.

Gurkin filed suit against Roy Wood, Associates General Insurance, Inc., and Tennessee Insurance, seeking a declaratory judgment mandating payment of the insurance proceeds as well as compensatory and punitive damages. Tennessee Insurance filed a counter-claim against Gurkin, seeking rescission of the insurance contract based on material misrepresentations and omissions in the insurance application. Tennessee Insurance also filed a cross claim against Wood, seeking indemnification under Wood's contract with Tennessee Insurance, which required Wood to indemnify the company for losses resulting from his negligence or other tortious conduct. By agreement of the parties, the trial court first heard only the issue of coverage.

At the trial, Allison Garretson ("Garretson") vice-president of underwriting and premium finance for Permanent General Companies, testified on behalf of Tennessee Insurance. Garretson testified that Gurkin's insurance coverage was rescinded based on two material misrepresentations in his insurance application. First, Garretson testified, the insurance company's investigation indicated that the Vehicle was not owned by Gurkin personally, as was stated on his insurance application, but rather by a commercial entity. Second, she testified, Tennessee Insurance had learned that Gurkin used the Vehicle for business purposes. Garretson said that, under the underwriting guidelines, had Tennessee Insurance known that the Vehicle was commercially owned, it would not have been insured. Even assuming the vehicle was personally owned by Gurkin, she testified, had Tennessee Insurance known about the business use of the vehicle, it would have charged the additional premium required by the underwriting guidelines for all acceptable business uses.

At the outset of the trial, the parties had stipulated that the Vehicle was registered under the name "Gurkins." In her testimony, Garretson cited this fact as support for Tennessee Insurance's contention that the Vehicle was commercially owned, rather than by Gurkin individually, based on her understanding that "Gurkins ... is a company."

Garretson testified that Tennessee Insurance concluded that the Vehicle had business uses based on a number of factors uncovered during its investigation. She noted several of Gurkin's uses for the vehicle:

Mr. Gurkin used his vehicle to drive and make multiple stops. There was quite a bit of frequency in the travel to go to Moscow and Grand Junction and the bank and the farms and so forth, and so there was a substantial amount of use that . . . met the definition of business use . . .

Garretson also noted that Gurkin had "a trader occupation that was undertaken for a profit, for a wage or a salary, and that's how the vehicle was being used was in the course of business." She testified that even though Gurkin occasionally transported merchandise from one store to the other, an unacceptable business use under the underwriting guidelines, such use would not have precluded coverage. Garretson also testified that there were errors on the insurance application completed by Wood and that, had the application and the subsequent diary letters returned by Wood indicated the name of the registered owner and all of Gurkin's uses for the Vehicle, Tennessee Insurance would have had an opportunity to investigate further and make a more informed decision on insuring Gurkin. Garretson talked about how Tennessee Insurance analyzed business use. She testified that, if a client used the vehicle for business purposes at all, the client was to indicate this on the application, and the client, agent and underwriter would subsequently discuss the nature of the business use. The underwriter would then make the decision of whether and at what rate to insure the applicant based on the underwriting guidelines. Garretson testified that "the way the vehicle is being used in the course of business may" lead to exclusion of coverage. If the use is not covered in the underwriting guidelines, "[i]t comes to the judgment of the underwriter to evaluate each scenario and each risk and understand the characteristics of each risk and make a determination" on whether to refuse coverage or provide coverage with an additional premium.

Gurkin testified on his own behalf. Gurkin said that, until shortly before the trial, he believed that the Vehicle was titled in his name. Immediately before the trial, he learned that the Vehicle was titled under the name "Gurkins." Gurkin testified that he personally paid for the Vehicle and its insurance premiums. Gurkin also entered into evidence the divorce decree between him and his wife in which he was awarded the Vehicle in the division of marital property.

Wood testified as well. Wood stated that he had known Gurkin since 1995 and that they were friends. He testified that he had written the insurance for Gurkin and Son for five to seven years, car insurance for all of Gurkin's family members, life insurance for him and his brothers, and homeowner's insurance for his parents. Wood said that, through past dealings, he had become highly familiar with the operation of the Gurkin family business and the family members' uses for their vehicles at the time he wrote the insurance at issue.

Wood explained that he wrote the insurance for Gurkin's vehicle based on a prior policy he had written for Gurkin and his personal knowledge of Gurkin's intended uses for the Vehicle. At the time he wrote the application, Wood testified, he understood Gurkin drove from his Collierville home to work at Grand Junction, stopping at the Moscow Gurkin's store two or three times a week along the way to leave receipts and bills. He testified that he understood Gurkin to stop at the bank in Grand Junction regularly for transactions related to the Grand Junction store. Wood said that he followed the underwriting guidelines, that these uses did not constitute business use under the guidelines, and that he therefore wrote the application for personal use.

Responding to a set of hypotheticals on cross examination, Wood essentially admitted that he was unaware that Gurkin would make an occasional trip to another store location to transfer merchandise, that Gurkin would drive to the Grand Junction store and then double back to Moscow for business meetings with his brothers, and that Gurkin regularly drove to work on his revenue producing farm. Wood testified that these would be considered business uses. However, Wood only considered it necessary to indicate business use on the application if it constituted over fifty percent of the use of the Vehicle. Wood asserted that, considering everything, he would still write Gurkin's insurance application as not including business use.

After hearing the evidence, the trial court found that Gurkin had made no misrepresentations to Tennessee Insurance concerning either the ownership or the use of the Vehicle. Regarding the ownership of the Vehicle, the trial court said: "I don't find that under the facts of this case that this was truly a commercially owned vehicle, notwithstanding the registration stipulation, and there is no evidence of a business owner as Gurkin's anywhere." The trial court said that, even though Gurkin's divorce decree was issued after this controversy arose, the evidence nevertheless suggested that the Vehicle was owned by Gurkin individually, pointing to Gurkin's regular and exclusive use of the payment for and financing of the Vehicle. Further, the trial court found that Wood was not negligent in failing to discover the name on the registration, and therefore not liable to Tennessee Insurance under their indemnification agreement, because "there was no testimony about the agent having some responsibility to go and check the Motor Vehicle Department's registrations as to the names of registration in terms of any claim of a breach of duty by the agent." Addressing the Vehicle's use, the trial court held:

"I just don't see any proof in the record as to what the misrepresentation as to business use is.... [T]he agent who wrote this policy, Mr. Wood, not only does not claim that there was a misrepresentation by the insured but actually disavows and disputes that there was a misrepresentation and tells the Court by his testimony that he was aware of the manner, occasions and types of uses to which this vehicle was made by Mr. Gurkin, and he said that he knew what Mr. Gurkin was doing with this truck.... [He] looked at the policy and used his best judgment that there wasn't anything in the excluded categories that his awareness as a matter of fact of the uses of this vehicle would cause him to put it into anything but the category which he put it, which was a personal vehicle."

Thus, the trial court found no misrepresentations on the Vehicle's use because Wood had overall knowledge of Gurkin's uses for the Vehicle and determined they were not business uses pursuant to the underwriting guidelines. The trial court held that there was no evidence that Wood's assessment was negligent:

"I haven't heard testimony from the defense that relates to the types of matters and manners of use with respect to, quote, business, unquote, in as matters of fact that would have materially influenced the assessment by the agent or... would contraindicate a reasonable and appropriate allocation of designation as personal with respect to this vehicle in terms of the information known to the agent, and I don't see any negligent assessment by the agent with regard to the appropriate considerations representing the interest of his principle that would constitute negligence on his part with respect to his judgment and determination that this was a personal coverage vehicle."

Therefore, the trial court determined that Wood had considered the proper factors in determining whether Gurkin had a business use for the Vehicle and that Wood's assessment that the Vehicle did not have a business use was reasonable.

II. Analysis & Holding

Tennessee Insurance rescinded Gurkin's insurance policy on the basis of Gurkin's alleged misrepresentations pursuant to Tennessee Code Annotated section 56-7-103. The statute provides:

No written or oral misrepresentation or warranty therein made in the negotiations of a contract or policy of insurance, or in the application therefore, by the insured or in the insured's behalf, shall be deemed material or defeat or void the policy or prevent its attaching, unless such misrepresentation or warranty is made with the actual intent to deceive, or unless the matter represented increases the risk of loss.

Thus, Tennessee Insurance was justified in rescinding the policy if Gurkin (1) made an unintentional misrepresentation that increased the risk of loss for the insurance company, or (2) made any misrepresentation with intent to deceive.

The determination of whether a misrepresentation, intentional or unintentional, has been made at all is a question of fact. If it is determined that a misrepresentation occurred, and that misrepresentation was unintentional, the issue becomes whether the misrepresentation materially increased the insurer's risk of loss as a matter of law. In the context of an insurance application, a misrepresentation "increases the risk of loss when it is of such importance that it naturally and reasonably influences the judgment of the insurer in making the contract."

We first address the contention that Gurkin misrepresented ownership of the Vehicle by stating in his application that he and his wife were the owners rather than Gurkin and Son. The trial court found that this was not a misrepresentation because Gurkin in fact owned the vehicle. Tennessee Insurance argues that the evidence preponderates against such a finding, pointing to the registration of the Vehicle to "Gurkins" as conclusive proof that Gurkin's family business owned the truck. However, as the trial court noted, there is no evidence on the record of any legal entity named "Gurkins" that could have owned the Vehicle. Further, it is undisputed that Gurkin personally arranged the financing for the Vehicle, made payments on the loan, and was responsible for payment of the insurance premium. Even discounting the Vehicle's inclusion in the division of marital property during Gurkin's divorce proceedings, the evidence taken as a whole simply does not preponderate against the trial court's finding that Gurkin personally owned the truck. Therefore, the trial court's finding that Gurkin made no misrepresentation regarding the ownership of the Vehicle is affirmed.

Next, we address the assertion that Gurkin misrepresented his use of the Vehicle. Because an agent's knowledge is imparted to his principal, Tennessee Insurance is deemed to know of the uses of the Vehicle of which Wood was aware, and it cannot be said that Gurkin made a misrepresentation regarding those uses. Wood was aware Gurkin would drive to the Moscow store to leave receipts and bills two to three times per week. Wood also knew that Gurkin made regular stops to the bank in Grand Junction for purposes related to the operation of the Grand Junction store. Therefore, we focus on the limited uses of which Wood was not aware, namely, the fact that Gurkin occasionally brought inventory from one store to the other, infrequently made deposits for his brothers' stores when they were unable to do so, regularly stopped at the Grand Junction store before attending business meetings with his brothers, and regularly drove to his revenue-producing farm. We must determine whether these constitute business uses which Gurkin failed to disclose.

Garretson testified that an underwriter would consult the guidelines to determine whether a given use constituted a business use, and that if a use was not covered by the underwriting guidelines, the

underwriter would use his or her reasonable judgment to determine whether it constituted a business use. Only one of the uses of which Wood was not aware, transporting merchandise from one store to another, is ostensibly listed as a business use under the guidelines. The testimony was that this happened "occasionally," when one store unexpectedly ran low on a certain type of merchandise. As to the remaining uses, an underwriter would be presumed to use reasonable judgment and good sense. The fact that Gurkin used the truck to drive to the Grand Junction store before going to the Moscow store for business-related meetings, that he infrequently made deposits for his brothers, or that he drove to his farm, simply is not a business use. Overall, it appears that Gurkin just used the truck to drive wherever he needed to go, and that any "business" aspect of his use was de minimus. Under these circumstances, the evidence does not preponderate against the trial court's finding that Gurkin made no misrepresentations regarding his use of the Vehicle.

Tennessee Insurance also appeals the trial court's finding that the agent, Wood, was not negligent because Wood failed to convey his knowledge about the Vehicle's uses to Tennessee Insurance and, in the alternative, failed to make a diligent inquiry as to Gurkin's uses of the Vehicle. The trial court found that Wood was not negligent because Wood applied the underwriting guidelines to the uses of which he was aware and reasonably determined that they were not business uses. The evidence does not preponderate against this conclusion. Wood understood Gurkin to be using the Vehicle for all of his needs. The only arguable business uses of which Wood was aware was Gurkin's driving to the Grand Junction store, with a stop at the Moscow store two to three times per week, and to the bank to make deposits and obtain change for the Grand Junction store. These likewise are de minimus. Under these circumstances, we agree with the trial court's conclusion that, based on what he knew, Wood reasonably determined that Gurkin's truck was for personal use and that Wood was not negligent in failing to tell Tennessee Insurance what he knew.

To the extent that Wood failed to ferret out all of Gurkin's uses for the Vehicle, Wood cannot be held liable, even assuming he was negligent, because he was not the proximate cause of any harm to Tennessee Insurance. As noted above, Gurkin's failure to report these activities as business uses did not constitute a misrepresentation. Thus, had Wood reported these uses, Tennessee Insurance could not reasonably have charged an additional premium for business use. Therefore, Wood cannot be held liable for Tennessee Insurance's failure to learn of these uses, because the lack of knowledge caused no damage to the insurance company. Accordingly, the evidence does not preponderate against the trial court's holding that Wood had no liability to Tennessee Insurance. Therefore, the decision of the trial court is affirmed.

STATUTE OF LIMITATIONS

Gardiner Park Development v. Matherly Land Surveying

KY Court of Appeals, 2005

I. Note

In Plaza Bottle Shop, Inc. v. Al Torstrick Ins. Agency, Inc., 712 S.W.2d 349 (KV.APP. 1986), this Court considered whether an insurance agent qualified as a professional enabling him to plead the statute of limitations of KRS 413.245. The Court noted that the mere fact that one is required to be licensed by the state does not automatically make the services he or she provides "professional services." Profession has traditionally been defined at common law as consisting of law, medicine, and theology. The Court observed that there was no indication from the legislature that it intended for KRS 413.245 to apply to any calling except the traditional three. However, it acknowledged that other occupations are generally considered to be professions such as accounting, engineering, and

teaching but observed that, "the admission to [the profession] requires higher education, special knowledge and training[.]" Based on the fact that an insurance agent has no need to have obtained any more education than a high school diploma, the Court determined that KRS 413.245 was not intended to apply to claims against insurance agents.

... Beyond those categories noted in the previous paragraph courts have held that certified financial planners are not professionals. Kuntz v. Muehler. 603 N.W.2d 43. 47 (N.D.1999). An insurance agent is not a professional. Chase Scientific Research. Inc. v. NIA Group. Inc.. 96 N.Y.2d 20. 30. 749 N.E.2d 161. 167. 725 N.Y.S.2d 592. 598 (N.Y.App.2001).

. . . The legislature clearly intended for professionals providing professional services to be subject to a one-year statute of limitations whether the claim was one based on tort or contract. However, as was stated in Plaza Bottle Shop, supra, there is no indication that it meant to include any professions except law, medicine, and divinity. But, the legislature has enacted other statutes defining profession and professional services more broadly than the traditional three. Therefore, while the law of this jurisdiction does not limit the application of KRS 413.245 to only the traditional three "professions," we conclude that it should still be construed narrowly to effectuate the intent of the legislature that there is a distinction between professions and other occupations.

413.245 Actions for professional service malpractice.

Notwithstanding any other prescribed limitation of actions which might otherwise appear applicable, except those provided in KRS 413.140, a civil action, whether brought in tort or contract, arising out of any act or omission in rendering, or failing to render, professional services for others shall be brought within one (1) year from the date of the occurrence or from the date when the cause of action was, or reasonably should have been, discovered by the party injured. Time shall not commence against a party under legal disability until removal of the disability.

Plaza Bottle Shop. Inc. v. Al Torstrick Insurance Agency. Inc.

KY Court of Appeals, 1986 (Rev Denied)

I. Background

The factual background is alleged to be that from May, 1978, to 1983, Torstrick provided all the insurance coverage for Plaza Bottle and was its agent for that purpose. Plaza Bottle was advised to purchase one or more policies with United States Fire Insurance Company covering such risks as workers' compensation, personal property, plate glass, mercantile robbery, bodily injury and property damage liability. It relied exclusively upon Torstrick for its liability coverage needs and for placement with appropriate carriers of such coverages. Such reliance was known and encouraged by Torstrick. The carrier of the policies supplied as an endorsement "Coverage X" which covered liability for situations where "such liability is imposed upon the insured by reason of selling, serving or giving of any alcoholic beverage at or from the insured premises...." In the trade, this is commonly referred to as dramshop liability coverage. Basically, it protects against claims for injuries to patrons or others resulting from the sale of intoxicating beverages by the insured establishment.

The policies selected for and sold to Plaza Bottle did not have "Coverage X." During the policy periods applicable, Plaza Bottle was sued in two separate suits for the deaths of three teenagers killed in two separate incidents. The allegations were that the teenagers purchased alcoholic beverages from Plaza Bottle, and this fact caused or contributed to their deaths.

Plaza Bottle's insurer defended the cases initially but refused to afford further defense because there was no contract between the parties for dramshop coverage. A judgment in a separate declaratory judgment action permitted the carrier to retire from the field of battle and left Plaza Bottle to go its defense alone. Plaza Bottle claims it first learned that it had no insurance applicable to these matters in November, 1980, when the carrier notified it of such.

On August 9, 1983, this action was filed against Torstrick for its negligence in failing to inform its client about dramshop coverage or the need therefore and in failing to procure "Coverage X" based upon the insured's need of such coverage, all of which was a breach of the duty owed by Torstrick, the agent, to Plaza Bottle.

Summary judgment was granted, as stated hereinbefore, on the ground that the action was barred by the provisions of KRS 413.245. Clearly, the appellant's cause of action began to run in November of 1980 when it was informed there was no liquor liability coverage, not when the insurer declared or when it was determined it had no duty to defend or, as appellant urges, not when the judgments were rendered in the wrongful death actions. Thus, the trial court's judgment would be sound if KRS 413.245 were applicable; however, we do not believe it is and we reverse.

II. Analysis & Discussion

The sole issue for our consideration in this appeal is whether the services rendered by an insurance agent are "professional services" as contemplated by the statute. KRS 413.243 defines "professional service" as "any service rendered in a profession required to be licensed, administered and regulated as professions in the Commonwealth...."

It is significant to the issue before us that the statute does not provide that such services include any services rendered in a trade or occupation required to be licensed. The mere fact that one is licensed or regulated by the state does not make his services "professional" within the purview of this statute. The appellee's assertion that a broad interpretation be given this statute to include all who are licensed would result in the inclusion of embalmers, realtors and beauticians, a result we believe unreasonable, absurd and clearly not reflective of the intent of our legislators. Although the previous rule in Kentucky was that statutes of limitations should be strictly construed, KRS 446.080 provides that "[a]ll statutes of this state shall be liberally construed with a view to promote their objects and carry out the intent of the legislature...." We should strain neither the facts nor the statute in favor of its application and thereby extend or apply KRS 413.245 to include insurance agents unless it is clear the legislators intended this class to fall within its provisions.

As stated hereinabove, we do not believe our lawmakers so intended. In fact, we have no reason to believe the legislature intended the statute to apply to those practicing any vocations other than the traditional ones or to those commonly thought of as "professions." Originally, and historically, the word "profession" was applied only to law, medicine, and theology or divinity, and these were known as the three "learned professions," and it has frequently been said that formerly these were specifically known merely as "the professions."

Although today a "profession" connotes other vocations such as accounting, engineering and teaching, the admission to which requires higher education, special knowledge and training, we do not believe insurance agents, who need have no more education than a high school diploma to qualify for a license (KRS 304.9-105(4)(a)) fall within the purview of the statute.

For the reasons stated, we are of the opinion that Plaza Bottle's cause of action against Torstrick for its negligence in failing to procure insurance coverage based on the agency relationship is encompassed within KRS 413.120(1), an action upon a contract not in writing, express or implied, the five-year limitation.

The summary judgment is reversed and the trial court is respectfully directed to reinstate appellant's cause of action.

BAD FAITH

Wittmer v State Farm Mutual Automobile Insurance Company

KY Supreme Court, 1993

I. Background

Loretta Wittmer and Tamara Jones were involved in a motor vehicle accident on October 19, 1988, in Owensboro, Kentucky. Jones failed to yield the right-of-way after a stop sign and struck Wittmer's vehicle in the side, causing it to careen out of control into a pole. Jones carried liability insurance with State Farm, whose claims representative contacted Wittmer within a few days after the accident and offered to pay her \$3,562.66, the cost of repairs to the vehicle using new parts. Wittmer had purchased the car new only three weeks before, and had about 1,000 miles on it.

She refused State Farm's offer because she wanted State Farm to replace her vehicle with a new vehicle equivalent to hers before it was damaged. When State Farm refused to offer more than the cost of repair she went to an attorney. Her attorney negotiated with State Farm, eventually demanding "the difference between the fair market value (FMV) immediately before and immediately after" the car was damaged, placing the before FMV at \$10,500, which was substantially equivalent to the new car value of Wittmer's vehicle. The after FMV was stated at \$4,000, and the difference demanded was \$6,500.

The lawyer's position was, and remains to this day, that the fact that a vehicle is repaired, no matter how perfectly, necessarily depreciates its FMV when compared to an identical car which has never been wrecked, and State Farm has unreasonably refused to take this factor into account. The problem with the settlement demand letter from Wittmer's lawyer is that, while rejecting cost of repair, the figures set forth for before and after FMV are not attributed to any reliable source, or supporting documents of any kind. They are described simply as "[o]ur computation." Likewise, the letter demands "loss of use" at "\$280," an unsubstantiated figure.

Wittmer's principal claim, throughout this litigation, has been that because the UCSPA specifies it is an "unfair claims settlement practice" to "refuse to pay claims without conducting a reasonable investigation based upon all available information," when State Farm used repair cost rather than obtaining appraisals to fix the difference in FMV, it violated the terms of the Act. However, the facts are that Wittmer's counsel did not obtain and present appraisals in connection with his demand letter. Further, Wittmer's trial expert (whose credibility was arguably impaired since he was a brother-in-law to one of Wittmer's attorneys) testified to a substantially lower before FMV than the new car value presented in Wittmer's demand letter and testified that the difference in FMV was \$5,150 rather than the \$6,500 claimed in the demand letter.

State Farm's trial witness was the repair shop operator who had provided the repair estimate. He testified the difference in FMV was \$3,000 to \$3,500. Ultimately the jury fixed the FMV difference at \$3,700.

State Farm acknowledges that when a vehicle has been wrecked, even though perfectly repaired, this could make a difference to a knowledgeable buyer. But nobody has ever put a dollar value on this difference. Further, the regulations provided by the Commissioner of Insurance to implement the Act, to provide insurers with guidelines for dealing with the public under the UCSPA, specify that: "Repair estimates or appraisers' reports may be used to indicate the difference in fair market value."

Wittmer sued Jones in tort, alleging property damage to her automobile and, in the same Complaint, sued State Farm charging violation of the UCSPA, demanding damages sustained by reason of such violation, plus prejudgment interest, attorney's fees and court costs. Jones answered alleging contributory fault as part of her defense. State Farm utilized a different lawyer to defend its insured from the one used to defend the company, and moved to bifurcate the issues to avoid prejudice that might accrue to Jones' defense from having the claims joined for trial.

The trial court overruled this motion. Thereafter, notwithstanding the joinder, the jury at trial found Wittmer 30% at fault, and apportioned the \$3,700 in damages awarded against Jones accordingly, and awarded "0" damages against State Farm. The jury verdict found that there was a violation of the UCSPA even though no damages were awarded.

The only element of damages specified in the instructions on the UCSPA claim for the jury's consideration was: "Emotional distress and mental anguish suffered by reason of violating the Kentucky Unfair Claims Settlement Practices Act."

State Farm suggests the verdict was "0" because, if anything, there were only "technical violations" of the act. The trial court decided not to instruct on punitive damages finding insufficient evidence to warrant such a claim. The trial court entered judgment on the verdict for State Farm.

Wittmer appealed claiming the instructions were in error because they did not allow the jury to consider prejudgment interest or punitive damages, and the Court of Appeals agreed, reversing and remanding on error in the instructions. Also, Wittmer claimed the trial court's instruction on damages was not sufficient to cover her "economic loss" from being deprived of a vehicle "for 840 days," the time period from the date of accident until she finally bought a new car. In this, the Court of Appeals affirmed the trial court. Finally, Wittmer also appealed the verdict and judgment in her claim against Jones, claiming she was entitled to a directed verdict placing 100% of the fault for the accident upon Jones and that jury verdicts for storage costs and loss of use were inadequate as a matter of law. The Court of Appeals affirmed the trial court on this issue.

State Farm moved for discretionary review of the Court of Appeals decision, claiming "the facts offered at trial did not support an instruction on punitive damages" and "the trial court did not err in failing to award prejudgment interest." Wittmer has also filed a motion for discretionary review against Jones, her principal claims being: (1) as a matter of law, Jones was 100% at fault for this accident, and (2) the trial court erred in failing to instruct against State Farm on economic loss from being deprived of her vehicle in addition to emotional distress and mental anguish.

II. Analysis & Holding

The gravamen of Wittmer's complaint is that State Farm had an affirmative duty to obtain appraisals establishing the before and after FMV of Wittmer's vehicle, and to offer this sum in payment of Wittmer's claim, rather than offering cost of repair. Further, Wittmer argues that if the offer of cost of repair was intended as a compromise based on disputed liability, the State Farm adjuster failed to "promptly provide a reasonable explanation of the basis" for denying full payment.

Although State Farm, through Jones, successfully contested liability in part at the trial, it has never claimed that at the outset its adjuster was trying to compromise the loss when he offered to pay repair costs to satisfy Wittmer's property damage claim. On the contrary, his dispute with Wittmer was over whether the offer of repair costs was sufficient to pay what the law required. We conclude that, in present circumstances, this offer was sufficient to comply with the duty to negotiate in good faith posed by the UCSPA, and State Farm was entitled to a directed verdict on the claim of statutory bad faith. We do so for two interdependent reasons. The first involves the nature of the tort with which State Farm is charged, bad faith failure to promptly pay Wittmer's property damage claim in conformity with her demand. The second involves the nature of the proof offered to establish this claim.

We start with the proposition that there is no such thing as a "technical violation" of the UCSPA, at least in the sense of establishing a private cause of action for tortious misconduct justifying a claim of bad faith:

"[A]n insured must prove three elements in order to prevail against an insurance company for alleged refusal in bad faith to pay the insured's claim: (1) the insurer must be obligated to pay the claim under the terms of the policy; (2) the insurer must lack a reasonable basis in law or fact for denying the claim; and (3) it must be shown that the insurer either knew there was no reasonable basis for denying the claim or acted with reckless disregard for whether such a basis existed.... [A]n insurer is ... entitled to challenge a claim and litigate it if the claim is debatable on the law or the facts."

The problem in the present case, at the trial level, was that the judge concluded there might be evidence that some sort of technical violations of the UCSPA occurred sufficient to submit the case against State Farm to the jury, but recognized there was no evidence of bad faith sufficient to justify punitive damages. Before the cause of action exists in the first place, there must be evidence sufficient to warrant punitive damages.

This means there must be sufficient evidence of intentional misconduct or reckless disregard of the rights of an insured or a claimant to warrant submitting the right to award punitive damages to the jury. If there is such evidence, the jury should award consequential damages and may award punitive damages. The jury's decision as to whether to award punitive damages remains discretionary because the nature of punitive damages is such that the decision is always a matter within the jury's discretion.

FAILURE TO PROCURE COVERAGE

Settle v KY Farm Bureau

KY Court of Appeals, 2004

I. Background

Sometime in 1987, Farm Bureau sent a blanket mailing to all its clients, stating that the Legislature had recently mandated mine subsidence insurance. The letter stated that the coverage had been added to their policy, the premium had accordingly been increased, and that if the client did not want the coverage, the client should sign and return the attached waiver to Farm Bureau. It is undisputed that Terry Settle signed the waiver form and sent it back to Farm Bureau, although Terry maintains that he does not remember doing so. As a result of this waiver, Farm Bureau eliminated the mine subsidence coverage from the Settles' policy. Thereafter, the Settles never requested that mine subsidence coverage be added to their policy.

In 2000, shortly before Bruce Hendrix's death, the Settles remodeled their home. According to Terry, he thereafter went to Hendrix to increase his homeowner's coverage, requesting that the coverage be increased to \$45,000 or \$50,000. Terry also claims that he further told Hendrix, "If there is anything else I need, just put it on there." Terry alleges that Hendrix's response was, "I will take care of it." Hendrix died some two weeks later and Ricky Hoskins, the agent of record for Farm Bureau since 1985, took over the Settles' account.

In July of 2001, Terry installed some new doors in his house. Around six weeks later, he began to notice the doors were sticking. At that time he also noticed that his foundation had cracked and lifted up and that cracks were forming in his driveway. It is the Settles' position that this damage to their property was caused by subsidence from an underground coal mine located on their property which had been mined out decades earlier and which the Settles were unaware of until the damage occurred.

The Settles ultimately filed a claim with Farm Bureau for the damage caused by the mine subsidence. Farm Bureau denied the claim because the mine subsidence coverage had been excluded from their policy. According to the Settles, after making their claim, Ricky Hoskins came to their house and apologized to them for not having mine subsidence coverage and stated that it was his fault they did not have said coverage. He then told the Settles that he would see what he could do to try to correct the matter.

Farm Bureau denied the Settles' claim based on the mine subsidence coverage waiver signed by Terry in 1987. Subsequently, on August 27, 2002, the Settles filed the action herein against Farm Bureau and Ricky Hoskins alleging that the mine subsidence claim was wrongfully denied. The Settles maintained that by virtue of their long business relationship and course of dealing with Farm Bureau, Farm Bureau had a duty to advise them of the need for mine subsidence coverage and to make sure said coverage was included in their policy. In the alternative, the Settles claimed that Hoskins should be held responsible for the loss given his admission that it was his fault that they did not have the coverage they needed.

On April 21, 2003, the trial court granted Farm Bureau's and Hoskins's motion for summary judgment. The court adjudged that the defendants met their statutory duty to advise the Settles of the availability of mine subsidence coverage with the notice sent to the Settles in 1987 and that the defendants did not have an additional duty to the Settles beyond that notice. This appeal by the Settles followed.

II. Analysis & Decision

The Settles cite cases from outside this jurisdiction on this issue of the duty of an insurer to advise the insured. We deem reliance on those cases to be misplaced since there exists a Kentucky case nearly on point, Mullins v. Commonwealth Life Insurance Co., KY., 839 S.W.2d 245 (1992). In Mullins, the Court was faced with the issue of whether the insurer owed the insured a duty to advise of the need for and availability of underinsured motorists coverage. The Court recognized that there is generally no affirmative duty to advise by virtue of the agency relationship alone. However:

[A]n implied assumption of duty may be present when: (1) the insured pays the insurance agent consideration beyond a mere payment of the premium; (2) there is a course of dealing over an extended period of time which would put an objectively reasonable insurance agent on notice that his advice is being sought and relied on; or (3) the insured clearly makes a request for advice.

The facts alleged by the Settles as to course of dealing were as follows. The Settles had dealt exclusively with Farm Bureau for twenty-five years for all of their insurance needs. Terry testified in his deposition that he relied on Farm Bureau, in particular, Hendrix, to see that he had the right kinds of coverage at the right amounts. Terry stated that when he spoke to Hendrix in 2000 to increase his home coverage, he told Hendrix "Anything I need on my policy just put it in there." Terry alleges that Hendrix told him, "[A]ll I need to know is how much you need on your house. Everything else automatically goes up." According to Terry, Hendrix assured him that "he would take care of it." It is undisputed that the Settles never specifically requested or even inquired about mine subsidence coverage.

In Mullins, the insured requested from her insurer a "policy as good as I can get on liability and no-fault" since she could not "afford full coverage." The Court held that such a request did not create an implied or express duty to advise of the need for optional coverage such as underinsured motorist insurance, thus, the insurer was not responsible for the lack of said coverage. The Court stated:

To impose a duty to advise under the facts of this case would alter the expressed public policy of the Commonwealth established by the General Assembly on the dates the policy was issued, and when the injury occurred. If such a duty to advise should be imposed, it should be imposed as a statutory one, and not expanded by the judiciary.

Under the facts in the present case, we cannot say that Farm Bureau had an implied affirmative duty to advise the Settles of the need for mine subsidence coverage beyond the notice sent in 1987. In our view, Terry's request in 2000 to increase his home insurance and give him anything he needed did not put the onus on Farm Bureau to inform the Settles about every kind of coverage they might need, notwithstanding the fact that Farm Bureau was the Settles' sole insurer for twenty-five years. Despite Terry's assertion that he relied on Hendrix to see that he had whatever coverage he needed, we do not see that Farm Bureau was ever put on notice that they were responsible for determining the extent of the Settles' full insurance needs. We do acknowledge Farm Bureau's statutory duty to advise of the need for mine subsidence coverage, which we agree with the trial court was met in this case, as we shall discuss further below...

Mullins v. Commonwealth Life Insurance

I. Background

The car insurance policy initially purchased by the Mullinses in April of 1984, exceeded statutorily dictated minimums, and consisted of the following coverage: liability of \$50,000 per person, \$100,000 per accident and \$50,000 property damage; \$10,000/\$20,000 uninsured motorist limits, and \$20,000 no-fault (representing the basic \$10,000, plus \$10,000 of added RB). While Shepherd, the insurance agent, could not recall anything concerning this transaction, Mrs. Mullins testified, at deposition, that she requested a "good" policy.

The Mullinses were temporarily without an automobile insurance policy once their initial 1984 policy lapsed, due to nonpayment in 1985. Coverage essentially identical to the previous policy was reissued in October of 1985, through insurance agent, Vanover, except that uninsured motorist coverage was increased to \$50,000/\$100,000, while no-fault was reduced to the statutory minimum of \$10,000.

Mrs. Mullins, in deposition, testified that when she purchased the new policy, she instructed agent Vanover:

"I told her (Vanover) I wanted as good of a policy as I could get on liability and no-fault, everything I could get on it, because I couldn't afford full coverage."

Vanover, while unable to recollect Mrs. Mullins' "exact words," testified in deposition that the Mullinses indicated they wanted as inexpensive coverage as they could acquire, and that no specific policy coverage was discussed. Vanover further asserted that the policy sold to the Mullinses was a standard policy package set up within the office.

The record reveals that Mrs. Mullins read the policy, and made no further contact with Vanover regarding it. In deposition, Mrs. Mullins testified that she discovered the existence of UIM coverage when she called Vanover to find out if the Mullinses' policy included this coverage. Mrs. Mullins placed this call after discovering that medical expenses incurred by her son, Anthony, when he was injured in an automobile accident, would not be covered by the other driver's insurance.

Eric Tachau, a certified property and casualty underwriter, asserts in the record: (1) that both insurance agents failed to perform their professional duties because they did not explain to the insurance purchaser the availability, or desirability, of UIM coverage; and (2) that the Capital Holding Group of Insurance Companies failed to deal in good faith with their customers because their employees/agents were not instructed about UIM coverage, in order that information regarding the availability of such coverage could be conveyed to purchasers of their automobile insurance policies. Appellants assert that summary judgment was improperly granted in favor of the appellees because two issues of material fact exist: (1) whether the appellees owed a duty of ordinary care to advise Mrs. Mullins on the availability of both UIM coverage and added RB; and (2) whether Capital Enterprise Insurance Company (hereinafter Capital); separately, and individually, violated the Consumer Protection Act, by failing to make UIM coverage and added no-fault protection more readily available to its customers, and by failing to instruct its agents to advise customers as to the availability of these insurance coverages.

The trial court granted summary judgment in favor of the appellees and interpreted KRS 304.39-320 as requiring that UIM coverage must be offered "only upon request." So finding, the trial court further ruled that UIM coverage is optional, rather than mandatory. The Court of Appeals affirmed the trial

court, and further held that allegations pertaining to Commonwealth's actions, pursuant to the Consumer Protection Act, even if true, fell outside the statute's understood parameters. After reviewing the record, we likewise affirm the trial court's grant of summary judgment in favor of the appellees.

II. Analysis & Decision

Appellants' negligence action requires: (1) a duty on the part of the defendant; (2) a breach of that duty; and (3) consequent injury. Thus to find potential liability to exist in the case at bar, there must first exist an affirmative duty of the appellees to advise the Mullinses about the availability of UIM coverage.

UIM coverage is optional, rather than mandatory. The fact that UIM coverage is optional, is reemphasized when comparing the language found in KRS 304.39-320, with language found in both KRS 304.39-030(1), a statute covering basic reparations benefits, with language found in KRS 304.39-110, a statute covering tort liability. KRS 304.39-030(1) provides in part that "every person suffering loss from an injury arising out of maintenance or use of a motor vehicle has a right to basic reparations benefits." Likewise, KRS 304.39-110(1) reads in part, "[t]he requirement of security for payment of tort liabilities ..." "The legislature obviously could have made [UIM] coverage mandatory [as it did in KRS 304.20-020(1), KRS 304.39-030, and KRS 304.39-1101], but elected to require it to be furnished only "upon request."

Appellants argue that even though appellees were not statutorily required to advise the Mullinses about availability of UIM coverage and added RB, an issue of material fact remains because the appellees were bound by a common law duty to exercise ordinary care to prevent foreseeable harm to their customers. Appellants assert that using ordinary care under the facts of the instant case; encompasses a common law duty of the appellees to inform them about UIM and added RB. The question of duty presents an issue of law. While Kentucky courts have not ruled on the specific issue at bar, other jurisdictions have generally found "no affirmative duty to advise is assumed by mere creation of an agency relationship."

An insurance agent ordinarily only assumes those duties found in an agency relationship. An agent owes his principal the obligation to deal in good faith and to carry out the principal's instructions. Other jurisdictions have found that, generally, an insurer may assume a duty to advise an insured when: (1) he expressly undertakes to advise the insured; or (2) he impliedly undertakes to advise the insured. The insured has the burden of proving that the insurer assumed such a duty.

An implied assumption of duty may be present when: (1) the insured pays the insurance agent consideration beyond a mere payment of the premium; (2) there is a course of dealing over an extended period of time which would put an objectively reasonable insurance agent on notice that his advice is being sought and relied on; or (3) the insured clearly makes a request for advice.

The appellants in the case at bar neither paid the insurance agent an amount beyond the premium for such advice, nor had a long-term course of dealing with the insurance agent, nor expressly asked for advice. Thus, it appears no implied assumption of duty to advise is implicated.

Appellants assert that Mrs. Mullins' request for a "policy as good as I can get on liability and no-fault," is a request for advice. Other jurisdictions have interpreted a request for "full coverage," "the best policy," or "similar expressions as not placing an insurance agent under a duty to determine the insured's full insurance needs, to advise the insured about coverage, or to use his discretion and expertise to determine what coverage the insured should purchase."

The Court of Appeals, determined that an insured's request for "full coverage," did not constitute a request for optional coverage, UIM coverage being optional. In the case at bar, Mrs. Mullins admits to asking for a policy as good as she could purchase "on liability and no-fault," since she could not "afford full coverage." Since her request was for less than full coverage, it precludes including optional coverages such as UIM and added RB, within its parameters, because we do not find circumstances creating an express or implied assumption of a duty to advise.

We note that while appellants fail to produce facts evidencing an express assumption of duty to advise, such a duty may be present if the company, or agent, represents directly, or by advertising, that it will assume responsibility to advise the customer as to what is needed. When an insurance company or an agent "holds itself out" to the public as a counselor and/or advisor, the scope of duty to advise is commensurate with the obligation assumed by the insurance company or agent selling the insurance.

The principle involved here is simply that a person who holds himself out to the public as possessing special knowledge, skill or expertise must perform his activities according to the standard of his profession. If he does not, he may be held liable under ordinary tort principles of negligence for the damage he causes by his failure to adhere to the standard.

The 1990 Legislature, after this cause of action arose, in KRS 304.20-040(12) enacted a type of insurance advisor provision:

Except where the maximum limits of coverage have been purchased, every notice of first renewal shall include a provision or be accompanied by a notice stating in substance that added uninsured motorists, underinsured motorists, and personal injury protection coverages may be purchased by the insured.

With this statutory provision, insurance companies now are required to advise their insured of the availability of this protection in the first notice of renewal. While this provision was enacted after this cause of action accrued, the General Assembly expressed its intent in this area by the then-applicable statutes. We therefore decline to judicially interpose a rule to the contrary.

Failing to find the existence of a statutorily expressed, or implied assumption of duty to advise appellants, we thus conclude there is no issue of material fact warranting reversal of the trial court's grant of summary judgment to the appellees, concerning the question of their duty to advise on the availability and desirability of purchasing UIM coverage and added RB.

KY INSURANCE LAW

304.9-020 Definitions for subtitle.

1. "Agent" means an individual or business entity appointed by an insurer to sell or to solicit applications for insurance or annuity contracts or to negotiate insurance or annuity contracts on its behalf
2. "Appointment" means a notification filed with the insurance office that an insurer has established an agency relationship with a producer
3. "Appointment renewal" means continuation of an insurer's existing appointment based on payment of the required fee without submission of an appointment form

6. "Home state" means the District of Columbia and any state or territory of the United States in which a licensee maintains his or her principal place of residence or principal place of business and is licensed by that state
7. "Insurance producer" means an individual or business entity required to be licensed under the laws of Kentucky to sell, solicit, or negotiate insurance or annuity contracts. Insurance producer includes agent, managing general agent, surplus lines broker, reinsurance intermediary broker and manager, rental vehicle agent and managing employee, specialty credit producer and managing employee, and consultant
12. "Sell" means to exchange a contract of insurance by any means, for money or other valuable consideration, on behalf of an insurer
13. "Solicit" means attempting to sell insurance or asking or urging a person to apply for a particular kind of insurance from a particular insurer;
15. "Terminate" means the cancellation of the relationship between an insurance producer and the insurer or the termination of an insurance producer's authority to transact insurance;

304.9-030 Available insurance agent licenses.

1. Unless denied a license according to KRS 304.9-440, applicants who have met the requirements for the license in accordance with this subtitle, shall be issued the applicable license.
- 2.
3. An insurance agent may receive qualification for a license in one (1) or more of the following applicable lines of authority:
4.
 - A. Life - insurance coverage on human lives including benefits of endowment and annuities, and may include benefits in the event of death or dismemberment by accident and benefits for disability income
 - B. Health -- insurance coverage for sickness, bodily injury, or accidental death and may include benefits for disability income
 - C. Property - insurance coverage for the direct or consequential loss or damage to property of every kind
 - D. Casualty - insurance coverage against legal liability, including that for death, injury, or disability, or damage to real or personal property
 - E. Variable life and variable annuity products - insurance coverage provided under variable life insurance contracts and variable annuities
 - F. Limited line insurance as identified in KRS 304.9-230
 - G. Personal lines -- property and casualty insurance coverage sold to individuals and families for primarily noncommercial purposes
 - H. Any other line of insurance authorized by Kentucky law and deemed by the executive director appropriate to be issued as a separate line of authority
5. A resident applicant for a variable life and variable annuities line of authority shall hold an active life line of authority.

304.9-035 Insurer liable for acts of its agents

Any insurer shall be liable for the acts of its agents when the agents are acting in their capacity as representatives of the insurer and are acting within the scope of their authority. Licensed individuals designated by a business entity to exercise the business entity's agent license shall be deemed agents of the insurer if the business entity holds an appointment from the insurer.

Advisory Opinion 2004-7 - Acting as an agent; Termination of appointments

Advisory Opinion 2001 -08 was issued to re-emphasize the Department's position concerning the meaning of "acting as an agent." This advisory opinion is meant to clarify this area of confusion centering on one of the activities identified in Advisory Opinion 2001 -08 as "acting as an agent." The opinion states:

"However, the Department considers a person engaged in any of the following activities to be acting as an agent: 1) collecting or even holding premium in any manner; 2) explaining coverage or benefits to insureds or prospective insureds; 3) quoting rates; 4) actively seeking insureds for a particular insurer; or 5) taking/filling out applications. Anyone found to be engaging in one or more of the named activities, who is not licensed as an agent is in violation of KRS 304.9-080, unless that person is exempted from the definition of an agent pursuant to KRS 304.9-090"

This clarification stems from complaints from agents stating that they work alone and cannot afford to maintain another employee with a producer license for the sole purpose of accepting premium payments and they cannot always be present in the agency to receive them. While the Office strongly supports Advisory Opinion 2001-08, the first defined act listed in the paragraph above does need clarification.

It is the Office's position that "collecting or even holding premium in any manner" does not refer to the act of receiving a premium payment check and issuing a receipt. Simply holding the check or cash in one's hand is not enough to constitute "holding premium"; otherwise all members of the postal service who deliver payments would have to be licensed.

Therefore a clerical employee of an insurance agent may receive payments and record them and issue receipts as long as the employee does not deposit the premium into an account in the employee's name, fail to inform the agent of payment, or otherwise wrongfully withhold payment from the agent or the insurer, or in some other fashion deals with the payment negligently or convert it to his own use. This act is to be performed purely as a clerical function. It is also to be understood that the employee cannot bind coverage—only the agent can do so.

304.9-080 Licensure requirements – Forms

1. An individual or business entity shall not sell, solicit, or negotiate insurance in this state unless the individual or business entity is licensed as the appropriate insurance producer for that line of authority in accordance with this subtitle or Subtitle 10 of this chapter.
2. No individual or business entity shall in this state be, act as, or hold himself or herself out as an adjuster unless then licensed as an adjuster. No individual shall in this state be, act as, or hold himself or herself out as a consultant unless then licensed as a consultant. No consultant shall act as a consultant with respect to any kind of insurance as to which he or she is not then licensed as a consultant.
3. A consultant license shall cover either or both of the following categories, as selected by the licensee:

A. Property and casualty

B. Life and health

A consultant licensed in both categories shall qualify separately for, and be licensed in, each category.

4. No individual licensed as a consultant shall act as a consultant until he or she has filed with the executive director a bond or insurance in accordance with KRS 304.9-330.
5. Except as provided in KRS 304.9-410 and KRS 304.9-270(4), no agent shall place, and no insurer shall accept, any insurance with any insurer as to which the agent does not then hold a license and appointment as agent under this subtitle.
6. No rental vehicle agent, rental vehicle managing employee, specialty credit producer, or specialty credit managing employee shall place, and no insurer shall accept, any insurance with any insurer as to which the licensee does not then hold a license and appointment under this subtitle.
7. The executive director shall prescribe and furnish all forms required under this subtitle as to licenses and appointments.

304.9-105 General qualifications for agent license.

1. An individual applying for an agent license shall make application to the executive director on the uniform individual application or other application prescribed by the executive director. Before approving the application, the executive director shall find that the applicant:
 - A. Is at least eighteen (18) years of age
 - B. Has fulfilled the residence requirements as set forth in KRS 304.9-120 or is a nonresident who is not eligible to be issued a license in accordance with KRS 304.9-140
 - C. Has not committed any act that is a ground for denial, suspension, or revocation set forth in KRS 304.9-440
 - D. Is trustworthy, reliable, and of good reputation, evidence of which shall be determined through an investigation by the executive director
 - E. Is competent to exercise the license and has:
 1. Except for variable life and variable annuities line of authority and limited lines of authority identified in KRS 304.9-230, completed a pre-licensing course of study consisting of forty (40) hours for life and health, forty (40) hours for property and casualty, or twenty (20) hours for each line of authority, as applicable, for which the individual has applied. The executive director shall promulgate administrative regulations to carry out the purpose of this section;
 2. Except for variable life and variable annuities line of authority and limited lines of authority identified in accordance with KRS 304.9-230, successfully passed the examinations required by the executive director for the lines of authority for which the individual has applied; and
 3. Paid the fees set forth in KRS 304.4-010; and
 - F. Is financially responsible to exercise the license and has:
 1. **(a)** Filed with the executive director the certificate of an insurer authorized to write legal liability insurance in this state, that the insurer has and will keep in effect on behalf of the person a policy of insurance covering the legal liability of the licensed person as the result of erroneous acts or failure to act in his or her capacity as an insurance agent, and enuring to the benefit of any aggrieved party as the result of any single occurrence in the sum of not less than twenty thousand dollars (\$20,000) and one hundred thousand dollars (\$100,000) in the aggregate for all occurrences within

one (1) year, and that the policy shall not be terminated unless at least thirty (30) days' prior written notice will have been given to the executive director

(b) Deposited with the executive director cash, or a cash surety bond executed by an insurer authorized to write business in this Commonwealth, in the sum of twenty thousand dollars (\$20,000), which shall be subject to lawful levy of execution by any party to whom the licensee has been found to be legally liable as the result of erroneous acts or failure to act in his or her capacity as an agent; or

(c) Filed with the executive director on his or her behalf, by an authorized insurer or group of affiliated insurers for which he or she is or is to become an exclusive agent, an agreement whereby the insurer or group of affiliated insurers agrees to assume responsibility, to the benefit of any aggrieved party, for legal liability of the licensed person as the result of erroneous acts or failure to act in his or her capacity as an insurance agent on behalf of the insurer or group of affiliated insurers in the sum of twenty thousand dollars (\$20,000) for any single occurrence and that the agreement shall not be terminated until the license is surrendered to the executive director or at least thirty (30) days' prior written notice will have been given to the executive director, whichever shall first occur and

2. Agreed with the executive director that if at any time notice is given to the executive director that any policy filed in accordance with subparagraph 1 .a. of this paragraph, or agreement filed in accordance with subparagraph 1 .c. of this paragraph, is to be terminated and has not been replaced by another policy or agreement within the time established by regulations of the executive director, or if any deposit in accordance with subparagraph 1.b. of this paragraph be reduced through levy of execution and not replaced by any necessary additional deposit within the time established by administrative regulations of the executive director, any and all licenses held by the licensee are revoked and shall be promptly surrendered to the executive director without demand.

2. The executive director may require additional information or submissions from applicants and may obtain any documents or information reasonably necessary to verify the information contained in an application.

304.9-295 Biennial continuing education requirements for licensed agents -Exceptions – Courses - Number of hours - Failure to complete – Penalty

1. This section shall apply to individuals who hold licenses or lines of authority requiring continuing education each biennium.
2. Beginning January 31, 2006, the continuing education biennial compliance date for an individual resident licensee shall be as follows:
 - A. A licensee whose birth date is in an even-numbered year shall satisfy continuing education requirements on or before the last day of the licensee's birth month in the even-numbered year. A licensee shall show proof of compliance to the executive director within sixty (60) days after the continuing education biennial compliance date. If the licensee has not held the license for one (1) year, the compliance date is adjusted to the next even numbered year and each subsequent even-numbered year thereafter. If the license becomes inactive and reissued within a twelve (12) month period, the compliance date shall remain the same;

- B. A licensee whose birth date is in an odd-numbered year shall satisfy continuing education requirements and show proof of compliance to the executive director on or before the last day of the licensee's birth month in the odd-numbered year. A licensee shall show proof of compliance to the executive director within sixty (60) days after the continuing education biennial compliance date. If the licensee has not held the license for one (1) year, the compliance date is adjusted to the next odd-numbered year and each subsequent odd-numbered year thereafter. If the license becomes inactive and reissued within a twelve (12) month period, the compliance date shall remain the same.
3. A licensee, who holds an agent license and who is not exempt under subsection (3) of this section, shall satisfactorily complete a minimum of twenty-four (24) hours of continuing education courses, of which twelve (12) shall be classroom hours and three (3) hours shall have a course concentration in ethics, during each continuing education biennium.
 4. Only continuing education courses approved by the executive director shall be used to satisfy the continuing education requirement of subsection (4) of this section and any other continuing education requirement of this chapter.
 5. Every licensee subject to this section shall furnish to the executive director written certification as to the continuing education courses satisfactorily completed by the licensee. The certification shall be signed by or on behalf of the provider sponsoring the continuing education course. The certification shall be on a form prescribed by the executive director.
 6. The license or line of authority requiring continuing education shall terminate if the individual holding the license or line of authority fails to comply with the continuing education requirement and has not been granted an extension of time to comply in accordance with subsection (8) of this section. If the license has terminated, the license shall be promptly surrendered to the executive director without demand. If the line of authority has terminated but another line of authority not requiring continuing education is still in effect, the license shall be promptly delivered to the executive director for reissuance as to the line of authority still in effect.

304.12-030 Replacement life insurance - "Twisting" prohibited.

1. As used in this section:
 - A. "Replacement" means any transaction in which a new life insurance policy or annuity contract is to be purchased and it is known or should be known to the proposing producer, or to the proposing insurer if there is no producer, that by reason of the transaction, an existing life insurance policy or annuity contract has been or is to be:
 - B. Lapsed, forfeited, surrendered or partially surrendered, assigned to the replacing insurer, or otherwise terminated;
 - C. Converted to reduced paid-up insurance, continued as extended term insurance, or otherwise reduced in value by the use of no forfeiture benefits or other policy values;
 - D. Amended so as to effect either a reduction in benefits or in the term for which coverage would otherwise remain in force or for which benefits would be paid;
 - E. Reissued with any reduction in cash value; or
 - F. Used in a financed purchase;
 - G. "Existing insurer" means the insurance company whose existing life insurance policy or annuity contract is or will be changed or affected in a manner described within the definition of replacement transaction
 - H. "Replacing insurer" means the insurance company that issues or proposes to issue a new life insurance policy or annuity contract that replaces an existing policy or contract or is a financed purchase

- I. "Existing life insurance policy or annuity contract" means any individual life insurance policy or annuity in force, including a life insurance policy under a binding or conditional receipt or a life insurance policy or annuity contract that is within an unconditional refund period
 - J. "Financed purchase" means the purchase of a new policy involving the actual or intended use of funds obtained by the withdrawal or surrender of, or by borrowing from values of, an existing policy to pay all or part of any premium due on the new policy. If a withdrawal, surrender, or borrowing involving the policy values of an existing policy is used to pay premiums on a new policy owned by the same policyholder and issued by the same company within four (4) months before or thirteen (13) months after the effective date of the new policy, it is prima facie evidence of the policyholder's intent to finance the purchase of the new policy with existing policy values. This prima facie standard does not affect the monitoring obligations of the existing insurer
 - K. "Direct-response solicitation" means a solicitation through a sponsoring or endorsing entity or individual solely through mails, telephone, the Internet. Or mass communication media.
2. No replacing insurer shall issue any life insurance policy or annuity contract in a replacement transaction to replace an existing life insurance policy or annuity contract unless the replacing insurer shall agree in writing with the insured that:
- A. The new life insurance policy or annuity contract issued by the replacing insurer will not be contestable by it in the event of such insured's death to any greater extent than the existing life insurance policy or annuity contract would have been contestable by the existing insurer had such replacement not taken place provided, however, that this paragraph shall not apply to that amount of insurance written and issued which exceeds the amount of the existing life insurance; and
 - B. The policy or contract owner shall have the right to return the policy or contract within thirty (30) days of the delivery of the policy or contract and receive an unconditional full refund of all premiums or considerations paid on it, including any policy fees or charges, or in the case of a variable or market adjustment policy or contract, a payment of the cash surrender value provided under the policy or contract plus the fees and other charges deducted from the gross premiums or considerations or imposed under such policy or contract.
3. Unless otherwise specifically included, subsection (2) of this section shall not apply to:
- A. Credit life insurance
 - B. Group life insurance or group annuities where there is no direct solicitation of individuals by an insurance producer. Direct solicitation shall not include any group meeting held by an insurance producer solely for the purpose of educating or enrolling individuals or, when initiated by an individual member of the group, assisting with the selection of investment options offered by a single annuity provider in connection with enrolling that individual. The executive director shall promulgate administrative regulations for group life insurance or group annuity certificates marketed through direct response solicitation
 - C. Group life insurance and annuities used to fund prearranged funeral contracts
 - D. An application to the existing insurer that issued the existing policy or contract when a contractual policy change or conversion privilege is being exercised, or when the existing policy or contract is being replaced by the same insurer pursuant to a program filed with and approved by the executive director

- E. Existing life insurance that is a nonconvertible term life insurance policy which will expire in five (5) years or less and cannot be renewed
- F. Proposed life insurance that is to replace life insurance under a binding or conditional receipt issued by the same company
- G. Policies or contracts used to fund:
 - 1. An employee pension or welfare benefit plan that is covered by the Employee Retirement and Income Security Act (ERISA)
 - 2. A plan described by Sections 402(a), 401 (k) or 403(b) of the Internal Revenue Code, where the plan, for purposes of ERISA, is established or maintained by an employer
 - 3. A governmental or church plan defined in Section 414 of the Internal Revenue Code, a governmental or church welfare benefit plan, or a deferred compensation plan of a state or local government or tax exempt organization under Section 457 of the Internal Revenue Code
 - 4. A nonqualified deferred compensation arrangement established or maintained by an employer or plan sponsor. Notwithstanding the provisions of this paragraph, subsection (2) of this section shall apply to policies or contracts used to fund any plan or arrangement that is funded solely by contributions an employee elects to make, whether on a pre-tax or after-tax basis, and where the insurer has been notified that plan participants may choose from among two (2) or more insurers and there is a direct solicitation of an individual employee by an insurance producer for the purchase of a contract or policy. As used in this paragraph, direct solicitation shall not include any group meeting held by an insurance producer solely for the purpose of educating individuals about the plan or arrangement or enrolling individuals in the plan or arrangement or, when initiated by an individual employee, assisting with the selection of investment options offered by a single insurer in connection with enrolling that individual employee
- H. Where new coverage is provided under a life insurance policy or contract and the cost is borne wholly by the insured's employer or by an association of which the insured is a member
- I. Immediate annuities that are purchased with proceeds from an existing contract. Immediate annuities purchased with proceeds from an existing policy are not exempted from the requirements of this section
- J. Structured settlements.

4. No person shall make or issue, or cause to be made or issued, any written or oral statement of a material fact which is untrue or omit to state a material fact necessary in order to make the statements made, in the light of circumstances under which they were made, not misleading with respect to comparisons as to the terms, conditions, or benefits contained in any policy for the purpose of inducing or attempting or tending to induce the policyholder to lapse, forfeit, borrow against, surrender, retain, exchange, modify, convert, or otherwise affect or dispose of any insurance policy.

304.12-090 Rebates prohibited.

1. No insurer or employee or representative thereof shall knowingly charge, demand, or receive a premium for any insurance policy except in accordance with the applicable filing on file with the executive director. No such insurer, employee, or representative shall pay, allow, or give, or offer to pay, allow, or give, directly or indirectly, as an inducement to insurance or after insurance has been effected, any rebate, discount, abatement, credit or reduction of the premium named in a policy, or any special favor or advantage in the dividends or other benefits to accrue thereon, or any valuable consideration or inducements whatever, or give, sell, or purchase, or offer to give, sell, or purchase anything of value whatsoever not specified in the policy, except to the extent provided for in such applicable filing.
2. No insured named in a policy, nor any employee or representative thereof shall knowingly receive or accept, directly or indirectly, any such rebate, discount, abatement or reduction of premium, or any special favor or advantage or valuable consideration or inducement.
3. Subsection (1) and (2) of this section shall not apply as to life insurance and health insurance. Except as expressly provided by law no insurer, employee, or representative shall knowingly permit or offer to make or make any contract of life insurance, life annuity or health insurance, or agreement as to such contract other than as plainly expressed in the contract issued thereon, or pay or allow, or give or offer to pay, allow or give, directly or indirectly, as inducement to such insurance, or annuity, any rebate of premiums payable on the contract, or any special favor or advantage in the dividends or other benefits thereon, or any valuable consideration or inducement whatever not expressed in the contract.

4.

Advisory Opinion 2004-5 - Rebating and Illegal Inducements

The Office of Insurance has received several complaints and inquiries regarding the business practice by some licensees of offering free administrative services in exchange for the clients insurance business. The free services are offered for both insurance and non-insurance programs, such as Section 125 plans. This Advisory Opinion clarifies the Office's historic position regarding that business practice. KRS 304.12-090 prohibits an insurer, employee, or representative from giving, directly or indirectly, anything of value as an inducement to insurance or after insurance has been effected.

The insurance business practice of offering administrative services at a free or reduced cost in connection with an insurance transaction violates the statutes quoted above. Any violators will be subject to administrative action, which may include civil penalties or sanctions against the license if, after a hearing in accordance with the law, they are deemed to be guilty of such violation.

This Advisory Opinion has been issued industry-wide and is intended as notice to all insurers and agents that such practices cannot be tolerated. Insurers are charged with notifying their appointed agents of this Office policy. Professional associations are charged with notifying their memberships.

No insurer, insurance producer as defined in KRS 304.9-020(7), or other person shall, as an inducement to insurance, or in connection with any insurance transaction, provide in any policy for, or offer, sell, buy, or offer or promise to buy, sell, give, promise, or allow to the insured or prospective insured or to any other person on his behalf in any manner whatsoever:

1. Any employment
2. Any shares of stock or other securities issued or at any time to be issued or any interest therein or rights thereto
3. Any advisory board contract, or any similar contract, agreement or understanding, offering, providing for, or promising any profits or special returns or special dividends
4. Any prizes, goods, wares, merchandise, or property of an aggregate value in excess of twenty-five dollars (\$25)