

Ethical Issues Part II

©Commonwealth Schools of Insurance, Inc.



P.O. Box 22414

Louisville, KY 40252-0414

Telephone: 502.425.5987

Fax: 502-429-0755

Web Site: www.commonwealthschools.com Email: info@commonwealthschools.com

DISCLOSURE

This booklet is intended to provide you with accurate and useful information, ideas and applications. However, the information contained herein is subject to change through legislation or from industry practice.

The sample codes presented herein were accurate as of the date this publication was created. However, any changes by the respective organizations may substantially affect the information presented.

This material is presented and distributed for educational purposes only. The material does not constitute legal, accounting, or other professional advice.

©Commonwealth Schools of Insurance, Inc.

INTRODUCTION

"To be trusted is a greater compliment than to be loved."

Some people feel the moral and ethical fiber of our society is deteriorating rapidly. Others see both positive signs and disturbing signs, but feel optimistic. While there is room for a difference of opinion on this issue, most people agree on the importance of maintaining a high ethical standard in a society that is to survive and prosper.

Some would argue that it is even more important to maintain a high ethical standard in the insurance industry. What is there about the insurance transaction that makes a high ethical standard so important? Some of the unique aspects of the insurance industry combine to create this necessity.

Some people would argue that ethical business practices are limited to doing what is legal. As long as you are not breaking the law, you are acting ethically. Others would argue that this view is very short sighted. However, at a minimum, ethical behavior requires that insurance or financial services professionals conduct their business in accordance with state and federal laws.

FIDUCIARY DUTY

Fiduciary has been defined as: "A person who stands in a special relation of trust, confidence, or responsibility in his obligations to others, as a company director or an agent of a principal."

Insurance agents automatically have a fiduciary responsibility to the insurer they represent by the nature of their contractual relationship. But they also have a fiduciary responsibility to clients, one that rests on several factors.

The agent is the intermediary between the company he or she represents and the client. And, even if the client does not know a great deal about the particular company represented, almost anyone in the market for any type of insurance has some idea of what insurance companies do, although the idea may not be totally accurate.

One of the first duties of an insurance agent is to make certain that the client is familiar with the particular company's record for financial stability and attention to valid claims. A brief brochure that can be left with the client serves the purpose well. Also, an agent can introduce information about the company into the conversation, thus establishing a basis for trust.

That is another reason an insurance agent must understand the fiduciary nature of his or her responsibility to clients. Insurance is about money, about value, about worth. At its simplest, it is a way of paying for the loss of something we value before that loss occurs. And when clients purchase a policy, they are concerned, primarily, with three things.

- What is the value of the thing to be insured?
- What will it cost to insure it?
- How much will I get if a loss occurs?

Thus, when going over the policy, explanations should be tied to those three things, because that is what the client is thinking about.

For example, in discussing a P&C policy, make sure the client understands why it is so important to file claims within the time frame that the policy states. Tie that time limit to the third question--how much will I get if a loss occurs? Make sure the client understands the penalty if a timely claim is not filed.

What does all this have to do with ethics? Everything. Because a basic fact about ethics is that, they regulate our behavior with others, taking care of them, but also taking care of us. A client depends upon the agent to sell a policy that will meet the client's needs within the limitations of what the client can afford to pay. Making sure the client understands how the policy works, avoids trouble later.

Case Study: John Gray sold a standard property policy to his friend, Anne, and her partner, Karen. Anne and Karen own a shoe store, which occupies the bottom floor of a building with an apartment on the entire second floor. The building owner has been renting this apartment out, but when the last renter leaves, does not find a replacement, and the apartment remains vacant for a number of months.

During one weekend, a pipe in the apartment kitchen bursts. The water has not been turned off, and the water breaks through the ceiling of the stock room in the shoe store below. A lot of stock, as well as all the carpet in the store, are ruined.

Anne and Karen call John to make a claim. He points out the section in the policy that states that this sort of water damage is not covered. End of story? Not likely.

Anne talks to a lawyer, who asks several questions.

- Did John deliver the policy in person, and go over each section it contains? No, he did not.
- Did John inspect the property to be insured, and determine that the apartment above the store was empty? No, he did not.
- Did John ask questions about the property? No, he did not.

Anne's lawyer called the claim department of the company, which then paid the claim in full. Why? Because John represented to Anne and Karen that the policy would cover losses to their property. Since he did not go over the exclusions, and since courts normally find against the party writing the contract in this sort of dispute, the insurer John represents was liable for the loss.

In other words, the courts fully realize that an insurance contract is a product of a fiduciary relationship, one in which trust and confidence are paramount. **DUTIES AND OBLIGATIONS TO CLIENTS** In the world of insurance, client's must decide when to insure, what to insure and how much to cover and pay. As an agent, it is your job to analyze these needs and be an advocate or problem solver to make sure the requested risk has been transferred. A client views policies in terms of obtaining reduced uncertainty. In most cases, your customers can only hope that the policy they purchase is appropriate. That is why agents are vital players in solving client needs.

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

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

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

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

For example, cases have looked to whether the insured made express representations to the agent about the importance of arranging a set of policies that would prevent a gap in coverage. The insured relied on these agents to obtain the appropriate coverage, and the agents failed to use reasonable care, skill and diligence to procure suitable policies. The allegations in the complaints make clear that the insured expected the agents to respond to the couple's unique, personal insurance needs. A \$600,000 claim proved that a gap in coverage existed and therefore it was not a suitable policy.

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

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

Risk

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

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

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

Identifying Client Risks

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

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

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

The Importance of Applications

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

Once you and your client have identified their risk exposures, you need to determine a strategy to handle it. Consider the following options: A client with an identified risk can either control it or finance it. Controlling client risks involves avoiding or reducing them:

Avoiding Risks

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

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

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

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

Needs-Based Analysis

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

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

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

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

The problem is personalized to arouse interest in a possible solution. Like any system, needs analysis works effectively only when it is used as it is designed. The system builds upon itself in terms of both content and data and is most effective when used from start to finish. Shortcuts undermine the effectiveness of the process. An agent following this system from start to finish should never be accused of less than professional point-of sale practices.

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

Needs Based Selling?

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

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

Needs analysis helps the agent sell the right amount of insurance to the client for the right reasons. In today's competitive environment, agents cannot afford the exposure of makeshift or piecemeal sales practices. They must provide a needs-based analysis for their clients and generate trustworthy recommendations based on this investigation.

Learning how to effectively determine needs gives the opportunity to offer a full array of financial products and services.

EDUCATION

In order to educate clients, agents must maintain their own knowledge. Continuing education is one of the hallmarks of a professional, both in formal courses and in informal study on one's own. While in earlier days, there were few insurance policies, and those few were relatively simple, today's market has a wide variety of insurance instruments which can be tailored quite precisely to fit a client's needs.

Agent education should focus on at least three areas:

1. New products from the company or companies represented;
2. Legislation and regulations affecting insurance
3. Tax considerations, particularly in the life insurance field.

Educating the client begins with the application process. In many cases, the client will be required to sign authorizations for Medical Information Bureau reports; for inspection reports; and for credit reports. While some people sign these authorizations with no objection, many people feel that such reports are an invasion of their privacy.

It is up to the agent to explain the necessity of such reports in the underwriting process, and to stress the confidentiality of the information thus obtained.

The application process also offers opportunities for unethical behavior on the part of the agent. For example, imagine a case in which the prospect's new hobby is skydiving. Obviously, this is a high-risk behavior, which would affect the premium if the company knows about it.

The agent may decide that chances are slim that the prospect will die in a skydiving, or that the client may give the hobby up. To keep the premium down, the agent suggests that the prospect simply omit information about the hobby on the application. All other data on the application is such that the policy is issued at a standard rate.

No harm done, right? That is the case until the client does indeed die in a skydiving accident. If that happens, the policy will not pay, because the client concealed information vital to the underwriting process.

However, even if the worst does not happen, what sort of trust is the agent building? Having proved that he or she is not above lying, how much confidence can the agent expect the client to continue to have?

In addition, the agent may lose the sale if the client refuses the policy on the grounds that the rated premium is too high. However, ethics is not concerned with sales. They are concerned with service. Ethics demand honesty in every instance.

There is yet another reason for full disclosure of all information relevant to the underwriting process, one, which may appear self-serving, but one, which gives a strong motivation for living up to an ethical code. The policyholder or the beneficiaries may sue the agent.

Further, Agents who do not disclose information that may result in higher premiums will eventually have a case in which this dishonesty hurts a client. And just as news about ethical agents who can be trusted spreads through a community, so does news about those who do not observe a professional ethical code.

Agents also have an ethical obligation to compare the plan they are proposing with similar competitive products. In fact, about two-thirds of the states in the U.S. require by law that agents provide clients with a copy of the National Association of Insurance Commissioners Buyer's Guide - or something similar - so that comparisons with other products may be made.

INSURANCE DOCUMENTS

There are two facets of insurance policies that need particular explanation in order that the client fully understands them. One is the binder and the other is the conditional receipt.

Binder

A binder is a written acknowledgment that the coverage offered under the policy is in effect during the time it takes for the company to issue the policy. Only agents who have been given binding authority by the insurers they represent may issue binders.

Such a document should have the following information:

1. Name of the insurer
2. Perils insured under the policy
3. Policy amount
4. Type of insurance
5. Exclusions, if any
6. Time period the binder covers
7. Any conditions affecting the coverage

The client, the agent, and the insurer should all have a copy of the binder. Binders are primarily used for property and casualty insurance.

Conditional Receipt

A conditional receipt, used in life and health insurance, is similar to a binder in that it provides coverage once the initial premium is paid, and before the policy is issued. It is different from a binder in that coverage is provided during this period only if the applicant meets the underwriting requirements for the particular coverage. In other words, coverage depends upon the insurability of the client.

Many disputes have arisen between agents and survivors of an applicant who died or suffered an injury or illness during the period between application and issuance of the policy, because the conditional nature of the interim coverage was not understood.

Agents should also explain to clients that once the underwriting department of the insurer receives the applications, further information may be needed. Anything which delays the issuance of the policy is detrimental to both applicant and agent.

It is therefore highly important that the agent obtain all possible relevant information from the client before sending the application in. Taking time to ask questions that will reveal particular risks that affect the policy will save time later.

Once the agent is satisfied that the information on the application is both thorough and accurate, he or she has an ethical responsibility to the client to submit the application to the insurer as soon as it is possible to do so.

Policy

The agent has the further responsibility to deliver the policy as soon as it is issued, and to sit down with the client and go over its contents. However, what if the policy is not issued as applied for? What if the policy is rated or rejected?

The agent should first be certain that he or she understands the basis for the rating or rejection, and, having understood it, should determine if there is any information that could supplement or correct the information on which the rating or rejection is based. If there is no remedy for the rating or rejection, the agent should meet with the client and explain why the policy has been rated, or why it has been rejected.

While having to conduct such an interview with a client may not be pleasant, agents have an ethical responsibility to let clients know that the policy has been rated or rejected so that the client may look for coverage elsewhere.

Practice of Law

Because of the nature of estate or business planning, agents must be particularly careful not to cross the line from proper and appropriate advice to clients and engaging in the unauthorized practice of law. Normally, agents will work with a client's attorney and accountant to come up with an estate or business plan. The key words are "work with."

The American Bar Association has distinct opinions about what is ethical and what is unethical behavior for insurance agents operating in these two fields. Each state adopts its own rules regulating the practice of law. The Kentucky Supreme Court defines the unauthorized practice of law as follows:

SCR 3.020 Practice of law defined

“The practice of law is any service rendered involving legal knowledge or legal advice, whether of representation, counsel or advocacy in or out of court, rendered in respect to the rights, duties, obligations, liabilities, or business relations of one requiring the services. But nothing herein shall prevent any natural person not holding himself out as a practicing attorney from drawing any instrument to which he is a party without consideration unto himself therefore.”

The ABA opinions may be stated as follows:

1. Non-lawyers may determine, analyze, and organize the assets of a client to take care of the needs of the living and of survivors after a death, and may also present general information about laws that affect asset use.
2. Non-lawyers may not do legal research; draw up legal documents, such as a will; put advice in specific legal terms; or use legal principals to define the client's particular needs.
3. Insurance agents behave unethically when they try to steer business to a particular attorney, or when they try to talk clients out of seeking legal advice.
4. Fee-splitting with attorneys is unethical.

CONSEQUENCES OF BREACH OF RESPONSIBILITY TO CLIENTS

An agent who breaches his or her responsibility to clients to behave in an ethical manner will be exposed to two types of consequences, personal and legal. Depending upon the seriousness of the breach, the agent may suffer anything from loss of a client to loss of a job.

Case Example: Jane Dawson, a new and highly enthusiastic life insurance agent, is interested in earning as much money as she can her first year, even when periodic payments are much better suited to their individual financial needs. She uses every kind of persuasion she can think of, including making clients feel inferior to people who can pay annual premiums, to place her policies.

Not only can Jane expect a high percent of lapses in the policies she sells, but she can also forget about getting referrals from the clients she misuses in this way. Nor should she expect these clients to purchase new policies from her when their old ones lapse.

Case Example: Another example of unethical, not illegal, behavior is the agent who is so persistent that the client finally buys something just to get rid of the unwelcome voice on the telephone or E-mail message. Again, the policy will probably lapse, and the "client" will hardly refer friends and relatives to be bothered in the same way

Such tactics give the insurance field a bad name, which ethical, professional agents then must overcome. Though agents who can use high-pressure tactics to achieve their own ends may eventually cross the line into illegal behavior, and thus have their license suspended or withdrawn, many such agents never cross that line. It is up to their brokers, managers, and fellow agents to discourage such tactics, which violate a cornerstone of the insurance profession, that of concern for the welfare of others.

Since public trust is so essential in the insurance field, it should not surprise high pressure agents who do not fit in with the professional image their company or agency wishes to convey that they are asked to stop representing the company, or leave the agency.

Finally, there are also legal consequences for unethical conduct, which can include suspension or revocation of the agent's license, as well as lawsuits in criminal or civil court.

AGENT'S OBLIGATIONS UNDER AGENCY LAW

The agent generally assumes duties normally found in any agency relationship. The law of agency is a universal area of the law that determines an agent's status and specifically binds the agent 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.

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

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

Therefore, the insurers are most often legally responsible for the acts of the agent and are regularly sued by third parties (clients of the agent) who feel they have been wronged. Of course, when a policy owner sues his insurance company, agents are often named for various breaches of duty between client and agent. Agent liability may also exist where insurance companies sue their own agents. Insurance companies, 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, are neither 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, AAs, 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.

Creating Agency

There are 3 ways to form an agency:

1. Appointment
2. Estoppel
3. Ratification

Agency by appointment is done by a contract, usually written, that defines the specific authority the principal gives to the agent to use on its behalf. This is the usual way in which agency is created.

Agency by Estoppel is created where an individual or legal entity acting on behalf of a principal does not in fact have the legal authority to do so, but the principal has allowed a situation to develop in which innocent third parties assume that the agent does in fact have proper authority, and enters into a contract with the principal. The principal may then legally be estopped (barred) from claiming that the agency did not in fact exist.

Three factors determine agency by estoppel.

- The principal's actions were such that an agency appeared to exist.
- An innocent third party, on the grounds of the principal's actions, believes agency to exist.
- The third party could be injured by actions taken on the strength of a belief in the agency relationship.

Case Example: Howard Smith and Son have an independent agency representing a number of companies. One of the companies become dissatisfied with the way the Smiths handle their business and cancels its agency contract with them. But the person assigned to go to the Smith's office and retrieve all stationery, policies, and other materials bearing the name of the company delays doing so.

In the meantime, one of the agents in the office places a number of new policies with clients, all from the company which has canceled the agency contract. Since the clients have no way of knowing that the Smith Agency no longer legally represents the company with which their contracts are made, that company has no recourse under law, but is liable for the policies the Smiths wrote.

Agency by ratification describes a situation in which someone acts as though he or she has a principal's authority to act on its behalf, when actually no such authority exists. But if such an individual performs an act that is seen as beneficial to the principal, the principal may ratify that act, and the presumed authority behind it.

Case Example: Louise Morgan is going to work for AAA Insurance Agency. The contract papers were filled out, and Louise assumes she is now an authorized agent of the companies AAA represents. In actuality, the contract has not been finalized, and Louise has no authority to bind any principal to a contract she sells.

Louise calls on her oldest friend, who has been waiting to buy a large policy from her. She fills out all the necessary papers, and then drives her friend to the airport for a three-week trip abroad.

When Louise goes into the office the next morning, she discovers that she did not have the authority to make that sale. But, when her manager reviews the policy, she realizes this is a policy the company definitely wants. Louise's action in placing the insurance is ratified, making her authority retroactive. Note that this ratification may be for that single act.

CREDIBILITY

We have already discussed the trust and confidence that is essential in an agent's relationship with clients. Now let us look at the desired quality of the relationship between the principal and the agent, a relationship which can have a definite effect on the insurer's credibility in society.

Loyalty

Loyalty is at the basis of a trusting relationship between a principal and an agent. Loyalty means adhering strictly to the lines of authority the principal has given the agent, and acting with absolute integrity in carrying out the principal's business. Loyalty precludes agents acting in concert with agents from competing principals to take business away from a principal.

Unless an agent has specific authority to represent more than one company, he or she may not do so. Independent agents and brokers of course represent several companies, with the full knowledge of all involved. The agency contract sets limits within which an ethical agent stays.

Reasonable Care

There is a concept in common law known as the "reasonable man standard." This standard holds that persons engaged in activities, which can result in harm to others, or their property must exert reasonable care in the exercise of their duties. So, too, is an agent required to use reasonable care in carrying out his or her activities on behalf of the insurer / principal?

Case Example: Joe and Helen Black have a health and accident policy, written by agent Joan Higgins. Joe is in an automobile accident and suffers serious injuries which hospitalize him for months. Helen almost never leaves his bedside; they have no children, Joe is all she has.

Months later, when Joe is home recuperating, Helen calls Joan to complain that she has never received a check from the company for her claim. Joan investigates, and finds that the claim, which

she helped Helen fill out and then left for Helen to get supplemental information from the physician in charge before signing it and mailing it to the claim department, never reached the company.

She calls Helen, who looks through her desk, and finds the claim, still not mailed. The date for a timely filing of the loss has long since passed. And while it will be possible for Joan to straighten out this mess, reasonable care would have prevented it happening in the first place.

With no one to help her, and as distraught as she was, Helen needed Joan to see the claim filing process through. Not only is the client badly served, but the company has the additional trouble of dealing with the claim, and has also suffered a credibility loss, since Helen has complained bitterly to neighbors and friends about the company's negligence in her case.

The reasonable care standard requires that ethical agents take into account the factors in their clients' lives that might affect their ability to handle their own claims effectively and efficiently, and deal with other matter arising from the coverage they have bought. In this way, they are establishing and/or maintaining their company's public image.

FINANCIAL STABILITY OF INSURER

An insurer's fiscal stability rests upon its ability to accurately calculate the monetary amount of the risks it assumes through the policies it issues and to charge rates which balance that sum, all within the rating regulatory framework governing the industry. In addition, while the carelessness of only one agent in dealing with application and premiums would not harm a company, imagine if a large percentage of agents representing an insurer behaved irresponsibly in these matters? Agents thus have an ethical responsibility to the insured to be aware of the effects their activities may have upon its fiscal stability.

Agents must be sure to fully disclose all relevant information when filling out an application. They thus protect their principal from issuing policies that should be rejected, or not asking for additional information such as credit reports on Medical Bureau of Information reports that might affect their underwriting decision.

Agents should also deliver applications to the insurer as soon as is reasonably possible. Such efficiency protects the applicant, ensuring coverage within a reasonable time period, and also protects the insurer in cases in which a binder provides coverage under a policy that is later rejected.

Agents must be particularly honest and ethical in handling any premiums they may collect. Since payment to the agent legally constitutes payment to the insurer, coverage may begin with the premium payment, if the application has been approved. Even in states that allow premiums to be commingled with an agent's personal funds, such behavior does not conform to the highest ethical standards, for a number of reasons.

Premiums belong to the insurer, not to the agent. And, if something happens, such as the agent dying or succumbing to a serious illness, it may be quite difficult to establish how much of the money in his or her personal accounts actually belongs to the principal.

Finally, the agent must be aware of and be prepared to refuse new business that the agent knows will lapse. Lapsed policies are costly to the agent, but even more so to the insurer. The agent may have to deal with only a few, but if many agents write policies they are fairly certain will lapse, in order to

make their monthly sales total look good, the company's administrative costs in handling the applications, taking them through the underwriting process, issuing the policies, and then finally tracking them through the period when no premiums are paid, and the policies lapse, can be extremely burdensome.

ROLE OF THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

As its name implies, the NAIC is formed of insurance commissioners working together to achieve four major goals:

1. Encourage states to have uniformity in their insurance regulations and laws;
2. Help in the administration of regulations and laws;
3. See that policyholders' interests are protected;
4. See to it that states contain to regulate the insurance industry.

The NAIC uses model laws which are presented to each state legislature; such models help insure the uniformity among state laws that work to the benefit of an industry which crosses state lines.

Insurance commissioners in each state are charged with investigating claims of unethical or unlawful behavior; overseeing the issuance of licenses; levying penalties for violations of ethical practice--penalties may include fines, or the suspension or revocation of the agent or company to do business in that state; and seeing to it that penalties are carried out.

STATE LAWS GOVERNING INSURANCE

State laws governing insurance fall into several broad categories. And while those defining Unfair Trade Practices are most relevant to this course, we will present a summary of the other areas states regulate.

Licensing of agents is a major method by which states regulate the insurance industry. Licensing laws require that companies have a license or certificate of authority that allows them to do business in the state. And, the agents of the company must also fulfill licensing requirements before they are allowed to act for the insurer in the state.

Licensing laws are the gateway through which individuals found to be trustworthy and competent enter the insurance field, and they are also the door which closes on those found untrustworthy or incompetent. Whether the door is closed for only a certain period, as when a license is suspended or revoked, the state is the final authority of who shall and who shall not solicit and place insurance within its borders.

States also regulate contract provisions. Standardized policies or provisions in some endurance lines help meet the criteria of uniformity proclaimed by the NAIC. State law may require that certain terms be defined in a particular way. Other laws state that policies be easy to read, written with clear and simple wording. And, states may forbid certain provisions being included in a policy.

States require that any insurance policy to be sold in that state be submitted for review and approval before it is offered to consumers; states have the power to reject policies which do not conform to their regulations and laws.

Rates are also regulated by law, with companies in most states having to file rates assigned to their policies with the state insurance department for review.

There are three main areas insurance commissioners look at concerning rates:

1. Rates must not be so low that they do not cover the insurer's anticipated losses and administrative expenses; nor must they be lowered to establish an unfair advantage over other companies.
2. Rates must not be so high that they exceed anticipated losses and administrative expense, thus placing an unnecessary expense on consumers.
3. Rates must be fair, in that no individual with the same RISK as another pays a higher rate. If a higher rate is paid for the exact same coverage, then there must be a valid reason, such as age, physical condition, and the like, for the difference.

Insurance commissioners also have the legal right to investigate and examine companies operating within their states. They may conduct examinations when they have reason to suspect that the company is in violation of insurance laws, and they are required to examine all domestic insurers at periods set by law.

Bolstering the efforts of the NAIC and state regulators to regulate those areas of the insurance industry which are key in its ability to serve the public fairly are Codes of Ethics formulated and promulgated by two major groups, the Independent Insurance Agents of America, and the American Institute for Chartered Property and Casualty Underwriters. Copies of these codes are appended at the end of this course.

UNFAIR TRADE PRACTICES

Laws dealing specifically with unfair trade practices are a result of a growing awareness in our society that the Roman slogan *caveat emptor* (let the buyer beware), gives merchants much too great an advantage, particularly when the market is filled with products that the consumer cannot possibly be knowledgeable about. As products become more complicated, consumer protection laws are absolutely necessary.

Insurance has been regulated by the states since the beginning of the industry's history in this country. States made certain that company charters had certain provision, and at a later time had boards that supervised insurance companies' financial stability. And, until 1944, insurance was not considered commerce and thus was not subject to regulation by Congress.

The status of insurance as commerce was tested in 1869 in landmark case tried before the U.S. Supreme Court. The Court ruled that insurance was not commerce, and this opinion held through a number of court challenges until 1944, when the Court, ruled that insurance was commerce, and the federal government could regulate it.

The states had been regulating insurance for a long time, and had been doing this effectively. To undo all this and replace it with federal regulation seemed unwise, as well as impractical. The McCarran-Ferguson Act, passed by Congress in 1945, left insurance regulation to the states, with Congress regulating the industry only if the states failed to do an adequate job. However, this Act also placed on states the specific duty to regulate trade practices of insurers and agents.

The NAIC drew up a model act that dealt with Unfair Trade Practices, and most of the states have passed laws based upon this model. At the core of unfair trade practices is the quality of communication about the product and the sales process between buyer and seller.

Consumers must have all the information they need in order to make a decision, and that information must be accurate and true. The information should be produced in such a manner that the consumer has it in time to make the decision; if more information is required, or some action taken before the sale can be made, the seller is required to act in a timely manner. And, no tactics which try to unduly influence the buyer must be used.

MISREPRESENTATIONS

No person may cause, or permit to be made, issued or circulated in any written or oral form, any estimate, illustration, circular, statement, sales presentation, omission or comparison that does any of the following:

- Misrepresents the terms, benefits, advantages or conditions of any insurance policy
- Misrepresents the dividends or share of surplus to be received on any insurance policy
- Makes any false or misleading statements as to the dividends or shares of surplus previously paid on any insurance policy
- Misrepresents or is misleading as to the financial condition of any person or the legal reserve system upon which any life insurer operates;
- Uses any name or title of any insurance policy or class of policies that misrepresent the true nature of the policies
- Misrepresents any material fact for the purpose of inducing or tending to induce the lapse, forfeiture, exchange, conversion, replacement or surrender any insurance policy (this illegal practice is known as twisting)
- Misrepresents any material fact for the purpose of effecting a pledge, assignment, or loan on any insurance policy
- Misrepresents any insurance policy as being a share of stock

No ethical agent would twist a policy: replace a policy the prospect already has with another one, when the replacement will cause the prospect some harm. But because there are situations in which a policy legitimately should be replaced, this whole area of replacing policies can be a challenge.

Case Example: Jack Walters has had a term policy with a face value of \$50,000 for ten years. Since it is a term policy, it has no cash value. Jack is only 30 years old, and is in good health.

His insurance agent looks at the amount of premium Jack pays annually for the \$50,000 worth of term and sees that Jack could buy \$25,000 of permanent life insurance in a policy that will have cash value. Since Jack wants more insurance, and since the additional amount he can spend annually will buy another \$75,000 worth of permanent insurance, his agent can ethically suggest that Jack carry \$100,000 of permanent insurance that has cash value, letting the term policy drop.

But suppose that Jack is older, and his health isn't so good? Suppose the permanent insurance is rated, so that the additional amount of premium insurance is rated, so that the additional amount of premium Jack can afford will only purchase \$30,000 of permanent insurance? Then an ethical agent

will recommend that Jack keep the \$50,000 in term, since what he needs is protection, not automatic savings.

Sometimes a prospect will make the decision to change insurers or drop one policy for another even when the agent advises against this action. And if the prospect is capable of making decisions, if the agent is certain that the prospect fully understands both contracts, then the decision rests with the prospect, and the agent's actions are not unethical.

The primary hallmarks of twisting are deceit and misrepresentation: deliberate attempts to make a prospect believe something other than the truth, either by omitting details, or by making statements that are false.

FALSE OR MISLEADING ADVERTISING

It is unlawful for any person to place before the public in any form, through written, published or electronic media, any advertisement, announcement or statement which is untrue, deceptive or misleading about the business of insurance or the conduct of any person engaged in the insurance business.

The NAIC has written up guidelines for insurance advertising which further detail the principles contained in the above section. Note particularly number four, which concerns testimonial. In a time when everything from beer to automobiles is sold on the strength of some celebrity's testimonials, the personal opinion of some well-known individual can be a powerful sales tool. This creates a climate in which an opinion can be sold, making it all the more important that any testimonial conform to NAIC Guidelines.

NAIC Guidelines for Insurance Advertising

1. All insurance advertisements must be truthful and not misleading in fact or implication. Words or phrases that are clear only through familiarity with insurance terminology cannot be used.
2. All information required to be disclosed must be printed conspicuously next to the statements to which the information related and displayed in such prominence that it is not minimized, confusing or misleading.
3. Deceptive words, phrases or illustrations may not be used to describe a policy, its benefits, the losses to be covered or premiums payable.
4. Testimonial must be genuine, represent the current opinion of the author, be applicable to the policy advertised and be accurately reproduced.
5. Disparaging remarks or statements about another insurer, agency or agent of another insurer, their products and services may not be used in any advertisement.
6. The identity of the insurer must be clear in all advertisements, as well as the name, address and phone number of the agent placing the advertisement.

DEFAMATION

No agent shall make any written or oral statement which is false, maliciously critical of, or derogatory to, any person engaged in the business of insurance and which is calculated to injure any such person.

This is a particularly important section. Since the relationship between an agent and his or her client must be one of absolute trust, anything that weakens or destroys an insured's trust is harmful. If the statements that make an insured think twice about the trustworthiness of an agent are false, then real injury can be remedied in a court of law.

Case Example: Sue Harris calls on a friend whom she considers to be an excellent prospect for business insurance, only to find that the friend is already discussing such a policy with an agent from Company X.

Sue manages, in the course of her visit, to imply that the agent is incompetent, and has made serious errors in other such cases. Sue further implies that Company X has been in trouble with the insurance commissioner, and that its finances are shaky. None of what Sue says is true, but she counts upon the fact that she said all of this only on the condition that the client not repeat it to keep anyone from learning what she has said.

This prospect, however, is a fair person who believes everyone should have an opportunity to defend themselves. The prospect passes on what Sue has said to the agent in question, who immediately reports Sue to the insurance commissioner, charging her with defamation.

BOYCOTT, COERCION OR INTIMIDATION

It is a violation of the law for any person to commit, or agree to commit, any act of boycott, coercion, or intimidation resulting in or tending to result in an unreasonable restraint of, or monopoly in, the business of insurance.

While activity such as just described seems foreign to the field of insurance, consider a situation like this. Firm A is going to need a very large group policy, one that will result in a significant commission for the agent who places the business. Firm B, an important customer of Firm A, is owned by a man whose brother is an insurance agent for Company Y.

Firm B's owner tells his brother that he will tell the president of Firm A to buy the group policy from him, and that if he does not, he will lose Firm B's business. This is clearly coercion, and is illegal under unfair trade practices laws. Of course, agents frequently ask someone to put in a good word with a prospect. But when the good word is put in by a person who has the power to do some sort of harm to the prospect, the situation could present ethical, and legal, problems.

False Financial Statements

It is unlawful for any person to make a false entry, or willfully omit a true entry of a material fact in any book, report, or statement of any person engaged in the insurance business. It is illegal for any person to knowingly file with any supervisory or public official, or to knowingly make, publish, circulate or place before the public, any false material statement of fact as to the financial condition of any person engaged in the insurance business.

When insurance companies become insolvent, an investigation will very often show that officers of the company have used false financial statements to conceal the company's shaky condition. Because the taxpayers of a state must cover the losses to policyholders when an insurer becomes insolvent, filing false financial statements is a serious offense, one punishable by both fines and imprisonment.

And while insolvency may be inadvertent, a result of poor business and bad luck, there have been instances where officers of insurance companies raided the company treasury, often transferring the funds to offshore banks, leaving only a shell and a financial mess for the taxpayers to clean up.

Prohibited Inducements

No person shall issue or deliver, or permit agents, officers or employees to issue or deliver, capital stock, benefit certificates or shares in any corporation, securities, and special or advisory board contracts, or any contract promising returns and profits, as an inducement to insurance.

Case Example: Hank Johnson owns an independent insurance agency. He very much wants the property and casualty insurance of Joe Hanover, a contractor with a business worth millions. In order to get Joe to place the business with him, Hank offers Joe a share in his agency, which is worth 2% of Hank's annual profits. Joe accepts the share, and Hank gets the business. Both Hank and Joe are guilty of unfair trade practices.

Unfair Discrimination

With respect to life insurance and annuities, it is a violation of law for any person to unfairly discriminate between individuals of the same class, in the rates charged, the dividends or other benefits payable, or in any other terms or conditions of the contract.

With respect to accident and health insurance, it is unlawful to make any unfair discrimination between individuals of the same class and essentially the same hazard in the amount of premium, policy fees, or rates charged for the policy or contract, or in the benefits payable, or in terms and conditions of the contract, or in any other manner.

The law further provides that insurers cannot refuse to insure, refuse to continue to insure, or limit the amount or kind of insurance available to an individual, or charge a different rate for the same coverage, solely because a person is blind or partially blind, or mentally or physically disabled. This section does not prohibit an insurer from such discrimination when the refusal or limitation is based on sound actuarial principles. This section does not modify any other provision of the law relating to the termination, modification, issuance or renewal of any insurance policy or contract.

It is illegal to engage in, to make, or to permit any unfair discrimination between individuals or risks of essentially the same hazard by refusing to issue, refusing to renew, canceling or limiting the insurance coverage solely because of the geographic location of the individual risk, or with respect to any residential property risk (including personal property contained therein) solely because of the age of the property unless:

- The refusal, cancellation or limitation is for a business purpose that is not a mere pretext for unfair discrimination
- The refusal, cancellation or limitation is required by law or a regulatory mandate

Note the emphasis on geographic location in this section, and also on age of property. This is recognition of the fact that individuals living in inner-city areas were sometimes charged higher fees for coverage than individuals living in the suburbs, even though geographic location was not one of the bases of actuarial determination of rates.

The mere age of a property does not in itself denote decrepitude. Many very old properties have been maintained, or restored, until their condition is equal to that of a brand-new structure. This section recognizes the possibility that people living in certain areas, or whose homes are in structures of a certain age, may be subject to rate discrimination that is not tied to actuarial principles.

Illegal Rebates and Inducements

Except as otherwise provided by law, no person shall knowingly make or offer to make any contract of insurance or annuity, which offers a rebate as an inducement to the purchase of insurance. Nor may any agent make an agreement regarding such policy or contract that is not specified in the policy or contract.

Rebating includes any of the following activities when used as an inducement to the purchase of insurance or annuities:

- Making agreements that are not plainly expressed in the policy
- Paying or giving directly or indirectly a rebate or other consideration of the required premium payment nor specified on the contract
- Giving any special favor or advantage in dividends or other benefits
- Giving any valuable consideration not specified in the contract
- Giving, selling, offering or promising any shares of stock or other securities, or any dividends, returns or profits, on such securities, or any advisory board contracts

It is not only illegal for an insurer or agent to give or permit a rebate, it is illegal for an insurer representative of an insured to receive or accompany such rebate, special favor, other valuable consideration or illegal inducement.

There are exceptions to the provisions concerning discrimination and rebates. In the case of life or annuity contracts, it is legal to pay fair and equitable bonuses to policyholders or to abate premiums from a surplus nonparticipating policy.

The following would not be considered rebating:

- Readjustment of the rate of premium for a group insurance policy based on the loss or expense experience under the policy, at the end of the first or any subsequent policy year.
- In the case of insurers, allowing their bona fide employees to receive a reduction on the premiums paid by them on policies or contracts on their own lives and property, and on the lives and property of their spouses and dependent children.
- Issuing life or accident and sickness policies or annuity contracts on a salary savings or payroll deduction plan at a reduced rate consistent with the savings made by the use of such plan.
- Paying commissions or other compensation to duly licensed agents or brokers.

- Allowing or returning to participating policyholders, members or subscribers, dividends, savings or unabsorbed premium payments.

UNFAIR CLAIM SETTLEMENT PRACTICES

If an agent or insurer is frequently guilty of any of the following acts, then the agent or insurer is guilty of doing business with unfair claim settlement practices.

- Attempting to settle claims for less than the amount for which a reasonable person would believe one was entitled, based on written or printed advertising material accompanying or made a part of an application.
- Attempting settlement of claims on the basis of applications that were altered without notice to, the knowledge of, or consent of insured's
- Making claims payments without including a statement of the coverage under which the claim is being paid.
- Making known to insured's or claimant that the company has a policy of appealing arbitration awards in favor of insured's or claimants in order to compel them to accept settlements or compromises less than the amount awarded in arbitration.
- Delaying the investigation or payment of claims by requiring an insured, a claimant, or the physician of either to submit a preliminary claim report, and then requiring the subsequent submission of formal proof of loss forms, both of which contain substantially the same information.
- Failing to promptly settle claims under one portion of a policy for the purpose of influencing settlements under other portions of the policy.
- Failing to promptly provide a reasonable explanation for denial of a claim or for the offer of a compromise settlement.
- Knowingly misrepresenting, to claimants, relevant facts or policy provisions relating to coverage at issue
- Failing to acknowledge with reasonable promptness, communications pertaining to claims
- Failing to adopt and implement reasonable standards for the prompt investigation of claims OR failing to affirm or deny coverage of claims within a reasonable time after proof of loss has been completed
- Not attempting in good faith to make prompt, fair and equitable settlement of claims in which the insurer's liability has become reasonable clear.
- Compelling insured to institute suites to recover amounts due under its policies by offering substantially less than the amounts ultimately recovered in such suits brought by insured's

The law also forbids insurers from making use of a certain repair or replacement facility a condition of claim settlement.

While the insurance commissioner is the only person empowered to seek judicial action should an agent or insurer violate the claims settlement section of the law, when the commissioner takes action, persons involved may seek their own legal remedy.

COMPLAINT RECORD

Insurers by law must keep a record of all the complaints they have received since the last examination by the commissioner, or during the previous three years, whichever date covers the most recent period. Records include the number of complaints, the lines of insurance involved, nature of the complaints, how the complaints were taken care of, and how long it took to deal with each complaint. A complaint is defined by written communication from the policyholder that expresses a grievance concerning an agent or insurer.

These complaint records serve several useful purposes. They provide the insurance commissioner with information about the kinds of problems consumers are having, and with information about whether the problems are legitimate misunderstandings or are unfair trade practices. Legitimate misunderstandings can be corrected with, for example, clearer policies; unfair trade practice violations can be investigated.

FALSE APPLICATION STATEMENTS

This section prohibits any person from making false or fraudulent statements or representations on or relative to an application for insurance coverage for the specific purpose of gaining a commission, a fee, money or some other benefit from any agent, broker, insurer or individual.

Note that this would apply to an applicant who, through false statements, will obtain coverage that would have been rejected were the truth known.

UNFAIR TRADE PRACTICES OF LIENHOLDERS

Because many mortgages or loans are made only on the condition that life insurance to pay off the loan be assigned or purchased, there are specific trade practices relating to these transactions.

All individuals who lend money and/or extend credit, and those who solicit insurance covering real or personal property, are required to state in writing that the borrower may purchase insurance relative to the loan/credit from an agent or insurer of the borrower's choice.

Further, it is illegal for a person involved in a loan/credit transaction to:

- Require, as a condition precedent to the extension of credit or any subsequent renewal of a credit agreement, that the borrower purchase insurance through a particular insurer, agent or broker purchase insurance through a particular insurer, agent or broker
- Unreasonably disapprove any insurance policy provided by a borrower to protect the loan by insuring the borrower's life, or any policy for the protection of property securing the loan

- Require that any debtor, borrower, mortgagor, purchaser, insurer, broker or agent pay a separate charge of any kind in connection with the handling of any insurance policy required as security for a loan or real estate, or pay a separate charge for substituting the insurance policy of one insurer for that of another
- Use or disclose information including, but not limited to, policy information and policy expiration dates on policies insuring property being used as collateral security to a loan, when such information is to the advantage of the lender or to the detriment of the borrower, insurer or agent complying with the insurance requirement

Disapproval by a lender of an insurance policy provided by a borrower shall be deemed unreasonable if it is not based solely on reasonable standards uniformly applied, relating to the extent of coverage required and the financial soundness and services of the insurer. Such standards may not discriminate against any particular type of insurer, nor call for disapproval of a policy because it contains coverage in addition to that required by the creditor.

No person who lends money or extends credit shall solicit insurance on real or personal property after a person indicated interest in securing a first mortgage credit extension, until the person has actually received a commitment in writing from the lender as to a loan or credit extension.

The Commission may investigate the affairs of any person to whom this section applies to determine whether that person has violated these provisions. If a violation is found, violators shall be subject to the same procedures and penalties as are applicable for other violations of the laws against unfair trade practices.

DISCLOSURE OF INFORMATION

When an annuity, an accident and sickness policy, or a life insurance policy, will have an accumulated cash value, the person soliciting or affecting the sales of such policy shall furnish disclosure information as required by the Commission's rules and regulations.

INVESTIGATIONS

The Commission has the power to examine and investigate the conduct of each person/entity whose activities are covered by unfair trade practices laws to determine whether that person/entity has been or is engaging in an act or method which constitutes unfair competition, or is unfair or deceptive as defined by the Code.

An agent found guilty of unfair trade practices by the Insurance Commission can lose his or her license, or have it suspended for a period. To understand the gravity of offenses under the unfair trade practices laws, consider this list, which details cause for license suspension or termination.

A license can be suspended or terminated if:

1. An agent makes a materially untrue statement when applying for an agent's license
2. An agent violates or does not comply with other states' insurance laws
3. An agent obtains a license fraudulently
4. An agent misappropriates funds

5. An agent misrepresents a contract's terms
6. An agent is convicted of a felony
7. An agent is convicted of an unfair trade practice
8. An agent's license in another state is suspended
9. An agent engages in fraudulent, coercive or dishonest practices; or is incompetent; untrustworthy; or financially irresponsible.

INTRA-COMPANY REPLACEMENT

If an appointed agent replaces an existing individual accident and sickness policy with another policy which is issued by the same insurer, and has substantially the same benefits as the old policy, the insurer may not pay a commission or other compensation to that agent except in an amount that does not exceed what the renewal commission would have been had the old policy stayed in force.

AVOIDING PROBLEMS & COMPLAINTS

It is estimated that one in seven agents face an errors and omissions claim each year. Charges like these will challenge your reputation, waste enormous time and could threaten your financial well-being. Basic measures to limit liability always begin by avoiding claims at the outset. Of course, this is easier said than done, since there is no foolproof method to sidetrack a lawsuit from a client or an insurer. There are, however, some steps that agents can use to help reduce the possibility of a claim developing and present a reasonable defense if one does.

Know your basic legal responsibilities as an agent and only exceed them when you are absolutely sure what you're doing. When you decide that you want to be more than an agent understand that it comes with a high price tag: added liability. Also, make sure you are complying with basic license responsibilities to keep from becoming a commissioner's target for suspension or revocation.

Learn from other agent mistakes. Study their errors, learn from them and make sure you don't repeat them.

Be aware of and avoid current industry conflicts that could develop into problems for your agency. There are hundreds of professional industry publications that will help you keep abreast. Once you are aware of a potential problem, take action to make sure you avoid or minimize the potential conflicts.

Maintain a strong code of ethics. Be as honest and responsible as possible.

Be consistent in your level of due care. Write or obtain a procedures manual that forces you to treat client situations the same way every time, and follow it. Courts and attorneys alike are quick to point out any inconsistency or lack of standard operating procedures where the client with a problem was handled different than another client.

Know every trade practice and consumer protection rule you can. The violation of "unfair practice rules" is a really big deal to lawyers. Review your state insurance code. Learn the applicable statutes and regulations. When in doubt, ask the state for guidance.

Use client disclosures whenever possible. There is nothing more convincing than a client's own signature witnessing his knowledge of the situation.

Get connected to the latest office protocol systems. The ability to access a note concerning a client conversation or the way you “package” correspondence can make a big difference in the outcome of a claim or avoiding one at the outset. You want a system that will produce solid evidence.

Maintain and understand your errors and omission insurance. This policy is your “first line of defense”, but you must know its limitations and gaps. Read the policy and where in doubt, ask for clarification in writing.

KNOW YOUR PRODUCER & LICENSE RESPONSIBILITIES

Agent / Client Duties

As we pointed out previously, the agent generally assumes only those duties normally found in any agency relationship. Your agency contract is a good source of basic duties. Overall, the basic duty of agents is to offer a company’s coverage, take the application and where necessary bind it (temporary receipt). Where clients have come to you and requested coverage, you need to decide whether it is available and if the client qualifies.

Agents have a responsibility to know the differences in the products being sold. While you do not need to obtain “complete” coverage in every case, you have a duty to explain policy options that are reasonably priced and widely available for the policy you are suggesting.

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

Agent / Company Duties

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

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

These duties include duty of care and skill, using standard care and skill; duty of good conduct or acting so as not to bring disrepute to the principal; duty to give information by communicating with the principal and clients; duty to keep accounts by keeping track of money; duty to act as authorized; duty to be practical and not attempt the impossible; and duty to obey or comply with the principal's directions. A violation of these duties can be considered grounds for termination or legal exposure to the principal or insurance company.

Areas of additional concern include clerical mistakes, erroneous policy limits, omissions of endorsement, misappropriating premiums, failure to disclose risk, failure to cancel or notify cancellation, authority to bind, premium financing activities and unfair trade practices.

Agent Integrity

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

Qualifications

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

Lack of Business Skills or Reputation

Licenses have been revoked where the agent is not of good business reputation, has shown incompetence or untrustworthiness in the conduct of any business, or has exposed the public or those dealing with him or her to danger of loss. For example, an application for an insurance license was denied by one state on the basis of reports and allegations in other states involving the applicant's violations of laws, misdealing, and mismanagement.

Activities Circumventing Laws

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

1. Did not actively and in good faith carry on as a business the transactions That are permitted by law
2. Avoids or prevents the operation or enforcement of insurance laws
3. Knowingly misrepresents any terms or the effect of a policy or contract
4. Fails to perform a duty or act expressly required of him or her by the insurance code. For example, a Commissioner revoked a license because the agent misrepresented benefits of policies he was selling and had entered false answers in applications as to the physical condition of the applicants

Agent Dishonesty

Agents have lost their license because they have engaged in fraudulent practices or conducted any business in a dishonest manner. A licensee is also subject to disciplinary action if he or she has been convicted of a public offense involving a fraudulent act or an act of dishonesty in acceptance of money or property. Furthermore, most Insurance Commissioners will discipline any licensee who aids or abets any person in an act or omission, which would be grounds for disciplinary action against the persons he or she aided or abetted.

For example, a license was revoked after an agent made a concerted effort to attract "bad risk business" from drivers whose licenses had been suspended or revoked. The Commissioner found that the agent had sent out deceptive and misleading solicitation letters and advertising from which it could be inferred that the agents could place automobile insurance at lower rates than could others because of their "volume plan".

Moreover, the letters appeared to be official correspondence of the Department of Motor Vehicles. Clients would be induced to sign contracts with the agents where the agent would advance the premiums to the insurance company. The prospective insured would agree to

repay the agents for the amount of the premium plus "charges" amounting to an interest rate of 40 percent per annum. The interest rates charged were usurious and violated state law.

Catchall Category

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

License Responsibilities

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

License Authority

A person or employee shall not act in the capacity of an agent without holding a valid agent license. It is generally assumed that anyone quoting premiums or terms of an insurance contract should be licensed. However, insurance departments across the country have pushed to constantly expand the definition of who in an agency should be subjected to licensing as an insurance producer.

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

At the agency level, some insurance departments require agencies to be licensed both as corporate entities and as individual agency owners and principals.

Temporary licensing can be requested when the agency principal or owner dies or to fill a void in an insurer's marketing force. This allows the surviving family to conduct business with existing clients. These licenses are usually limited to 30-days with two renewals for a total of 90 days.

Recent controversy has surfaced concerning the granting of producer licensing and special privileges to special interest groups like financial institutions and self-insured group purchasers. Independent agents are protesting this treatment and have requested new rules be established by the National Association of Insurance Commissioners.

Notice of Appointment

In addition to license requirements, states generally require a notice of appointment be filed with the insurance department. This document is executed between the agent and insurer and authorizes the agent to transact one or more classes of insurance business.

An agent may be appointed with several insurers. Upon termination of all appointments, an agent's license becomes inactive. While inactive, it can be renewed and reactivated by the filing of a new appointment.

License Domicile

Agent domicile is a rapidly changing area of law. Currently, many states will grant non-residents a producer license. The rules are fairly straightforward: Agents and brokers of insureds with exposures in several states must be licensed in those states before they can collect a commission for the coverage they have written. However, since a non-resident agent "exports" premiums and business outside a given state, many states are beginning to erect barriers to prevent outside solicitation.

More than one state has strictly prohibited agents and firms from entering to solicit insurance business without forming a corporation or agency and physically opening an office in the state. Soliciting is defined as direct mail, telephone or any other form of communication, such as fax.

Other new rules and regulations enacted in some states require that insurance policies be countersigned by licensed resident agents of the insurer, regardless of where the contracts are made or the residency of the insured's.

Many states require proof of continuing education credits for non-resident agents in those lines of insurance they are licensed or physically go to the state and pass a test before renewal or relicensing.

Display of License

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

Records

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

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

Agent Files

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

Agent Business & Marketing Practices

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

Concealment

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

Communication that is generally considered exempt from concealment include: Matters which 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 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 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 agents 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, persuading 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, advertising 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 the "replacement notice" shall be sent to the existing insurer. Additional requirements typically include the completion of specific sections of the insurance application where the agent must acknowledge that he or she is aware of the replacement

Privacy

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

AGENT ETHICS

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

Someday, it may be real important for a court and jury to hear that you have a history of serving the client without consideration for how much commission you made or how busy you were.

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

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

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

- The capital needs of a family are met by a \$1 million life insurance policy when the breadwinner dies prematurely.

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

Sales ethics involve more than compliance with the law and more than not telling lies because an incomplete answer can be just as deceptive as a lie.

The work of an insurance agent often impacts the entire financial well-being and future of businesses and families. Ethics place the interest of these clients above an agent's commission.

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

AGENT DISCLOSURE

Client Disclosure

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

Before using any disclosure letter speak to an attorney for approval. Also, know that specific products may require different wording.

Agents have successfully used disclosures to qualify a promise of coverage.

Case 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.

Case 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.

Nothing can prevent a lawsuit, but an agent will be ahead to demonstrate client knowledge about product and service by using disclosures. Further, an agent would be better positioned if he could demonstrate client knowledge in advance of the sale. Some legal advisors recommend inserting a binding arbitration clause to hopefully circumvent the long, expensive process of a judicial proceeding. Only a competent attorney should prepare these types of disclosures and clauses.

Insurer Disclosure

As between agent and insurer, the obligations and duties of both should be fully disclosed in the agency agreement, general agency agreement or explicitly detailed in other written documents. Agents reading these documents should be clear on issues of authority, advertising, waivers, venue, materials and records, rules & regulations, supervision, audits, commissions, special conditions, indemnification, termination conditions, etc.

As accountability grows, some agent contracts are including aggressive hold harmless agreements that impose liability on agents for any claims, regardless of fault, while others contain personal indemnification clauses that place an agent's home and personal assets at risk.

With all of these disclosures present, it is a wonder how disputes develop between agents and their insurance companies. The answer lies in the interpretation of these agreements and circumstances that can be quite different for each transaction.

Agents and brokers have been sued by their insurers for failure to comply with terms of agency agreements ranging from gross misappropriation of premiums to seemingly small violations involving clerical errors.

In many of these cases, the attorney for the defense had to go beyond the written disclosure by defending the agent or broker on the following points of law:

Agency Relationship

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

Proximate Cause & Reliance

In cases where the insurer sues a broker for failing to supply correct or complete information on the risk or client, brokers have countered that the insurer would have agreed to underwrite the risk even if he had not supplied correct or complete information.

As a practical matter, it is rare to encounter liability insurance litigation in which the insurer can prove that it would not have provided coverage if better information has been provided.

Estoppel

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

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

Ratification

When an insurer can be shown to have a practice of issuing policies even though the broker has supplied incomplete information, the broker may be able to establish that the insurer has ratified the broker's actions and adopted them as the insurer's own.

Ratification of unauthorized acts of an agent can be sufficient in some cases to release the broker/agent from liability to the principal.

ERRORS & OMISSIONS INSURANCE

Like other professionals, insurance agents should carry their own errors and omissions insurance. One author suggests that the highest level of agent ethics occurs when errors and omissions insurance is purchased for the protection of clients.

While this is indeed a noble gesture, it is more likely that agents purchase these policies for more selfish motives. After all, we have entered an era of high accountability and cannot hope to survive a major claim without this protection. In some states, for example, the punitive awards can be as high as three times the amount of compensatory awards (some policies do not cover punitive damages).

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

There is no standard errors and omissions policy. Most policies are written on a claims-made basis rather than on an occurrence basis. Claims made means the insurer is only responsible for claims filed while the policy was in force. This could represent a problem down the road a few years, if the agent moves or retires. Even death is not an excuse, where a "hot shot" attorney can file his client's claim against the agent's estate.

Policies today also have some very significant limitations, caps, gaps, consent clauses and relatively high deductibles. So many loopholes, in fact, that an agent is likely to feel the financial impact of any litigation almost immediately and under certain conditions may receive no protection whatsoever. Some older style policies even require the agent to pay the entire claim before the errors and omissions insurer has any obligation at all. These are referred to as indemnification policies.

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

Exclusions

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

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

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

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

In addition to the claims made limitation, there are many other important coverage exclusions an agent must consider, such as:

- Insurer insolvency
- Receivership, bankruptcy, liquidation or financial inability to pay;
- Acts by the agent that are dishonest, fraudulent, criminal, malicious or committed while knowing the conduct was wrong;
- Promises or guarantees as to interest rates or fluctuations of interest rates in policies sold, the market value of any insurance or financial product or future premium payments
- Activities of the agent related to any employee benefit plan as defined under ERISA
- Agent violations of the rules and regulations of the Securities Exchange
- Commission, the National Association of Security dealers or any similar federal or state security statute
- Violations of the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA) or the Employee Retirement Income Security Act (ERISA)
- Discrimination or unfair competition charges, violations of the Racketeer Influenced Corrupt Organizations Act (RICO), and structured settlement placements.

In most of the instances above, the standard agent's errors and omissions policy will not pay a claim. In the case of an insolvent company that retains client's money or refuses to make good on a claim, the agent will not even be defended according to specific terms that exist in most policies.

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

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

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

If you want your errors and omissions to do more, you can pay more and upgrade your coverage. Critical policy options that you might consider include first dollar defense coverage, defense costs in addition to policy limits, adequate liability limits, the availability of prior-acts coverage and coverage carrier solvency.

Obviously, the concerned agent would do better to avoid malpractice claims at the outset by doing everything possible to investigate safety and solvency of any proposed carrier, acting professionally, keeping current, and due care. Further, there is no substitute for operating in a prudent, ethical manner rather than rely only on an errors and omission policy.

Dealing With E&O Claims

If you feel you have a potential errors and omissions claim, you should first review your policy for the reporting requirements that you need to meet. Most E&O carriers want you to report an incident right away. However, it is important to know what your company determines to be an “incident”. If in doubt, you might want to call the company anyway and discuss it with them.

Generally, it is in your best interest to cooperate fully with the E&O company by assisting in any evidence gathering and witness lists. However, this same spirit of cooperation does not always extend to your client.

Most errors and omissions insurers do not want you or any staff member to make any voluntary admission of guilt to the client. Never blame the insurance company in any way or make any statement that might lead them to believe that the situation will be cured.

While you can be cordial and calm in dealing with the client, be careful not to give any advice, legal or otherwise. If you are absolutely positive the claim is wrong, you can deny it, but never offer to settle.

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

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

OFFICE PROTOCOL

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

The legal purpose of documenting client transactions is to establish evidence. Evidence can be parole evidence, which is oral (difficult to prove in court), or it can be hearsay evidence (behind the scenes notes), which are written but not generally admissible unless it is collected under ordinary business rules. You should develop standard operating procedures, which require the following evidence rules for the best protection possible:

- Reduce oral agreements to writing as soon as possible and indicate that the written document is the entire agreement.
- Handle ordinary course of business using an operating manual that is followed consistently.
- Instead of "post-it" notes and scattered comments in client files make a point to transfer the content of these notes to a formal log kept in every client file.

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

Automated Equipment

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

Application for Insurance

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

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

The Agent's File

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

For example, in one case a lack of notation regarding a client conversation three years before the loss was evidence upon which a jury concluded that the agent misrepresented the terms of the policy to the insured.

By law, insurance companies generally have access to your files. Therefore, it would be wise to never make a derogatory comment about a client in these files. Also, when a claim or potential claim situation surfaces, it is always a good idea to check with your errors and omissions insurer before you turn over any documents.

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

Correspondence

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

E-Mail

E-mail messages and correspondence is fast replacing written memos, faxes, phones calls and more. The ease of use, however, may hide liabilities that you need to address. For instance, confidential notes or information can be unintentionally sent without saving a copy, or worse yet, sent to the wrong party. E-Mail users often hit the "enter" key before they think, and just hitting "delete" doesn't automatically eliminate a message or derogatory remark. The system may "back-up".

E-Mail communications are just as binding, admissible and prohibitive in court as other communications. Attorneys are finding damaging information in E-Mail files that they can't find elsewhere. That is why it is imperative to have use guidelines for E-Mail.

For liability purposes, all parties who have access to E-Mail in your company should apply good judgment. They should communicate with E-Mail as they would in a public meeting. Sensitive information should be encrypted to protect it from being transmitted via the Internet.

Operations Manual

As you read above, standard operating procedures are steps that you follow consistently in selling and serving client. Standard procedures can be critical in establishing your notes and

records as usable evidence in a trial. Further, it can be suggested that an agent who is careful to follow set procedures is usually found to be more credible in his own defense. Both are important reasons to document procedures in an operations manual.

Some errors and omission insurers are requiring agents to have and see their operations manual before coverage can commence. You should also be aware that in an insurance dispute, the existence of such a manual may be uncovered. From a defense standpoint, the manual and your adherence to it may prove that you are a diligent agent. From a plaintiff's vantage, non-compliance of policy procedures that you establish may work against you.

An operations manual should detail standard procedures to follow in dealing with clients, insurers and special services you offer. Your operations manual should cover procedures for dealing with client applications, claims, policies and certificates, insurance companies and any special services you plan to offer.

The following is a basic outline of information that could be included in your manual. Because agencies and insurances differ widely, you will want to add issues that are specific to your business before implementing any procedures.

- Client needs and requests should always be noted in the file. Many agents routinely take 5 minutes after a client interview or phone call to document the needs and requests of the client in the file. Even if you have to shut the door and set the answering machine, this is important.
- Always be consistent. If you ask one client to accept or deny a specific endorsement or make sure that you ask the same question of others.
- Note the date or nature of all correspondence that notifies a client that his application has been accepted or denied. Equally important is logging notification of clients or potential clients that coverage is not available.
- Create a "hot list" or "follow-up" file for all transactions that require additional review. A contact management or database system is excellent for noting the need to review the client file within 10 days, 20 days or on a specific date to check a renewal, ordered endorsement.
- Your operations manual should also layout office procedures to be followed for handling and logging phone messages, faxes (copy thermal paper before putting in file), e-mail, photographs,, microfilm, proof of mailing receipts as well as how long and where storage and "deep storage" of records will be kept. Standard procedures using window envelopes (advisable) for all notifications should also be established.
- All oral agreements and binders should be reduced to writing and dated in the file.
- Policies received should be checked against "specimen policies" to be sure it is the same contract and against the client application to be sure it meets client needs.
- Endorsements should be processed as soon as possible. Make notes that show the policy has been endorsed and create a follow-up system that compares any endorsement papers mailed with the endorsement received from the insurance company.
- Cancellation procedures should comply with state regulations and policy provisions. Notices to client should be tracked and posted in the client file. Also, be sure that the client does not continue receiving a bill after cancellation.

- Renewals should be sent within a specified time before expiration of the policy (usually 60-90 days). Experts agree that if you can't reach the client you should order the renewal anyway. Posting and tracking any notices to file is very important.
- Expirations should comply with state and policy provisions. Always notify client of any expiration.
- Claims should receive immediate attention and all requests should be promptly sent to the insurer. A follow-up note to the file should be prepared. Do not tell the client that the claim will be paid unless you are absolutely sure. Do not offer any legal advice to the client. Compare claim awards to policy limits accuracy.

ADDITIONAL PRIVACY ISSUES

HIPAA

As life and health insurance agents, you are exposed to and trusted with personal medical information from the clients you work with. It has always been good business practice to view this type of information as confidential. In 1996, however, the federal government passed the Health Insurance Portability and Accountability Act (HIPAA) that provides specific rules for how we must protect personal medical information. It is no longer an option.

Who is required to comply?

There are three types of organizations that are required to comply with the rules outlined in HIPAA.

Covered Entities: A Covered Entity includes health plans, healthcare clearinghouses, and most health care providers. Note that the law considers employer group health plans as Covered Entities.

Business Associates: A Business Associate includes in business or individual who works with a Covered Entity and creates, uses, receives, or discloses protected health information.

Employer and Other Sponsors of Group Health Plans: An Employer and Other Sponsors of Group Health Plans includes all employers that receive protected health information as well as other organizations that sponsor group health plans (for example, a union).

Protected Health Information

HIPAA defines Protected Health Information as any individually identifiable health information that is created or received by a healthcare provider, health plan, employer, or healthcare clearinghouse. Note that the definition of Protected Health Information includes a person's name and address.

HIPAA requires that a group health plan does not disclose this information except for the following permitted or required disclosures:

Permitted Disclosures

- To the individual
- To carryout treatment, payment, or healthcare operations
- With a valid authorization
- Under limited circumstances, when the individual has the opportunity to agree or object to the use or disclosure
- For defined "public good function" and for very limited "marketing" purposes

- Group health plans may make disclosures of protected health information to business associates if the plan obtains satisfactory assurance that the business associate will adequately safeguard the information

Required Disclosures

- To an individual seeking to access their protected information
- To an individual seeking an accounting of disclosures of their protected health information
- When required by the Secretary of HHS to investigate or determine the group health plan's compliance with the regulation.

-

Business Associates

As life and health agents, you fall under the definition of a "Business Associate;" consequently, you will be required to enter into a "Business Associate Contract" with the health plans with which we work. These contracts are required to have the following provisions:

- Establish the permitted uses and disclosures of protected health information
- Provide that the business associate will not use nor further disclose the information other than as allowed under the contract or required by law
- Provide that the business associate will use appropriate safeguards to prevent the unauthorized disclosure of information
- Require the business associate to report to the health plan any unauthorized uses or disclosures of the information
- Ensure that any agents or subcontractors to whom the business associate discloses protected health information agrees to these same restrictions
- Provide that the business associate will make protected health information available for inspection
- Provide that the business associate will make protected health information available to amend and that the business associate has the capacity to make amendments
- Provide that business associates can provide for an accounting all of their disclosures of protected health information
- Require that the business associate agrees to make its internal practices, books, and records available to the Secretary of HHS for inspection, if necessary
- Provide that the business associate agrees to return or destroy, if feasible, all information and limit future uses and disclosures to those purposes that make its return or destruction infeasible, and
- Authorize the termination of the contract if the business associate has violated a material term of the contract

GLBA

As a life and health insurance agent, you also need to be familiar with requirements of the Gramm-Leach-Bliley Act (GLBA) of 1999. This law put into place privacy requirements for the protection of consumer's non-public, personal financial information. GLMA is specifically designed for and directed at the professionals working within the financial services industry.

The first step in determining the impact of GLBA on your business is to determine if you receive information that is protected by the law. The type of information protected includes:

- Information that comes from an individual seeking to obtain an insurance product
- Information that is financial in nature; information that relates to a personal, family, or household product or service
- Information that is non-public, and information that identifies the individual.

If you receive this type of information, the second step is to determine if you disclose the information in any way. As an agent doing business in the insurance industry, it is nearly impossible to not disclose this protected information as defined by GLMA. The final step in this process is to determine the appropriate discloser and authorization documents you should use within the course of your daily business.

Each individual state's government has the job of enforcing the GLBA requirements within the insurance industry. While efforts have been made to promote consistency from state to state, the reality is that each state's compliance measures can and may be different. As a life and health agent, you need to be familiar with the compliance measures for each state in which you do business.