Help

Claims Today!

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INTRODUCTION TO CLAIMS

The total impact of an insurance claim can be either a most comforting or a most devastating event. Sure, insurance indemnifies in the event of a covered loss and helps to offset. But, sometimes, there can be non-covered costs, unexpected liabilities and policy ambiguities that have a large affect on insureds, their lifestyle and/or their company's operations, market share, and overall public perception. These costs may include emotional adjustments, relocation, rehabilitation, lost work time, production downtime resulting in excessive loss in time, loss of key employees, increased costs of selecting and training new employees, and costs to improve poor company image, just to name a few.

As an agent, you have certainly come to realize that when your clients have problems, you have problems. Therefore, anything you can do to eliminate these problems "***pre-loss",*** is a clear "win" for you and your insurer. This does not presume that you are to become some kind of super ***claims gatekeeper***. However, in order to best serve your client and your own personal exposure to claim uncertainties, you should consider taking your practice to a higher level of risk management.

Agent Risk Management

Risk managing can be defined as any conscious action (or decision not to act) that identifies, reduces the frequency, severity, or unpredictability of loss claims. As you know, sometimes there is simply no coverage available for certain exposures or the clear definition of coverage is uncertain or ambiguous. These are times when your role and obligation is to identify the "gap in coverage" to your client so they understand, in no uncertain terms, that an exposure still exists. In other moments, you become their advisor on ways to mitigate potential claims. In either case, you are managing their claims through loss control.

Risk or loss control can focus on actual harm, not on the money paid to restore, compensate for, or otherwise finance this harm, which is the concern of risk financing. For example, when a machine is destroyed or a person dies, an organization, a family or society as a whole suffers a loss of resources. Risk control strives to reduce the frequency or the severity of this loss of resources. From a risk control perspective, the extent of such a loss of resources is not changed just because, for example, inflation or deflation alters the monetary valuation of the loss. Similarly, the severity of the loss is not reduced because the owner of the machine or the family of the deceased receives financial compensation for the loss.

A risk control measure is risk control only for one or more specified exposures. For example, fire-suppression sprinklers are risk control for fire damage, but not for loss by embezzlement. Similarly, a sprinkler system can be effective risk control for most fires. However, if the system uses water as an extinguishant, the water is a hazard rather than a safety measure for grease fires, which are spread or intensified by water. In short, specifying a risk control measure also requires specifying the exposure being controlled.

Perspective of a Given Entity

The effect of a given risk control technique can be measured only from perspective of a given entity. For example, pedestrians are exposed to bodily injury from being struck by automobiles, and drivers are exposed to the liability from such accidents. The pedestrians' exposure to injury and the drivers' exposure to liability are two different exposures growing out of the same circumstances. Any risk control technique that safeguards pedestrians from being struck by automobiles has different risk control effects for the pedestrians than for the automobile drivers. For the pedestrians, the effect is to safeguard against bodily injury; for the automobile drivers, the effect is to protect against liability. For one entity, an elevated walkway is risk control for a personnel loss; for the other, it is risk control for a liability loss.

Identifying Loss Exposure

To identify exposures, or possibilities of loss, the risk management professional must be able to do three things:

- Apply a logical classification scheme for identifying all possible exposures to loss.
- Employ proper methods for identifying those specific loss exposures that particular persons or organization faces at a particular time.
- Test the significance of these actual loss exposures by the degree to which they may occur and disclose to clients the possible results and remedies.

Loss exposures are typically categorized in terms of their first dimension -- the nature of the value exposed to loss. All financial losses that are the concern of risk management, excluding losses of purely sentimental value, can be categorized as *property losses, net income loss, liability losses, or personnel losses.* Let's look at a simulated loss a hospital occurs due to a toxic chemical leak in its parking lot"

Property losses could include damage that a person or business suffers to its building, damage to a parking lot where corrosive chemical flowed, and damage that the owners of automobiles parked in the parking suffered from the chemical that had been spilled.

Net income loss is the second major type of loss exposure. The hospital suffers income loss because some of the prospective patients chose to defer elective surgery or to have it performed in some other “safer” hospital. With respect to extra expense, the hospital incurred additional costs in overtime for its maintenance crews cleaning the grounds and in making special arrangements for temporary substitute parking facilities.

Liability loss exposure is a factor at the same hospital because some of the patients felt that the hospital had not taken appropriate precautions to protect its patients against foreseeable hazards from the nearby railroad tracks. The hospital employees who were injured or who suffered ill effects from the toxic chemical could bring workers’ compensation claims against the hospital.

Personnel losses result from death, disability, retirement, resignation, or unemployment. A vital executive or technician may have been sickened by toxic fumes and unable to come to work for the two weeks required to clean the parking lot. Then each of these two organizations would have suffered a personnel loss.

Loss histories are a record of past losses for an important indicator of accidental losses that may strike an organization. Prior accidents and lawsuits may well repeat themselves unless the organization’s operations have changed in some fundamental. For many organizations,

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

Financial statements are another method of identifying loss exposure. These financial statements must include balance sheets, profit and loss statements, and funds flow statements for a series of years. Profit and loss statements are often called income statements, and funds flow statements may be labeled sources and uses of funds.

Any document that tells something about a person or an organization's operations, such as contracts, correspondence, minutes of meetings, and internal memoranda, trusts, leases, common area CC&R's, etc. also tell something about loss exposures. There are many recent claims against agents who ignored or forgot to ask or read these types of documents.

Personal inspections can be necessary evil, especially where you are the single source for a client's insurance coverage. Asking questions or, in the case of a business, consulting with experts within and outside the organization also plays a part in identifying exposure to loss.

It seems like a lot of work, but then, you already know that the job of a responsible casualty agent is not for sissies!

CURRENT CLAIMS EVENTS

Before we get involved in the many facets and inner workings of the world of claims, it might be helpful to understand some of the current events shaping the industry.

The Hard Markets

The general downturn in business is forcing companies to look for ways to reduce costs in all areas -- especially claims. Risk avoidance, loss control, fraud avoidance, electronic productivity, automating workflow, legacy system improvements, etc . . . all are encouraged to make the handling of claims more efficient.

Challenging the Claim

In response to certain state legislation aimed at reducing premiums (Proposition 103 California, for example), insurers are challenging accident claims far more aggressively than in the past. They have been less willing to settle claims. The industry says they need to be more efficient. Critics describe the tactics as "low-balling" and unfair to require accident victims to pay their own costs or sue "at-fault parties" to recover medical and other accident-related expenses.

Class Action Problems

A disturbing trend is the severity of individual claims and wholesale growth in class-action lawsuits. The cost of the American civil liability system runs close to $200 billion. That represents almost 3%% of the nation's gross domestic product, compared with 1.4% in 1970 and 0.6% in 1950. These rising costs have spurred efforts for tort reform, which have passed in almost every state. However, not enough to ebb the growth of suits.

Lawyers say the industry should expect new cases to attract massive numbers of complaintants and have a wider scope, reaching beyond manufacturers and sellers, to building owners, landlords, contractors and public housing authorities. The base is getting broader, touching every aspects of our lives.

Technology is also playing a role here. A case in point: Two Illinois residents recently filed a class action lawsuit against State Farm concerning the use of non-factory authorized parts to repair their vehicles. Their lawyers established a website to recruit additional litigants. Other lawyers say they use the Internet to look for opportunities in class action insurance claims.

In essence, people today are not waiting for something to happen to sue, they're out looking for vulnerabilities.

In some cases, the insurers themselves are taking pro-active roles in mounting multi-million-dollar lawsuits against their own policyholders as in the case of manufacturers of polybutylene pipes for residential and commercial construction projects.

Natural Disasters / Global Warming

The insurance business is the first in line to be affected by climate change. In recent years there have been at least fifteen "billion-dollar" climate-related natural disasters that have put some reinsurers out of business and the outlook is not good. The "greenhouse effect" may actually be a real threat creating the need for insurers / reinsurers to raise premiums or exit form the market completely.

Fraud

There is much discussion in the industry as to the level of fraud occurring and the ways to reduce it. Insurers claim to be losing between $85 and $120 billion a year to fraud. Unfortunately, the way most states investigate, it is a real question whether they consider insurance fraud to be a crime. For instance, a study by the Coalition Against Insurance Fraud (CAIF) determined that there were 2,123 convictions of fraud in the year 2000. That's roughly 52 per state -- not a serious attempt to tackle this area of crime by any means.

Clearly, these convictions are just the tip of the iceberg; but why? Some argue that the difficulty in prosecuting insurance fraud is that insurance companies must use federal racketeering laws to pursue the perpetrators in court. Well, it just doesn't happen. This means that insurers pass along the costs of fraud to the good citizens. In fact, the CAIF estimates that insurance fraud is the equivalent of a annual hidden tax of more than $1,000 per family on the costs of goods and services in the United States.

The problem will get worse, say experts, as long as insurers continue to use the centralized or regionalized claims approach and handle claims by phone or mail; as opposed to the old fashioned method, where adjusters got out on the street to eyeball the claimants, visit the doctors signing the claim documents, and personally negotiate and settle the claim. Some say that the huge outlay for "man-hours" isn't feasible. Others argue that repositioning some of the millions lost to insurance fraud into better claims handling will save more in the long run.

Fraud Detection

The industry knows that insurance fraud is growing at an alarming rate. However, insurance personnel are overwhelmed with information to manually sift through and analyze claim files for the proper detection of fraud activities. The criminals know this and have found that the low conviction rate makes it easier and safer to commit insurance fraud than drug dealing, robbery and other illegal crimes.

Technology advances may help. New software advances using predictive, similarity search and visual link resources are proving to be effective investigative tools.

Predictive Technology: Monitoring the life of a claim to uncover suspicious activity patterns. In essence, characteristics of claims are compared to fit historical patterns of fraud producing fraud-risk scores to alert adjusters.

Similarity Search Technology: A similarity search engine pours through databases to help identify those who might commit insurance fraud through the use of similar but different names, addresses, telephone numbers or other identification.

Visual Link Technology: Computers analyze large amounts of data to find significant relationships among what appear to be unrelated statistics. Patterns emerge that can help

interpret relationships among people, places, entities, etc to assist in the identification and investigation of fraudulent activities.

Internet Fraud

Currently, the web is not being used for claims in any meaningful way. However, as carriers expand their presence and begin integrating claims services electronically, the forging of documents and falsifying accident reports will most likely be commonplace.

When business slows down, the motivation for fraud increases and the Internet is no exception to the rule. Misleading web ads are rampant and the source of many claim problems. Consider an insurance agent in Florida who advertised on his web site the following:

If you are HIV-positive, you probably think you can't buy life insurance. Now you can!

Clients responding were encouraged to lie about their HIV status on life applications. The DOI intervened and the agent was convicted of claims fraud, application fraud, second-degree theft, criminal solicitation and communications fraud.

"All Claims" Database

Slowly, but surely, the insurance industry is moving toward a national "all-claims" database system to be used by insurers and law enforcement agencies to help identify questionable claims and other insurance fraud. The National Insurance Crime Bureau and the Insurance Services Office (ISO) are the motivating entities behind the database effort which will focus on bodily injury, workers' compensation, property and vehicle claims.

The value of such a system can go well beyond detection of fraud. It can aid claims managers in the often fluid area of ***insurance benchmarking***. For instance, what is a six-year-old's ability to use his legs "worth" in this country? By researching a central database of legal verdicts throughout the country, a more accurate and fair figure can be derived. Knowing this kind of data can help reduce legal expenses because both sides could have a clearer picture of a case's value early on. In addition, cases could settle quicker.

The downside of using a central database is seen by some as a privacy issue. And there is legislation being proposed that could greatly limit the use of data. There is even concern among industry critics that information in the database can be used against insurers, such as a market conduct investigation.

The bottom line is that while these concerns may be legitimate, proper use of the data, such as not including specific names unless criminal intent is involved, may yield far more benefits than negatives.

September 11

The effects of 9/11 on America and property insurers are profound. Businesses and claim managers are only now beginning to see results on the downline. Business interruption claims, for example, are being filed whether or not there was any direct physical loss of property. Consider the travel agency that simply lost business due to the first FAA shut-down in air traffic and later to the decreased number of people desiring to travel. It is still not clear how far "civil authority coverage" may extend for these and other types of businesses who were far from any crash sites. After all, the common intent of this coverage was to insure property against

damage to a nearby property or where police / fire cordoned off an area for public safety reasons such as happens after a major windstorm to prevent looting or possible danger to onlookers.

The urban riots of the 1960s saw large numbers of claims from businesses well outside the areas of violence. This prompted major ISO form changes requiring that damage occur to property "adjacent" to an insured premises along with many other restrictions of coverage.

Homeowners near the 9/11 crash sites are also effected. Most policies in effect at the time of the attack may have had language similar to the ISO HO-3,which covers loss of use of the residence premises if a covered loss makes them "not fit to live in" or if a "civil authority prohibits use of the residence premises as a direct result of damage to a neighboring premise.

Coverage analysis of the many claims still being submitted will necessarily be dependent on the particular facts of each individual claim.

Network Problems

The recent experience of insurers with network repairs has been frustrating and expensive. One insurer must pay $456 million in damages to recompensate insureds whose cars had been repaired with aftermarket crash parts. The recent windshield network problem is another example. In an effort to lower costs, glass networks were directing business to their ***own glass shops***. Lawsuits based on improper replacement glass, urethanes and techniques have "raised the bar" on liability and the risk of not choosing qualified vendors. Overall, the costs to insurance carriers rose dramatically.

As a result of these activities, several state legislators have adopted ***anti-steering*** reform bills and insurance executives are looking at shifting their business to independent ***call centers*** that operate in fields detached from suppliers, such as technology or software. These new generation call centers offer full-service claims handling, including extensive auditing of work and billing, monthly statistical analysis of claims, and greater program compliance. The problem of paying different amounts for the identical part or windshield is eliminated. In addition, increased competition from repair shops can result in improved bottom lines. Carriers and agents are better assured that their customers are professionally served and that work is done correctly, completely and cost-effectively.

E-Business Claims

As the computer and internet become an important element, perhaps even dominate our professional and personal lives, the question of data and access coverage comes into play. Most traditional forms including Property, Business Income and CGL policies require that physical or tangible damage occur to be eligible. In State Auto vs Midwest (2001), the courts determined that lost computer data did not constitute tangible property. However, loss of use of computers WAS a loss of tangible property.

In Seagate Tech vs St Paul Fire (2001), the manufacturer of disk drives found to be defective was found liable for rendering a company's computer unusable. Seagate sought coverage under the property damage clause of their CGL but was denied by the court because the computers in question were not rendered unusable. The ruling did not bode well for companies looking to rely on their CGL to protect against liabilities that may arise as a result of hacking activity or malicious code that erased, copied or corrupted computer data, but still left the computer system operational.

Look for new CGL language with exclusionary language related to computer losses as well as new, innovative policies / endorsements offering first party and third party coverage for multimedia offenses, intellectual property perils, trade and copyright infringement, breach of computer security, business interruption, extortion and theft of ***digital assets***.

American Disabilities Act

Insurance companies and their agents will see increased activity in the area of civil rights claims, particularly those dealing with the American Disabilities Act (ADA). In **Parker vs. Metropolitan Life (1995)** a client alleged unlawful ADA discrimination because the disability plan, administered by Metropolitan Life, distinguished between benefits for mental and physical disabilities. The client had already received the maximum two years of benefit for a mental disorder although the plan provided for payments to age sixty-five for individuals with physical disorders. Although the client did not prevail, the courts would have allowed these benefits for someone else who was ADA "eligible".

AIDs / HIV

Cases are surfacing that challenge the AIDs/HIV policy exclusions and limitations. In one case, the limitation was outlined in the policy and listed in the data page entitled "Schedule of Benefits". The courts held that although the line pertaining to the limitation was clearly eligible, it was not highlighted, set apart, or emphasized in any way. Therefore, the limitation was not enforceable. **(Gonzales vs American Life - 1994)**.

Defining Occupation

In **Oglesby vs Penn Mutual Life (1995)** the insurer denied a disability claim to a client radiologist (vascular interventional radiologist) since a spine and neck problem still allowed him to practice within the same specialty but still permitted him to work as a radiologist. The courts disagreed because the insurance company initially listed his occupation as "radiologist" then later narrowed it to "vascular interventional radiologist". In essence, they could not deny benefits. Look for more of these "narrow definition" conflicts which may involve agents.

Psychologically Induced Illness

In **Rizk vs Dun & Bradstreet / Met Life (1994)** the client claimed he was unable to perform certain work tasks due to back injuries. The insurer denied claims because they felt that client's injuries were at least partially ***psychologically induced***. The courts, ruled in favor of the client because his disability was "total" as defined by the policy regardless of whether the illness was psychologically stimulated.

Experimental Treatment

There will undoubtedly be many cases defining what is ***experimental treatment*** under health policies in the years ahead. Recent cases have "tested" policy meaning regarding alleged experimental breast cancer treatment, AIDs-related liver transplants, bone marrow transplants, etc. Clients have lost their claim for coverage on the basis of a legitimate denial based on policy terms **(Wolf vs. Prudential Insurance - 1995)** and **Hendricks vs Central Reserve Life Insurance - 1994)** and **(Barnett vs Kaiser Foundation Health Plan - 1994)**. Insurance companies have lost their cases where an exclusion about experimental treatment was NOT highlighted in a conspicuous manner **(Gonzales vs Associates Life Insurance - 1994)** or

where policy language was considered ambiguous **(Fredericks vs Blue Cross of Michigan - 1995)** and **(Bailey vs Blue Cross of Virginia - 1994)**.

Language Barriers

There are new cases developing in the area of language misunderstandings where clients have pursued claims on the basis they did not fully comprehend the matters at hand. In **Parsaie vs United Olympic Life Insurance (1994)** a client prevailed in her action against a health insurer because she understood little English and could not read the application. She relied on the advice of the agent but failed to disclose a preexisting condition. The courts determined that the insurance company could only deny coverage where an intent to deceive was found. In this case, they said there was no intent to deceive.

Defining Accidental

Policy language often limits coverage for "accidentally sustained" injuries. Thus, cases have and are developing where attempted suicides have left clients permanently or severely injured. Since the injuries were self-inflicted, insurance companies have refused to pay. In one case, the insurer lost to a client who attempted suicide because "accidental" was NOT defined in the plan documents **(Casey vs Uddeholm Corp - 1994)**. In another example, the client also prevailed because the courts decided her treatment for an attempted drug overdose suicide was really treatment for her underlying depression. Further, the insurer was found to have misled her by not informing that mental and nervous disorders would not be covered if followed by an attempted suicide **(Lutheran Medical Center vs Contractors Health Plan - 1994)**. Finally an insurer was prohibited from withholding a claim because the client had a "subjective expectation of survival", thus even though his injuries were self-inflicted it was still deemed an accident **(Todd vs AIF Life Insurance - 1995)**.

Tenants As Implied Beneficiaries

The courts are leaning more and more to the proposition that tenant's are ***implied beneficiaries*** under a landlord's policy. In **Bannock vs Sahlberry - 1994** the tenant and landlord had only an oral lease agreement. Even though the tenant was responsible for the fire, the landlord's insurer could not recover from the tenant since he was an implied "additional insured". However, in the reverse situation, a landlord could not be construed to be an implied beneficiary of the tenant's policy **(American National Fire Insurance vs A. Secondino - 1995)**. More bizarre is the case of **Cigna Fire vs Leonard (1994)**. Here, the tenant was required to obtain fire insurance naming the landlord and mortgagee as additional insureds. However, he only purchased insurance on himself and then proceeded to intentionally burn his business to the ground along with the landlord's building. The courts denied the landlord and mortgagee's claim against the tenant's insurer because there was "no clear intention to cover the lessor or the mortgagee". Only the tenant was named in the policy but his claim was denied under the policy's arson provision.

EIL vs CGL

Within the last 20 years the insurance industry introduced environmental impairment liability insurance (EIL) in an effort to provide pollution coverage for events the industry deemed not to be covered by the more well-known comprehensive general liability policy (CGL). A very important distinction between these coverages is that EIL policies are ***claims-made*** policies, while CGL policies are ***occurrence-based***. The introduction of EIL insurance provided clients

an alternative that was broader than CGL coverage in some respects, while narrower in others. For example, the insurance industry's position is that EIL insurance affords coverage for the gradual release of contaminants that, according to the carriers, would no be covered under typical CGL policies. On the other hand, as discussed above, claims under an EIL policy must be made during the policy period.

One issue that continues to surface is the relationship of EIL coverage to other insurance purchased. For example, assume a company purchases both primary CGL insurance and EIL insurance. The question then arises whether the EIL insurance is primary coinsurance or excess to the CGL. In **Rhone-Poulenc vs International Insurance (1994)**, the client owned both EIL and CGL policies. However, the EIL policy contained a provision that loss or damage could not be recoverable as long as other insurance was in force. The courts ruled that the EIL was indeed excess coverage, however, there could be cases where EIL, if purchased alone, could be the primary insurer for environmental liabilities.

Recent court decisions have and will greatly effect CGL policies. In the past two decades, a precedent case (International Surplus Lines vs Devonshire) held that CGLs cover only those liabilities arising from torts. New cases (Vanderberg vs Superior Court of California) now say that CGLs cover BOTH tort and contractual liability. The underlying reason that courts ruled against insurers is the CGL phrase ***"legally obligated to pay as damages' describes liability based on breach of duty imposed by law, i.e.tort rather than contract".***

The courts rejected the distinction between tort and contract liability saying ***" A reasonable layperson would certainly understand ' legally obligated to pay' to refer to any obligation which is binding and enforceable under the law"***. Experts feel that this decision could have far-reaching negative effects on insurers across the country, just as the International case had positive effects when it was decided in 1979.

Contamination

Despite the fact that policies have been written as "All Risk" insurers continue to deny contamination claims based on policy exclusions. In **W.H. Breshears vs Federated Mutual Insurance (1994)**, the court rejected a client's claim for coverage on the basis that an oil spill on his property was not "covered property" because it was "land" and "pavement" only, not considered "property". In **Conde vs State Farm Fire & Casualty (1994)**, a client was denied coverage, which was upheld by the court, for contamination caused to his home by an exterminator's negligence because "contamination" was not defined in the policy. The court also rejected the client's argument that the exterminator's negligence (a covered peril) was the actual cause of loss.

"Sick Building" Syndrom

People have an unusual ability to acquire the problems and illnesses of others. Most "sick building" illnesses are found to be psychologically based rather than rooted in fact. In **Sternmann vs May Department Stores (1994)**, an employee claimed a long-term disability from toxic exposure at her place of work. The company refused full disability coverage since tests showed that toxic levels did not exist in the building. The courts ruled against the client even though her physician's diagnosis was total disability due to toxic exposure and chemical sensitivity.

Asbestos

The removal of asbestos continues to be a major source of conflict between clients and insurance companies. In **University of Cincinnati vs Arkwright Insurance - 1995** asbestos was found in a dormitory that suffered a partial loss due to fire. The client's all risk policy did not cover the removal of asbestos since it was not considered an unexpected event

Lead

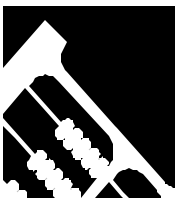
New standards introduced in September 1996 require property owners who are selling or renting real estate built prior to 1977 to disclose any known lead-based paint or lead hazards. Experts believe that the next wave of lawsuits will result from these disclosures and potential client illnesses, real or not.

Business Interruption

On the heels of major hurricanes and earthquake, claims are surfacing concerning business interruption where clients have been forced to close stores and businesses incurring major damages. A major issue that occurs in these cases is the determination of income. Most policies include a clause similar to this: "In calculating your lost income we will consider your situation before the loss and what your situation would probably have been if the loss had not occurred". In **American Auto Insurance vs Fisherman's Paradise (1994)**, the client lost his argument that his store would have made huge profits in the aftermath of Hurricane Andrew if it were left undamaged. The courts disagreed indicating that hypothetical profits would have created a "windfall" not contemplated by the policy.

Miscellaneous Actions

In addition to the events mentioned above, experts anticipate actions in the areas of Y2K compliance, Fen-Phen and Redux diet drugs, latex gloves, construction product defects, intellectual property, tobacco and carbon monoxide.



COMPANIES & CLAIMS

COMPANIES

Insuring History

One of the earliest kinds of insurance originated around 3000 B.C. in ancient Babylon, a center of commerce through which mercantile goods were shipped to all parts of the civilized world. Because Babylon was so centrally located, it quite naturally became the hub of international shipping routes, and many merchants were either robbed or captured for ransom. To minimize their losses, merchants developed an agreement, known as a "bottomry contract," which was essentially a loan provided to the owner of a ship with a stipulation that if the goods were lost or destroyed at sea, there would be no obligation to pay back the loan. An extra charge, or a premium, was assessed to spread the risk of loss among the various shippers and merchants. Bottomry contracts became an accepted part of maritime trade, but eventually the hijackings and looting on the high seas became so rampant that neither the merchants nor the vessel owners could any longer afford the high premiums which became necessary to cover the staggering losses.

Life insurance arose around 600 B.C. in Rome and Greece, where burial and death benefits were provided to the citizens by religious fraternities. By the first century A.D., the funeral expenses of slain Roman soldiers were paid from funds of a burial society to which each Roman soldier had to contribute. In Genoa during the early fifteenth century, it was quite common to insure the lives of pregnant women and slaves.

Fire insurance grew out of the ashes of the great fire in London in 1666, which left more than 200,000 people homeless and destroyed nearly 1,400 buildings. By the time the English colonists settled in the New World, fire insurance coverage was quite common.

The original automobile liability insurance policy was issued in the United States in 1897 by the Travelers Insurance Company to a mechanic from Massachusetts who had constructed a one-cylinder automobile for his personal use. Less than a year later, a doctor who used an electric car to make patient rounds purchased the first personal liability and property damage vehicle policy to insure his Stanley Steamer.

The Philadelphia Contributionship for the Insurance of Houses from Loss by Fire, founded in 1752 by Benjamin Franklin, was the first insurance company in America. The number of insurance companies quickly grew; however, speculative investments, poor management and imprudent risks drove many insurance companies out of business in the latter part of the eighteenth century. Between 1870 and 1872, more than 33 insurance companies were liquidated. Dividends declared that could not be funded and the construction of office buildings for a cost exceeding assets by many insurance companies contributed to the failure of an additional 48 insurance companies over the ensuing five years.

Early in the twentieth century, a prototype health care insurance policy was issued as a supplement to disability insurance. The Great Depression left overwhelming numbers of Americans unemployed with little or no money to pay bills, including the costs of medical care. More than 400 bankrupt hospitals closed by 1933. Third-party providers were established to

spread the losses and the risks that mounted because patients could not meet their medical expenses. One of the most significant steps in the development of the third-party provider concept was the Baylor University Hospital Plan of 1929, which was established as a health care plan for school teachers in Dallas. Under this plan, which served as a model for the earliest Blue Cross health care plans, each teacher contributed an annual sum of six dollars in return for a guarantee of 21 free days a year of hospital care in a semiprivate room. Three years later, participants in the Baylor Plan were offered services in a variety of hospitals. In 1938, private insurance companies began to offer coverage for surgical expense benefits, and five years later, group medical expenses were added to health care plans. During World War II, health care benefits replaced additional wages that were frozen for the duration of the war. With the advent of Medicare and Medicaid in the 60s, the federal government became the largest third-party provider in the United States.

Fundamentals of Insurance

Purpose of Insurance

The fundamental purpose of insurance is to provide protection against risks of loss that attend the ownership and use of real and personal property and the health and life of an individual. Conceptually, the ownership of any type of property or engaging in any activity involves some risk of loss, and, presumably, for the right price, insurance could be acquired that would protect against such loss.

In reality, most persons cannot afford to insure against losses on an individual basis. Therefore, insurance is feasible only when there is a sizable group of individuals willing to pay a sufficient amount into an insurance pool so that risks can be spread among the participants at a reasonable price.

Insurance as a Legal Contract

Insurance is a legal contractual arrangement creating corresponding rights and duties among the parties to a policy. An insurer has the privilege of specifying the conditions and rules which apply to those who wish to participate in the insurance pool, and a policyholder has a duty to obey such rules and conditions if he or she anticipates coverage for insured losses.

Notwithstanding the contractual nature of a policy, an insurer cannot compel a policyholder to pay premiums, but in such event it can deny claims or cancel the insurance policy.

Parties to an Insurance Policy

The central parties to an insurance policy involve the "issuer," the "owner," the "insured" and the "beneficiaries." The "issuer" is the company that extends insurance coverage over the subject matter by the sale of a contract known as an insurance policy. The issuer is commonly referred to as the "insurer," and less frequently as a "carrier." The "owner" of an insurance policy is the purchaser of the policy. The "insured" is the person who is protected against loss and may or may not be the owner of the policy.

If a man takes out a $1 million life insurance policy on his wife, naming his children as the parties to receive the proceeds of the policy upon the event of her death, he is the owner of the policy, the insured is his wife and the children are the "beneficiaries." A "named insured" is a person or persons whose name is shown on the cover page or the front of a policy.

Even though he or she may not be included specifically on the front of a policy, a spouse who is a resident in the same household as a named insured would automatically assume the same status. An "additional insured" is a person designated under a policy by way of endorsement, because such person has either a legal liability or an insurable interest in respect of the property.

Significant Definitions

The concept of insurance is facilitated by an understanding of certain other terms that are customarily used in the industry and that have established legal meanings. A "loss" commonly means being without a tangible or intangible that previously had ownership assigned to it. In insurance parlance the term is more restricted and has come to mean "an unplanned, undesired reduction of value on an economic basis."

Losses are not to be confused with expenses. In an insurance sense, expenses relate to something that is predictable, such as depreciation. Insurable losses are either "direct" or "indirect." If "direct," a loss is the immediate or first result of a peril. An "indirect" loss, the secondary result of an insured peril, is sometimes designated as a "consequential loss."

There can be no indirect loss without a direct loss. Insurance policies distinguish between direct and indirect losses when specifying the types and amounts of coverage.

A "***chance of loss***" refers to a ratio or a fraction where the numerator is the actual or anticipated degree of loss, and the denominator is the total number of loss exposures. By way of illustration, if there are 1,000 vehicles in an insurance pool, and the underwriters expect three of these vehicles to be destroyed during a flood, the expected "chance of loss" is 0.003 or 3/1,000. The "chance of loss" is determined in part by the number of claims filed for a given period, and it is a chance of loss that drives the necessity for insurance.

The ***causative agent*** of the loss is referred to as a "peril." Criminal acts, fires, tornadoes, hurricanes, floods and slip-and-fall accidents are all examples of insurable perils. Losses caused by perils are at the very heart of an insurance policy.

However, coverage under every insurance policy is not predicated upon a specific peril. Except perhaps for suicide, an insurance policy does not specify the peril causing a death. "Hazards" are conditions that enhance the degree of severity or the frequency of a loss.

Another important concept, particularly in property insurance, is "***proximate cause***," the first peril in a chain of events without which a loss would not have been sustained. If the pilot of a small Cessna, lost in a fog, flew into a petroleum storage tank which exploded, causing several houses in the surrounding area to burn to the ground, the proximate cause of the destruction of the houses would be the plane crash.

Not all situations involving multiple perils are that clear, and when that is the case it may take litigation to determine the proximate cause of the underlying event specified in a claim. One of the basic rules of insurance coverage is that an insured cannot collect unless either the proximate cause or one of the other occurrences in the chain of events is an insured peril.

There are two specific definitions of the term "risk." In the first situation, "risk" is a "variation" in possible outcomes of an event predicated upon chance. The more frequent the number of outcomes, the more enhanced is the risk. The second interpretation of "risk" is "the uncertainty involving a possible loss." Those involved in the insurance business sometimes refer to a risk as an "exposure to loss." The "degree of risk" is an index of the specificity with which the outcome

of an event founded on chance can be foreseen. The less accurate the forecast of an outcome, the greater the amount of risk. For an insurance company, a better record of predicting the outcome translates into economic benefits. One of the greatest uncertainties in predicting risk is the uncertain aspect of human behavior.

A "***third-party loss***" occurs when there is damage to the property or health of a person other than the insured. If the insured was sailing on a lake when the boom on her boat hit her friend on the head, a third-party loss would be involved. If the boom knocked the insured unconscious, a first-party loss would have occurred.

"***Premiums***" are periodic payments made during the term of an insurance policy by an owner to the issuer for insuring against a loss. Funds attributable to premiums are placed into various investment vehicles by an insurance company. The payment of losses are funded by an insurance company from premiums and income earned on the investment of premiums.

An insurer may be a third party, such as a private company or the government, or a self-insurer. Private insurers are usually involved in selling vehicle and life insurance. The government is an insurer to the extent it provides Medicare and Medicaid coverage, flood insurance, veterans disability benefits and FDIC coverage for savings and other types of bank accounts. As the cost of obtaining health insurance continues to increase, many business are covering health care plans for employees through self-insurance. In such case, employees contribute to a pool, usually through payroll deductions, and certain medical costs are then paid for by the employer, functioning in the capacity of an insurer.

Suitability of Loss for Insurance Coverage

Not every exposure to loss is suitable for insurance coverage. A number of factors determine whether an exposure to loss is appropriate, including the existence of a suitable class of similar items exposed to the same peril, accidental losses, specific losses that cause extreme economic hardship and a significant probability of a low incidence of catastrophic losses.

To be relatively successful, a carrier must accurately predict losses before they occur in order to reduce risks. Accuracy in prediction cannot be attained unless a large pool is involved. In order to establish a fair premium, the units in a pool must be substantially similar; otherwise, the pool cannot equitably transfer the expenses relative to the losses. Perils faced by each unit in an insurance pool should be identical. If half the roofs in a condominium complex were covered with wood shingles and the remaining half with composition shingles, the first half would pose a much greater fire hazard, and the risk of loss would be allocated inappropriately among all of the condominium owners.

Intentional losses are against public policy. If a policyholder could burn down his or her building and collect for the loss, the expenses would not be spread equitably among the insured pool. Thus, for a loss to be insurable in a practical sense, it must be accidental and beyond the control of a policyholder. It is that same principle that excludes normal wear and tear from the umbrella of property insurance coverage.

Notwithstanding this basic principle, it is curious that many carriers consider a suicide by a policyholder that occurs within two years of acquiring a life insurance policy to be an intentional loss. If that same suicide occurred two years and one day after the policy was issued, it would be treated as an accidental loss, the result of some type of mental illness.

In ascertaining the nature and extent of a casualty, a competent claims adjuster appreciates that a loss must be measurable, definite and of a sufficient degree of severity to cause economic hardship. It must be beyond question that a loss has occurred. Termite damage is not a proper

subject of property damage coverage because of the difficulty of determining when the loss occurred and the extent of the damage. It should be noted that guarantees given by termite inspectors to pay for subsequent damage if their treatment is ineffective is contingent on follow-up inspections and as such is classified as a service contract and not as insurance. Insured losses must be quantifiable. The loss of a pet is not an insurable transaction because of the difficulty of measuring an emotional loss, but the theft of a stud racehorse is covered because the economic loss can be quantified. The large-loss principle means that the purchase of insurance is only appropriate when a potential loss is large and uncertain.

Many catastrophic losses are not insurable because the occurrence of a few could possibly bankrupt an insurer. A "***catastrophic loss***" is one that is, relative to the amount of the property in an insurance pool, extraordinarily large. Generally, catastrophic losses have two characteristics. They cannot be predicted with any degree of accuracy and they are limited in geographical scope. Tornadoes, which occur with some regularity, are insurable perils. On the other hand, earthquakes are not predictable and thus are not typically suitable as an insurable peril. In that sense, a catastrophic loss may also be thought of as a loss that is unpredictable and capable of producing damage that is extraordinarily large relative to the quantity of property in the insurance pool. Theoretically, a private system of insurance could ascribe a premium of sufficient size to cover a catastrophic event, but, because of the uncertainty underlying predictability, the premium would be out of reach for most people, and a large reserve would have to be maintained by a carrier to cover the contingency of a catastrophic event.

From the standpoint of a policyholder, an insurable risk is one that does not require the payment of prohibitive premiums. The financial status of the insured as well as his or her attitude toward and tolerance of risk determine what may be prohibitive to him or her. The potential loss must be of sufficient magnitude to create economic difficulties for a policyholder if not covered by insurance. There are situations which generally are uninsurable, such as losses attributable to changes in price or a competitive market environment. Then there are political risks, such as insurrections, war and devaluation of currency, which are usually not insurable hazards either, although some such perils may be insured by a government instrumentality.

Claims Made Coverage

The ability to predict risks has a direct bearing on the establishment of premiums. Reliance on long-term predictions presents an inherent difficulty in setting reasonable rates. There are two forms of insurance coverage, and each has a distinct impact on the process of pricing insurance.

"***Occurrence coverage***" policies extend coverage for liability for activities that occur over a policy year, notwithstanding the fact that a suit might be brought at a later date to determine liability on the part of a carrier. The duty of a carrier to provide indemnification for an insured for losses incurred during a policy year could theoretically extend to claims filed a substantial time after the expiration of that term.

Thus, it becomes necessary for a carrier to fashion a premium that covers the eventual or probable results of any present activities. If both the severity and the number of claims is likely to increase over the immediate future, pricing of insurance can become extremely difficult. Because of the burdensome nature of establishing premiums with confidence under occurrence coverage policies, a trend has developed to issue "claims-made" policies.

A ***claims-made policy*** provides insurance coverage against liability for any claims that are presented to an insurance carrier during a policy year, regardless of when the underlying conduct giving rise to the liability occurred. The premiums for a claims-made policy can be set with more certainty because there is no necessity for a carrier to predict exposure to claims that

are more long-term in nature. Because a policyholder under a claims-made insurance agreement is always under the threat of having his or her policy canceled because of unsafe operations, there is an inherent incentive in claims-made insurance to create safe conditions in the insured environment.

Insurance Company Structure

Types of Insurance Companies

There are two fundamental types of insurance companies—the mutual insurance company and the stock insurance company. A mutual insurance company is owned by its policyholders. Dividends, if any, are paid to the policyholders. The ability to pay dividends is nearly directly proportional to the profitability of a mutual insurance company. Favorable operating results are common in a mutual company. Premiums usually exceed the amount necessary to pay anticipated losses and expenses, resulting in "built-in" premiums to the policyholders.

Policyholders are vested with rights similar to those of shareholders in a for-profit corporation. They can elect directors and vote on extraordinary corporate transactions, such as a change in bylaws or an increase or decrease in the number of directors. Even though mutual insurance companies are designated as not-for-profit corporations, typically they are run efficiently and economically.

Mutual Insurance Companies

Perhaps the most significant type of mutual insurance company is the "advance premium mutual," in which premiums are paid by policyholders upon commencement of insurance coverage, and upon termination, policyholders become eligible for a dividend. Advance premium mutual companies ordinarily do a very high volume of business. In the "assessment mutual," policyholders may or may not pay premiums at the inception of coverage, but they are liable for their pro rata share of expenses and company losses upon termination of their policy. The "factory mutual" is a third type of mutual insurance company which provides significant loss protection such as frequent examination of the insured premises. Factories must satisfy rigid safety requirements, such as including fire alarms and sprinkler systems on the premises, before they can qualify for coverage. A deposit of the entire premium for years in advance may be required.

Stock Insurance Companies

The other type of insurance company is a stock insurance company, which is substantially like any other corporation. It is not a prerequisite that a policyholder must first be a stockholder in the insurance company. Another difference between a mutual insurance company and a stock insurance company is that in the latter, stockholders are not liable for their share of corporate expenses and losses.

The Reciprocal Exchange

A "reciprocal exchange" is similar to a mutual insurance company due to the fact that policyholders provide insurance for each other on a nonprofit basis, although a reciprocal exchange is an unincorporated vehicle. Reciprocal exchanges are popular in the western part of the United States, providing a substantial amount of vehicle insurance. A reciprocal exchange is managed by an attorney-in-fact who is responsible for the performance of all the management functions of the organization.

Divisions

The basic functions of most insurance companies are carried out among four corporate divisions—underwriting, marketing, finance and claims. The underwriting department is responsible for the evaluation of risks, determining which risks will be underwritten and setting premium rates. Tailoring policies to individual needs, directing sales and advertising are the functions of the marketing department. The finance department is responsible for corporate and financial activities, tax preparation, investments, annual reports and the preparation and filing of necessary reports with state and federal regulatory agencies. The claims department, perhaps the least favored department because of its perception of contributing to the shrinkage of the bottom line, handles the investigation, evaluation and settlement of claims.

Claims Departments

Within the claims division of a sizable insurance carrier, there may be a corporate office claims department which establishes claims procedures and practices for the entire carrier, a regional claims office which supervises branch claims offices within its jurisdiction, and branch claims offices which supervise claims representatives or adjusters as well as the investigation, evaluation and disposition of all but the largest and most troublesome claims presented to a carrier.

The head of a corporate office claims division is responsible for the following:

- The development and communication of procedures and practices for the investigation, evaluation, direction and settlement of claims and the audit of payments of claims to policyholders and other named insureds.
- Verifying that disbursements are proper and in conformity with contract provisions of insurance policies.
- Insuring that policyholders receive the benefits purchased, service and protection.
- Deterring of questionable, unreasonable, inflated, fraudulent or frivolous claims.
- The effective pursuit and supervision of reinsurance, subrogation and salvage recovery.
- Overseeing the establishment and maintenance of efficient and prompt processing and disposition of claims.
- Monitoring significant litigation.
- Discouraging unnecessary expense.

Branch Claims Office

The branch claims facility is the office to which most claims are directed. Most branch offices are located in significant population centers. The personnel within a branch claims office handle and supervise claims and issue the settlements.

The Adjuster

An insurance adjuster, sometimes referred to as a "claims representative," a "claims specialist," an "examiner," a "senior adjuster," a "general adjuster" or an "executive general adjuster," is a professional, trained in the examination, evaluation and dispensation of claims. In addition, a standard part of the responsibilities of any adjuster is to counteract exaggerated, fraudulent or frivolous claims that are brought against a carrier.

Some insurance carriers use both field adjusters, who spend substantial amounts of time at the site of an accident or a loss, and office adjusters, who for the most part remain in their offices

handling claims by telephone under the direct supervision of a claims manager. Originally, office adjusters handled only small claims

in which there was little or no liability. Presently, most claims are processed by an office adjuster over the telephone. If a claim is within elementary guidelines, many carriers will allow an office adjuster to settle the claim over the telephone without the intervention of an outside adjuster, thus reducing administrative and overhead expenses considerably for an insurer. Quick resolution of small claims also enables a carrier to establish a reputation for the effective handling of claims. Claims of a larger magnitude, or in which liability of a carrier is in dispute, may be assigned to a field examiner who makes personal contacts with both the claimant and witnesses and is responsible for the direct inspection of the subject or site of a loss.

Field adjusters also handle the investigation, evaluation, negotiation and settlement of claims. Many also take a considerable amount of criticism from claimants. A number of observers of the insurance industry believe that field adjusters are drastically underpaid and are perceived to be low on the corporate ladder, resulting in a high turnover in such personnel.

It is arguable that the extensive use of office examiners reduces carrier overhead since many of their investigations tend to be rather superficial and the claims get little more attention than satisfying proper documentation. Favorable performance ratings tend to be given to the office examiner who has stuffed his or her file with the most paperwork—police reports, newspaper articles, accident reports, estimates, receipts and medical records.

Adjusters, whether in the office or the field, must keep written progress reports about their investigation and disposition of claim files under their supervision and control. All telephone calls, instructions from supervisors and activities taken on each claim are recorded. Also, both field and office adjusters are, for legal purposes, agents of an insurance carrier. As a result, an insurance company is responsible for the actions of agents that are carried out in the ordinary course of business. Inadvertent or negligent acts or omissions can result in a carrier having to pay a claim it might not otherwise have intended to pay.

The professional loss claims adjuster must possess a substantial degree of expertise and knowledge to avoid imposing a settlement of unwarranted claims on a carrier. To that end, there are two legal principles that an adjuster must be extremely familiar with—"waiver" and "estoppel." The intentional abandonment of a known right is designated as a "waiver," and "estoppel" is the result of behavior that is incompatible with asserting a known right.

The successful assertion of either one of these legal defenses by a claimant could result in a carrier being saddled with liability it might have otherwise avoided. Suppose a policy contained a provision requiring the filing of a proof of loss within 30 days after a claim was filed. If the carrier waives its right to receive such proof of loss from the claimant, it would very well be estopped from demanding one on the thirty-first day, and, as a result, might not avoid coverage on that fact alone.

Independent Adjusters

A smaller insurance company that does not have branch offices may employ the services of an independent adjuster to provide claims services relative to the investigation, evaluation and settlement of claims. Independent appraisers are typically hired by carriers for several reasons. During certain times of the year, such as hurricane and tornado season or during the early spring when flooding is rampant, the needs of many carriers are increased such that a number of extra adjusters are required. The holidays and summer months are seasons when theft is at a peak, again requiring an increased staff of adjusters. In less densely populated areas, such as small towns and rural areas, the number of claims is not typically large enough to justify staffing

a full-time office, so carriers look to independent adjusters to take care of the infrequent number of claims that are filed in such places.

An independent adjuster is self-employed, in some cases working for him/herself and in other instances associating with a large group of professional independent adjusters. An independent adjuster may have to pass exhaustive examinations provided by the state department of insurance to obtain a license. Typically, an independent adjuster receives remuneration on a case-by-case basis, charging an hourly rate and recouping expenses. Adjusters do not collect a certain percentage of settled amounts. Independent adjusters should be motivated to arrive at a fair and quick disposition of a claim to avoid being reported to the state insurance department for unethical or underhanded practices.

Public Adjusters

Sometimes referred to as a "loss consultant," a public adjuster also works independently of a carrier, but, unlike an independent adjuster, he or she is typically hired by a claimant. Many public adjusters have scanners in the fire and police departments. Unlike an independent adjuster, a public adjuster works on a percentage of the amount recovered. In some states, a public adjuster must be licensed before he or she can offer his or her services to the public. A competent public adjuster is a professional who handles all the paperwork involved with a claim and negotiates a settlement with the carrier on behalf of a claimant. On average, a public adjuster recovers at a minimum at least 17 percent more than a claimant could by acting on his or her own behalf.

Public adjusters are perceived by some carriers as ambulance chasers, and hiring one can result in a carrier giving a claimant a difficult time in processing and settling a claim. However, a legitimate and competent public adjuster is usually thoroughly grounded in the subtle provisions of a policy and the inner workings of the claims department of a carrier.

Line Supervisors

The direct responsibility for supervising adjusters is that of a line supervisor, who specializes in claims surrounding a line or specific type of insurance, such as liability, personal injury, theft, fire, collision, workers' compensation or tort claims. Typically, a line supervisor has the final word on the disposition or settlement of a claim. A line supervisor usually reports directly to a claims manager who is in charge of a branch office and is rarely involved with a claim.

Claims Adjusting in Catastrophic Situations

Claims adjusting stands alongside marketing and underwriting as the three most important functions of an insurance company, especially since the final value of an insurance contract is only determined in a situation involving a loss.

One of the most remarkable trends in the development of insurance over the past several decades has been the organization of a team of insurance experts to deal effectively and swiftly with losses in major catastrophes. The result is immediate loss adjustment in an area of a disaster. Insurance professionals, including claims adjusters, sometimes use superhuman efforts investigating, evaluating and settling claims, often working long hours under very stressful conditions. The mobile operation may involve the use of sound trucks to advise policyholders of the availability of loss claims adjustment services. Temporary living facilities may be located. Cleanup crews may be made available. Also, the insurance team may assist

the victims in securing lumber and other building supplies to begin needed repairs and reconstruction of their homes.

Interdependency Between the Claims Department and the Underwriters

One of the responsibilities of the claims department of an insurance company is to advise the underwriters about unfavorable laws, areas with an excessive incidence of claims, various cost items and other potentially burdensome items. In turn, the underwriters should advise the claims department about stressful situations developing between the company and any policyholders.

When a request for underwriting is submitted by an insurance company, the underwriter must rely on information about the carrier, much of which comes from the claims department. Information such as the length of the claims history, the number of occurrences and the desirability of an account is needed. Claims files assist an underwriter in determining what can go wrong through an evaluation of the costs of different kinds of losses and practices of maintaining reserves. The underwriter uses this information to price the insurance product and to predict the number and size of possible losses. Expenses involved in investigation and negotiation of claims and the cost of litigation can drive the general and administrative overhead and related expenses of an insurance company through the roof if there is little or no cooperation between the claims department of an insurance carrier and that company's underwriters.

Another area of invaluable input involves the clarity and meaning of language used in policies. When an underwriter fashions a policy, he or she may have one meaning in mind that is not consistent with that gleaned by the claims department in their experience with claims processing. New policies tend to carry phrases and words that have not been exposed to judicial determination and interpretation.

Serious losses are sometimes subjected to postmortem examination. Conferences between the underwriters and the claims departments can help minimize or prevent future problems.

Interdependency Between the Marketing and Claims Departments

One commonalty that exists between the marketing and claims departments of an insurance carrier is that both represent the carrier to the public. Nothing tests the performance quality of an insurance product more than a claim. An unsatisfactory resolution of a claim indicates that the insurance product has failed to perform its intended need and function. The claims department can measure the delivery end of a carrier for the marketing department. Many facts developed from experiences with claims can make for a better insurance product.

Relationship Between the Claims and Loss-Control Departments

A significant amount of information from a claims department can enhance a loss-control specialist's knowledge of what to guard against in an attempt to reduce losses. Safety improvements and other changes may be warranted. Pre-claim activity should have as its goal the mitigation of losses. Necessary evidence should not be lost or misplaced after a loss. Claims and loss control should work together to prepare and maintain records that are invaluable following a loss. Such a system enhances quality control of the insurance product. The combined input of both departments can be provided to an underwriter to help in the decision about whether an insured's potential loss is desirable.

Cooperation between loss control and claims is especially useful in the area of workers' compensation. Loss control personnel may possess specialized information not well known to the claims staff, such as mechanical, technical and engineering matters. By their collaborative efforts, they can prevent and reduce losses and solve technical problems that go hand in hand with claims. Claims and loss control cooperation can develop practices and routines that help to minimize accidents in the workplace. In the investigation of claims, a loss-control department can provide information to the claims department such as standards, codes, technical opinions and laboratory assistance. Accurate information about losses is important to help emphasize to the carrier the trends in—and resulting costs of—accidents and their effects on premiums and rates and the need for a reliable safety program.

Regulation of Insurers

Until 1944, the insurance industry was a cartel. Price-fixing was quite common among large insurance companies during the first half of the twentieth century, until the Supreme Court held that the issuance of insurance policies involved activities in interstate commerce and that such practices violated federal antitrust laws. Following a considerable amount of lobbying pressure by the insurance industry, Congress passed the McCarran-Ferguson Act, which exempted the insurance industry from federal oversight and granted states the right to regulate insurance. It is that legislation that has kept the federal government out of the regulation of the insurance industry. As a result, anti-competitive practices that continued to some extent through the 1950s and 1960s, including market allocations and price-fixing, remained free of federal regulation.

Regulation of the insurance industry basically occurs at two levels. First, there is regulation of products offered by insurance companies, and secondly, there is a separate body of statutes, rules and regulations, and judicial interpretations that serve to govern the organization and operation of insurance companies.

Regulation of Insurance Companies

Typically, insurance companies are regulated by a state insurance commission or administration consisting of three to five members appointed by the governor. The insurance commission selects an individual, sometimes known as the insurance commissioner, to oversee the management of the daily functions of the state insurance department. In a number of states, the insurance commission is responsible for setting or approving rates, although there is a growing trend to allow rates to be determined by the marketplace instead of by regulatory mandate.

Under state law, insurance companies must set aside a certain amount of funds, called reserves, to safeguard against insolvency. Some insurance companies are authorized to pay dividends to shareholders, and the amounts which can be paid may be regulated by state law. Insurance companies, brokers and agents may be subject to the licensing requirements of the state insurance commission. Annual continuing education programs may also be imposed upon insurance personnel, subject to licensing requirements.

Examination and licensing of adjusters falls within the responsibility of a state insurance commission. Insurance commissions also assist consumers in their relationships with the insurance industry. Insurance departments can and often do assist consumers in finding adequate coverage at affordable rates, insure the fairness and reasonableness of rates and the prevention of deceptive and dishonest tactics involving sales and marketing and the investigation, disposition and settlement of claims.

State insurance departments investigate and resolve individual consumer complaints in all lines of insurance. Many departments maintain a hotline unit, staffed with a number of experienced

personnel who process complaints, forward them to carriers and monitor the resolution of such complaints. Some state departments publish consumer bulletins and pamphlets concerning such matters as rate-comparison studies, complaint-ratio studies and consumer guides on workers' compensation; life, group and individual health plans; automobile insurance; life insurance; and homeowner's insurance. Some states have strong and well-staffed independent departments, while others may be unduly influenced either by the insurance lobby or by inadequate resources.

Other functions which a state board or commission of insurance may have responsibility for include licensing qualified insurance companies, fire protection industries, premium finance companies, health maintenance organizations and prepaid legal service groups; conducting building inspections and arson investigations; promulgating forms for insurance companies to use; regulating and controlling the authorized insurance activities of unlicensed insurance companies; and supervising or conserving companies in various stages of financial difficulty and possibly seeing to their orderly liquidation.

Insurance carriers are required to file complete yearly financial reports with the insurance departments of nearly every state in which they do business. A public record, the report contains detailed financial information about the company's net worth, assets and liabilities, and income for the year covered by the report.

Regulation of Insurance Products

The manner in which the law treats an insurance product determines whether such product will be regulated as a separate line of insurance and also how new insurance and investment vehicles will evolve. Some of the more controversial products in which the issue of whether "insurance" was involved were the variable annuity, warranty and service contracts, automobile clubs, dental plans, legal plans, other forms of prepayment plans, and bail bonds. Even when the element of risk-taking is only apparent and superficial, the product is likely to be designated as an "insurance product."

The line between insurance and non-insurance products has been altered in recent years. The traditional notion of insurance as a two-interest, two-party contract has been modified by recent trends. The old notion of insurance as an indemnity has been weakened considerably. The task of defining a product as insurance has become more complicated because of the dual nature of offering both compensation for losses and opportunity for investment. The assignment of delineating insurance is made even more difficult by the massive body of statutory definitions and judicial interpretations. In reality, the lack of effective regulatory control from state to state can impact the implicit acceptance of some questionable products as bona-fide insurance instruments.

Legal definitions of insurance may or may not take into consideration common concepts that underlie the definition within the public and industry sectors. From the standpoint of a consumer, the most significant focus is on the transfer of risk, the payment of premiums and satisfaction of a claim for a loss by the carrier. From the insurer's perspective, the insuring mechanism comes into focus. The application of large numbers and other statistical indicia of probability, compensation, greater knowledge, financial strength, deterrence, prevention, accumulation of reserves and the amount of premiums all come into play. Also, there is the view of the group, which may impact upon the decision of insurance. Under the collective perspective, insurance is seen to be a function in which a number of individuals are able to safeguard their interests and protect themselves against misfortune by having the losses of a few paid for from the premiums of many. Sometimes, just the very need for regulation may result in courts and legislatures stretching the definition of insurance.

Discrimination

In the past, many insurance carriers have engaged in discrimination against people with serious disabilities and diseases by either charging enhanced premiums or denying coverage entirely. As a rule of thumb, life insurance cannot be written if the projected chance of loss is in excess of 500 percent of the standard rate of mortality. A number of diseases, including AIDS, result in a chance of death considerably higher than this rate. Developing a classification scheme for such persons of high risk is quite problematic. The traditional use of medical examinations and questionnaires seeking to obtain information about an applicant's medical and personal background and employment history have drawn objections from such applicants and their legal representatives.

Questions about an applicant's drug use and sexual preference have been litigated and have been determined in many instances to be discriminatory.

Another approach to underwriting insurance where AIDS and other catastrophic diseases may be an issue involves medical testing. Questions have been raised about who will have access to such information and how the applicants will be notified of the test results. Even the question of whether an applicant has a constitutional right to health and life insurance has been litigated. Under the Americans With Disabilities Act, it has been held that everyone must have equal access to public accommodations, and the suggestion has even been made that insurance is a public accommodation. Insurance carriers have established special insurance pools for residents of inner cities in high crime areas and for people with poor driving records, leading to the issue of whether people with AIDS are not in an analogous situation. One school of thought holds that the insurance industry should be responsible for spreading medical costs associated with AIDS across the general insured population to relieve the victims and their families of the onerous burden, and the countervailing theory is to the effect that health insurance premiums cannot be set high enough to cover the costs of treating AIDS. Implementation of the first theory could bankrupt the insurance industry, spelling financial disaster for everyone involved.

The Insurance Policy

An insurance policy is a legally-binding contract between an insurance carrier and a policyholder that sets forth certain obligations, such as a requirement on the part of a policyholder to pay premiums in a timely manner, in return for a duty on the part of an insurer to cover losses relating to an insurable event included in the policy upon presentation of a valid claim by an insured.

Generally, an insurance company can establish any number of terms in a policy, provided such terms are not illegal or against public policy. If covered and excluded property and liabilities are specified in clear and unambiguous language, a court typically will not require a carrier to pay for anything not contained in the policy.

Property & casualty insurance companies offer a variety of policies that cover losses resulting from illnesses and job-related injuries, protection for employers against fraudulent or dishonest acts of employees, losses of or damages to real and personal property arising from vandalism, theft, fire, windstorm and other perils and injuries to others or damage to their property for which an insured is responsible. The property & casualty insurance product differs from other insurance company products, such as an annuities, in that tangible payments or benefits are paid only after the occasion of a loss. A contemporary insurance package may contain a broad range of liability and property insurance at rates considerably less than if each type of insurance was purchased separately.

An insurance policy issued by a property and casualty carrier typically has a number of characteristics in common, including:

- The declaration page—The first page of nearly every insurance policy contains a "declaration page," which sets forth the name and address of the policyholder, the maximum dollar limit of coverage, a description of the property or liability to be insured, the amount of the premiums, the date upon which payment is due and the types of coverage.
- The insurance agreement—This part of a policy includes the relative obligations and responsibilities of both the carrier and the policyholder.
- Terms and conditions—The terms and conditions of an insurance policy are the essential elements that elaborate upon the nature of coverage and specify what is required of both parties in the event of an insured loss.
- Exclusions—This section describes the kinds of property and liability that are excluded from coverage under an insurance policy.
- Fraud and concealment—These provisions allow a carrier to either deny coverage or declare a policy to be void in the event a policyholder committed fraud or concealed facts during the application process or while pursuing a claim.
- Exclusions of peril—Any number of perilous losses may be excluded from coverage, including those caused by an enemy attack, civil war, rebellion or specific "Acts of God." Also, this section may provide that coverage will be denied or excluded if a policyholder fails to use reasonable means to preserve and protect damaged property during or after a loss.
- Waivers—Generally, this section provides that the only modifications or amendments to a policy that are acceptable to a carrier are those that are in writing and attached to the policy as an endorsement.
- Cancellation—The conditions under which a policy may be canceled are included in this section. Policyholders can cancel a policy at any time; whereas restrictions upon cancellation are usually imposed upon the carrier. This section also provides for the return of premiums on a pro rata basis if the policy is canceled by the carrier.
- Interests of a mortgagee—This section includes provisions that if property covered by a policy is mortgaged, a lender has a vested interest in such property that is recognized by the insurer.
- Pro rata contributions—The provision that each carrier will pay a share of a loss in proportion to the degree of coverage provided when there is more than one policy in effect for the same property is included in this section.
- Requirements of a policyholder in the event of a loss—A policyholder's responsibilities to an insurer in the event of a loss, including notification to the carrier, protecting damaged property from additional losses, presentation of a proof of loss to the carrier and providing all other pertinent financial information and evidence which must accompany a claim are included.
- Appraisal—The procedures to be followed should a carrier and an insured disagree on the value or degree of a loss and desire to select and pay for independent and competent appraisers to mediate and settle a claim are the subject of this section.
- A carrier's obligations—This part permits a carrier to take possession of some or all of damaged property at a mutually acceptable value after settlement, to repair, replace or rebuild the property out of materials of a similar quality and type or to settle a claim in cash.
- Subrogation—The rights of a carrier to legally recoup the amount of settlement from a third party who is responsible for a loss after payment of a claim are detailed in this section.

A Standard Versus a Nonstandard Policy

For many substantial types of coverage, a significant number of carriers utilize a standard form of contract containing identical or substantially similar terms which have developed through legislation, rules and regulations, case law or custom within the industry. Associations or organizations that are responsible for developing rates and establishing policy forms prepare, modify and distribute standard policy forms.

Nonstandard forms are those developed by and for a carrier that do not conform in substance to the terms and conditions of a standard insurance policy.

There are a number of advantages which underlie the use of uniform policies of insurance, including the following:

- Comparable statistics—The use of standard forms facilitates the comparison of claims experience of different carriers. Rate making becomes easier when loss experience and premiums are founded on similar coverage.
- Reduction of litigation—The use of words, provisions, terms and phrases whose significance has been established through case law is intended to deter ambiguity and reduce the chances of litigation to determine the meaning of an insurance contract. This is especially important to insurance companies since ambiguous and vague terminology is typically interpreted against an insurance company.
- Economy—If standard insurance contract forms were not available, a carrier would have to incur the expenses of hiring a policy design expert to develop its policies. Unnecessary efforts and duplication of efforts would be uneconomical. Standardization allows for a concentration of experts, and the costs of their products can be shared by a number of carriers.
- Parallel coverage—When insurers use standard insurance policies, losses involving multiple carriers are less complicated. Uniform forms enhance risk sharing.
- Simplicity—Producers who act on behalf of more than one underwriter or insurer can learn and understand the competition's coverage if uniform policies are used. Insurance personnel can be trained more easily and efficiently when standard forms are studied and deviations are more easily understood.

Terms and Conditions of A Policy

An insurance policy is first and foremost a contract, subject to all of the rules involving the interpretation of the meanings of its terms and conditions. An insurance company may establish such terms as it sees fit, so long as there is no illegality involved and the terms are not against public policy. Certain risks may be insured against and others may be excluded, as long as both the coverage and the exclusions are detailed in clear, concise and unambiguous terminology. Because the words in a policy are those of the carrier, they are generally construed by courts in favor of the policyholder and against the insurer.

Exclusions cannot be expanded by implication. They should be stated clearly, and if the language is susceptible to dual interpretation, the one which favors coverage will be adopted. An adjuster should read a policy with a view as to how it would be perceived by an ordinary layperson, not by an attorney or some other expert on insurance. A policy has to be read and understood in its entirety when determining coverage. Single sentences or groups of phrases are not to be read apart from other relevant sections of a policy.

A consumer is less likely to appeal a claim or file litigation after the claims process has been initiated if he or she understands the terms and conditions of a policy and the standard types of coverage.

Also, the number of claims should be reduced if consumers know what is covered under a policy and what is not. An adjuster must be able to interpret a policy if he or she is to effectively resolve a claim.

The reasonable expectations of a policyholder will govern an interpretation of the terms and conditions of an insurance policy. Most insurance policies are what are referred to legally as "adhesion contracts," a type of legally-binding agreement in which there is little or no bargaining among the parties involved. There is very little give and take or negotiating that goes on between a carrier and a prospective insured when an application for insurance is taken.

Legal Interpretations

The ***ultimate interpreter*** of an insurance policy is neither a policyholder, an attorney, a carrier, a mediator, an arbitrator nor a state insurance commission. That decision lies with the courts. Questions brought before a court about the meaning of the terminology of an insurance policy result in decisions which ultimately evolve into a body of case law. A carrier is required to act in a manner consistent with such case law when the investigation, evaluation and settlement of claims are involved. To do otherwise can result in actionable "bad faith" or "unfair claims settlement" practices.

When evaluating the relative interests of a policyholder in light of those of a carrier, courts have consistently decided quite liberally in favor of the insured. The position of a policyholder must be quite clearly erroneous before a court will rule in favor of the insurance company. Late reports of a loss are not often the basis for a court denying a claim, unless the rights of the carrier have been significantly prejudiced by such action on the part of a policyholder.

Experts believe that the ***ultimate effect of a body of court decisions*** has been to broaden coverage and to include unwritten terms and conditions in a policy that might not have been intended by either a policyholder or a carrier. Another result is a growing body of judicially-crafted standard practices that must be followed by the insurance industry in general. For instance, a number of carriers have been required to advance a sum to cover additional living expenses in situations where a dwelling is uninhabitable, even though the carrier may not have been required to do so by the terms of the underlying policy.

Because courts have been favorably disposed toward policyholders, carriers have been compelled to adopt exhaustive measures to preserve and protect their rights and privileges under a policy. Company representatives, including agents and claims adjusters, must pay particular attention to dealing honestly and fairly with existing and would-be policyholders.

Notwithstanding the judicial prejudice toward a policyholder supported by a growing body of statutes and case law, there is still plenty of room for variation among carriers with reference to the processing of claims. Nevertheless, carriers are expected to interpret the evaluation and settlement aspects of claim satisfaction in a manner consistent with judicial and statutory law. In areas where the interpretation is questionable, a carrier may have a certain degree of latitude in interpreting the terms and conditions of a policy. Inherent in this latitude is a wide variety of methods by which carriers approach the investigation, evaluation and settlement of claims.

A company's attitude toward claims and claims administration and adjustment reflects a carrier's policy involving the resolution of controversial claims and the avoidance of litigation. Carriers may go to great lengths to offer superior service to policyholders by reimbursing claimants for

questionable claims or those not under coverage. On the other hand, approaches to claims may reflect a policy that is inconsistent with industry practice or not in keeping with specific terms of a policy.

CLAIMS

Notification of a loss to an insurance company by a policyholder or a third person constitutes a claim for payment. Before satisfaction of any claim, a carrier will require an investigation of the facts and circumstances underlying the situation which gave rise to a claim. The adjustment of losses in the industry is probably most significant in property insurance because of the partial nature of such damages and the difficulty of measuring the extent of such losses. This concern does not normally affect life insurance since the loss is complete and the amount of the payment is always a certain sum, the face value of the policy.

One of the first steps in the investigation of a claim is to ascertain if the insurance carrier is responsible for payment of a loss. Infrequently, a claimant will file a claim with the wrong company or describe property that is not the subject of a policy. Other claims may be filed after a policy has expired or when the time for the payment of a premium or premiums has expired. Some losses, such as damage due to floods, may have been specifically excluded from coverage. In a few cases, coverage may not be forthcoming because an applicant filed a fraudulent claim.

Once a carrier has determined it is liable to pay for a loss, the company must then determine the actual amount of damages done. If a carrier and a policyholder can agree on the amount of coverage, the claim will be settled. If not, arbitration proceedings may be warranted. A carrier must take care not to reduce payments for legitimate losses below a level which would constitute an unfair settlement of a claim. If a claimant is willing to settle for less than what the insurer thinks the claim is worth, it would be a show of good faith for the company to pay the reasonable value of a claim.

Once a claim is accepted and agreed upon, it will be paid promptly by a carrier. If a claim is denied or if a claimant thinks the proposed settlement amount is insufficient, the insured can secure the services of a lawyer and sue the carrier.

Claims as an Insurance Company Expense

An insurance carrier is in the business of handling many risks, and the business does not come cheaply. Most insurance companies are significantly large entities, bureaucratic institutions that operate with very substantial amounts of overhead, including rent, utilities, salaries, company vehicles, legal costs, sales commissions and expenses resulting from the settlement of claims. All of such costs are included in calculating what amount of premiums to charge. Such expenses also include the costs of frivolous, exaggerated and fraudulent claims.

People have been known to burn down buildings and fake their own deaths in order to recover under both property and life insurance policies. Some insurance companies are owned by private investors and others by policyholders. In either case, claims are paid from funds attributable to premiums collected and from income from investing such premiums.

Parties Involved in an Insurance Claim

The parties involved in an insurance claim can involve an insured, a carrier, a beneficiary, a third party who may have suffered losses, a staff claims adjuster, an independent adjuster, a specialized investigator, a mediator, an arbitrator, a lawyer and the state insurance department. An agent who sold an insurance contract to a policyholder may also be useful in reporting the claim directly to the carrier, keeping the policyholder advised of the investigation and the resolution and disposition of the claim.

Elements of a Valid Claim

In order for a casualty or a loss to be covered by insurance, a few basic elements must exist:

- Losses must be fortuitous—Except for death, a loss which is covered by a certain situation is not a valid basis for an insurance claim, since a policy insures against a risk. Losses covered by normal wear and tear or deterioration are the result of a known condition, and therefore are not covered, even if an insurance policy did not specifically exclude such losses.
- Losses must be occasioned by an extraneous factor—If a loss is caused by an inherent physical condition rather than an external agent, coverage will not apply. For example, a policyholder decided to paint her old airplane with a polyethylene paint, necessitating removal of the old paint with a special solvent and the application of an undercoat. A week after she finished applying the paint, it began to chip. The owner of the aircraft consulted an aircraft paint shop on the field where she hangars her plane. The owner of the shop concluded that either the undercoat was applied improperly or there was a defect in the composition of the undercoat. There is no insurable loss because it was not occasioned by an extraneous cause.
- Damages caused by intentional actions of a policyholder—If an empty building in the middle of an enormous vacant field is destroyed by a surrounding grass fire, coverage would be applicable. If, on the other hand, the owner dropped a match intentionally onto a pile of kerosene soaked rags he placed behind the building, not only would he be guilty of arson, but he would not be able to recover from his carrier for any losses to the building because it is against public policy to insure a loss which is caused by the intentional act of a policyholder.
- Only legal property can be the subject of a valid claim—Illegal property cannot be the subject of a valid binding contract. A policyholder cannot store contraband in his or her garage or house and then make a claim for the loss of stolen property if the garage or house burns down.
- A loss must be sustained—The mere happening of a perilous or catastrophic occasion involving insurable property cannot be the subject of a valid claim unless an actual loss has been sustained. If property that has no value is stored in a building that is damaged, there can be no recovery for such worthless property since no loss has been sustained.
- There must be an "insurable interest" in the property—A policyholder must have some degree of legal or equitable interest in the property which is the subject of an insurance claim. If an antique car dealer had an insurance policy on a classic auto that he shipped to a buyer in another state and the car was stolen just after the buyer took delivery, the seller could not file a valid claim on the stolen vehicle simply because he still had a policy covering the car, because at the time of the theft he was no longer the owner.
- Rights of a Claimant
- One of the most significant laws that provides protection to consumers while impacting investigation, evaluation and settlement of claims on the part of an insurance carrier is the "Model Unfair Claim Settlement Practices Act," which has been adopted in one form or another by a substantial number of states. The enumeration of such rights is not by any means exclusive as other legal rights of policyholders that have been established both by legislation and by case law. Also, such rights may serve as a guideline to some courts when confronted with the question of an unfair settlement practice.

Below are some practices involving an insured or a claimant that are illegal under the ***Model Uniform Claim Settlement Practices Act***.

- Failure to adopt and maintain sound criteria for the investigation and processing of claims.
- Misstating policy terms or relevant facts that affect coverage.

- Failure to provide for prompt and equitable settlement of claims when liability is relatively certain.
- Using advertising material that would lead a reasonable person to believe that a claim could be settled for one amount and then refusing to settle for such amount.
- Failing to inform the insured, upon request, under which part of a policy a claim has been paid.
- Failure or refusal to provide an explanation of the reasons relied on in a policy or under the laws for either compromising or denying a claim.
- Misrepresenting the statute of limitations.
- Delaying the investigation or payment of a claim by using multiple forms to obtain the same information relative to a claim.
- Failure to act promptly upon notification of a claim arising under a policy.
- Forcing an insured to sue to recover for a loss by offering to settle a claim for significantly less than what is ordinarily recovered in a suit for like claims.

The Impact of the Law on Insurance Claims

The claims process is a method of translating the rights provided to a policyholder under an insurance policy into a remedy. Several decades ago, there were only a few laws that applied specifically to insurance claims which were subject to the ordinary rules of interpretation affecting contract performance and breach, resulting in protection to carriers from liability for special damages for failure to defend or settle claims as required by a policy. When an insurer was sued, the only penalty that was ordinarily incurred was a judgment in which the carrier was ordered to satisfy the very claim it sought unsuccessfully to avoid. Insurers had a significant strategic advantage since there was little incentive to promptly and fully settle claims.

In the past 20 to 30 years, a growing body of statutes, rules and regulations, and judicial decisions have arisen, creating new responsibilities on the part of carriers where few had previously existed, resulting in the playing field between carriers and policyholders being more balanced. Growing statutory and case laws have proved in many instances to be quite onerous, and curiously have had an unexpected side effect in that carriers have been encouraged to pay invalid or exaggerated claims just to avoid burdensome litigation.

There are three sets of developments that have resulted in the imposition of extraordinary burdens on insurance companies—the extra-contract or judicially-imposed liability for failure to pay a first-party claim, the creation of a duty or obligation to settle claims and the elaboration of a carrier's duty to defend an insured liability. Underlying all of these developments has been a failure on the part of those who prepare insurance policies to specify clearly the corresponding rights and obligations of both the carrier and the policyholder. As a result, carriers have had an abundance of discretion in determining whether and how to settle claims and how to satisfy other contractual obligations. Some courts have managed to limit this discretion through an equitable, economic application of insurance laws.

When the terms and conditions of an insurance policy are not crafted with a great amount of specificity, sufficient detail must be provided by legislation or by case law. One method of achieving this is to tailor the terms and conditions in such a fashion as the parties would have done if they would have agreed upon the inclusion of such details in the policy. An adjuster can minimize the possibility of legal or judicial intervention on this basis by not abusing the discretion delegated to it by interpreting the policy or taking actions inconsistent with the expectations of a policyholder. Adjusters should be aware that failure to do so may constitute "bad faith" from a legal perspective. The elements of evil intent or deliberate wrongdoing are not necessarily inherent in the legal concept of bad faith. Exceeding the discretion allowed by a contract is

frequently enough to constitute bad faith on the part of a carrier. It must be recognized that the term "bad faith" varies from one setting to another as well as from one jurisdiction to another.

One significant development in the legal regulation of claims that has occurred over the past several decades is the evolution of a new cause of action for the bad faith refusal of a carrier to pay claims of first parties. Prior to that, a policyholder could only recover an amount of damages equal to the policyholder's losses under conventional contract law. The measure of damages, being only what the carrier would have otherwise been obligated to pay, did virtually nothing to deter a carrier from breaching a policy. And since the policy was the product of a carrier, the inequitable situation could not be alleviated by including a fuller measure of damages in the insurance contract. More and more, courts are now awarding damages that are not contemplated by the insurance contract, such as legal fees, consequential damages, pain and suffering and exemplary or punitive damages. The great majority of bad-faith cases involve defective investigation of insurance claims which results in an inappropriate denial of claims. Unlimited recovery of damages not provided by the terms and conditions of a policy can lead to overcaution on the part of the insurance industry, similar to the degree of safeguards adopted by the medical profession in overdiagnosing and overtreating to avoid liability. Several states have attempted to stem this development by passing laws that allow recovery of reasonable legal fees and a modest amount of punitive damages in bad-faith cases.

Generally, ***punitive damages*** can only be recovered in bad-faith litigation upon proof by the claimant of an intention on the part of an insured to inflict injury or damages. Liability often turns on the intent of the denial. A simple but erroneous conclusion that one is not entitled to coverage would probably be less than a sufficient basis for punitive damages. If denial was made with flagrant disregard of the necessity to investigate, punitive damages may be appropriate. A claim that an adjuster may initially refuse to investigate may be only one of negligence, but a stubborn and willful continuance to refuse to investigate can turn quickly into a case involving bad faith. The appropriate test for determining the existence of bad faith should be whether a carrier took improper advantage of its strategic position with respect to a claimant. Because of the new measure of liability for denial of claims, it is possible that more fraudulent, exaggerated and frivolous claims will be filed in the future.

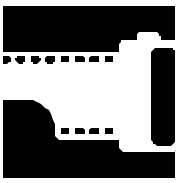
At the same time, another body of case law has arisen with respect to an insurer's duty to settle third-party claims against the insured that has impacted the entire procedure of claims investigation, evaluation and settlement. A first review of an ordinary insurance policy would have the reader conclude that a carrier has near complete discretion about whether to settle or litigate third-party claims. A standard provision appearing in an insurance policy typically provides that, "the insurer shall defend any suit against the insured in which the claimant alleges property damage or bodily injury and seeks damages payable under the terms and conditions of this policy, notwithstanding that the allegations may be false, fraudulent or groundless. The company may at its own discretion conduct such investigation and settlement of any suit or claim as it shall deem appropriate."

Such discretion has frequently led to disagreements and serious conflicts between a carrier and a policyholder. The problem becomes most obvious in a situation where policy coverage is set at one amount and a claimant asserts liability in excess of that amount. If a claimant offers to settle for the limits of coverage and the carrier refuses, the insured is left with the possibility of threatened litigation and, ultimately, a judgment in excess of the policy coverage amounts. Some courts have held that a carrier owes a policyholder equal consideration when weighing the relative interests of its own with those of a policyholder, hoping to establish a deterrence against carriers making institutional decisions to create a reputation for being tough on settlements. The problem with this approach is it places a burden on a carrier to entertain a settlement offer as though there were no policy limitations on coverage, when the penalty for

failing to settle a reasonable offer is liability for the entire claim on the part of the carrier. The imposition of a duty to settle reasonable claims has resulted in part in protection for the carrier against liability for coverage exceeding the limitations set forth in a policy.

The extent of a carrier's duty to defend litigation brought against the insured by a third party is also in flux. Under traditional circumstances, carriers had less motive to breach their duty to defend a policyholder against third-party liability claims than they did to refuse to settle reasonable offers, since in the first instance the insurer was typically liable only for the amount of the reasonable settlement. Bad faith was not ordinarily involved in a decision not to defend, but rather the driving force was an unbridled contractual provision in a policy which limited the duty to defend to circumstances in which the carrier could reasonably expect to have to pay the costs of the defense.

The more contemporary cases involving bad faith have effected a realignment of the balance between a policyholder and a carrier with respect to relative advantages enjoyed by both. Regulation is justified on the theory that both parties become adversaries, potential courtroom foes, immediately upon the filing of a claim. The insurer's interest is set aside if it has no ultimate duty to cover the loss of the policyholder. On the other hand, the policyholder is assured a defense in almost every case when it can be reasonably expected that one will be necessary. The readjustments do not necessarily create a mandatory obligation on the part of the insured; rather, they impose liabilities for acting unreasonably.



CLAIM EVALUATION & INVESTIGATION

INVESTIGATION OF A CLAIM

Generally, the burden of proving the existence of a loss is upon a policyholder. An insurer does not have a legal duty to prove that a loss that is the subject of a claim has not been sustained by a policyholder unless and until the claimant has met his or her initial burden of proof. Although these relative obligations on the part of a policyholder and an insurance carrier are not stated in a policy, they are accepted throughout the insurance industry and are recognized by the judicial system. Notwithstanding the general rule about the burden of proving the existence of a loss, in situations where it is extremely difficult for an insured to demonstrate a loss, a carrier must accept the policyholder's word concerning facts surrounding a loss unless it is able to obtain conflicting evidence. A carrier has a legal right to require a policyholder to prove that the value of a claimed loss is as stated in the notice to the carrier or the proof of loss. The financial burden of demonstrating a loss, including the cost of an appraisal or an estimation of repairs or replacement, is upon the claimant.

Procedural Reasons for Denying a Claim or Terminating a Policy

When an insurance company receives a claim from a policyholder, it assumes a duty to carry out a thorough and competent investigation of the claim to determine what coverage for the underlying loss is applicable and which benefits are payable under the policy. Once a policyholder has filed a claim for insurance, the company will assign the claim to an adjuster, who is the person in charge of investigation, negotiation, evaluation and settlement of a claim. The initial task of an adjuster is to see if the policy in question is in full force and effect. If there are exclusions that apply or if premiums have not been paid timely as required under the terms and conditions of the policy, coverage may not be forthcoming. Another set of circumstances which may enable a carrier to avoid coverage is the existence of fraudulent conduct on the part of a policyholder, either at the time an application for insurance coverage was taken or when the claimant prepared the notice or proof of loss. An adjuster must also satisfy him/herself that the claimant complied with any duties imposed upon him or her by the policy that apply after a loss. Following is a typical clause in an insurance policy that allows a carrier to nullify coverage in the event of fraud, misrepresentation or concealment:

Concealment or Fraud.
The entire policy will be void if whether before or after a loss, an "insured" has:

- Intentionally concealed or misrepresented any material fact or circumstance.
- Engaged in fraudulent conduct.
- Made false statements relating to this insurance.

Concealment
Concealment involves a failure to divulge facts to a carrier which, if otherwise known, would have affected the decision of the carrier to grant coverage or honor a claim. For example, a policyholder represented in an application for health insurance that he never had surgery, when

in fact he had a craniotomy. If the carrier had known of his neurosurgical history, it would have designated his condition as a "preexisting condition," either limiting or denying coverage for that situation. Sometime after the policy was issued, the insured began having seizures which resulted from residual trauma. When the policyholder filed a claim for medication that was prescribed by his physician to control seizures, an astute claims adjuster examined the medical records of the policyholder to see if there was any medical evidence indicating the existence of seizures or any other condition that might have been the basis for convulsions. After it was determined that the policyholder intentionally withheld information about his neurological condition, the policy was canceled.

Misrepresentation

Misrepresentation, as opposed to concealment, is a misstatement of a fact that is material to the underwriting decision, which can also lead to denial of a claim or termination of a policy. If an applicant for a homeowners policy represented to the carrier that there were functioning smoke detectors on the property and the property was destroyed by fire after the applicant was accepted for coverage, in all probability the carrier would deny coverage for the policyholder's loss or terminate the insurance policy.

Duties of an Insured in the Event of a Loss

Virtually every insurance policy involving the loss of property contains a provision providing what steps must be taken by a policyholder in the event of a loss. If an insurance claims adjuster determines that the policyholder failed to comply with such conditions, he or she may recommend denial of the claim to the carrier.

Review and Examination of a Claim

The next step in the investigation of a claim is a thorough review and examination of the allegations set forth in the notice provided by the claimant to the insurance company. The adjuster should ask the claimant to document the losses detailed in a claim. If a claimant asserted that his or her wheelchair was stolen, the adjuster should require proof that the policyholder did in fact purchase the wheelchair. Independent verification of the facts stated in the claim may be accomplished by reviewing any reports that were filed with the police or by conducting interviews with witnesses. The adjuster will probably want to verify that the policyholder did nothing to worsen the condition of any damaged property or that he or she contributed to the situation which brought about the losses.

CLAIM EVALUATION

The evaluation of an insurance claim involves assessing the damages or the extent of losses surrounding real and personal property, personal injury or loss of life. In complicated cases, the process can often be quite lengthy. The first step in an evaluation of a loss set forth in an insurance claim actually occurs when a carrier sends an adjuster for an on-site inspection, investigation and estimation of damages. The adjuster should attempt to verify that losses are covered by the policy in question. In the case of damage or losses to property, an adjuster's task is facilitated if a claimant has not made any repairs other than those essential to preservation of the property, and if he or she has been able to secure maximum cooperation from the claimant during the investigation and evaluation of the claim. Dollar losses are then calculated by taking inventory of the damages claimed. Each specific item of damage or loss is assigned a value, using either an assessment made by a claimant or a determination by an adjuster who employs external sources, such as established indexes of value or the estimates of a repair shop or a professional appraiser.

Repair estimates, receipts, service charges and repair bills are evaluated to arrive at an estimation of the amounts which will eventually constitute a settlement. All information bearing on the evaluation of a claim presented by a claimant to an adjuster will be considered. Inadequate or irrelevant information may lead to an undervalued claim.

Disputes About Evaluation of a Claim

Disputes between an insurer and a claimant about the value of a claimed loss constitute one of the most frequent disagreements between a policyholder and an insured. During the processing of a claim, one of the most difficult tasks confronting an insurance adjuster is determining what a claim is worth. Inherent in such determination is placing an accurate value upon the subject of an insurance claim so that every claim can be reduced to a specific dollar amount. Placing the value on a life in the event of death is at best arbitrary. The benefits of future earnings that certain of the survivors would have been entitled to, funeral expenses and medical costs are amenable to quantification, but such other aspects as loss of consortium and companionship are not capable of being reduced to a dollar amount. Another problematic area involves the evaluation of personal property losses. Items such as family heirlooms and antiques have an intrinsic value to a claimant that can never be replaced. In situations where a claimant has lost everything, such as in a fire or a tornado, it may be impossible to provide a evidence of ownership of and complete or adequate inventory of every piece of personal property that was owned before the disaster.

Use of an Independent Expert

In the event of a property loss, an insurance adjuster frequently uses the services of an independent expert to evaluate a loss. A claimant who has had damages to a house or a roof might employ the services of an independent contractor to make necessary repairs, but a carrier is not legally bound to pay the contractor for his or her services at any price. In reality, a contractor works for the claimant. Because it is difficult for one adjuster to be intimately familiar with the costs of repairs and replacements involving every conceivable type of property, it is frequently necessary for a carrier to use the services of an expert to assist an appraiser in establishing a value for a recommended settlement. There are a number of independent experts whose professional training and experience are frequently employed by carriers to assist in the investigation and evaluation of claims, including engineers, meteorologists, doctors, chemists, aircraft and aviation specialists, marine personnel, jewelry dealers, photographers, detectives, private investigators, safety engineers and vibration consultants. One very expensive aspect of the operation of an insurance company is the defense of claims in court. There are large numbers of attorneys who specialize in such practice, and most are outside lawyers, not associated with the legal staff of an insurance carrier.

Actual Cash Value

One of the most arduous tasks of an adjuster is a balancing act involving the assignment of a value to items that are the subject of a claim while performing his or her responsibility of reducing a claim to a dollar amount. An ordinary insurance policy covering personal or real property provides that benefits payable for damaged or lost property are the "actual cash value" of such property at the time of loss. A typical provision might be as follows:

The market value of an article or piece of property is the price which it might be expected to bring if offered for sale in a fair market; not the price which might be obtained on a sale at public auction or sale forced by the necessity of the owner, but such a price as would be fixed by negotiation and mutual agreement, after ample time to find a purchaser, as between a vendor

who is willing (but not compelled) to sell and a purchaser who desires to buy (but is not compelled) a particular article or piece of property.

By establishing the actual cash value as the price that one might anticipate an article or piece of property to bring if offered for sale in a fair market where there is a willing seller and a willing buyer, a forced sale or a price obtained at a public auction would be excluded as determinative of market value. The term "actual cash value" is defined under the laws of some states, and, in other jurisdictions, customary definitions have come into use because of court definitions.

When a market exists for used goods like the kind in question which may have been stolen or destroyed, the value can be measured against the price it would have brought in the open used market. An adjuster cannot reduce a claim to a dollar amount unless he or she knows what items have been lost or damaged. An adjuster will ask a claimant to prove ownership of an item which is the basis of a claim, and may be suspicious if a policyholder asserts that he or she purchased a large amount of items for cash. When there is no public market for a used item, the actual cash value may be determined by taking the acquisition cost of a new item and subtracting an amount reflecting the used component of the item, which is called depreciation.

Depreciation

Depreciation is calculated by an insurance carrier using the rule of thumb that an item loses value every year over its expected life. Since property generally depreciates more rapidly in the earlier years, this method of computing depreciation can be quite generous to an insured. Many carriers employ depreciation tables in evaluating what dollar amount to place on damaged property. Placing a dollar value on used personal property is quite subjective. Some insurance companies insist that the starting point for placing a value on a used item of personal property is the original cost, even though it may only be a fragment of the cost of replacement.

Replacement Cost

When old property is involved, the deduction for depreciation might reduce the settled amount to a level below the actual replacement cost. In such a case, a carrier may allow an insured to pay additional premiums for an endorsement that substitutes replacement cost for actual cash value. Under replacement cost coverage, settlement is conditioned upon a claimant actually replacing the damaged or lost property. If the claimant elects not to replace the property, the settled amount is limited to actual cash value.

Another exception to an actual cash value policy is a "***stated value***" policy, in which the insurer and the carrier agree at the time of issuing a policy that the property in question has a specific value. The carrier must then pay the stated value rather than the actual cash value.

Evaluation of Extraordinary Items

Certain items of personal property are not susceptible to replacement value coverage and should be insured separately if coverage is available. There is no rate book that an adjuster can turn to for determining the value of a loss of an extraordinary object, such as an expensive lithograph, a quilt from the Revolutionary War era or a two-carat diamond inlaid in a customized setting. A reputable certified appraiser should have been consulted before the item in question was insured, but if that was not the case, one will have to be used by an adjuster. Other items which may be included as extraordinary for purposes of coverage include furs, vintage automobiles, boats and aircraft, antiques, guns and certain articles of clothing. An appraiser

may seek information about whether the item has depreciated in determining the amount of the settlement.

Evaluating Minor Personal Injury Claims

In the event of a minor personal injury, a claim may be filed by the insured or a third party who was on the insured's premises during the time of an injury or may have been injured while a passenger in a vehicle belonging to the insured. Frequently, in determining how much to allow in a claim for minor personal injury, an adjuster may be bound by the consensus of what other carriers allow as well as applicable case law. In an evaluation of a minor personal injury claim, an examiner or adjuster will take the following factors into consideration:

- Determination of which carrier will cover a claim—In certain instances, such as the destruction of a house by a tornado, there is no question that if coverage applies it will be extended by the carrier which provided a homeowners policy to the owner of the property. In other cases, such as a multi-car pileup, it may not be obvious which carrier must cover the accident, and, frequently, protracted litigation may be necessary to determine which company or companies must pay. In an event where multiple carriers may be involved, an examiner will determine from police reports and statements whether another carrier should have been notified of the underlying event.
- Medical expenses—Medical expenses are reviewed carefully to determine reasonableness and the possibility of double coverage. If a claimant has both personal medical insurance and automobile coverage, it must be determined who will be the primary carrier. If a claimant was working at the time of an accident, it will also be necessary to determine if workers' compensation is applicable.
- Loss of earnings—Wage-loss information is analyzed for lost income or earnings capacity. An insurance examiner will compare wage statements provided on a W-2, a 1099, or a recent federal or state income tax return. If a claimant presents lost wages from a job which he or she was about to begin, but was prevented from doing so by an accident, an examiner will ask the prospective employer to verify such claimed wage losses.
- Disability—An examiner will evaluate the underlying facts upon which a claim for disability is based. Medical reports and the nature of the underlying treatment will be examined. In the case of an absence of medical treatment, an adjuster will look to see if there is other surrounding evidence to prove or disprove a claim of disability.

Death Due to an Accident

In a claim involving death due to an accident, "wrongful death" statutes may apply in many states. Under such statutes, a surviving spouse, parents or children of the deceased may recover damages from the party responsible for the death. In such a case, one who could so recover becomes the claimant.

One of the first factors which must be determined is whether the deceased contributed by his or her own negligence to his or her death. Were his or her actions the sole causative factor or was there another party whose negligence resulted in the underlying death? The answers determine the amount of the damages which an insurance company may have to pay. Another factor to be considered in calculating damages is whether the deceased survived for any period of time after the accident occurred and if the deceased incurred pain and suffering. An examiner must determine if the deceased was conscious before his or her death for any amount of time.

An adjuster must obtain a copy of the death certificate to verify the cause of death. Traces of alcohol or drugs in the blood of the deceased may confirm contributory negligence. Police

investigations and witness statements are useful in this determination and other matters affecting the cause of death.

Settlement of a Claim

The vast majority of insurance claims are paid promptly and without the involvement of a great deal of complexity. Many cases are settled or disposed of through negotiation between a claimant and an adjuster. Insurance adjusters should know that compromise is the basis of a successfully negotiated claim and that non-reciprocal compromises may constitute an invitation to litigation. Negotiations must be made in good faith for an offer to be fair and reasonable. Successful dispositions of an insurance claim, based upon a compromised settlement, must also be based upon a consideration of all of the underlying facts. Reasonable demands or concessions made at inappropriate times have an adverse impact on a settlement. Unreasonable offers should be refused. Settlement agreements should not be signed unless an adjuster and a claimant are reasonably satisfied with the terms and conditions of the proposed settlement.

Release

No matter what the type of claim, a release is the ultimate objective of an insurance company. A release is a legally-binding document which provides that the person who executed it settled the claim for a valuable consideration, and did so knowingly. After a release is signed, and notarized, if required, the insurance company dispenses a check to the party affected by the release. Once signed, the company is entitled to rely on representations by an insured that the claim is settled, and that no additional claims will be made which arose out of the same accident or set of facts.

Following are some of the more important aspects of a release:

- Reading the release—A release must be in readable form and should have been reviewed and understood by the insured. A lawyer should be involved if the release cannot be understood by the parties involved.
- Good faith—A release should be obtained in good faith. Material misinformation on the part of an adjuster or an insurance company may lead to a release being set aside by a court. In the event of a personal injury, a medical statement should be obtained from a qualified physician before a release is signed.
- Waiting period—In a number of states, there is a legally-prescribed waiting period that must by observed before a release can be executed. The waiting period protects an insured or an injured party from receiving inadequate medical treatment or sums insufficient to remedy property damage. It also deters a carrier from avoiding its obligations under a policy. Some states require a waiting period to be 30 days in duration. If signed in less than the requisite time, a release may be invalid.
- Expenses—A release typically covers all expenses, whether past, present or future, paid or unpaid. If any third parties paid expenses on behalf of the insured, those payments should be included in a release.
- Assets of a Carrier—These must be sufficient to cover a release.
- Other Carriers—If additional carriers are involved, they should be apprised of the release.

Negotiating a Settlement

The negotiation of a settlement is a business transaction between a policyholder and an insurance adjuster who is acting on behalf of a carrier. Personal feelings and emotions should be kept out of the negotiating environment. Objectivity should prevail. There should be no insistence on the part of either party to bend or mold contractual provisions or legal precedents. Both parties should be able to detach themselves from personal prejudices which either may hold about the other party. Threats to cancel a policy on the part of either party are out of place. Negotiation does not have to be a win-or-lose proposition. A fair and equitable disposition or settlement leaves both the policyholder and the carrier feeling like winners. A claim settled within reasonable limits is one in which an adjuster can feel that he or she has done a satisfactory job both for the insured and his or her employer. Adjusters should expect a policyholder to approach the negotiating process with a proposed settlement that is on the high side. By being creative and doing a little extra work in approaching a claim, it is possible for an adjuster to arrive at an amount which is fair and equitable to both the insured and the carrier.

Appraisal

A method which is frequently used to settle a claim between a carrier and a claimant is an appraisal. The standard appraisal provision that is contained in an insurance policy is required under the laws of some states and is a normal provision in a policy covering personal or real property. Either party to an insurance policy has the right to demand an appraisal.

The appraisal method, used infrequently because most claimants are not aware of the process, can be employed to determine the value of real and personal property. Most of the time it is used to settle disagreements that develop over the expenses of restoring commercial, industrial or residential property destroyed by fire. Appraisals are only appropriate when there is a significant amount of money in controversy. In order to satisfy the requirements of a competent appraiser, the one selected should have impressive credentials in a given area. Licensed contractors specializing in reconstruction of burned properties or an established art dealer when the property involved is a rare painting would probably satisfy the "competent" requirement. In actual practice, an umpire is rarely used to resolve a dispute between two appraisers. The appraisal award is binding on both parties.

Reduction and Denial of Claims

Most reductions or denials of claims result from clauses or phrases in a policy which exclude certain property or transactions from insurance coverage. In order for an exclusion to be valid it must be set forth in a policy in plain, concise and clear language, and the burden is generally on the carrier to prove that the exclusion is both clear and understandable and is applicable to the situation underlying a claim.

If an exclusion is vague, unclear or not capable of being understood, a court will ordinarily construe the language in favor of the claimant. This trend follows a 200 year-old judicial practice that if language in a policy is capable of being interpreted in two different ways, that which favors a policyholder will be upheld. When a claim is filed, an adjuster will conduct his or her examination with a view to whether or not it is payable. If a policy is not in force, if it has expired and premium payments have not been satisfied, the company may deny coverage. Many policies contain a grace period during which a policy can be reinstated if an insured brings all of the delinquent payments up to date. Another issue that must be resolved, especially where a health care claim is involved, is whether the claimant is covered under the policy. Certain medical checkups are excluded from coverage, so it becomes necessary to determine if a visit to a physician was routine or the result of an existing medical condition, disability or disease.

If an insurance application has not been filled out completely and accurately, anything which was not included may be used by a carrier to limit or deny coverage. In the worst possible case, a policy may be canceled. Inflated, overly-exaggerated, frivolous, fraudulent and deceptive claims may also result in the denial of coverage or cancellation of a policy. Claimants are entitled to a written explanation containing the reasons for the denial of a claim. Most state laws require that such an explanation be provided in writing, and failure on the part of the carrier to do so may constitute an unfair claims practice. A claimant's rights are governed to a large extent by the phrases and words included in the governing insurance policy. Claims may be denied for something as trivial as failing to follow the company's specific requirements for filing out claim forms or for failing to file such a claim in a timely manner.

Litigation

"Bad-faith" litigation can be an expensive way to settle a claim for a carrier. A lawsuit in which a carrier is charged with having handled a claim in bad faith or making an unreasonable refusal to pay a valid claim is costly and onerous to a carrier. Bad faith can encompass a carrier's failure to investigate, evaluate and settle a claim adequately or within a reasonable amount of time. Recovery will entitle a claimant at the very least to the amount of benefits explicitly provided for within the policy and, depending upon the nature of the circumstances, may lead to the recovery of incidental damages, economic loss, future damages, amounts for mental distress or punitive damages. Punitive damages are provided for by law to deter a carrier from engaging in bad faith practices. The California Supreme Court has held that insurance carriers have a relationship of trust with their clients which underlie the interest of the public. Taking advantage of that relationship, public policy dictates imposing punitive damages on a carrier and an attempt to restore the contractual relationship between the carrier and a policyholder. Some states that do not allow punitive damages provide for other kinds of damages or penalties. There are some recent judicial guidelines which must be satisfied before an award of punitive damages would be appropriate. They include:

- An ongoing practice of nonpayment of claims by a carrier.
- A constant and unremedied pattern of egregious practices by an insurer.
- Malicious disregard of the rights of a policyholder.
- The absence of any reasonable basis for the alleged misconduct.
- Actions which constitute more than just a mistake of law or fact, an honest error of judgment, over-zealousness, simple negligence, witlessness, bureaucratic inertia or human failing.

Although no dissertation on the rights of a consumer is intended, it is prudent for an adjuster to have a general awareness of what guidelines a court might use in assessing some of the factors set forth above as the basis for an award of punitive damages. In particular, with regard to the rights of a policyholder, the ones included as specific terms and conditions under a policy will be evaluated, but there are additional ones to be considered. Although it does not have the force of a law, the National Association of Professional Insurance Agents and Consumer Insurance Interest Group has adopted an Insurance Consumer's Bill of Rights and Responsibilities, which can serve as a judicial guide as to what constitutes equitable insurance practices and reliable representation by an insurance agent. Some of the items included are:

- The right to a voice—A consumer should have a vote in any significant decisions which affect him or her, including the right to a response to any suggestions or inquiries made by a consumer.
- The right to safeguards—A consumer is entitled to be advised of his or her rights as well as his or her obligations which arise under an insurance policy.

- The right to a remedy—Claims must be handled and settled in a timely and equitable fashion. Mediation, appraisal and arbitration procedures, and an appeal to the state insurance department or commission must be available.

Although a consumer's rights are emphasized, an adjuster should also be aware that the Insurance Consumer Bill of Rights and Responsibilities imposes concurrent obligations on a consumer, including a duty to timely and accurately file claims, to read the policy before purchase and to seek professional help to aid in understanding terms and conditions, to minimize risks and losses, to report any fraudulent conduct to law enforcement authorities and regulatory agencies, to maintain accurate records and inform the insurance company of any changes, and to comply with policy provisions concerning claims and payment of premiums.

One of the most significant consumer protection laws (which was discussed briefly before), serving as another set of judicial guidelines when the appropriateness of punitive damages is at issue, is the ***Model Unfair Claim Settlement Practices Act***, which has been adopted in one form or another by many states. Following are some unfair claims practices under this act:

- Failing to adopt and maintain sound criteria for the investigation and processing of claims.
- Misstating policy terms or relevant facts that affect coverage.
- Failing to provide for prompt and equitable settlement of claims when liability is relatively certain.
- Using advertising material that would lead a reasonable person to believe that a claim could be settled for one amount and then refusing to settle for such amount.
- Failing to inform the insured, upon request, under which part of a policy a claim has been paid.
- Failing or refusing to provide an explanation of the reasons relied on in a policy or under the laws for either compromising or denying a claim.
- Misrepresenting the statute of limitations.
- Delaying the investigation or payment of a claim by using multiple forms to obtain the same information relative to a claim.
- Failing to act promptly upon notification of a claim arising under a policy.
- Forcing an insured to sue to recover for a loss by offering to settle a claim for significantly less than what is ordinarily recovered in a suit for similar claims.
- Failing to deny or confirm coverage within a reasonable period of time after proof-of-loss requirements have been satisfied by an insured.
- Settling on the basis of a claim form that was altered by the insurer without permission of or notice to the insured or his or her representative.
- Using the threat of appealing awards or claims to force an insured to accept a lesser amount in settlement of a claim.
- Advising the insured not to obtain legal advice.

Since insurance policies are contracts, a wrongful denial of a claim can give rise to a breach of a contract cause of action as well. Under a breach of contract case, all a claimant has to prove is that he or she was entitled to recover. The motives or conduct on behalf of the carrier or the claimant is not at issue. If a claimant can prove a carrier issued a policy with no intention to pay claims, there may be cause for fraud. Other legal causes of action might include intentional infliction of emotional distress, malicious prosecution, negligence or conspiracy, depending on the underlying circumstances. Courts have held that under certain circumstances, an insurance company owes a special duty to an insured because the company stands in a special relationship with such party. Insurance companies must respond to settlement offers from third parties in a reasonable manner, and failing to respond to such an offer or rejecting a reasonable offer may result in liability on the part of a carrier for bad faith. Under a bad faith claim, an

insured can recover damages, which could include the amount of an excessive judgment against a claimant. Some courts have held that the insurer is under a legal obligation to settle claims a claimant has against its own carrier as well or be liable for first-party bad faith claims.

Small Claims Court

If a disagreement between a carrier and a claimant cannot be resolved and involves a small amount of damages, typically no more than $5,000, a claimant may elect to pursue the matter in small claims court. Since some courts will not allow a defendant to employ a lawyer to appear on his or her behalf, an adjuster may have to represent the carrier. If nobody from the insurance company makes an appearance, a claimant will be entitled to a default judgment. Adverse judgments usually can be appealed to the next highest trial court, which will result in a new trial.

Subrogation

Under the laws of most states, an insurance company which pays an insured for a loss occasioned by a third party is entitled to be subrogated or substituted in place of the insured with respect to the insured's rights to sue such third party. By way of illustration, if a pilot swerved off a taxi way and ran into a restaurant near the end of the field, the pilot would probably be liable for any damages to the restaurant. If the owner of the restaurant filed a claim with his or her insurance carrier and the carrier paid for losses to the owner's property, the restaurant owner's carrier would be entitled to be subrogated to the restaurant owner's rights against the pilot. An insurance company cannot avoid payment by insisting that an insured must first attempt to collect directly from a third party or its insurance carrier. On the other hand, the restaurant owner could not legally collect from both his or her carrier and the pilot or the pilot's insurance carrier. If the restaurant owner waived his or her right to collect for damages from the pilot or the pilot's carrier, he or she would also be waiving the right of his or her insurer to sue the pilot. In that case, the restaurant owner would be estopped from collecting damages from his or her own carrier. Subrogation does not exist with respect to life insurance policies, since such coverage is not a contract of indemnity. Following is a typical subrogation provision found in an insurance policy:

Our Right to Recover Payment

If we make a payment under this policy, and the person to or for whom payment was made has a right to recover the damages from another, we shall be subrogated to that right. That person shall do:

- Whatever is necessary to enable us to exercise our rights.
- Nothing after loss to prejudice them.

If we make a payment under this policy and the person to or for whom payment is made recovers damages from another, that person shall:

- Hold in trust for us the proceeds of the recovery.
- Reimburse us to the extent of our payment.

INVESTIGATION PRINCIPLES

The constant goal of a good investigator should be to strive to uncover evidence and valid facts. If he finds that the best information, evidence, photographs and testimonies rest with the insured, the sooner he will be able to work out settlement negotiations for the position of the case.

Due to excessive demands, lack of liability or settlements of a claim may not be consummated and may have to be tried in court. It then becomes most important to show the facts in some tangible form that can be presented as evidence in court. This is accomplished by means of signed statements, affidavits, reporters' statements, photography, diagrams, specialists' testimonies and, where possible, by actually producing the object which was involved in the accident or allegation. It may be true that a defective faucet broke in the claimant's hands, causing his or her hand to be severely lacerated. An examination of the porcelain handle might reveal that it was struck by an object, such as a hammer, and for this reason the claims person can introduce the handle itself, as well as expert testimony concerning it in the trial. The object is naturally the best possible piece of evidence.

It is obvious that such a handle, or some similar evidence should be put in a place of safe keeping and properly identified so that someone will be able to testify at the trial that it was reserved intact and in exactly the same condition from the time immediately after the accident until the moment it is presented in court.

An effective investigation must be planned in advance and properly timed. There must be order and execution. There can be no set pattern in the investigation of a casualty claim because of the varied circumstances in each case which calls for individual handling.

A claims person need not be a politician or a press agent to be a successful investigator, but it helps to have some elements of both. By establishing friendly contacts with the various police agencies, hospital and motor vehicle clerks, and various officials on both high and low levels, he or she will not only obtain a great deal more information, but will get information more quickly. Once the claims person has established a good contact, a telephone call may save hours of travel and waiting time. The claims person should never antagonize those upon whom he or she may subsequently have to call for information, no matter how great the provocation. He should take the time to establish friendly relations with police sergeants, hospital officials or clerks, record clerks and others in similar positions upon whom he is calling for the first time. It will be time well spent. If certain rules or regulations require the investigator to obtain forms or go through red tape routines which he or she feels are cumbersome, he should follow the procedure in good grace and not request shortcuts that will embarrass the clerks who have to abide by those rules.

Friendly contacts are invaluable for picking up gossip or hearsay which may often lead to pertinent information.

The scope of an investigation is determined as it develops. If the case is one to settle and if the demands are within reason, all efforts should be bent upon disposing of the case and eliminating or avoiding any investigation which will serve no ultimate purpose. Over-investigation can be just as costly in the long run as under-investigation. This is particularly applicable in property damage claims of the average kind where the liability has been determined and the damages established.

If the claims person has decided that to see the claimant first is most advantageous in a certain case, he or she will usually find it advisable to get in touch with the insured by telephone and obtain an oral version of the accident before taking the signed statement. If the claims person cannot talk to the insured right away, he or she should see that the insured is notified to give no signed statement to anyone but his own company representative and to be cautious about any verbal information he may be forced to give in making a claim of his own against the other party. Unless a claims person is handling property damage, medical payments, or other run-of-the-mill claims, the investigation will be made by personal interviews. He or she will have to meet, question and take statements from insureds, claimants and witnesses. These people come from all economic groups and have various religious, cultural, economic and national backgrounds. The claim representative must be tolerant, in the accepted usage of this term. It is a broad term and has often been misused, but tolerance includes respecting differences in point of view, politics, dress, mode of life, and other such matters as well as race, religion and foreign background. A claims person must not show prejudices of any sort.

The claims person is usually the insured's first contact with an employee of the company with which he or she is insured. Because of this the claims person's job is to make every effort to see that the interview is pleasant, affable and as smoothly-running as possible. He or she should take all the time needed to get the information necessary to protect the insured's interests, but should not drag out the interview to the point of a social visit, especially if he or she has interrupted the insured or is using time which the insured could spend profitably in some other manner.

In this interview it is best to give the insured a briefing on what may be expected of him in the event that settlement negotiations fail and the case has to be tried. If the matter is brought up by the insured, it is also well to acquaint him with those things the insurer cannot do for him. Some insureds, for example, expect the company claims person to press their claim against the third party. It must be tactfully explained that it would be both unlawful and improper to do so, unless there are subrogation rights involved.

The problem of representation before a criminal court or traffic hearing will also often come up. The same explanation must be given in this respect. If the adjuster is a company representative, he or she should remember that although he may be the local attorney of record for his company, he or she is not in the general practice of law, and it would be both improper and unwise to represent an insured in either a criminal matter, a traffic hearing, or an action against third parties not involving subrogation rights. The claims person may always attend such hearings as an observer, but to take responsibility for the outcome is inadvisable.

Unless a claims person has reached a point where it can be determined that a first-call settlement is possible, it is not advisable to make a definite commitment the first time he or she sees the claimant. Nor should the claims person decline the claim until he or she has completed the investigation. A claims person should not miss the opportunity to obtain from the claimant written permission to get the doctor's and hospital records, whether he or she intends to use these immediately, or some time in the future. The claims person will have no better opportunity to get this permission than on the initial visit. Any attempt to get a signed statement or further information after the claimant has disclosed the fact that he is being represented by counsel is unethical and deceitful.

An investigator must remember that the control he maintains will depend upon the impression he makes upon the claimant. If he indicates by attitude and gesture, as well as by words, that he intends to act fairly and ethically within the limits set by the policy, his batting average on settlements will be pretty high. Each company has its own policy with reference to such payments. They are becoming more prevalent and have generally helped to keep some serious

cases under reasonable control. The claims person will learn the attitude of his or her company concerning such payments and act accordingly.

One question the investigator will probably ask more often than any other in the investigation of casualty claims is, "Do you know or have you heard of anyone who saw the accident?" He or she will also try to learn this from the insured, the claimant, police offices and many others as well as outside witnesses, and will scan the police and motor vehicle bureau reports to determine the names of any possible witnesses. The investigator will attend traffic hearings and criminal proceedings, and read the transcripts. He or she will interview coroners and read transcripts of the coroners inquests to determine the names of possible witnesses to an accident.

In serious cases where the effort is warranted, he will make neighborhood investigations, and if he wants the best results, will make them at the same hour of the day when the accident occurred, and as soon after the accident as possible. Making a neighborhood investigation requires common sense and a great deal of persistence and determination. First of all it means calling on every store in the immediate vicinity that was open at the time of the accident and finding out not only whether the proprietor or the sales people saw the accident, but also whether there were any customers in the store at the time. It also means checking with these people to determine whether they know of anyone else who saw the accident.

In addition to covering the houses in the immediate vicinity, it also normally means knocking on the door of every apartment that has a window facing onto the scene of the accident. Time after time, investigators have located witnesses who were looking out of an upper story window down onto the scene of an accident. The investigator must ask all of these people whether they know of anyone else who might have seen the accident. Sometimes this involves interviewing four or five people before he tracks down the witness. This individual may be merely described generally since no one may know his name or address.

Most people's lives are set in a fairly well-defined pattern. If buses or trolley cars were present at the time of an accident, it is not unusual to find certain people in them at the same time and place on a subsequent day. Bus or trolley drivers can usually be interviewed through the company for whom they work. Very often the claim departments in these companies will do the preliminary interviewing for the investigator. A claims person may possibly learn that telephone linemen or outside workers of other kinds were present at the scene of the accident, and he will have to track them down. If it is warranted, he should check with delivery people who may have been working in the area at the time of the accident, including mailmen, parcel deliveries, newspaper delivery men and others. After a case has gone into suit, information may be obtained that may lead to the discovery of other witnesses, by means of interrogatories and depositions. If such information is obtained, it should be followed up immediately. Occasionally, in important cases, a catchy advertisement in a local paper will bring forth a witness. All of this presupposes the fact that the nature of the accident deserves this kind of attention.

If the investigator contacts the witnesses promptly, he should be sure to obtain from them the identifying information and the names and addresses of relatives and friends who have a permanent address, and follow this up with regular periodic checkups concerning their availability so that he will have no problems locating the witnesses when he needs them. There will be occasions, however, since no one is infallible, when he will find it necessary to locate a witness that he has lost track of because the witness no longer lives at the last address which the investigator has for him.

There are various "skip-trace" organizations that specialize in locating missing persons for a reasonable fee. All claims persons occasionally have use for such organizations. There will,

however, be many instances when, because of the time element, or because other methods have been unsuccessful, a claims person may have to make every effort to locate a witness who has apparently disappeared. If so, he should know that there is no magic formula for locating a missing witness. Should the claims person use some ingenuity, imagination, and a good deal of tenacity, he will probably accomplish his object. It is very difficult for an individual in this country to disappear without leaving any trace whatsoever.

Locating the Witness Checklist

As a stimulant to the investigator's imagination, the following checklist is offered as leads for locating the missing witness:

- A registered letter, return receipt with address requested, sent to the last known address of the witness.
- Telephone directories.
- City directories.
- Interview with janitor or landlord at last known address for any possible leads, including:
  - Names and addresses of relatives or friends.
  - Names of company or collector on an industrial life insurance policy.
  - Names of credit or collection agencies or individuals.
  - Name of any federal, veterans' or other organizations that the witness may have belonged to.
- Canvass of the neighborhood or building for any possible leads from friends, relatives or acquaintances. It is essential that such investigations be repeated several times since the investigator will almost never find everyone home the first time the canvass is made. There is also always the possibility that someone he saw before has since seen or heard from a missing witness.
- Business establishments, stores and banks in the immediate vicinity.
- Churches and church organizations.
- Local doctors and dentists who may have treated the witness at one time.
- Local parochial or public schools.
- Name of a moving firm whose vehicles may have been observed by the janitor or any of the neighbors.
- Any former employer of the witness or any member of his family. From this source, the investigator may obtain:
  - Union affiliations.
  - Names of references on employment records.
  - Type of work and employment.
  - Information from fellow workmen.
- Automobile or Motor Vehicle Bureaus may have information concerning the witness' address if an automobile has been registered in his name, or if a driver's or chauffeur's license has been issued to him.
- Local election records.
- Utility and telephone companies.
- Military service or veteran's administration records.
- Credit accounts at department stores.
- Welfare agencies.
- Police records.
- Tax records.
- Marriage, birth, or death records of the witness or his immediate family.
- Judgment records.

- Golf, tennis or other athletic clubs that the witness may have belonged to, including leads to any hobbies that the witness may have had.
- Credit card organizations.

Potential witnesses comprise a variety of individuals. An insured or a claimant is an interested witness because he is interested in the outcome. One who knows neither party and is not interested in the outcome, except as a matter of justice, is a disinterested witness. Witnesses are often designated as friendly or hostile, adverse or favorable. These terms are self-explanatory. In interviewing witnesses, a claims person's approach must be one of genuine sincerity. He may have to explain to the witness why it is important to the insurance company to pay just and proper claims and to avoid time-consuming additional investigation and litigation expenses. However, if he can convince the average person that he is sincerely interested in seeing that justice is done, whether or not it affects the company adversely, he will usually get the witness' cooperation and in most cases, a signed statement, without too much difficulty.

Occasionally, a witness will give an initial impression of hostility that is merely a defense mechanism on his part. He may believe that a version unfavorable to the claims adjuster will be received with antagonism. It is up to the claims person to avoid jumping to conclusions and break this false barrier down. He should not misrepresent himself, but should gain witness confidence by his honesty and fairness. Unless the circumstances are extraordinary, it is advisable to have seen both the insured and the claimant and to have visited the scene of the accident before interviewing the witnesses. This presumes that the claimant is not represented by counsel. It does not imply that there should be undue delay in interviewing the witnesses. They should be seen as soon as possible. Time can only dim their memory.

The claims person may wish to take a key witness on an important claim back to the scene of the accident so that he can refresh his memory and familiarize himself with distances and landmarks. While it is perfectly proper and often necessary to refresh the memory of the witness, the claims person should not try to lead him in any definite direction. If the witness is important to the case, the claims person should obtain not only his name and present address, but the name and address of someone such as a parent or other close relative who has a permanent residence and through whom the witness can always be located.

It is important that witnesses be interviewed under circumstances which are comfortable to them. The claims adjuster should not try to interview a witness at his place of business if such an interview might make him ill at ease. He should be seen at home if possible. He should take the time necessary to obtain a proper interview but he should not impose upon the witness. If there is no choice but to interview a witness at his place of employment, an attempt should be made to enlist the aid of his employer, but care must be used—it could boomerang. A good claim representative will try to find some common bond with a witness on which to establish a basis of friendship. If the witness is busy or has only a very short time to give the claims person, he should take whatever information he can, but prepare the way for an additional interview later when the witness is not so rushed. On a follow-up, the average witness will usually go overboard to give whatever information he can, since he feels responsible for the extra call.

Whenever a witness is interviewed, the claims person should obtain complete details and record them along with his impressions of that witness. Did he appear to be honest and sincere? Was he reluctant? Did he seem to be holding back any information? Did he give the impression that he was favoring either side? Was his manner of presentation such as to make him a good witness on the stand? Was his appearance favorable? Did he speak with an accent? Was he hesitant, or straightforward and direct in presentation? Did he appear intelligent and well-educated, or slow, stupid or ignorant?

Was he opinionated, timid or hesitant? Was he uncertain or positive in his statements? Was he friendly or belligerent? Did he have any speech impediment? What was the overall impression of his credibility? What is his reputation? Does he have any physical deformities? Does he appear vindictive?

Whatever his reason, if a witness persists in refusing to give information about an accident which the claims person has reason to believe he has seen or knows something about, it is important to obtain his negative signed statement so that he may be impeached if he tries subsequently to testify for the claimant at a trial.

Special Damages

Special damages is a term used in the investigation of casualty claims to denote losses that can be measured in definite sums of money. Allegations of special damages should not be taken at face value. If the nature of the case or the amount involved warrants it, the items should be checked for authenticity. If special damages have been exaggerated, it is a good indication that other features of the claim may need careful scrutiny. It is also a lot easier to dispose of a claim for a fair value after the claimant has been confronted with proven exaggerations in his special damage allegations.

Special damages which are ordinarily encountered in casualty claim work may be listed as follows:

- Lost time and earnings—It must be borne in mind that the claimant is entitled to his take-home pay only, and that he suffers no loss as a result of tax or other deductions, unless he is called upon to make up some items, such as insurance or hospitalization.
  - ***Where the employee is salaried:***
    - Check the employer's payroll records. Do not be satisfied with a verbal corroboration made by some clerk. In some instances, even a written letter cannot be taken on face value.
    - Check the exact lost time
    - Check the exact lost earnings. The employer may have paid all or part of the employee's salary.
    - Determine the amount of the regular salary.
    - Determine the amount of commissions and overtime, and obtain average salary for that particular time of the year.
    - Estimate tips and other gratuities, such as board and lodging.
    - Determine whether the injury has necessitated a change of job or employment.
    - Determine whether the injury has made it necessary for the claimant to obtain part-time work.
  - ***Where the claimant is self-employed:***
    - Check income tax records, including federal, state and city, if any.
    - Social Security tax, if possible.
    - Unemployment tax.
    - Examine private books and accounts.
- Property Damage—The following items will be discussed in great detail when we consider automobile property damage losses subsequently:
  - Estimate of repairs.
  - Appraisals and surveys.
  - Difference in value before and after the accident.
  - Exact amount of loss of use.
- Medical Expense

  - Doctors', specialists' and dentists' bills.
  - Travel expenses to and from doctors.
  - Registered nurses' fees.
  - Practical nurses' fees.
  - Hospital or clinic bills.
  - Cost of ambulance.
  - X-rays.
  - Laboratory fees.
  - Prosthetic appliance or surgical apparatus.
  - Medicines, drugs, etc.
- Funeral Expenses

Investigating Fatal Claims

In the investigation of fatal claims, the following points should be checked:

- Duration of the time the decedent lived after the accident, to determine the amount of possible pain and suffering.
- Age of the decedent.
- General health of the decedent. Determined by:
- Neighborhood canvass.
- Life insurance examinations.
- Army or school examinations.
- Medical history investigation, if warranted.
- General habits and morals, if warranted.
- Life expectancy.
- Earnings.
- Potential earning capacity and increases expected.
- Names and addresses of all close relatives.
- Age, sex and number of dependents.
- General economic condition and social status.
- Marital status with certificates or other documentary proof or written corroboration.
- Complete medical bills.
- Complete funeral expenses.
- Causal relationship between death and accident, derived from:
  - Coroner's report and transcript of hearing.
  - Death certificate.
  - Autopsy report.
  - Medical report.
  - Medical history.

You will often hear it said that the claim department is the eyes and ears of an insurance company. As has already been seen, its activities extend far beyond the old concept of routine claims handling. One of the important functions and duties of the claims person is to report to the underwriting department any information that may affect the desirability of a risk or the adequacy of the premium rate.

Ordinarily, it is not the province of the claim department to recommend the cancellation of a risk. There are many reasons why the underwriter may decide to retain a risk, despite some undesirable features. It is the duty of the claims department to bring to the attention of the underwriting department any information that may aid them in arriving at a proper decision

concerning cancellation, or which may necessitate corrective action. In the course of the investigation of an accident, much information will come to the attention of the claims person that might affect the desirability of a risk. Final decision concerning cancellation, however, should rest strictly with the underwriting department.

Risk Report

Most companies have some form for this purpose which is variously termed "Questionable Risk Report," "Confidential Risk Report," or some similar designation used for the same purpose. The types and kinds of deficiencies that should be noted and brought to the underwriters' attention can be grouped roughly into five categories. Examples of each, are:

Physical defects:

- Poor condition of an automobile or building.
- Defect of equipment, such as brakes, broken headlights, defective horn or steering mechanism on an automobile; defective machinery on compensation risks, and so forth.
- Improper equipment.
- Machinery safeguards not being used, or no safeguards provided.
- Dangerous machinery.
- Unoccupied premises.

Moral Hazards:

- Bad reputation of insured or driver with reference to speeding, reckless driving or criminal background.
- Police record.
- Philandering.
- Intoxication.
- Apparent collusion.
- Fraudulent acts or false statements.
- Illegal operation of vehicle, elevators, machinery, or equipment.

Physical Infirmities:

- Glasses required and not used, poor eyesight, or blind in one eye.
- Loss or impaired use of fingers, arm or leg.
- Insured or driver afflicted with epilepsy, heart condition or other infirmity or disease which could momentarily disable the driver.
- Insured or driver aged or infirm.

Matters Affecting Premium:

- Age of driver.
- Usual traveling distance on truck bearing local truck man's endorsement.
- Principal garaging of automobiles.
- Operations or employment not covered under compensation policy.
- Improper classification of automobile or job.

Other Hazards:

- Accident frequency or excessive traffic violations.
- Poor class of drivers or employees.
- Truck used to transport employees.
- Gross negligence or wanton disregard involved in an accident under investigation.
- Improper registration or no driver's license.
- Catastrophe hazard, such as transportation of butane gas, asphalt, or dynamite; fire hazard, and so on.
- Non-cooperation.
- Employment of minors.
- Occupational disease exposure.
- Unsafe practices.

Although it is not ordinarily the province of the claim department to recommend cancellation of a risk, as we have previously stated, a claims person should always notify the underwriting department when such cancellation might adversely affect an open claim or suit.

In some instances involving serious accidents, it is essential that the good will and complete cooperation of the insured be maintained, especially where he or she has some influence over others, such as witnesses and perhaps even a claimant. In such instances, the claim department may wish to take a calculated risk and remain on the policy, since cancellation might antagonize the insured and result in the loss of his or her future cooperation. In this type of case, it is the duty of the field claims person to let the underwriter know the circumstances, and request that no cancellation be made until further notice by him, or upon disposition of the claim or suit.

STATEMENTS FOR INSURANCE CLAIMS

Because the taking of signed statements takes up so much of the working time of the average casualty claims person, it is important that this phase of the operations be discussed in detail. Only a small percentage of the signed statements taken by an investigator may ever be used. However, all statements have potential importance, and the investigator must learn how to take a correct, proper and complete statement early in his training.

A claims person, therefore, may have some preconceived ideas about the manner in which a signed statement should be taken, and about the average person's reluctance to sign it. Experience will be his best teacher, but he can learn how to avoid a few of the pitfalls from the experience of others. Above all, he should relax and be natural. Anxiety is a sign of uncertainty and will be as obvious as timidity.

One should immediately get a signed statement. The longer it is delayed, the less likely that it will be obtained. If the purpose and reasons for obtaining signed statements are understood, the claims person will be that much more qualified and prepared to answer questions asked by the witnesses. Why is a signed statement so important in claims work?

Importance of Signed Statements

There are several reasons why signed statements are critical:

- It provides an opportunity to obtain details in a permanent record form while they are fresh in the minds of the witnesses. Unless an investigator can take shorthand, no notes will be as comprehensive as a complete statement taken from a witness.
- It can be used as a subsequent refresher, if memory dims the details. This may become important if the case goes into suit and eventually to trial.
- Signed statements can sometimes be used as a substitute for the witness' personal testimony if the witness is not available to give his own version. Unless statements are taken by a court reporter, are depositions, or are notarized, it might be difficult to get them admitted in evidence. Signed statements are subject to the same rules of evidence as other testimony.
- A witness' statement can be used to discredit him either before or during trial if he should attempt to change his story.
- Once the witness has signed a statement, he is less likely to change his story, for he realizes that his statement can be used against him.
- A signed statement is a reliable and usually accurate factual record of the information obtained for the file and for transmission to the home office.
- A signed statement can be used as a means of convincing opposing counsel of the falsity of certain allegations and make him more amenable to a fair settlement figure.
- The first thing to do in preparing and planning for a signed statement is to obtain a signed statement that is logical, concise and in chronological order. The claims person must plan his strategy in advance. The average statement involving an automobile accident should not require the seasoned claims person to spend much preliminary time jotting down points of information he does not wish to forget in questioning the witness.

For the new claims person in the field, it is best to do sufficient preliminary planning on every case until the taking of certain types of signed statements become second nature. The less time that is available to take a statement, the more preliminary planning is necessary, so that the most relevant information can be obtained in the least amount of time. Ordinarily, it is not only common courtesy, but intelligent handling to see a witness when he or she has the time to spare. This is not always possible, and to arrange for another appointment without making any attempt to get a signed statement during the first interview can be disastrous. Any delay provides too many opportunities for the witness to change his mind or to be persuaded to change it.

The approach to interviewing the witness is very important. Anything that is done to antagonize the witness defeats the purpose for which he is being interviewed. The manner in which witness cooperation is gained is something personal to each claims person and cannot be learned by reading a book.

The claims person should attempt to gain the attention and interest of the insured on some common basis of appreciation or endeavor. Confidence should be gained by the sincerity and evident fair-mindedness of the claims person. He should not simply introduce himself, and then sit down and immediately pull out a writing pad. Rather, the claims person should talk to the witness first, and put him at ease. The witness will shortly begin to talk about the accident quite naturally. The claims person should let him talk, if both have the time. The claims person can then start taking notes of salient points that he wishes to include in the statement. This will be the outline and preparation before writing the actual statement.

The claims person must watch for reactions from a witness and must be able to change his approach the moment he senses antagonism. The sight of a statement pad will often cause an immediate negative reaction. Accordingly, the claims person must put the witness at ease by explaining his mission, and he must convince the witness of his desire to get the true facts.

When the interview is concluded, the witness should be thanked for the time he has graciously given.

For the most part, taking signed statements is a matter of common sense. The new claims person however, may find a few guidelines helpful in establishing a procedure.

Principles of Handling a Claim

There are a number of elementary principles with which a person handling a claim should be familiar:

- ***Coverage Problems***—Whenever a coverage problem is involved, two separate signed statements should be obtained from the insured; one covering the facts of the accident, and the other covering the information to be obtained on the coverage problem. The statement concerning coverage problems will usually contain references to the agent or broker as well as to the insured's carrier, which should not be in the statement concerning the facts of the accident. Most states still forbid the injection of insurance coverage status in the trial of an action for negligence.
- ***First Person***—The statement should be written in the first person in order to show that the witness is doing the talking.
- ***Separate Statements***—No two people will ever see an accident exactly alike. It is, therefore, a good practice to obtain a separate signed statement from each witness. The claims person should refrain from having one witness add either his signature to the statement of another, or even a paragraph to the effect that his version of the accident corresponds with a version as stated by the other witness. There are unusual circumstances that could make such a practice acceptable where the alternative would be no statement at all from the second witness, but this should be the exception rather than the rule.
- ***Legible Writing***—The handwriting on the statement must be legible. If the handwriting of the claims person is difficult to decipher, he should get a portable typewriter or computer or have the witness write out the statement himself. Requests to have the witness write out a statement may not always be granted, but the request will usually make the witness much more amenable to signing the one written or typed by the claims person. ***Handwritten statements*** should be written in ink. Where the witness is willing to write his own signed statement, the claims person will have to help him or her with it and this could be troublesome where the statement may have to be admitted into evidence. When the witness writes his or her own statement without any direction whatsoever, it will usually be inadequate; therefore, the claims person often has a difficult decision to make regarding this issue. In any event, the claims person should never request that a witness who is self-conscious about his education or spelling write his own statement.
- ***Narrative Form***—Unless a court reporter's statement is being taken, the straight narrative form is the best form for the ordinary signed statement. The question and answer type of statement looks too legalistic for the average layman. It may breed suspicion, whereas the ordinary narrative statement would not. Narrative however, does not mean to imply that the claims person is to write a novel. He or she should be specific, brief and to the point without overlooking important material. The question and answer form usually requires a great deal of extraneous writing. It may, for instance, require a whole series of questions to obtain personal and comparatively unimportant details about the witness before the claims adjuster can get to the meat of the statement. In addition, if the answers are not written exactly as given, it could lead to misinterpretation that might cause the entire statement to be discredited.
- ***Arrangement***—Although every effort should be made to arrange the statement chronologically for easy reading, the writer should not be afraid to add paragraphs at the

end, either upon request by the witness or to cover information that he forgot to include previously in the body of the statement. In other words, he should be orderly but need not make a fixation of it.

- It has been said that the signed statement should be taken without paragraphing, under the belief that in breaking the statements into paragraphs, there is some opportunity for the one who holds the statement to add a few words after it has been signed. It is more important than the suspicion that might be aroused by leaving part of the line unfilled.
- ***Solitary Interview***—If the claims person can possibly avoid it, he should not try to take a signed statement from a witness when the witness is surrounded by family and friends. It is best to suggest tactfully that the noise and disturbance will be too great for concentration. Then, if possible, he should attempt to interview the witness alone where he will have his undivided attention. There are exceptions, such as if the witness is very young, in a hospital or other institution, or is illiterate or unfamiliar with the English language. Again, it is recognized that there may be times when gatherings are unavoidable and when the claims person must either take a signed statement under adverse conditions or not get one at all.
- ***Style***—Whenever it is appropriate, simple language and short sentences should be used. The written statement should record as closely as possible the witness' manner of speech, but bad grammar or objectionable language should not be used purposely. Occasionally, the investigator will take down a direct quotation. When this is done, he must, of course, use the exact language of the witness. However, bad grammar is an obvious condescension that leaves as bad an impression as the use of words that are far beyond the obvious knowledge of the witness. The claims person should refrain from using unfamiliar legal, medical or technical language.
- ***Preprinted forms***—The claims person should avoid the use of preprinted forms in taking signed statements. They serve no useful purpose and, again, will only create suspicion and be less effective if needed to be presented as evidence.
- ***Factual Material***—Whenever possible, try to give factual information and avoid opinions or conclusions. While this is not always possible or even advisable, some effort should be made to keep opinion and conclusion at a minimum, unless it is pertinent. If any statements overheard by a witness immediately after an accident are included, they should be quoted as close to verbatim as possible. If an opinion based upon obvious circumstantial evidence is included, it should be kept to a minimum and wherever possible such words as "probably" and "perhaps" should be avoided. Also, where possible, recognized designations of speed, distance and direction should be used to indicate speed. Approximate miles per hour should be used instead of such words as "fast," "slow" or "moderate." The points of a compass rather than "right" or "left" should be given, and distance should be measured from such landmarks as large trees, mail boxes, buildings, etc. While it is advisable to be as definite as possible, it is not advisable to be dogmatically so. A statement that a car was traveling at thirty-seven miles per hour could be torn to pieces on cross examination.
- ***Insurance***—All mention concerning the name of the company that is involved in the investigation, or the phrase "insurance company" should be avoided. It may be necessary to use this statement in a court trial and the introduction of insurance in any form may cause a mistrial.
- ***Conditions Affecting Statement***—A signed statement should not be taken from anyone who is under the influence of alcohol or narcotics, or who is in a state of shock following an accident. If a witness has slurred speech, seems drowsy or is unusually slow in his answers to ordinary questions, the investigator should be doubly cautious and make thorough inquiries concerning the witness' condition before obtaining a statement from him. This is one of the few exceptions to the rule of promptness. To obtain an effective statement and to keep his ethics above reproach, the claims person must observe local laws, ordinances, or codes that regulate the time or place for the taking of statements. If, for instance, he must take a statement in a hospital under circumstances that permit it, he should try to have a nurse, attendant, or possibly doctor present as a witness. The attendant will also be able to

attest to the fact that the patient was free from apparent unusual pain and from the influence of narcotics and that the witness appeared to be in a rational frame of mind.

- ***Objectionable Phraseology***—The use of objectionable words or phrases should be avoided unless the investigator is quoting what the witness said. Otherwise, any reference to race, religion, foreign background or any evidence of bigotry or obscenity should be scrupulously avoided. A completely innocent remark concerning race, intended merely as a descriptive appellation, could easily be misinterpreted by a juror.
- ***Preserving the Statement***—The claims person should refrain from physically mutilating a statement in any way. It is a valuable piece of evidence, and should not be soiled, torn or shopworn. In addition, it should not be date-stamped by an office clerk or by any other marking that might make it unacceptable as evidence.

Constructing a Statement

There will be times when, because of pressure, peculiarities of an individual, the facts of an accident, or for other reasons, the statement will not follow an orderly pattern. Most times the general construction of a signed statement should be obtained from a witness—the insured, claimant or disinterested outside witness—should follow an orderly, chronological form. This not only makes for easier reading, but indelibly impresses its pattern on the claims person so that he will automatically obtain the necessary information because it fits into his regular routine. An outline of a good construction pattern for a statement should include the following subjects generally in the order given:

- ***Date, Time and Address***—At the top and upper right-hand corner of the statement, always place the date and time when the statement was taken, and the address of the place where it was taken. By including the time, the claims person pegs down the surrounding circumstances more definitely, and makes it more difficult for a witness to later deny that he gave the statement.
- ***Identification of the Subject***—The first paragraph of the signed statement should be concerned with the identification of the subject who is giving the statement. It should include his name, age and address. It is of primary concern that the authenticity of a statement be provable. Therefore, the more personal details, within reason, that can be obtained and placed in a signed statement, the less likely it is that the witness will ever be able to deny that he gave it. It is suggested that such additional information as the witness' place of employment, Social Security number or other pertinent data be added to the statement where warranted. The degree of identification of the subject should depend on the nature of the accident and the type of witness with whom the investigator is dealing.
- ***Location and Reason for Witness' Presence***—This paragraph should be devoted to a description of the location of the accident and should include the reasons for the witness being there at the time. The direction in which the witness may have been walking or riding should be given, as well as the exact spot from which he viewed the accident. Naturally, in subsequent investigations the claims person should make it a point to check on the story given by a witness to determine whether he actually could have viewed the accident from the position where he says he was. Included here should be the facts indicating what attracted the witness' attention to the accident.
- ***Factual Details***—This paragraph should include the factual information concerning the details of the accident. It should, as far as possible, be confined to facts. Hearsay information should be avoided unless it involves spontaneous remarks made directly before or after the accident, or unless the remarks contain information which will attack the credibility of a witness. If, from the claims person's knowledge, he or she realizes that the information being given is obviously wrong because of an honest mistake on the part of the witness, he or she should try to clarify the situation before putting it down on paper. On the

other hand, if there is any question of dishonesty, or if the witness stubbornly maintains his position on the situation, it should be taken down as is. By doing so, the witness will at least destroy his value as a witness for the opposition.

- ***Physical Description***—The physical description of the scene of the accident should be as complete as possible, and should include weather and lighting conditions, road surfaces, road and other measurements, and any other pertinent details. Whenever possible, some effort should be made to get the witness to draw some form of diagram, illustrating the factual situation. Drawing the diagram will help clarify the facts and impress the interested parties with the credibility of the witness. It is important to have the diagram signed as well as the statement, and is best to keep the names of other witnesses out of the signed statement. They may turn out to be unreliable and the statement, if read in court, might create an erroneous impression.
- ***Injuries and Damage***—The next section of the signed statement can include details concerning the nature of the property damage and the injuries received. This should include not only as complete a description of the damage as possible, but an estimate of the cost of repairs, if one has been obtained. Description of the injuries should be as complete and detailed as possible, and should be in the language used by the claimant. The names of all attending doctors with their addresses should also be included.
- ***Special Damages***—In statements obtained from claimants, complete lists of all special damages should be obtained and itemized. The items that make up special damages have previously been covered.
- ***Police Action***—An indication of any possible arrests or other police action should be included toward the end of the statement.
- ***Corrections***—Having finished the body of the statement, it is now the duty and responsibility of the claims person to make sure that the statement contains the exact information given by the witness and that it does not deviate in any way from the information which he gave. Now is the time to give the witness the statement to review and to point out any errors, any parts of the statement which are not clear, or any sections which the witness for any reason whatsoever wishes to have changed. Wherever possible, all changes or corrections should be made by the witness in his own handwriting. If the witness shows any reluctance, or objects to making the corrections in his own handwriting, the claims person should make sure that each correction made is initialed by the witness. Under no circumstances should any portion of the statement be erased. Rarely is a statement written first-draft without needing some minor corrections. The claims person should not look upon this as something objectionable. The fact that a witness has made corrections in the body of a statement in his own handwriting, or has initialed such corrections, is an admission that he has not only read, but studied the statement. It would be difficult indeed for him to try to testify subsequently that he had not read the statement or was not aware of what it contained after having corrected it.
- ***Acknowledgment***—Having placed the pen in the hands of the witness for the purpose of making corrections, it then becomes a mere matter of routine procedure, after he has completed his corrections, to ask him to acknowledge the fact that he has read the statement and affirms the truth by adding in his own handwriting, the words "I have read the above and preceding number of pages, and state that the information contained therein is true and correct," or words of a similar nature. This sentence should be written on the line following the end of the statement, allowing for no empty space in between.
- ***Signature***—If the claims person has obtained the acknowledgment that the witness has read the statement and affirms the information to be true, in his own handwriting, he should not have any difficulty with the signature. Most witnesses will append it automatically. It is preferable that the claims person does not use the word "sign" in asking the witness to put his name down on the next line after the acknowledgment. The individual who continually bemoans the fact that he or she cannot obtain signed statements is one who is making excuses for certain internal deficiencies. A positive attitude (and this does not mean an

overly aggressive attitude), a matter-of-fact handling of the situation, and above all, the absence of any hint of defeatism or timidity, will ordinarily accomplish the necessary results. Refusals to sign a statement should be the exception, rather than the rule. No signature will ever be obtained without some effort or attempt to get it. Nor will it be obtained with an attitude or words that signify, "You don't want to sign this, do you?" Each page of the statement should be initialed by the witness or, preferably, signed with his full name. When a witness hesitates to put his signature on the statement, the claims person may point out to him that he is merely being asked to verify the truth of the statements he has made. It sometimes helps to ask the witness what phrase of a statement he seems uncertain about. If the witness adamantly refuses to sign the statement, in some instances a third party who was present during the time the statement was taken might be induced to add his signature to a paragraph attesting to the fact that the statement was read by (or to) the witness, and that he affirmed it to be true and correct. In some instances, witnesses may refuse to add their signatures to a statement but will not object to placing the letters "O.K." at the end. Sometimes, the witness might be willing to answer the following questions as written out by the person who has obtained the statement, "Have you read the above and preceding pages?" "Is the information contained therein true and correct?" An affirmative answer to each of these questions in his own handwriting has the same effect as though the witness had signed the statement. Occasionally, the very sight of a statement pad will affect a witness as a red flag affects a bull. He will vehemently and violently tell you that there is no use in your writing out a statement since he will absolutely refuse to sign it. The claims person must not let this throw him off balance. He should put his pad away, inform the witness that he is merely attempting to arrive at the truth and ask the witness to give the facts. After the claims person has obtained the witness' version verbally and after the witness has had a chance to calm down, the claims person can then explain to the witness that he does not want to rely on his memory in order to report on the facts as given by the witness. Accordingly, the claims person can indicate that he would like to make a few notes to be certain that he reports the information exactly as given to him. In most instances, if properly explained, the witness will not object. The claims person can then proceed to write up the statement. Surprisingly enough, the witness will often feel ashamed for having given vent to his anger and may sign the statement obligingly.

- ***Witness to the Statement***—Whenever practical, signed statements should be witnessed by one or two disinterested parties who should place their full names and addresses on the statement. The claims person taking the statement should not ordinarily witness it. Occasionally, a claims person will encounter a witness who does not have sufficient understanding of the English language to be able to read the statement. In that event, it is necessary to obtain a translator's affidavit or short statement appended to the bottom of the statement obtained from the witness. The affidavit or appended statement should indicate that the translator read the statement to the witness in his own language, that the witness understood it, and affirmed the facts contained therein to be true and correct. Such a clause can read as follows: *"I, John Doe, residing at [address] attest that I can fluently read and write French as well as English. I further state that I have read the above and preceding statement of Mary Smith and that I have accurately translated it into the French language which she understands. Mary Smith affirmed the fact that this is her statement, that she thoroughly understands it, and that the information contained therein is true and correct."* This paragraph should be signed by the translator and either witnessed or notarized. Before obtaining the signature of the translator, the signature of the witness should be obtained at the bottom of the statement, even though written in a foreign language.

Despite the fact that the percentage of illiteracy in this country is extremely low, the claims person will nevertheless encounter illiterate witnesses more often than he or she would think likely. Sometimes an illiterate person will attempt to cover up this ignorance by what may appear to be an obstinate refusal to confirm the statement by reading it, or to sign it. With a moderate

degree of persistence, the claims person should be able to recognize this. In any event, obtaining a statement from an illiterate person requires the utmost tact and diplomacy. The claims person should read the statement to the witness, make whatever corrections are necessary and, if possible, call in the services of a notary or some other reliable person in whom the witness has confidence and who the claims person believes to be reliable.

The claims person should have the third person reread the corrected statement to the witness and obtain the witness' assurance that the statement is true and correct. Then, in place of a signature, he or she should have his or her mark placed at the bottom of the statement and append a paragraph on the same page stating that the statement has been read to the witness and that this witness has affirmed that the information contained therein is true and correct. Such an appended statement, to be signed by the third person who has read it to the witness, can read as follows:

"I, John Doe, residing at [address], read the above and preceding [#] pages to Mary Smith. She stated that she understood the statement, affirmed that it was hers, and that it is true and correct."

This paragraph should be signed by the person who read the statement to the witness and corrections should all be initialed by this individual. If a notary has been called in to assist either as translator or to read the statement to an illiterate person, the notary should add his or her own form of affidavit.

In investigating serious or important claims, the claims person will obtain leads that will direct him or her to people who will deny any knowledge of the accident. In those instances where the denial is persistent, and where he or she believes there is a possibility that they are either covering up or may subsequently appear as witnesses for the opposition, every effort should be made to obtain a short, signed statement from such persons. It should state that they did not see the accident and from their own observation know nothing about it. Such a negative, signed statement will at least prevent that person from later appearing as a surprise witness for the opposition. If the witness does appear, it will enable the defense attorney to discredit this individual.

If a case which the claims person is investigating is of any consequence, it warrants a personal interview with every witness. Occasionally, the obstacles to personal interviews may be extreme, involving distance, weather conditions or the time element. The claims person may, therefore, after due consideration, and at a calculated risk, determine that the most advisable course of action is to attempt to get information from a witness through the mail. Having learned by now that the writing of a statement is an involved matter, proficiency in it requires practice.

Therefore, the claims person should not expect that the ordinary witness will always be able to write a satisfactory narrative account of an incident without help.

Again, proper judgment must be used to avoid asking so many questions that the witness is discouraged. At the same time, he should be thorough enough to get the information he needs. He should use great care and spend enough time to prepare the questions so that they will be pertinent and intelligible. As much care should be used in framing the accompanying letter to the witness as in the preparation of the questions themselves. He must remember that he is imposing on the time of the witness and that the witness is doing him a favor in complying with his request.

It has often been said that children make unreliable witnesses. It may, in fact, be quite the contrary. Some children have vivid imaginations and sometimes cross the borderline between

truth and fantasy. This, however, is usually not hard to determine. For the most part, a child who has sufficient mental development can be impressed with the importance of his remarks to the extent that he will make a reliably factual statement. The average child who is able to read and write will, for the most part, give a more straightforward and honest account than the average adult.

Whether the statement should be written in the handwriting of the child, or whether the claims person should write it out himself, is a matter of judgment involving elements of time and the child's personality, general intelligence and education. If the child has acquired reasonable skill in writing, it is advisable to have him write the statement himself. In this case particularly, it is essential that all useless verbiage be eliminated in order not to tire the child or cause him to lose interest. Such a statement should always be obtained in the presence of a parent, adult relative or friend. It is particularly important that the words used should not be incomprehensible to the child. His vocabulary will vary with his age and development.

SUBROGATION/ SALVAGE/CONTRIBUTION

Subrogation

Subrogation, in the insurance industry, is the term used to describe the right of an insurance carrier who has paid a claim as a result of an accident of loss covered under a policy, to recover from a wrongdoer for the damage caused, up to the amount paid by the insurer. In other words, the insurer is substituted for the insured for the purpose of making a claim against the third party wrongdoer to recover the money paid under the policy.

Subrogation plays a very important part in claims work. Proper handling of this phase of insurance can make the difference between a profitable and an unprofitable operation. Every dollar recovered after expenses is pure profit. Unlike the premium dollar, there are normally no commissions or other fees that must be deducted.

While the right of subrogation does not arise until after payment has been made to or for the insured by his insurance carrier, the claims person must be alert to the possibilities of subrogation from the very inception of the claim and must prepare his or her investigation accordingly. The right of subrogation may arise in law as a matter of equity or by contractual agreement. We are, of course, particularly concerned with the rights arising out of insurance policies.

Most casualty policies, where subrogation is a factor, contain a subrogation condition which reads as follows:

"In the event of any payment under this policy, the company shall be subrogated to all the insured's rights of recovery therefore against any person or organization and the insured shall execute and deliver instruments and papers and do whatever else is necessary to secure such rights. The insured shall do nothing after loss to prejudice such rights."

Exactly the same condition appears in the workers' compensation policies. Many of the state insurance statutes incorporate this or similar wording in their workers' compensation laws. Where subrogation rights are asserted under the conditions of the policy, such conditions become the sole measure of the insurer's rights. The insurer is limited to the rights of the insured and only to the extent of the amount paid by the insurer.

Subrogation may apply to the following kinds of insurance policies or bonds:

- Motor Vehicle
- Workers' Compensation
- Marine and Inland Marine
- Fire
- Fidelity-Surety

The basic principle of subrogation is the same in each instance. The insurer is substituted for the insured in any right of recovery against a wrongdoer. In workers' compensation claims, subrogation rights are subject to the laws of the various states. While these may differ in their requirements for bringing actions against the wrongdoer, their purpose is uniform in attempting to deny double recovery to the injured and in protecting whatever subrogation rights an insurer may have. The right of subrogation does not apply to life insurance or to accident and health policies unless the latter contain a specific subrogation clause, which is rare.

In all first party claims involving a third party wrongdoer, the insured has a choice of recovery, either under his or her first party policy, or against the third party wrongdoer, or his or her carrier. Recovery, however, can only be made once. Therefore, if the insured chooses to press the claim against the third party, and makes recovery without the consent of the insurer, he or she relinquishes his right to make a claim under the first party policy.

In the event that the insured recovers under the first party policy, he or she loses the right to recover against the wrongdoer to the extent of the amount paid him by the first party insurer. Accordingly, if settlement is made under a first party policy, the claims person should be certain that the insured is advised that he or she must not try to recover against the third party for the same damage. If recovery is made from the third party (or the third party carrier) after the claim has been paid under the first party policy, the first party carrier is entitled to repayment from the insured, assuming that such recovery is made without the knowledge or consent of the insurer.

On the other hand, the wrongdoing third party could remain liable to the first party insurer if he or she knew of the first party insurer's rights of subrogation at the time the latter settled the claim. It is therefore obvious that the company must notify the third party and his or her carrier of its interest in the matter as soon as possible after receiving a report of an accident. A release given by an insured ordinarily voids the right of subrogation unless a lien or some notice has been filed with the wrongdoer.

It has been held that the mere sending of a lien letter in advance of payment of a claim is not sufficient to hold the third party wrongdoer or his or her insurance carrier in double jeopardy unless the carrier with the subrogation rights notifies the wrongdoer or his carrier that payment has actually been made on the claim. The court held in that case that the plaintiff's right to subrogation did not actually arise until the claim had been paid and since the lien letter preceded any payment made, and did not give the amount of any expected payment, it was ineffective.

Accordingly, the letter notifying the wrongdoer or the carrier of subrogation rights should be followed by a notification that payment has been made including the amount of such payment. It is just as essential that the claims person keep possible subrogation involvement in mind when making a sizable property damage settlement. As we have indicated, payment of such a claim to a third party claimant where notice of subrogation rights has been received could put the company in a position of double jeopardy.

No single form can be devised to fit all situations. The following letter therefore is given as an example only.

"John J. Jones, insured under [Insurance Co.] Policy No. ____ has made claim or damage to the [automobile] caused by the negligent operation of your car resulting from the accident which occurred on [date of accident] at [place of accident]. The [Insurance Co.], because of its subrogation rights, hereby makes claim against you for the amount [state amount if known] which it has been or will be required to pay and requests prompt settlement of this claim. If, at the time of this accident, you were insured against loss arising out of claims of this kind, we suggest that you forward this letter to your insurance company without delay. Please let us know when this has been done and send us the name and address of your insurance company. We shall appreciate it if you will let us hear from you by return mail."

Subrogation rights are not necessarily limited to first party (collision, fire, theft, etc.) or workers' compensation policies only. They may arise because of vicarious liability imposed upon a third party insured under a financial responsibility statute or in some instances because of agency. For example, if payment is made under a non-ownership policy because of the negligence of the driver-owner of the automobile, the carrier may bring an action to recover the amount paid against the driver-owner.

In subrogation actions, suits may be brought in the name of the insured or may be required to be brought in the name of the carrier, depending upon the law of the jurisdiction involved, and the nature of the action being brought. In either event, investigation should be completed as soon as possible and action to recover should be taken without too much delay after payment has been made.

Any defense which a wrongdoer could ordinarily get away with can also be asserted against the insurer in a subrogation action. The insurer does not lose its right of subrogation by waiving any of its rights of subrogation or by waiving any of its policy defenses for breach of policy conditions such as late notice or failure to cooperate. However, the wrongdoer can defend a subrogation action against the insurer on the grounds that there was no coverage in the first place or that coverage was specifically excluded.

Subrogation rights do not extend to voluntary payments made by the insurer. Payment of a claim properly covered by an insurance policy is not construed as a voluntary payment. It is merely the fulfillment of a legal or contractual obligation. If the insurer chooses to pay a claim that is not covered, with full knowledge of this fact, he thereby becomes a mere volunteer and is not entitled to subrogation rights.

An insurer may waive his right of subrogation either by express agreement or by failure to act. If an insurer pays a claim with full knowledge of a settlement that has already been made between the insured and the wrongdoer, he waives his right of subrogation. In addition, if he induces the insured to make settlement with the third party, he loses his right of subrogation. Furthermore, if an insurer unreasonably delays a settlement, knowing that the insured has financial need, he may waive his right to subrogation in the event that settlement does not take care of the complete obligation under the policy.

Loan Receipt

An action against the wrongdoer, ordinarily brought under a subrogation clause, is usually brought in the name of the insured although, in some other instances, it may be brought in the name of the insurance company. A loan receipt is sometimes obtained for the purposes of:

- Permitting the insurer to bring an action against the wrongdoers in the name of the insured where this might otherwise be contested.
- In order to enable the insurer to pay the claim promptly because third party liability has been established.
- To further protect the insurer's rights of subrogation.

After a first party claim has been paid by an insurance case recovery against the wrongdoer, it becomes a primary concern of the insurer. Since the insured cannot make double recovery, it is obvious that his or her interest in any further action is greatly diminished, if it is not altogether extinguished. In view of the fact that the insurance company now becomes—under the laws of most states—the real party in interest, action must be prosecuted against the wrongdoer in its own name.

Judgment must be used in determining whether or not to press any subrogation rights that the company may have. If the amount involved is small and the liability doubtful, it would be patently unwise to press subrogation rights when by so doing an otherwise quiescent claim for bodily injury or extensive property damage may be activated. Even if the amount involved is substantial, it is sometimes inadvisable to press subrogation rights if this might result in a retaliatory claim for serious bodily injury on a case of doubtful liability. Any question about the advisability of asserting subrogation rights should ordinarily be discussed with the claims manager or home office before taking any definite action.

Factors Relating to Subrogation

Some factors which should be given consideration before making a final decision concerning subrogation are:

- ***The amount recoverable***—A substantial amount will warrant the expenditure of more time and effort than will a nominal amount.
- ***Expense***—The effort and expense involved in an attempt to recover should be warranted by the amount recoverable. It is not common sense to spend $20 worth of time in an effort to recover $10. This does not mean that no effort should be made to collect claims involving small amounts if this can be done through minimal efforts and without undue expense. Some effort should always be extended to make recovery by mail, telephone or personal contact when warranted. Expense factors to be considered are:
  - Cost of investigation in both time and money.
  - Legal fees.
  - Suit expenses such as reimbursement for witnesses' testimony and so forth.
- ***Insurance***—An attempt should always be made to find out whether the wrongdoing third party carries insurance and if so with what company and to what extent.
- ***Identity of the third party***—It is essential to establish the exact identity of the wrongdoer and determine whether he is an agent or an individual, co-partnership, corporation or whatever.
- ***Financial responsibility***—If the individual or his principal did not have insurance, an investigation should be made, in cases that warrant it, to determine the extent of financial responsibility of both the individual and his principal. This can be done fairly easily through one of the companies that specialize in this sort of work. There is little point in spending time and money to obtain a worthless judgment.
- ***Potential antagonisms***—The claims person should check with the insured to determine whether there will be any business repercussions if an action is brought against the wrongdoer. In some instances, the insured's right may arise out of a manufacturer-wholesaler, manufacturer-retailer, or similar relation-ship, in which the goodwill of the

wrongdoer may be important to the insured in a business way. Although this should not be the determining factor in the final analysis, as far as the claims department is concerned, it is always good business practice to discuss such matters with the underwriting department so that they can have the opportunity to decide whether any possible recovery would be worth the antagonism that might be created.

- Retaliation—Give primary consideration to the possibility that prosecution of subrogation rights might provoke a retaliatory property damage or bodily injury claim.
- Liability—Even though other factors prove favorable to pressing a subrogation action, lack of liability on the part of the third party can of course defeat all other considerations. It is usually inadvisable to spend the time, effort and money to press a subrogation claim unless it is felt that the chances of success are at least 50-50 or better.

The ***right of subrogation*** arises normally through common law, but as we have previously stated, is reaffirmed in the policy provisions. Actually a subrogation receipt adds nothing to the subrogation clause already provided for in the policy. In the event that the claims person may encounter the unusual circumstances in which there is no subrogation provision in the policy, he would be wise to obtain a subrogation receipt. Such receipt may be worded as follows:

"Received from [insured] through [insurer] ____ Dollars in full satisfaction, compromise and discharge all claims for loss and expense sustained to property insured under Policy No. ____ by reason of [describe the accident] which occurred [date] and in consideration of which the undersigned hereby assigns and transfers to the said company each and all claims and demands against any person, persons, corporation or property arising from or connected with such loss or damage and the said company is subrogated in the place of and to the claims and demands of the undersigned against the said person, corporation or property in the premises to the extent of the amount above named."

"Knock for Knock Agreements"

Agreements whereby the insurer does not press subrogation rights against another insurer as a matter of reciprocity are prevalent in the British Commonwealth of Nations and are known as "Knock for Knock Agreements." Such agreements assume that in the long run, the subrogation rights which an insurer may have are equalized by the claims which might be made against it as a result of which both parties avoid the time and expense necessary to press subrogation rights against each other.

There are several kinds of "Knock for Knock Agreements" that operate in various parts of the world. Sometimes in the United States, the idea is sponsored by local claim associations of various kinds.

A claim executives' association in Wisconsin designed a subrogation agreement that would apply to insurers who had claims against each other. This agreement outlines some thirteen specific instances which illustrate applicability of subrogation rights and the percentages of recovery in each instance. The same agreement or others patterned after it were adopted by other claim organizations. The advantage of these agreements is obvious in that it not only avoids unnecessary time and expense of individual collections, but also avoids cluttering the courts with numerous property damage claims that are disposed of without the necessity of litigation.

One of the programs sponsored by the American Insurance Association is the Inter-Company Arbitration Agreement. The purposes of this agreement are to improve claims service, to afford

relief to the courts and to prevent litigation of disputes between member companies as much as possible, thereby enhancing the confidence of the public in the insurance industry.

The vast majority of inter-company cases can and are quickly resolved by arbitration. These comprise, for the most part, property damage claims, usually in relatively small amounts, that would otherwise tend to clog the court calendars unnecessarily. There is also arbitration machinery that avoids legal expense and tends to lessen misunderstandings and friction among companies in the insurance industry, in addition to other advantages previously mentioned.

Practically all motor vehicle policies today covering collision losses are written on a deductible basis. Ordinarily, an insurer has no right to represent an insured in pressing the insured's claim against the third party. As a practical matter, the deductible feature of the policy is usually the smallest part of the claim and is tied in with the subrogation claim of the insurer. The general practice is for both carriers to treat the claim as a unit and dispose of the insured's (as well as the insurer's) claims in any settlement negotiations.

Where recovery for the deductible amount has been made, the amount due to the insured is to be determined by the general practice followed in any particular locality. In some areas, legal fees involved in the recovery are apportioned. In others, the insured will receive a proportionate share in the settlement and, by agreement in some jurisdictions, the insured's deductible is paid first and the remainder kept by the insurance company. The amount involved is so small that there is no legal precedent to follow. It becomes a matter of business and public relationships in each particular area.

Ordinarily, any recoveries made by a carrier under a subrogation action would make the excess carrier whole first. Under a district court decision in New York, the court permitted first recovery by the primary insurer because the primary insurer had taken a loan receipt. The court stated that the position of the excess insurer is no better than that of the insured. The decision gave no weight to the "custom" in the insurance industry for the proceeds of a subrogation recovery to be applied first to the payment made by the excess underwriter.

Salvage

Property upon which the total value has been paid as a result of a claim under an insurance policy rightfully belongs to the insurer. Such property is commonly known as salvage. Properly handled, it can be an important source of revenue for an insurance company. Despite the fact that an article may be considered a total loss for settlement purposes, more often than not, the damaged article has some monetary value. It sometimes takes a little ingenuity to find a market for some articles, but it can ordinarily be done with the use of a little imagination and effort.

Salvage is a matter to be considered not only in the disposition of first party claims but in the settlement of third party claims as well. The claims person will often find that a claimant may be willing to settle a claim for a lesser amount if permitted to keep the article that the company is paying for. In such an event, it is usually more practical and economical to permit the claimant to retain the salvage if adequate deduction is being made for the value of the property in its damaged condition. Automobile salvage is a highly specialized field in which there is usually some buyer available whether the market be high or low at the time. It must become part of a claim person's routine to become acquainted with dealers in wrecked cars so that he or she can always obtain a number of competitive bids on automobile salvage.

If the salvage involves a large object like an automobile, make sure that it is protected from weather damage as well as from theft. It is, of course, important that the claims person arranges

for economical storage until such time as he can dispose of the article so that the eventual amount recovered will at least be more than the storage charges. For this reason, it is also advisable to dispose of salvage as soon as possible after having carefully explored the available market.

Handling Salvage Claims

The following summarization is an outline of steps to be considered in the handling of a claim involving salvage.

- Whenever you have paid for the total loss of an article, either obtain credit for it from the claimant or take it in salvage, assuming that it is available and has some value.
- Protect the salvage from theft, further deterioration and the elements.
- Arrange for storage at the lowest possible cost.
- Explore the market for all possible buyers.
- Dispose of the salvage as soon as possible. Retention increases depreciation as well as storage charges.
- Ordinarily, avoid selling salvage to coworkers or to yourself. You may both become dissatisfied customers and may in addition leave yourself open to unwarranted suspicion.

Contribution

Although the subject of contribution does not properly belong in the category of subrogation or salvage, proper attention to it can be an important item of possible financial gain to a company. This is reason enough to make some mention of it here. The good claims person should always be conscious of the possibility that someone else's responsibility for the payment of a loss may be equal to his company's or even greater than it. In many instances, the automobile and public liability policies may overlap—the claims person must be awake to the possibility of such a situation. For example, an insured's automobile may have been involved in an accident while on the premises of the insured.

Ordinarily (excluding the operation of guest statutes), a passenger involved in a two-vehicle accident has a right of action against the owner and driver of the car in which he was a passenger as well as the owner and driver of the opposing car. Sometimes two cars will collide and injure a pedestrian or damage property belonging to someone else. Occasionally, there will be two similar policies covering the same insured. There may be other instances, as well as these mentioned, in which it is advisable to check the possibility of contribution. This should be prominent in the thinking of the claims person during the investigation of any casualty claim.

OBTAINING THE MEDICAL INFORMATION FOR CLAIMS HANDLING

The first time a trainee copies a hospital report, he or she may come out of the experience quite bewildered. Five years later, the individual may be inclined to criticize the diagnosis and question the treatment.

The truth of the matter is that the average person can, with some diligent study, acquire a good working knowledge of medical terminology and enough of an understanding of the field in which

he is interested to discuss injuries, and even treatment, quite intelligently. Of course, the physician who has spent years of his or her life studying and practicing medicine knows more than the claims person about medical problems. Therefore, while he or she should learn as much as possible, the claims person should never try to replace the physician.

Medical and legal textbooks should be available to the claims person, and he or she should be able to discuss medical problems with a resident or examining physician, or with the home office. Even if the office out of which he or she is working maintains a resident physician on its staff, there is still need for the claims person to have a certain familiarity with injuries or diseases which may result from, or may become aggravated by, accidental injury. The individual must, in any event, be able to:

- ***Evaluate the injury***—This can be done only if he or she is able to understand the medical reports and appraise their significance. If he cannot evaluate the injury, he obviously cannot evaluate the claim and must therefore, depend entirely upon his supervisor to set a figure on its value.
- ***Help detect fraud or malingering***—Unless he or she has at least some fundamental knowledge of symptoms, causes, and effects, he or she will be completely unprepared to determine the appropriateness of a particular claim.
- ***Help determine whether proper treatment is being given***—This is especially important in compensation claims. Claim adjusters, quite obviously, are human. They do become emotionally involved in their claims. It is natural, therefore both from the humanitarian and business point of view, for the claims person to be anxious for the claimant to receive the best possible treatment, so that he can make the quickest possible recovery.
- ***Learn when to order a medical examination and by whom it should be made***—Ordering an examination shortly after a claimant has received a fracture and is still in a cast is not only useless, but is a complete waste of money if there does not appear to be a question about the genuineness of the injury or the honesty of the claim. On the other hand, if there is or may be an element of fraud or malingering, the claims person may find it advisable to assign a medical examination as soon as possible, or at least after enough time has passed so that any subjective complaints would have materialized.

The best time to obtain medical information and a written authorization from the claimant to procure medical information is when the claims person first interviews the claimant.

Authorization should be phrased in simple language, and should avoid legal terminology. The authorization should state that the bearer is authorized to receive a medical report on the accident from the doctor or hospital involved, and should be signed by the claimant. Enough copies should be given so that medical information can be obtained from each attending physician, hospital, clinic, or any other person or organization that rendered medical services.

Components of Medical Information

Medical information obtained from the claimant should preferably be incorporated in a signed statement obtained from him. Whether obtained orally or in writing, the information should include:

- Detailed description of all objectives (noticeable evidence of injury).
- Detailed account of any unconsciousness, giving exact duration.
- Complete list of subjective complaints (not accompanied by noticeable evidence of injury), when they first developed, and their duration.
- Assistance rendered at the scene of the accident.
- First aid rendered and by whom.

- Name of hospital or doctor to whom the claimant was taken immediately after the accident.
- Name and address of family physician who subsequently treated the claimant.
- Name and address of any specialists who were called in for consultation and treatment
- Dates of all visits to physicians, specialists, hospitals or clinics.
- Dates of visits made by doctors or specialists to the home of claimant.
- Dates of admission to and discharge from a hospital.
- Information concerning X-rays—taken by whom, when and what part of the body they covered.
- Details of operations or casts.
- Details of the nature of the treatment rendered.
- Exact duration of confinement to bed.
- Exact duration of confinement to the home.
- Exact length of disability from work.
- Exact nature of present complaints, if any.
- Description of any scars or disfigurements (include snapshots or photographs, if obtainable).
- Complete details of previous medical history:
    - Family history, including inherited tendencies or weaknesses and the history of family deaths that might have a connection with the present or future disability of the claimant.
    - b. Names and addresses of all doctors and hospitals that were involved in previous serious ailments that might have a connection with the present disability or which might have been aggravated by the accident.
    - Complete list of previous operations, with full details, including previous X-rays taken.
    - Details concerning any previous protracted treatments.
    - General observations regarding obesity, undue nervousness, unusual despair or other indications of a similar nature that may have a direct bearing on the injury, disability or recovery.
    - History of previous disease, such as cancer or heart condition, which may have been aggravated as a result of the accident.
    - History of previous ailments or diseases which might have left after-effects, such as scarlet fever, measles, and so on.
    - History of any previous diseases which might affect healing in any manner, such as tuberculosis, syphilis, gonorrhea, diabetes and so on.
    - Special emphasis on previous injury to eyes, ears or any part of the body that may have impaired complete function or contributed to the cause of the accident.
    - Previous dental history, if applicable.
    - History of all extensive previous physical examinations, such as for life insurance, armed forces, or induction to the armed forces, employment, or school examinations.

In reporting the medical information, some comment should be made concerning the competency, qualifications, and reputation of the claimant's attending physician or physicians. If these are unknown to the claims person, the qualifications of the attending doctors should be checked in the local medical directory or directory of medical specialists.

Lien Laws

Congress (Veteran's Hospitals) and a number of state legislatures have, by statute, given hospitals and doctors a means of legally protecting their bills for services rendered in connection with casualty claims by allowing them to file a lien. Such a lien requires the party on whom it is served to pay the medical bills out of any money paid in settlement of a third-party claim.

These statutes are known as lien laws. Where applicable, they require notice of lien to be given by hospitals or doctors to third parties alleged to be liable for the injuries received by the claimant. In some instances, notice is required to be given to the third party insurance carrier, if known. Sometimes the liens must be filed in the county clerk's office in order to become effective.

Failure to comply with the provisions of the lien law after notice obligates the third party or his insurance carrier to reimburse the hospital or doctor for the bills covered in the lien, regardless of any settlement which may have been made with the claimant. Accordingly, it is obviously important to note the existence of any lien and take whatever steps may be necessary to insure payment of the bill before settlement is consummated. This may be done by issuing a separate draft to the claimant and the doctor or hospital for the amount of the bill at the time of settlement, if it is still unpaid.

In many jurisdictions, recognition of the lien will permit the claims person to obtain medical information from a hospital. Usually, there are certain prescribed forms which must be completed before the information will be released. The filing of a lien can sometimes be used to advantage when all other avenues for obtaining medical information have previously failed.

Getting Medical Information

One of the most important steps in the investigation of bodily injury claims is the problem of obtaining complete medical information from the claimant's attending physician as soon as possible. Most companies provide some sort of printed form for obtaining this information. We will shortly discuss some of the items of information that should be contained in a physicians' report. No definite rules can be established concerning the advisability of using such form, or the manner in which it is to be used. This will depend entirely on the claims person's knowledge of the attending physician. He should get to know his local physicians and their secretaries as soon as possible. The latter are often the guardians of the physician's time and records.

In some cases, a mailed request enclosing the form with a stamped, addressed envelope will suffice. In others, it may be necessary to call the physician on the telephone before sending such a form. Sometimes, especially where the injury is severe, the claims person should see the doctor personally. In such instances, there is no substitute for a personal interview.

If it is believed that the reaction to the request will be favorable, the claims person should arrange by telephone for a personal interview at the physician's convenience. In other instances, it may be advisable to call on a doctor during his office hours and wait until he has finished with his last patient. In no event should an attempt be made to interview a doctor while a patient is waiting to see him, unless the doctor invites the interview. Even if the doctor refuses written information, he may provide some verbal information that could be valuable. When a definite appointment has been made, a claims person should be absolutely sure that the appointment is kept promptly, and should never keep a doctor waiting. If at all possible, a medical report form should be completed during the interview. If the doctor is pressed for time he may request that the form be left with a stamped, addressed envelope to be forwarded at his earliest convenience.

Prompt medical information obtained from the claimant's attending physician will help to determine the need for a physical examination, and give the claims person an opportunity to prepare the case properly for defense, if necessary. If the attending physician's qualifications and integrity are unquestionable, settlement can often be effected based on his information without the delay and expense of a physical examination. It is equally important to obtain the

attending doctor's report where a physical examination is needed, so that the examining physician may have the benefit of the medical allegations before making his examination.

Most casualty claim departments have some printed or copied medical report form to be completed by attending doctors. In many instances these are so detailed that they discourage a busy doctor. He may either ignore them completely or fill them out in a sketchy manner. In other instances, forms have been so whittled down that they lose much of their potential value.

Components of Effective Medical Forms

To be most effective, the form should contain at least the following categories:

- Personal and descriptive data—This should include notation of the date, time, and place where the initial examination was made. It should also include at least the name, address, marital status, age, weight, height and occupation of the claimant.
- History of the accident—Whether or not detailed questions concerning the time, place, location and other factual details of the accident itself should be printed on the form is a matter of judgment. Suffice it to say that some provision must be made for the history or factual details concerning the accident.
- Previous medical history—Here the details included in the form may vary. For a checklist of the information that can be obtained under this category, see the list provided under "Medical Information to Be Obtained From the Claimant," discussed previously.
- Details concerning the initial examination—This includes any X-rays or laboratory test reports, and consultant's reports.
- Treatments rendered—This includes the type and the dates of all office and home visits.
- Diagnosis—This should include a detailed account of the doctor's findings concerning ailments and disability, with special emphasis on trauma.
- Prognosis—This concerns the estimated disability and possibility or probability of partial or ultimate recovery with emphasis on a possible partial or permanent disability.
- Conclusion and recommendations—Here the doctor should comment on recommendations concerning future treatments, operations, or further hospitalization, as well as any other details that affect the medical picture.
- Diagrams—Diagrams of various parts of the body are usually imprinted on the opposite side of the medical form to enable the doctor to show scars or indicate the location of fractures, burns, or other injuries.
- Doctor's bill—Provision should always be made for the doctor to show the amount of his bill up to the time the report is made, with provision for estimated future medical expense.

Dental History

In all cases involving injury to teeth, a claims person should obtain as complete a dental history as possible, including the general condition of the subject's teeth immediately before the accident, an account of any diseases of the mouth, details concerning bridge work or plates, pivots or caps, and any other information that might have a bearing on the injury allegedly sustained as a result of the accident under investigation. For instance, it is not unusual to find that teeth which may have been knocked out as a result of an accident were in advanced stages of decay.

Components of Hospital Records

In investigating serious accidents, a claims person should make a transcript of the complete hospital record. He should not be content with an abstract of the hospital records merely because the abstract will save him the bother of copying the record. This copying is admittedly a time-consuming and tedious chore, but it pays off often enough to make it worthwhile. An abstract is ordinarily only a very brief digest of the information contained in the record. If a case is important enough to warrant such an examination, every paper in the hospital records should be carefully scrutinized. The records will usually contain:

- ***Admission information***—Beside the ordinary information about the date of admission and the history of the accident as given by the patient, there may be welfare board reports concerning the financial background of the claimant, policy reports, an itemized list of the clothes and possessions of the claimant at the time of admission, condition of the clothes, and other extremely valuable information. The history of the accident as given by a claimant to a hospital attendant immediately after an accident can be of extreme importance if the claimant seems inclined to change his story later.
- ***Examination reports***—These are reports by attending physicians and interns, X-ray reports, notes and instructions by interns and doctors, details concerning treatment, pathologists' and laboratory reports.
- ***Nurses' notes***—Such notes, made for the benefit of the attending doctors and interns, contain comments that are often pertinent concerning a patient's attitude and morale and will also indicate what drugs have been administered.
- ***Diagnoses and prognoses***—These must be gathered from the various attending physicians and specialists, along with the date and circumstances under which the patient left the hospital. A nurse, whether in attendance in a hospital, nursing home, or private home, spends much more time with a patient than a doctor, and sees the patient under conditions that tend to be more personal and informal than the standard doctor-patient relationship. Not only does the nurse see the patient in unguarded moments, but also learns much more about the personality and character of the injured. She is the one who hears all of his subjective complaints, can observe his attitude and is the best judge as to whether or not the patient is exaggerating his injuries, consciously or otherwise. Accordingly, an alert investigator should not miss the opportunity to obtain information from this source.

Objectives of the Medical Examination

A proper medical examination can be an important source of information. It is also a valuable defense weapon but it should not be ordered indiscriminately. Consideration should be given to the ultimate objectives which are to:

- Help to determine if the allegations of disability are true and to corroborate the injuries sustained.
- Help to determine if the alleged injuries or disability resulted from the accident.
- Help to determine the true extent of any disability.
- Help to determine if the claimant is receiving proper, sufficient or too much treatment.
- Obtain the history of the accident as given to the examining physician or corroborate any conflict with the previous information he gave to the hospital or other doctors.

If the object of the examination is merely to corroborate information, then the hospital records, the reputation of the claimant's attending physician and the information he gives may be sufficient. However, in order to avoid second-guessing, where there is no allegation of further injury or disability, an attempt should be made to obtain a signed statement or report from the doctor.

Medical examinations should never be assigned routinely as a matter of course. It is a costly measure at best. When deciding on the advisability of a physical examination, the claims person should obtain as much medical information as he can from the attending physician, hospital records or other sources. Otherwise, the examining doctor may be concentrating on the effect of a fracture and completely miss a subsequent allegation of neurosis. The claims person must never forget that a medical examination can be a double-edged sword. Made by the wrong doctor at the wrong time, or without sufficient preparation, it can do more harm than good. Obviously, the doctor will be able to make a much more thorough examination, and one of greater value, if he is familiar at the outset with all the allegations and complaints.

Local custom and statutes vary with reference to the obtaining of physical examinations. When a case goes into suit, at least one physical examination is ordinarily permitted by law. However, in view of the fact that both the claimant and any attorney which he may have engaged are ordinarily anxious to obtain a settlement, they will in most instances cooperate to the extent of permitting at least one examination even when the case is not in suit. Since this may be the only examination that is permitted, the claims person must be intelligent about its use.

He or she must make the best use of the examination that is permitted. Except in the unusual or long disability case, it would be difficult to justify more than one examination. Reluctance on the part of either the claimant or his attorney to permit a medical examination is usually an indication that some attempt at exaggerating the injuries or the disability may be made. As has been said before, judgment must be used in determining when a physical examination should be made. If there is no question of fraud or malingering, or the propriety or necessity for further treatment, an examination should be delayed until the maximum healing has taken place.

Otherwise, a physical examination should be obtained as soon as enough time has elapsed to develop any subjective complaints that might be alleged in the future.

The physician making the examination should be properly qualified, impartial, honest, and should make a good impression as a witness. If the allegations require the services of a specialist, get a specialist to make an examination. Barring unusual circumstances, a jury will not give as much credence to a general practitioner as it will to a specialist. This can cause disaster if the specialist is testifying for the opposition. The claims person should not use doctors who may be even unconsciously biased in his favor. He should make arrangements with a physician who is thorough and competent, but not too busy to make a proper examination and give a proper report.

It is also important to remember the examining physician may have to testify at trial. Because some specialists rate their services quite highly, you should accordingly have an understanding with the doctor concerning costs before engaging his or her services. When the claims person has decided on a doctor, he or she should be given all the information available before the examination takes place. Under no circumstances should an examining physician advise the claimant about treatment, or suggest a course of treatment to him. Under rare circumstances, the attending physician may wish to consult with the doctor who made an examination for the company, but even here the situation must be handled with the greatest tact and diplomacy to avoid putting the company in a position where it may be accused of practicing medicine.

Finally, the claims person should make sure that the examining doctor's report is intelligible and that he or she thoroughly understands it. If not, it is important to discuss it with the doctor until all questionable points are cleared up.

The claims person, in making an assignment to a physician for a medical examination, or the claimant's physician, in evaluation, should know how to interpret information obtained from the

American Medical Directory, or from other medical directories published in this country or abroad. Such directories give information concerning the school or university from which a doctor graduated; the year of graduation; any specialties which he practices; any fellowships or special degrees or honors; any medical societies to which he belongs; his staff and hospital associations and other such valuable information that can help to determine a doctor's experience, education and competence.

However, it is important to remember that such background information, while exceedingly important, is not the complete picture. There are many general practitioners who are extremely competent medical practitioners, despite their lack of a specialty or higher degree, and despite the fact that they may not have graduated from a prestigious university or medical college.

Specialties

The development of medicine is marked by an ever-growing list of specialties to which practicing physicians more and more confine themselves. In fact, general practice is itself becoming a specialty. In rural areas, a country doctor must be a good practitioner who has some familiarity with all types of medicine, including surgery. In highly-populated cities, more and more medical professionals continue their studies along very specialized lines. With the growth of large clinics and medical centers, specialization is now commonplace.

In order to be able to determine the particular specialist to whom the claims person may wish to assign a physical examination, he or she should have at least some familiarity with the more common specialties which are being practiced today. These are as follows:

- Allergy—Deals with the unusual susceptibility of a person to a substance or substances usually harmless in similar amounts for the average person.
- Anesthesiology—The study of anesthesia and anesthetics.
- Bacteriology—The science that represents the study of bacteria and other microscopic organisms. Examining physicians usually refer their specimens to bacteriologists for bacteriological tests.
- Cardiology—The study of the heart and its functions.
- Clinical Pathology—A branch of medicine pertaining to or founded on actual treatment or observation of patients.
- Dermatology—The study of the skin and skin diseases.
- Gastroenterology—The study of the stomach and intestines and their diseases.
- Gynecology—Deals with female ailments, especially those of the genital, urinary and rectal areas.
- Internal medicine—Deals with the diagnosis of ailments within the body and covers an area encompassed by many specialized fields. An internal medicine specialist was formerly referred to as a diagnostician.
- Laryngology—Specializes in ailments of the throat, larynx and associated organs.
- Neurology—Deals with the nervous system and its disorders.
- Obstetrics—Deals with childbirth and the management of pregnancy and labor.
- Ophthalmology—Concerns the eye and its diseases and disorders.
- Otology—Deals with the ear and its diseases and disorders.
- Pathology—Studies the essential nature of disease and concerns itself especially with the structural and functional changes which cause or are caused by disease.
- Pediatrics—Concerns child development, and children's diseases and their treatment.
- Proctology—Deals with ailments of the rectum.
- Psychiatry—Specializes in the mind and its disorders.

- Internal medicine deals mainly with the use of X-rays in the treatment of disease.
- a) True b) False
- Radiology—Concerns the use of X-ray in the diagnosis and treatment of disease.
- Rhinology—Studies the nose and its diseases.
- Roentgenology—Deals with the use of X-ray, both in diagnosis and treatment.
- Urology—Specializes in disorders of the urinary tract and male reproductive organs.
- Surgery—Specializes in operative procedures. Three fields of surgery with which the claims person will most often come in contact are:
  - Neurological surgery—surgery which is confined to the nervous system, especially the spinal cord and the brain itself.
  - Orthopedic surgery—concerns itself with the preservation and restoration of the skeletal and muscular systems and is the branch with which we most often come in contact in dealing with fractures.
  - Plastic surgery—deals with the restoration and the building up of tissues as they affect the general appearance of an individual. The claims person will most often come in contact with this branch of medicine in dealing with permanent and disfiguring scars as a result of injury.

Veterans' Records

While some selective service records are privileged, the part of the record concerning physical disability and injury can usually be obtained without undue difficulty. This information usually contains a complete medical history and a record of any injuries, ailments, or treatments while in the service, particularly where there may have been any disability resulting in a pension. These records are most important where there is any allegation of neurological or psychiatric complications and can, if necessary, be subpoenaed in an action in federal court. In state courts, the power of subpoena with reference to such records is at the discretion of the judge.

Veteran records concerning disability are ordinarily very comprehensive and include among other items:

- Name, age and other personal data.
- Military record.
- A complete chronological medical history, including examination of admission, treatments and examination on discharge.
- A history of all accidents or injuries.
- Medical history.
- Nurses' notes, doctors' progress notes and doctors' orders.
- Laboratory tests, X-rays, electrocardiograms, etc.
- Clinical notes and outpatient records.
- Consultation records.
- Report of the Board of Medical Service.

CLAIMS MANAGEMENT

Whenever there is a general downturn in business, companies are forced to look at other ways to reduce costs. Since premium increases are slow to occur and difficult to implement, there is an emphasis placed on squeezing more profits from existing business. One way is to improve the efficiency in managing claims. Other ways include recognizing and correcting reasons that insurance fails to insure and minimizing conflicts between clients, agents and insurers.

10 HABITS FOR RESPONSIBLE CLAIM MANAGEMENT

1st Habit: Don't be a hero. This advice relates to the futile attempt on the part of a claims adjuster or claims counsel to attempt to economize on a case where the gravity of the injuries and damages of the claimant are so severe in relation to policy limits that it is an obviously futile exercise to attempt to "save" part of those policy limits. It also applies where a company has given authorization for settlement up to a certain amount, and the adjuster or defense counsel unwisely attempts to save a few dollars from the amount authorized when the authorized amount appears to be an appropriate settlement.

It is a particularly dangerous practice to attempt to save the company a few dollars when the company has advised the adjuster or insurance counsel to pay the amount stipulated. Counsel for the defense who disobeys the instruction does so at his or her own peril. In one 1977 Illinois case, the appellate court held that an insurance company could bring a malpractice action against the defense which ultimately resulted in the insurance company's exposure for excess liability over the policy limits.

2nd Habit: Listen to the advice of defense counsel. The danger is particularly severe, since the claims files on bad faith matters are subject to discovery by the plaintiff's attorney. Thus, if the claims file is replete with letters saying, "This is a bad one," "You better look out," "Pay this," and "This one could go over the policy," an insurer's failure to heed such warnings could result in a powerful claim of bad faith.

3rd Habit: Keep the insured client advised. Relating to the Second Commandment, if claims personnel have received advice regarding the possible outcome or the amount of liability involved, there is an absolute obligation to inform the insured. Courts have spelled out this duty:

A duty is imposed on the company to communicate to the insured the results of any investigation indicating liability in excess of the policy limits and any offers of settlements which have been made, so that he may take proper steps to protect his or her own interest.

The *ad damum* excess letter, sent by the insurance company, advises the insured that there is a good possibility that the claim of the plaintiff and a subsequent judgment may exceed the policy limits. The letter advises insureds that they have the right to secure independent counsel at their own expense to represent them for any such excess liability.

The *ad damum* letter is routinely used by many companies, particularly where it appears there is any possibility whatsoever that the amount in controversy may exceed the policy limits. It is probably prudent conduct on the part of an insurer to send out such a letter routinely in cases of serious personal injuries where insureds have only standard liability limits under their policies.

It is also safe to say that the insurer is obligated to respond accurately to requests from its insured with reference to the progress of any settlement negotiation. This point was spelled out in a 1976 New York case where an insured, while being interviewed by a representative of the insurer, inquired as to demands and offers. The claims representative declined to disclose this information on the grounds that it was "against company policy." An excess judgment was awarded the plaintiffs, and the insurer argued that the tender of the full policy limits on the eve of trial automatically insulated it from any liability for bad faith failure to settle within the policy limits. The court rejected this viewpoint and further stated: "We are of the view ... that the carrier is obliged in most circumstances to respond accurately to requests from the insured with reference to the progress of any settlement negotiations." The court further ruled that the insurance adjuster's refusal, on the grounds of company policy, in response to the insured's direct inquiry to disclose "how much was being asked and how much was being offered" was relevant on the issue of bad faith.

4th Habit: Do not deplete the policy carelessly when there are multiple claims. An insurer that wishers to pay policy limits but is confronted with multiple claims is in a dilemma. If it settles some claims but others go to judgment which cannot be satisfied by an exhausted policy, the company may be liable for bad faith.

When an insurer is confronted with multiple claims and is concerned that the policy limits will be inadequate to cover all of the claims, the law usually allows interpleader. When several claimants claim the same fund, and the insurer is uncertain which of the claimants has a right to the fund, the insurer runs the risk that, if some claimants are paid and others are not, it may subsequently incur bad faith liability. Thus, the insurer may file an "interpleader" suit, which requires the claimants to litigate their right to the fund in question. Remember, however, in matters involving insureds, there is always the duty to defend an insured, and an insurer cannot dismiss itself from the claims situation by use of the interpleader device.

5th Habitt: Investigate properly. Since bad faith law may evolve toward imposing liability upon insurers for ordinary negligence, it is clear that the failure to do a good job in investigating the insured's liability obviously exposes an insurer to liability for ordinary negligence.

The cause of action may arise out of mere negligence or out of a simple case of breach of contract—the breach of the implied covenant of good faith that the insurer will act in a manner that does not impair the legal rights of the insured. The insurer may be in trouble if there is an inadequate investigation conducted of the insured's liability.

6th Habit: Explore the possibility of settlement. At one time an insurer could sit back, relax and have no duty to initiate settlement discussion. Prior to modern discovery rules, the plaintiff's attorney usually did not know the policy limits, and it was a cardinal rule that insurers did not volunteer this information in most cases. Consequently, the plaintiff's counsel usually had insufficient information upon which to base a settlement demand.

7th Habit: Think bad faith. The possibility of a bad faith action must be considered in all cases. However, it is particularly important in cases where there is a policy with inadequate limits.

In every step of the claims investigation and settlement negotiations, the agent must maintain the highest level of professional conduct, communicating constantly with the insured client,

making certain that the investigation is a model of completeness and demonstrated diligence, and that all settlement negotiations are conducted with diligence and intelligence.

Of particular importance is the need for the adjuster/insurance agent to respond immediately and with diligence to communications by the plaintiff's attorney. If settlement offers are made within policy limits, the insurer must be diligent in evaluating the demands.

Even then the claims adjuster must think bad faith. There are other factors to consider besides the matter of damages. An adjuster may have made a well-informed evaluation of damages. However, one must also evaluate what may happen if the case goes to trial. One should consider thoroughly the question of liability. Even the best legal experts on the law can conclude that a case is a no-liability situation. However, once the case goes before a jury, juries begin to think of factors other than liability.

8th Habit: Consider a client's demands and not take all eternity. Waiting for settlements of cases until "reaching the courthouse steps" is no longer advisable. A number of court decisions have expressed impatience at such dilatory tactics, ruling that an insurer violates its fiduciary responsibility in attempting to resolve the case in a more timely manner.

The Unfair Claims Settlement Practices Statute, which most states have in existence today, provides that: "Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear" is prohibited. Of course, this provision relates to cases in which liability has become reasonably clear. If we are dealing in cases of disputed liability, one might argue that delay and dilatory tactics are a valid, legitimate defense tactic.

This duty of timeliness certainly is valid in cases involving clear-cut liability. In cases where claims adjusters and insurance counsel have concluded that there is doubtful or disputed liability, it seems to be an unfair requirement to deny the insurer the right to use defensive tactics of delay and procrastination. The insurer can avoid the appearance of delay and procrastination if it maintains a continuing dialogue with the insured, attempting to settle the claim commensurate with the liability exposure perceived by insurance counsel. Essentially the duty is one of communication. It does not mandate that claims must be paid merely because they are presented.

9th Habit: Don't induce the insured to contribute. Years ago, some insurance companies would seek a contribution from the insured before the insurer would deplete its policy. This is clearly not tolerated today, and courts have ruled that exhorting the insured to contribute something was in itself "suggestive of bad faith."

10th Habit: Consider the insured's interest. This is the greatest of the commandments since it embraces all of the others. "The law imposes upon the insurer the obligation of good faith—basically the duty to consider, in good faith, the insured's interests as well as its own when making decisions as to settlements."

MANAGING CLAIMS BETTER

Let's examine some of the methods that are emerging to shape the future of claim management:

Cost reduction through automation-- The ability to automate, increase productivity and improve workflow management in claim processing represents a major opportunity to reduce costs. Companies who work to automate processes and tasks traditionally performed by skilled labor will set new productivity standards that competitors will need to adopt to remain in the market.

Identification of exceptional claims-- Companies are under more pressure than ever to be more efficient in identifying "exceptional claims" that can be managed better by a skilled adjuster. Finding these claims early so they can be appropriately manages will help prevent losses and identify additional coverages. Examples might include claims with a high probability for subrogation, those need specific reserve limits as well as the ones that represent potential large losses or litigation that can be mitigated early on.

Detection of economic induced fraud-- When the economy is out of sorts, a growing number of out-of-work people turn to opportunistic fraud to replace lost wages. Scams include phony workers' comp claims, auto accidents and staged personal property burglaries. Business are also part of the mix where losses are orchestrated to create insurance windfalls. Uncovering the trends and indicators for this fraud is no small task. Central databases are essential, yet privacy issues create specific and limiting obstacles.

Electronic and web claims processing-- While the paperless claim is not quite here, a growing number of them are being processed electronically over the Internet with great results in efficiency. This is reducing the processing cycle from days and weeks to hours and minutes. This is more important in cases where large case exposure or large sums of money are involved. The same electronic processing may also reduce the prospect of multiple submissions where claims involving fraud are copied from one jurisdiction to another or where requested coverage is made for insured property that doesn't even exist or it is allegedly stolen.

Improvement in insurer "legacy" computers -- The industry is woefully behind the rest of the business community with aging hardware. Most systems are easily a decade old and replacement is too big an expense at this time. The answer lies in new "component" systems that can add "intelligence" to older systems without the cost to replace. Enhanced components will help automate claim management decisions and workflow tools resulting in reduced cycle time, better claim decisions and more!

A more automated claims process will not only improve quality to the claims management process, it will add consistency and improved adjuster conditions. Currently, the adjuster workforce is said to be aging and many skilled workers are retiring with few replacements. Cost-cutting measures, at the same time, have reduced training and mentoring programs resulting in newer workers having less access and resources. In addition, many are overworked. All of which creates a need for new ways to automate.

Clients need for privacy is a priority-- Privacy issues and potential invasion suits create a high level need to develop security and systems measures to protect personal and financial data collected in the claims process. This is especially acute when one considers that the sharing of claims information is important to the claims management.

CLAIM RESPONSE

Many times, a claim that ends up in appraisal or litigation is found to have the root of its problems traced to the early stages of the claim. In fact, many claim experts feel that the ***first***

48 hours following a loss are unique. This is the time when losses can be minimized and excess claims and client dissatisfaction avoided.

One of the key elements in the early phases of a claim is ***preserving the evidence***. Since recovery by subrogation is the standard in many cases, the carrier's success is dependent on his ability to pinpoint a defective product or negligent action to demonstrate its connection to the loss. Evidence that "clears the air" in a disagreement is also essential. However, in the chaos of a loss site, it is all too easy for well-intentioned individuals to compromise or destroy evidence that would have made the recovery possible.

For example, after a fire that originated around a recently installed furnace, the same heating and air company was invited by the homeowners to replace it. The failed equipment or workmanship, in this case, conveniently disappeared. It is true that in most suspected arson cases, fire authorities secure the area with barriers and tape. However, evidence can often be found beyond the secured area and may be unrecoverable where a premature demolition or clean-up has occurred.

Documenting the loss site in the earliest cycle of the loss is essential. For instance, the claim of heavy smoke damage was disputed by an adjuster who visited the scene. Unfortunately, since he did not document what he saw with photographs, his testimony at arbitration was discounted. Other times, an early photograph revealed that lost inventory claims were only a fraction of that shown.

The ***reduction of further building damage*** is another reason to proceed quickly after a loss. Activities like weather protection, restoration of heating and cooling, removing water and saturated materials, protecting floors and rapid drying as soon as possible can eliminate costly replacement later. Adequate shoring and bracing can save masonry walls from collapse and aggressive drying can save floors and electrical systems that would otherwise be lost. Site security may also be an issue. When alarm systems have been disabled by damage or loss of power, restoring them to service should be a high priority. Chemical and biological hazards pose an equal threat.

Minimizing personal property loss is yet another motivation to act early in the loss cycle. Retrieving or protecting data processing equipment, which can be the lifeblood of a business, should be a high priority. Exposure to a smoke-filled building, for instance, can generate corrosion in electronic circuits and chips in as little as 36 hours. The process is accelerated when the high humidity of fire hoses is added to the mix. What can be done? Special services are available to retrieve data, tent equipment, dehumidify rooms, "scrub the air" and equipment cleaning on short notice.

In the same vein, some companies have major investments in equipment like printing presses, office machines, processing equipment, milling machines and other high-tech production devices. They are all vulnerable to exposure to moisture, smoke, corrosion and mold. Packaged inventories are similarly affected. Airborne moisture can penetrate wrapping and cardboard storage boxes causing penetration, bowing, collapse and mold growth. However, aggressive treatment in the first 48 hours can avoid costly replacement.

Adequate working environments after a loss are yet another goal to achieve as early as possible. Emergency cleaning and deodorizing of offices, furnishings and equipment can help minimize loss of revenue and jobs.

The role of the professional adjuster in the early stages of a loss is to inspire realistic expectations by explaining provisions and procedures in the claim process. A time line must be

developed for the resolution of the claim and cooperation by the insured encouraged so that his personal preferences can be accommodated. Unfortunately, most insureds are conditioned otherwise since many automatically conclude that their best interests will not be represented by the insurer. However, an adjuster who addresses problems of the loss early, with a sense of urgency, will help build confidence and mitigate the chances of further damage or claim.

FAILING COVERAGE

A portion of some claims go from "bad to worse". In some cases the source can be an agent's negligence in providing full coverage or it can involve deeper issues such as inadequate or defective protection, coverage disputes, or the clear inability to pay, e.g. insolvency of the insurer. In any instance, the result is bound to disappoint a client and cause potentially harmful exposure to personal assets as well as liability for the insurer and agent. This is definitely an area to manage.

What goes wrong?

Coverage Shortfalls

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

Sometimes, insurance shortfalls cannot be helped. After all, nothing in life is guaranteed to work out right every time, and unexpected, freakish accidents and events can occur without warning. Unfortunately, there are also instances where the coverage provided by an agent was significantly less than needed and the agent paid the difference **(Insurance Company of North America vs J.L. Hubbard - 1975)**. Then too, there are times when the coverage purchased or sold to a client exceeded what was needed in one type of insurance at the expense of another insurance coverage being under funded and under covered, e.g., a high premium whole life policy leaves no monthly budget for health insurance, or an auto policy with low deductibles is chosen or sold instead of a higher deductible policy permitting the additional purchase of umbrella coverage. Where clients depend on an agent for multiple lines of insurance or simply because it's right to do so, agents need to consider the balancing of coverage to avoid critical shortfalls.

Coverage Disputes

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

One form of coverage dispute results when the agent fails to secure the promised coverage **(Bell vs. O'Leary - 1984)**. The courts have found that when an insurance broker agrees to obtain insurance for a client, with a view to earning a commission, the broker becomes the client's agent and owes a duty to the client to act with reasonable care, skill and diligence. As seen earlier, agents have been sued for neglecting to secure the requested coverage, failure to notify the client that the insurance is not available, failure to forward premiums on policies which then lapsed, unintentionally omitting a specific type of coverage, providing unsuitable coverage, failure to properly bind the client and much more!

A more common form of dispute occurs when the insured and the insurance company simply do not agree on the interpretation of coverage provided. In practice, insurance coverage cases can be extremely complex. It is not unusual for these cases to involve numerous parties on both sides of the litigation. And, since policyholders usually buy insurance in many layers of coverage, i.e., life, health, casualty, excess, umbrella, from many different insurance companies over many years, the number of companies brought into one insurance coverage case can be quite large. Coverage cases are also being consolidated by the courts where numerous policy holders and insurance companies have been found to be litigating coverage for the same underlying claims or addressing the same coverage issues. In one instance, a group of independent environmental coverage actions were ordered to collectively resolve many common contract issues and cooperate in case management and discovery procedures simply because they were similar.

Legal Maneuvers -- Attorneys at Work

Where coverage disagreements persist beyond an initial settlement, policy holders or their attorneys must begin the tedious task of processing documents and information relating to the insurance companies' interpretations and meanings of their policies. This often leads to a ***drafting history***. The drafting history contains detailed records of the insurance industry's deliberations regarding policies and seeks the original meaning of policy terms and the manner in which they were intended to apply. Courts have founds such histories to be relevant and material, as well as filings made by insurance industry organizations on behalf of their members to state insurance departments and insurance regulatory agencies.

Policy holders and their attorneys also seek ***underwriting and claims handling manuals*** written by insurance company experts that are used to provide guidance to insurance company employees. These manuals may demonstrate how the insurance company interpreted their policies. In addition, they may contain the company's official position on coverage, claims and loss control. Many courts have ordered the production of such manuals and guidelines in the early stages of coverage cases.

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

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

Agent Records

A dispute between you and a client or you and an insurance company may require that you produce certain records and evidence. In your own defense, you can typically produce any file, note or electronic record (fax, e-mail, computer record) as long as it is something generated in ***the ordinary course of business***. In other words, if you use as operations manual or stick "post-it" notes in you client files as ***standard operating procedure*** they are generally admissible. The test will be: Do you use these methods for ***every*** client**?** An example might be a standard checklist of coverages that you review with each client. If you can show that the client was offered, but refused a particular coverage on your checklist, it will be harder for clients to say they were unaware this coverage was available.

Keep in mind that most parties to a claim will eventually gain equal access to your records. So, you want to keep all legally required records and be consistent from file to file. Also, never write derogatory comments about clients or the company in files. This could work against you in a trial or settlement.

Agent Cooperation

The *Managing Conflict* section discusses several issues regarding defense of an insurance claim. A few of the more important items focus on agent cooperation. In a nutshell, most suits settle before going to trial so cooperation on all sides is generally desired. However, you should proceed with caution in any dispute or potential claim. Check with your errors and omissions carrier before discussing matters with clients or your represented companies. Don't try to settle the case, it could void your E&O policy. Don't make any promises to clients about resolving the matter or give them legal advice of any kind. Don't ever try to cover-up mistakes -- it mostly backfires. If your errors and omissions carrier wants to settle it is usually best to agree. If you don't, you could be liable for court judgements that exceed the settlement already proposed by your E&O carrier.

Insurance Litigation

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

Triggers of Coverage

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

In a *life policy*, the trigger seems clear: death. However, issues of whether the death was an accident or suicide within the incontestable period is often up for debate. *Disability and health policies*, however, have a higher propensity for dispute: What is a permanent disability? Are there waivers and if so, how long? What is a major illness? Has the deductible been met? Are there additional policy exclusions? In *long term care policies*, trigger of coverage is even more acute where a written declaration by a physician may be required to solidify a patient's inability to care for himself: the prerequisite for insurance benefits.

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

the insured..." Third, "bodily injury" is defined as "bodily injury, sickness or disease sustained by any person which occurs during the policy period", and "property damage" is defined as "injury to property which occurs during the policy period...".

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

Most of the litigation concerning coverage for latent injuries have raised at least four different explanations of when damage "occurs" and thus "triggers" coverage. 1) The date of exposure to the toxic substance *(the "exposure" theory)*; 2) the years in which the claimant incurred tangible injury *("injury in fact" theory)*; 3) the date of manifestation of injury *(the "manifestation" theory)* and 4) the year in which damage "occurs" or "could have occurred *(the "continuous trigger" theory)*. The "continuous trigger" theory has received considerable attention during the past twenty years surrounding property damage or bodily injury due to hazardous waste/environmental contamination. In essence, the courts have generally ruled that casualty insurance policies can be "triggered continuously" from the initial exposure to the contamination to the manifestation of any injury, disease or damage of property. By far, most policy holder attorneys adopt a "continuous trigger" approach to litigation. Insurance companies continue to argue, sometimes to no avail, that insurance policies cover an "occurrence" and NOT A "REOCCURRENCE".

Definitions

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

Bodily Injury - bodily injury, sickness or disease sustained by a person, including death resulting from any of these at any time.

Property Damage - physical injury to or destruction of tangible property which occurs during the policy period. Loss of use of tangible property which has not been physically injured or destroyed, provided such loss of use is caused by an occurrence during the policy period.

Occurrence - an accident, including continuous or repeated exposure to conditions, which results in bodily injury or property damage neither expected nor intended from the standpoint of the insured.

Conditions

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

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

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

Exclusions

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

Named Insured

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

Assignments

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

Rules of Construction

The rules governing the construction of insurance contracts are usually the same as those for other contracts -- the policy language is to be interpreted given its plain and ordinary meaning. If a court determines that an ambiguity exists in an insurance policy, it will look to any outside factors or evidence that may help determine the parties' intentions. Where an ambiguity is not capable of resolution, most courts have construed the ambiguity in favor of the insured. Other courts have applied a "reasonable expectations" test and construed ambiguous policy language based on what a reasonable person in the position of the insured would understand the language to mean.

Duty to Defend

The prevalent view by the courts is that an insurer has the duty to defend an insured where the policy language gives the insured a reasonable expectation that the insurer will provide a defense. Standard policies employ language reading: “the company shall have the right and duty to defend any suit against the insured seeking damages on the account of bodily injury or property damage even if the allegations of the suit are groundless, false, or fraudulent”. Insurers maintain the position that they may be contractually bound to defend, but may NOT be bound to pay, either because its insured is not factually or legally liable or because the occurrence is later proven to be outside the policy's coverage.

Coverage disputes are likely to develop and do, when an insurance company attempts to shield itself from any defense of an insured whatsoever, or when it withdraws from an action after it determines there is no basis for recovery. Other conflicts center around whether an insurer must defend only against an action that is a actual lawsuit seeking damages or be required to defend against all claims which may result in liability. In general, courts assume a connection between the filing of a complaint and the triggering of a duty to defend by an insurer. A ***PRP letter (Potentially Responsible Party)***, received by a client although not an actual claim, has also been interpreted by the courts to be a serious event that could, in fact, represent a new legal action against the insured. The duty to defend is typically established here, but not in the case of a simple *demand letter* which only exposes one to a potential threat of future litigation.

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

Breach of Contract / Refusal of Coverage

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

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

Bad Faith

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

Choice of Law / Venue

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

Lost Policies

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

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

Coverage disputes also evolve around the nature of damages or hidden exposures such as:

Environmental Litigation

There are numerous actions pending in state and federal court concerning the interpretation of commercial liability policies and environmental claims. Much of the confusion was started by the insurance companies themselves when they first marketed the 1966 standard form ***Comprehensive General Liability (C.G.L.)*** policy which represented coverage for environmental hazards. Some companies went so far as to refer to environmental problems, in their sales literature and presentations, as a "hidden exposure" that policy holders should consider. Agents were instructed to sell the new policy on the basis of its broadened coverage in the area of pollution which was then only a growing, but minor exposure.

Since the 1960s, the Environmental Protection Agency (EPA) has contended with almost 300 million tons of hazardous industrial chemical waste leading to passage of the Superfund legislation which has obtained almost $4 billion in settlements from waste generators, disposers and transporters of hazardous materials. Similar pending litigation involves other forms of mass tort liability, including asbestos, DES and other substances. The generators, disposers and transporters of hazardous waste and product manufacturers, installers and sellers faced with mass tort claims all turned to their insurance companies for coverage, and insurance coverage litigation often followed.

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

In the late 1970s and early 1980s, a number of carriers made even more dramatic moves by changing the "pollution exclusion" clause in their policies from the "sudden and accidental" variety to what is called the "absolute pollution exclusion". Although there are several versions of this exclusion, the basic thrust of each is to exclude coverage if the omission or discharge was accidental or sudden. Since most hazardous waste problems are sudden and accidental, the absolute exclusion appears to exclude most pollution incidents. A growing number of courts are siding with insurers where the absolute exclusion is in place. In these cases, most environmental exposure falls back to the insured and his own ability to cure the problem. The results can be devastating to a company, its owners and their respective estates.

In more recent years, new court cases are again changing interpretations of CGL. Past court cases held that CGLs covered only those liabilities arising from torts. The new precedents (**Vandeberg vs Devonshire**) now say that CGLs cover BOTH tort and contractual liability. Experts say that this decision has far-reaching negative effects on insurers across the country.

Excess Insurance Claims

With the increase in mass tort litigation, environmental litigation and substantial jury awards, excess insurance policies and the role of excess insurance carriers have received increased scrutiny. In general, the fact that a primary carrier owes duty to its insured is well known. With respect to an excess insurer, the courts continue to struggle with the origin of duty.

In coverage disputes where the insured is bringing action against BOTH a primary and excess insurer, the excess carriers sometimes moves to dismiss the lawsuit on the basis that the actual exhaustion of the underlying primary liability limits is a prerequisite to a claim under the excess policy. Policy holders, on the other hand, argue that the mere potential that the underlying insurance will be exhausted is enough to justify a coverage dispute against the excess carrier. The courts have sided with each.

Another area of dispute is the *drop down* -- where an excess insurer "drops down" to provide insurance when the primary insurer has become insolvent. Courts are split on this issue, although a majority currently feel that an excess insurer is NOT OBLIGATED to drop down and provide coverage to an insured. The court's determination is usually based upon the language of both the primary and excess insurance policies.

In yet another decision, the courts have determined that the "trigger" of excess coverage is the amount "indemnified", not the additional costs involved in defense nor punitive damages. In **Harnischfeger v. Harbor**, for example, the fact that the insured paid $3 million in defense and indemnity expenses could not yet trigger the $3 million excess policy limits because the legal expenses incurred were not a factor.

Business Insurance Disputes

In recent years, the number and variety of claims brought against business has increased significantly. In spite of this fact, many businesses have not given adequate consideration to the potential insurance coverage for these claims. As an example, businesses which face claims only against their directors and officers, might tend to ignore the possibility of comprehensive general liability (C.G.L.) insurance coverage. Likewise, when companies face claims of unfair business practices or statutory violations, they consider the bodily injury and property damage portions of their C.G.L. policies only, failing to consider the advertising injury and personal injury provisions, which may provide broader coverage.

In one advertising coverage dispute, the court held that the insured was NOT covered by its C.G.L. policy because the insured failed to establish that its advertising activity *caused* the alleged injuries. The insured was selling a product that "infringed" on a competitor suggesting that the relationship of selling and advertising were the same thing. Another court's rejection of coverage involved copyright infringement. Here, an insured distributed brochures that merely advertised copyrighted material for sale.

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

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

In a "*wrongful entry*" claim, the courts first rejected the insured's coverage under his C.G.L. because the insured trespassed AND committed battery against a tenant. The courts ruled that actual damages resulted from the battery only. Later, on appeal, the court reversed its decision since it was determined that the battery could not have taken place if the insured had not trespassed. The trespass made the battery possible.

Other, *business insurance coverage exclusions* occur under the following conditions:

Liability under contract, willful violation of a penal statute, offenses relating to employment, libel and slander made prior to effective date of insurance or with knowledge that it is false.

Defenses of the Insurer

Much attention is devoted to the "rights" of policy holders. Insurance companies, however, have their own safeguards, which help protect their interests, but add to the growing list of things that can go wrong with insurance. Depending on the issue at hand, the result of having these "built-in" protections can completely void a policy or greatly limit its scope of coverage. Defenses consist of legal tools and techniques that help an insurer initially determine pertinent aspects of the insurance risk for purposes of deciding whether to issue the policy and at what premium. After a policy is committed, additional policy conditions help the insurer "contain" the risk within the intended bounds of the contract. Over the years, a series of standard defense devices have evolved. These can be categorized as concealment, representations of the insured, conditions, warranties and limitations to coverage.

Concealment

The insured has the duty to disclose to the insurer all material facts that might influence a decision to issue a policy of insurance at all, or issue it at a particular level of premium. The holding back of information can, in some cases, constitute fraud by the insured and can render a policy ***void***. In general, the rule on determining when a policy is voided lies in the issue of "bad faith". If the insured withholds information that he knows would be necessary to the insurer in evaluating risk, the insurer has grounds to void the contract. Examples might include an life insurance policy where an insured has agreed to an examination by the insurer's physician but still fails to still to disclose a medical condition that is critical to the insurer's risk decision.

The burden of proof as to fraud in concealment falls on the insurance company. In some cases, courts have sided with the insurer in establishing fraud by "inference". An example might be discovered evidence that the insured had made a previous attempt to destroy the covered building. On occasion, the insured has won based on the argument that facts uncovered by the insurer were not material because it was NOT made a subject by the questions asked on the application even though most applications include a provision requiring the insured to represent that he or she has disclosed all material information. Again, the issue of bad faith enters the picture. Only when the insured conceals a fact in bad faith, ***knowing the fact to be material***, will the policy be voidable. An example is a life insurance application which contains a question as to how many times the insured has been hospitalized and for what causes. If the insurer describes one hospitalization but fails to mention a second, the incomplete answer is considered ***material*** and grounds for voidance of the policy. However, if the insured had left the answer blank or merely given a date without specifying the cause, the incompleteness would be

obvious and NOT grounds for voidance. The test is whether or not the reasonable insurer would be misled.

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

Misrepresentations

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

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

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

Many insurance conflicts center around materiality. A representation is considered material if it served to induce an insurer to enter into a contract that would otherwise be refused or issued at a different premium. The point where representations by an insured cause coverage problems is where such representations are made with the intent to deceive and defraud. The burden of proving a representation *to be* ***material*** falls on the insurance company. If a material representation is found to be substantially correct, or believed to be correct by the insured, the courts have not permitted a voidance or limitation of coverage. An example might be an insured indicating he has not seen a physician within the past five years when he has been to a doctor for treatment of minor and passing ailments.

Warranties & Conditions

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

In recent years, the effectiveness of warranties and conditions have come under fire. In fact, many statutes now place stiff definitions and limitations on warranties. One statute, for

example, provides that all statements made by the insured will be considered to be a "representation" rather than a warranty unless fraudulently made. As previously discussed, it is much harder to void a policy for misrepresentation than for a violation of a warranty or condition. Another statute requires that the breach of warranty is a defense for the insurer ONLY if it actually contributed to causing the loss, as opposed to simply increasing the risk. This is the most severe type of statute for the insurer, since even is cases in which the breach caused the loss, it is frequently impossible to prove the cause, e.g., a fire completely destroys a portion of a building.

Limitations on Coverage

Insurers over the years have attempted to control their exposure by tightening terms of the insurance contract. Adding personalized warranties and conditions is cumbersome and not always useful as a defense for insurers (see warranties and conditions above). Some courts, however, believe that insurers side-step warranties and conditions by creating numerous clauses that serve, instead, to ***limit coverage***. The reason insurers have do this is because many of the statutes which commonly limit warranty defenses, such as incontestibility, "contribute to loss" statutes and "increase the risk" statutes, do not apply to limitations to coverage.

There are several types of limitations that insurance companies can and do employ:

Limitations of Policy Subject Matter -- A homeowner's policy may cover most household possessions in general, but specifically exclude from coverage particular items like cash or coin collections. Likewise a health policy may exclude or waiver certain illnesses.

Limitations by Type of Peril -- A fire policy may except from coverage any loss caused by a fire resulting from lightening or earthquake.

Limitations on Proceeds Paid -- Casualty insurance policies frequently specify an upper limit of proceeds payable for any loss, as well as limiting the payment to the value of the insured's interest in the property damaged. Automobile policies generally fix the upper limit of coverage both in terms of maximum proceeds per person and maximum proceeds per accident.

Limitations on Period Covered -- Every policy will be specific as to the date of expiration, and in some cases, as with life insurance, will also specify a grace period beyond the date of expiration that insureds may make a premium payment. Also, the date of inception of a policy can be specified on the policy or can be subject to the occurrence of some event such as the payment of the first premium or delivery of the policy to the insured.

A limitation on coverage can cause considerable conflict between insurer and insured. One reason is the fact that in some instances, it is nearly impossible to determine from the wording of a clause whether it is a warranty or limitation. In response, the courts have developed two tests to distinguish the two.

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

Another test deals with risk. If a clause refers to a fact which ***potentially*** affects risk, but necessarily causes the loss, it is considered to be a warranty not a limitation. An example is a life insurance policy with a provision that excludes a death benefit WHILE the insured is flying in

a private plane. The insured can bring action to force payment of such a claim, EVEN if the insured died of a heart attack while in a private plane. The flying merely increased the risk, but need not be the actual cause of death. Such a clause is considered a warranty. On the other hand, if flying in the plane was the cause of death, it could be interpreted to be a limitation that is better defended by the insurance company.

Settlement Disputes

Some forms of insurance, like life insurance, are generally settled with ease since the amount paid in the event of loss is fixed by the contract. Similarly, in the case of accident insurance, the proceeds are measured by a specific amount agreed to be paid for loss of a particular limb or faculty, or, as in the case of health insurance, by the medical expenses actually incurred. By far, most settlement disputes occur over property/casualty policies where the payment in the event of loss is determined by an amount up to the "actual cash value" of the property at the time of loss. There are two basic approaches which insurance companies use in an attempt to arrive at a mutually agreeable value -- ***reproduction costs less depreciation and market value***.

Reproduction Cost Less Depreciation

This measure is aimed at determining the cost of replacing the exact depreciated property that was lost. If this were the only option for insureds, it would represent an extreme hardship where, for example, the owner of a fifty-year old home that is destroyed would have great difficulty replacing it with a new building on the depreciated settlement, For this reason, ***replacement cost insurance*** is offered. Here, depending on the wording of the contract, the insured may be required to actually repair or replace the building in order to collect full payment. The most pressing problem for insureds is to keep policy limits above the 80% of market value requirement. Insurance companies require policy limits above this level to assure adequate coverage and keep premium levels high. Insureds may lose, however, if inflation and rising house prices cause the limit of coverage to wind up below the 80% figure at the time of loss, thereby nullifying the replacement cost provision.

Market Value

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

Insurer Insolvency

When a state determines that an insurer is in trouble, the insurance commissioner usually files an application to the court. The court petitions the insurance company to show cause why the company should not be placed in rehabilitation or liquidation. Once a company is placed under supervision, an injunction is issued to restrain the insurer, its officers, agents and others from any disposition of property without court approval. ***Liquidation*** is the more severe condition where the insurance commissioner must take title to the insurer's assets and use them to pay creditors and policyowners. ***Rehabilitation***, on the other hand, allows for a restructuring of the insurer under the guidance of the commissioner. Unless the condition is extremely severe, companies are usually started in rehabilitation. If it is later determined that a restructuring will still not revive the insurer, a liquidation is ordered.

If an insurer is liquidated, all policy owners and other potential claimants MUST be informed and permitted to file a ***proof of claim*** with the insolvent estate. These claims will then be evaluated and a value established. Recent failures have demonstrated that claim values can be less than the amount due the policy holder. Under these conditions, a policy owner can file an appeal and seek a court decision before the actual liquidation of the company occurs. In order to protect the overall insurer estate, there are time limitations for filing these appeals.

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

1. Liquidation expenses and costs
2. Unpaid wages of employees of the insurer
3. Taxes
4. Policy holders, insureds and guaranty funds
5. Reinsurers and all other claims

If a reinsurer indemnifies a liquidating company, it is only required to pay to the liquidator the actual loss it indemnifies. In other words, the reinsurer can only be called upon to pay deficiencies up to the limit it has agreed, once the ceding company, the liquidating insurer, has made all possible payments. This provision, which appears in most reinsurance contracts, is called an ***insolvency clause***. The disadvantage of an insolvency clause is that policy owners, guaranty funds and other third-party claimants have no additional claim against reinsurance proceeds. An exception to this rule is where a ***cut through clause*** exists. A cut through endorsement would require a reinsurer to pay a loss or specified portion of a loss directly to the policy owner or insureds when an insolvency or another specific event occurs. General creditors and other third party claimants could be excluded under a cut through endorsement.

State Guaranty Funds

The liquidation process can be extremely involved and lengthy. This is the reason that ***guaranty funds*** were established. They are an advance payment system to pay off individuals and groups who would be devastated by the liquidation process. A claim against a state guaranty fund is typically limited to residents of that state. Payments are limited to certain amounts, depending on the type of insurance purchased. Once a claim has been paid, the guaranty association becomes ***subrogated*** to the claimant's rights to further payments. Thus, a policy holder who collected from a state fund forfeits his claim rights against the insolvent insurance company.

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

Exclusions

In general, guaranty acts exclude from coverage policies issued by entities that are not regulated under the standards applicable to legal reserve carriers. Insurance exchanges, assessment companies, fraternals, HMOs and, in many cases, the Blues (Blue Cross and Blue Shield -- especially where they have not been converted to legal reserve carriers), are commonly excluded.

The guaranty laws also commonly exclude from coverage policies or portions of policies under which the risk is borne by the policyholder or which are not guaranteed by the insurer. Variable accounts in some life policies or annuity contracts are examples.

Significant variation does exist in the treatment of unallocated funding obligations (UFOs), including GICs, which are commonly purchased as pension plan assets on professional, sophisticated advice by pension plan trustees.

Limits of Protection

Most guaranty associations limit their protection to policyholders who are residents of their own state. (It does not matter where the policyowner's beneficiaries live.) The trend toward adopting such a residents-only provision follows a major amendment to NAIC's model guaranty act adopted in 1985. Arizona, Virginia, West Virginia, Nevada, North Carolina and Oregon very recently amended their life-health guaranty laws to cover only their own residents.

However, if the insolvent insurer's domiciliary state follows the NAIC model, coverage would be extended by the domiciliary state to residents of another state if that state also has a similar guaranty act and the impaired company was not licensed there and the policyholder is not eligible for coverage there. An example of such a situation would be a New York resident who owns a policy of the Executive Life Insurance Company, which is domiciled (chartered) in California. Since New York has a life-health guaranty association but the company was not licensed to do business there, New York residents will be covered by the California Life Insurance Guaranty Association. However, residents of a jurisdiction such as the District of Columbia which does not have a life-health insurance guaranty association would have no guaranty association protection, even though Executive Life was licensed there.

Other states, like Alabama, still follow an older model act and guaranty benefits of impaired or insolvent insurers domiciled in their own state, no matter where the policyholders live, and also cover their own residents who are policyholders of licensed companies domiciled in other states, unless coverage is provided by the state of domicile.

Dollar Limits

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

Life and Health Guaranty Funds

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

Property/Casualty Guaranty Funds

Maximum Claim	$300,000 - $500,000

Individuals who have several policies may have additional limits. For example, a person who owned a term life insurance for $500,000, a whole life policy with cash values of $150,000 and a single premium annuity with an accumulated value of $200,000, will collect ONLY $300,000 -- the maximum aggregate limit per person regardless of how many policies. The fact that these policies may be spread among three different insurers does not make any difference. There would still be a $300,000 maximum in most states. The same is true for property/casualty claims. Regardless of the number of policies or how they are distributed among different

insurance companies, the maximum claim that can be paid by a state guaranty fund is fixed at between $300,000 and $500,000 per individual.

Triggers

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

Coverage Options

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

In multi-state insolvencies, most guaranty associations work through NOLGHA to secure an assumption reinsurance agreement with another insurer or a claims servicing agreement with a third party administrator on a multi-state basis.

If the impaired or insolvent insurer is licensed in more than one state, as most are, NOLHGA's affected member associations try to work closely through our Disposition Committee with domestic receivers to protect policyholders and insure early and equitable access of guaranty associations to the insolvent company's assets. On behalf of its participating member guaranty associations, NOLHGA's Disposition Committee expedites reinsurance assumptions, claims processing and audits.

Reinsurance

Reinsurance and insurer safety are closely related since reinsurance plays a vital role in helping all types of insurance companies meet their everyday commitments. Unfortunately, the reinsurance market has taken some heavy blows in recent years, including some direct links to primary insurer failures. Record losses and mis-management in have caused many to leave or fold making reinsurance harder to come by and more expensive when you can. The shakeout is a huge wake-up call for the industry, including agents, who need to be more alert to their own company’s reinsurance arrangements in the future.

Some primary insurance companies who also sell reinsurance have suffered the hazards of double exposure by having to pay claims from BOTH their primary and reinsurance divisions. It is also the contention of some industry groups that abuse of the reinsurance system, including some questionable reinsurance schemes by depressed insurers and foreign reinsurers, has been a key factor in almost every insolvency.

Reinsurance Defined

Reinsurance is often described as the ***insurance of insurance*** companies because it provides reimbursement for the insurer's losses under policies covered by the reinsurance contract. Insurance placed with the reinsurer is called the ***ceded amount*** , and the company that receives the benefit of the insurance is called the ***ceding insurer***. Insurance purchased by reinsurers to cover their own losses is called ***retrocession***. The process of reinsurance involves a transaction whereby the reinsurer, for a premium, agrees to indemnify the ceding

insurer or reinsured against all or part of its losses under policies written. It is a transaction which does not involve the policy holder who looks only to his insurer for defense and indemnity against loss. Reinsurance is purchased by a primary or an excess ceding insurer for its own benefit so that it can ***spread its risks and limit its own liability*** from large or catastrophic losses.

Reinsurance is often confused with excess or surplus line insurance. However, the two are totally unrelated. Excess and surplus line insurers are primary companies providing direct coverage to insurance consumers. Their function is to supplement the standard admitted insurance markets. Excess and surplus line insurers are, in turn, large purchasers of reinsurance.

Sources & Reasons For Reinsurance

Reinsurance can be obtained through ***three distinct sources*** : professional reinsurers, reinsurance departments of primary insurance companies and unauthorized alien reinsurers. The insurance premium charged policy holders by insurers includes the cost of reinsuring the risk. In other words, there is ***no added charge to the policy holder***. The primary company calculates the premium on a gross basis and all reinsurance expenses are incorporated in the premium. The insurer has the responsibility to evaluate the risk in its totality and to price the risk according to the potential loss exposures. The distribution of the ***reinsurance premium between the insurer and the reinsurer*** is a separate transaction which ***does not involve the policy holder***.

There are many ***reasons primary insurers purchase reinsurance***. The two most important are to limit their liabilities and to increase their capacity. An insurance company may wish to ***cap its exposure*** to losses in one or a combination of three ways: ***a per risk limitation, a catastrophic loss limitation or an aggregate of loss limitation.***

Prudent insurance management and certain insurance regulations demand that a company place a limitation commensurate with that company's surplus or equity on any one potential loss exposure, even though the company may provide coverage under an insurance policy in amounts considerably in excess of this prudent "retention". This is where reinsurance comes in. The individual company's retention may be anywhere from a few thousand dollars to several hundred thousand or even in the million dollar range. Whatever the loss exposure may be above the retention, up to the policy limits of the reinsurance contract, if any, becomes the responsibility of the reinsurer.

Most companies also seek to protect themselves from a disastrous accumulation of losses arising from a single event. For instance, a hurricane or an earthquake. No one single loss payment arising from the event might be beyond the company's individual risk retention level, but the accumulation of all the losses arising from the incident might be excessive for that company. Generally speaking, an insurer estimates the probable maximum loss to which it may be exposed, based on its business concentration in any particular geographical area, compares that exposure to its surplus and purchases reinsurance to cover the potential losses which exceed a prudent level of catastrophic retention.

Another approach often used by companies to limit their potential liabilities attempts to cap the aggregate losses which may be sustained over a specific period -- say one year -- either with respect to its total combined losses for the period or the combined losses for certain lines of insurance. The important reason an insurer may want to purchase aggregate loss reinsurance is to stabilize its operations from year to year.

By providing a mechanism whereby companies may limit their loss exposures to levels commensurate with their surplus, reinsurance allows those companies to offer coverage limits considerably in excess of what they could provide otherwise. This is a crucial function for small to medium size companies, allowing them to offer coverage limits which meet the needs of their policy holders. If only the larger insurers could do so, there would ensue considerably less competition and insurance capacity would be much more restricted than it is today.

Reinsurance further ***enhances an enlarged capacity*** by a variety of other approaches which are related to accounting procedures. When an insurance company issues a policy, the expenses associated with issuing the policy, such as taxes, agent commissions and administrative expenses, become a current charge on surplus, while the premium collected must be set aside as an unearned premium reserve. The premium can only be considered as earned by the company and available to it over the life of the policy. This mismatch in accounting between premium and expenses makes good sense from a regulatory standpoint in that it allows for a more conservative accounting, commensurate with regulation for solvency. But it penalizes insurers to the extent that the more business they write, the more they must draw down on their surplus, thus reducing their capacity. By reinsuring a part of the business written, an insurer is able to limit the impact of the mismatch since the reinsurer must reimburse its client company for its proportionate share of expenses. The reinsurer then is the one which must reduce its surplus by the expenses it absorbs from its reinsured.

Similarly, when a claim is presented to an insurance company, a loss reserve must be established for the amount of anticipated claim payment. The reserve also comes from the company's surplus. However, to the extent a reinsurance recovery is anticipated on the claim and the reinsurer qualifies under state regulation, the insurer may limit its loss reserve to the extent of its own estimated "out of pocket" liability.

There are other approaches to reinsurance as a mechanism to enhance capacity. One such approach which was used perhaps to excess in the past is known as a "loss portfolio transfer". Under this transaction, the insurer "sells" a portion of its loss reserves to the reinsurer which promises to pay the claims represented by these reserves when they are finally adjusted. Assuming that the loss reserves being transferred to the reinsurer exceed the payment which the insurer makes to the reinsurer, the difference may be added to the insurer's surplus, thus, enhancing its capacity.

Reinsurers provide ***other services*** besides financial transactions aimed at limiting an insurer's exposure to losses, stabilizing an insurer's operation or enhancing its surplus to increase capacity. Many reinsurers are equipped to provide guidance to insurers in underwriting, claims reserving and handling, investments and even general management. These services are particularly important to smaller companies or to those which may wish to enter new lines of insurance.

Limitations of Reinsurance

First and foremost, ***reinsurance does not change*** the inherent nature of risk being insured. Thus, it does not make a bad risk insurable. Neither is reinsurance, nor can it be made to be, a subsidy allowing underpricing of risks. Also, reinsurance does not make a risk exposure more predictable or desirable. While it may limit the exposure to a risk from the standpoint of the primary insurer, the total risk exposure is not altered through the presence of reinsurance.

Regulation of Reinsurance

Regulation cannot substitute for good management practices. The placement of reinsurance is a major responsibility of insurance management. It is a responsibility which cannot be substituted by regulation. There are many public and private resources and controls available

to check the security and management of reinsurance companies. For instance, all states today require ***reinsurance contracts*** to include certain clauses which are of overriding public policy. All contracts, for example, must ***contain an insolvency clause which requires the reinsurer to pay all reinsurance proceeds to the liquidator***, in the case of insolvency of the insurer, without diminution resulting from the insolvency.

Probably the biggest issue with regard to reinsurance regulation is the control and policing of ***offshore or alien reinsurers***. The ***U.S. is one of very few countries in which alien insurers may operate*** either through wholly owned subsidiaries or through branches or, in fact, both. A foreign domicile adds an additional ***layer*** of insulation between U.S. regulators and the reinsurer. A simplistic approach would be to limit the U.S. reinsurance market to U.S. domestic or licensed companies. Traditionally, however, the international reinsurance markets have been the main source of retrocession insurance. The influence of the London markets, in particular Lloyd's of London, has been substantial.

While it is true that reinsurers must file financial reports and are examined like primary insurers, there are some areas, where regulation of alien reinsurers fall short:

- Regulation of reinsurance cannot be so restrictive as to preclude adequate capacity. Regulators cannot be so rigid as to completely banish the supply of reinsurance.
- The channeling of reinsurance to more secure markets seems to be defeated by U.S. tax policy. The only tax on U.S. reinsurance premiums ceded to alien companies is the U.S. excise tax, a one percent gross premium tax. U.S. reinsurers, on the other hand, pay income tax equivalent to 7.5 percent of premium. The resulting difference has placed ***U.S. reinsurers at a major competitive disadvantage*** which is very real indeed. In a recent press interview, when asked why Bermuda is such an important reinsurance center and whether it could maintain its preeminent position, one of the island's leading reinsurance brokers answered, "because freedom from corporation tax allows reinsurers to offer highly competitive prices".
- The difficulties in regulating an international commodity such as insurance and reinsurance are, in part, due to the limited geographic reach of regulators, as noted in the report. However, the major difference is accounting conventions, country to country, are themselves major obstacles which would not disappear under a federal regulatory system. To establish minimum solvency standards for all companies doing business in the U.S. becomes a formidable task when these differences are taken into consideration. As an example, the required valuation of assets by many Continental reinsurers results in a reported capitalization which would be grossly inadequate to sustain their net written premium, based on U.S. standards. Yet, many of these companies are solid, conservative entities.
- Currency fluctuation is another element which any international regulatory system must consider. Settlement payments could lose substantial value when siphoned through the "swings" of a wild currency exchange.

This brief discussion of reinsurance leaves little doubt that mismanagement or fraud, even when limited, can lead not only to massive financial losses, but also to a loss of confidence in the integrity of insurance and its regulatory structure. To prevent future similar occurrences without unduly stifling the insurance and reinsurance competitive environment is a challenge which, if successfully attained, will be of great public benefit.

CLAIM PREVENTION

The total impact of an insurance claim can devastate you, your client, his home or business. Sure, insurance indemnifies in the event of a covered loss and helps to offset. But there are other uninsured costs that have a large impact on insureds, their lifestyle and/or their company's operations, market share, and overall public perception. These costs may include emotional adjustments, relocation, rehabilitation, lost work time, production downtime resulting in excessive loss in time, loss of key employees, increased costs of selecting and training new employees, and costs to improve poor company image, just to name a few.

Claim prevention or loss control is a plan of action to reduce or eliminate hazards and losses to hopefully prevent the claim or accident from ever developing and/or minimize its impact. A good loss control plan might . . .

- Analyze claims experience to determine patterns and causes of losses
- Review or help client to establish risk management programs
- Evaluate current loss control measures against expected results
- Identify several alternative solutions
- Help select the most cost-effective option

The most effective method to control insurance claims is to prevent losses from occurring ~ **preloss--**and to also contain the extent of losses after they occur--**postloss**. Any accident, fire or explosion in a home or place of business may mean family disruption or the loss of community prestige, employee morale, and customer goodwill. In addition to these intangible costs, there can be property loss and injury to employees that could add up to thousands of dollars in medical and legal expenses. By working closely with the policyholder, a loss control program can be individually planned. The object is to assist in minimizing possible accident situations and fire and explosion hazards. Improving operating efficiency and safety can also add to increased production and reduced insurance costs.

JOB SAFETY

Through targeted consulting, education, and training, instilling safety as an organizational value can significantly reduce injury experience. A company can apply proven theories and methods that have translated into positive and sustained results. Companies who live and breathe the best in safety every day, all embrace successful **safety management** that includes strategies and a process for making the essential elements of a safety program happen that is invigorated by its commitment to

- Safety
- Its partnerships with employees
- Its trust, pride, and empowerment in coming together to make a difference in safety

The savings are earned one day at a time, one employee at a time. A best practices safety management system and continuous improvement process approach can help clarify and

demonstrate safety's contribution to employee value and company profitability. These practices help to position safety towards the top of an organization, integrated into the company's overall business objectives.

The outcomes of safety best practices are helping to convince skeptics that productivity, quality, profitability, and safety and health are complementary goals. Excelling in safety management also is a competitive market tool to help companies succeed in today's markets. Safety management is a long-term vehicle for "return on investment." It helps us to shift the paradigm thinking of safety as an expense and to embrace it as an investor's "initial investment" outlay for rewarding returns over the long term. Good safety management is also the right thing to do. The success stories of safety best practices companies are inspiring.

The Agent's Role

The agent should anticipate and work to solve customers' concerns by providing the consultancy to optimize their specific safety management system. He can do this by helping them to translate into lower incident rates and higher returns on investment. The agent should strive to be a **safety solutions provider** to his clients and this will be accomplished by:

- fostering a balance of social responsibility through ethical consciousness
- adopting the best safety practices resulting in positive financial management
- encouraging clients to develop and deliver quality innovative safety management systems and processes
- diligently studying his client's business in order to deploy customized solutions that will have the greatest return on investment for the client continuously improving his methods and resources to provide premier customer service

Claim Issues

Industrial Hygiene

Asthma Management

Occupational asthma is described as the #1 leading occupational lung disorder not just in the United States but also in the industrialized world. Up to 15% of adult asthma cases are said to be "occupational asthma." It is the fourth leading cause of death in the United States. The National Institute of Occupational Safety & Health estimates that more than twenty million U.S. workers in a wide range of industries and occupations are potentially exposed to at least one of over 250 organic and inorganic substances/agents allegedly "known" to be associated with "occupational asthma."

The ability to properly *diagnose* occupational asthma is critical in identifying the need for preventive and treatment intervention. But, diagnosis of occupational asthma has not always had a clear process. It is often confounded by a number of factors. Not all asthmas are caused by occupational exposure, although many asthmas, not occupationally-caused, may be aggravated in the workplace by a number of irritants.

Issues of adequacy in the identification, diagnosis and management of asthma in the work place have concerned medical professionals. Extensive studies and research now provide a process for the identification, diagnosis, treatment, and management of workplace asthma that advocates and urges a systematic, thorough, and prompt approach with clinicians and employers both playing key roles.

Assessment of work-related asthma must start with "a thorough occupational and non-occupational history." In addition to noting several non-occupational assessment considerations, researchers advocate that the medical community includes an "investigation" of the workplace, including a walk-through, if possible, to better understand exposures, exacerbations, and an individual's work history.

Clinical tests are stressed as an important part of the diagnostic assessment so that work-related asthma is objectively confirmed by tests designed to measure expiration flow, lung capacity and lung function associated with specific exposure to causative/aggravating agents. A number of work-related assessment factors are presented for clinicians to investigate as part of the exposure history. Factors include:

- changes in work responsibilities or job duties
- changes in ventilation or other ambient conditions
- exposure to spills
- temporal patterns of respiratory symptoms and the presence of similar symptoms in coworkers

The development of occupational asthma (OA) can be temporally associated with an unusual incident at work, such as a spill or fire. As a consequence, clinicians are instructed on the importance in determining the role the worker played in the incident, the proximity to the point source, the size of the room and ventilation, the duration of exposure, and the type and efficacy of respiratory protection.

By the late 90s asthma had become such a significant public health concern that a number of national initiatives were underway to get a better handle on asthma prevalence and management. One of the most comprehensive surveys of public knowledge, attitudes and behavior toward asthma was conducted.
The survey yielded five major conclusions:

- Asthma management in America is falling far short of the National Institutes of Health goals and guidelines, "Guidelines for the Diagnosis and Management of Asthma."
- Poorly controlled asthma symptoms cause asthma sufferers to accept a much lower quality of life than need be.
- The level of care reported by patients does not meet standards.
- A widespread misunderstanding by patients exists of the underlying condition that causes asthma symptoms, as well as confusion about appropriate treatment and other aspects of asthma management.
- 71% of people with asthma feel there is a strong need for more patient education about asthma.

Asthma prevention and management belong to *workers, doctors* and *employers.* The widespread misunderstanding about asthma and its management, and the high-reported need for more asthma education underscore the need for **these three parties to work together** to help improve asthma understanding and management. Patient education should include information about community and self-help resources as an essential part of asthma management. In addition to written asthma management treatment plans and plan monitoring, national guidelines also expect an increase in the number of persons with asthma who receive assistance in assessing and reducing exposure to risk factors ***both in their home and work environments.***

Studies make it clear that employers have a distinct role in the managing of asthma as a work-place health issue. Work-related asthma is said to be the most common lung disease seen in occupational clinics. Work-related asthma includes both new onset asthma initiated by workplace exposures and pre-existing asthma exacerbated by workplace environments. In both cases, repeated exposure to asthmatic agents can lead to chronic pulmonary impairment. Certain substances in the occupational setting may produce hypersensitive bronchial airways and trigger asthmatic responses in sensitive individuals. Exposed workers may have symptoms even at low levels due to sensitization. Known causes of occupational asthma include (but are not limited to) isocyanates, flour/grain, glues/resins, solder and welding fumes, lab animals, and latex.

In the complex picture of asthma, researchers argue both that we are diagnosing occupational causes too often and not often enough. One side argues that employers are not paying enough attention to safety and the responsibility for disability that comes from exposure at work. The other side complains that workers unfairly blame work for medical problems that may be caused by smoking or a pre-existing disease that may be inherited.

Despite the arguments, asthma in the workplace is real. Experts agree that work-related asthma is preventable, and that workplace management practices and controls can be used to eliminate or minimize exposure. People with asthma can lead full, active lives with little disruption to work, family, or outside social activities. Experts agree that **education** for workers, medical specialists, and employers is a key first step.

Asbestos Exposures

Asbestos has moved into vermiculite concerns. The National Institute of Occupational Safety & Health (NIOSH) is targeting additional research related to occupational and potential public health risk concerns over exposure to vermiculite “contaminated with asbestos.” Past NIOSH research targeted former miners and residents of Libby, Montana and consumers and workers who came into contact with vermiculite end products, such as insulation and potting soil. NIOSH's past studies reported cancers and adverse health effects associated with asbestos exposure from the mining of asbestos-contaminated vermiculite. Future research is anticipated to help determine the distribution and concentration of asbestos contamination in vermiculite produced in various mines and used in different occupational settings.

Beryllium Exposure

Under a new law signed in October 2000, nuclear weapons workers with radiation-related cancers, lung disease, or silica-related disease (chronic silicosis), may be eligible to receive a $150,000 disability payment plus payment of future medical expenses associated with that disease, provided they meet certain eligibility requirements. Eligible candidates include employees of the Department of Energy (DOE), DOE contractors or subcontractors, private companies that provided beryllium for use by DOE, or, in the case of deceased workers, their survivors for purposes of the lump sum disability payment. Some are hoping that OSHA will expedite the reduction of the beryllium permissible exposure limit in occupational settings. Today, beryllium is used in the production of golf clubs and dental tools and may pose a potential health risk to workers exposed to the metal dust during manufacturing.

Second-Hand Smoke Exposure

An anti-smoking group, Action on Smoking and Health (ASH), has been pressuring OSHA to move forward with a standard that would protect workers from second-hand smoke. The group has expressed that they believe second-hand smoke is a higher priority and far outweighs

ergonomics. The group says that there is “clear scientific evidence” relating second-hand smoke exposures to deaths.

Safety Training

Safety training begins in the plant, office, job site, and boardroom. Loss control consultants can assist the management of a company in providing effective safety training for all levels of the organization. This includes providing visual aids dealing with on-the-job safety and health, safety guidebooks, posters, and audio-visual aids for use in safety training. Supervisor safety training courses and safety booklets for supervisors should be available at all times.

Safety Awards

The traditional approach to workplace safety has been to stress its importance through posters, slogans, and safety training programs, plus taking disciplinary action against those who break the rules. The better approach is to combine such traditional methods with the systematic use of positive reinforcement and extrinsic rewards using disciplinary action only to immediately stop dangerous behaviors.

Positive reinforcement and rewards come in a variety of forms. A firm might use trading stamps and/or token programs, specific verbal or written praise, short-term team competitions, and cash rewards in an effort to promote greater workplace safety.

Safety is a discipline and a value that is also its own tool for helping us protect financial results and people. Safety isn’t simply about compliance and rules and science. It is about a philosophical belief in goodness and in compassion for the welfare of others- for those we love and those with whom we work. Perhaps, then, workplace safety answers do not always reside in pure science or in our reliance solely on science for answers, but rather in a certain amount of care, prudence and prudent intervention.

Safety Systems

Cellular Phones and Wireless Technology

Cellular phone use and related health and accident research continue. The National Transportation Safety Board has held hearings on driver distractions, especially concerned with the potential for increased distractions related to newer media technologies being installed in vehicles. A National Highway Traffic Safety Administration survey found that 44% of drivers have phones available when they drive; 7% have email access; and 3% have fax capabilities. An estimated 25% of the 6.3 million crashes each year involve some form of distraction or inattention. One study reportedly found that talking on a phone while driving was almost as dangerous as driving drunk and quadrupled the risk of an accident.

Research shows that there may be a link between cell phones and headaches, memory loss, and sleeping disorders in children. Previous health warnings on cell phones have focused on microwave radiation and cancers. Studies have found “subtle effects” on brain function. England’s Safety Regulation Group also conducted studies on Boeing 737 and 747 aircrafts and claim that their results show that mobile phones with an output of 1-2W can cause deviations in the aircraft instruments beyond allowable limits.

In another study researchers looked at wireless communications products in the occupational context. The study looked at a large cohort of wireless communication products workers over a 20-year period. The researchers reported that their findings did not support a link between worker radio frequency exposure and mortality from brain cancers, lymphomas, or leukemia.

The researchers also say they "did not observe higher risk with increased exposure duration or latency."

Ergonomics

OSHA's new standard, which applies to general industry, has an effective date of January 16, 2001, and an enforcement date of October 16, 2001. The rule is to be phased-in over four years, unless court challenges or Congress stop the rule. A grandfather clause is included, provided certain requirements are met. The rule includes basic "screening tools." The agency also has a dedicated ergonomics web page with links designed to provide employers with an information kit, guidance, frequently asked answers and questions, and the rule itself.

Researchers continue to study and offer findings on the dynamics between computer-related work and health. In one study, researchers in Great Britain suggested a relationship between mechanical (physical motion), psychological and psychosocial factors. Among other findings, the researchers reported that dissatisfied employees were 4.7 times more likely to develop forearm pain and those with job stress had a 3.3 times higher risk. Other factors included repetitive motion of the arms and wrists, high levels of psychological distress, and boring or monotonous work.

NIOSH has been pulling together research agenda for musculoskeletal disorders. The research intends to target better surveillance tools, including outcome measures, an in-creased understanding into risk factors (biomechanical, psychological, and social)- both singly and in combination- and a better understanding of disease and disability, appropriate engineering interventions, and treatment protocols.

NIOSH also released a study in which the agency concluded that short, "strategically spaced" rest breaks could reduce musculoskeletal discomforts for computer operators. The study compared two rest-break schedules. Operators that had two conventional breaks (two 15-minute rest breaks, one in each half of the work shift) supplemented by four 5-minute breaks spaced throughout the workday, consistently reported less eye soreness, visual blurring, and upper body discomfort.

In a study involving computer operations and vision, researchers reported that 71% of participants reporting computer vision syndrome were eyeglass wearers. According to the study, eyeglasses prescribed for general use may not be adequate for computer work. The researchers suggest that eye doctors consider computer usage when determining vision correction, including prescribing special occupational lenses to meet the unique viewing distances and angles at computer stations. According to the study survey, eyeglass wearers report more neck, back, and eye/vision problems than non-wearers, due to awkward postures resulting from bi/tri-focal and progressive lenses use when viewing the computer. Vision prescriptions make it difficult for the wearer to see close up or at the typical monitor viewing distance.

Hearing Conservation

Noise-induced hearing loss (NIHL) is still one of the most written about topics in safety journals. It continues to be considered one of the most common and preventable of occupational disabilities. Recent studies show NIHL is on the rise in the construction industry, with street and highway workers, carpenters, and concrete workers cited as the most likely to be exposed. OSHA plans to explore a more effective standard for construction.

In the meantime, NIOSH and the United Brotherhood of Carpenters convened to develop a hearing loss prevention program specifically targeting carpenter apprentices. NIOSH also is undertaking a hearing study in the mining industry, in which it has proposed studying the role of emotional messages about hearing and hearing loss in an attempt to alter "self protective" behaviors around hearing conservation. NIOSH believes that self-protective behaviors can be influenced by messages around the impact of hearing loss, such as social isolation from family and friends; diminished ability to identify warnings/dangerous situations, and unrelenting ringing in the ears that can lower quality of life.

Drug Use in the Workplace

According to the semi-annual Drug Testing Index, considered a national trend benchmark, cheating on workplace drug tests by using chemical additives called masking agents or oxidizing adulterants, declined by 48% during the first half of 2000 compared to 1999. However, illegal drug use remained unchanged, although incidence rates for cocaine and opiates declined and marijuana incidence rates increased. There is some thought that the decline in cheating "appears" to be closely linked to heightened employer surveillance.

In an effort to improve highway safety, the National Transportation Safety Board (NTSB) has recommended that the US Department of Transportation study the relationship between over–the-counter drugs, common prescriptions, and accidents, and establish a list of approved medications that can be used safely by commercial drivers.

The NTSB also recommended that the DOT prohibit the use of any medication not on the list for twice the dosage interval before or during vehicle operation, but further urged the DOT to establish criteria for exceptions so that operators who require non-listed substances may be allowed when appropriate and safe to use those medications while working. Another recommendation urges a toxicological testing requirement in fatalities to help identify the role of common prescriptions and over the counter drugs.

Transportation Safety

On March 8, 2001 the new Federal Motor Carrier Safety Agency (FMCSA) was inaugurated, charged with improving motor carrier safety and dramatically reducing truck and bus-related fatalities by 2010. Some rule revisions have included reliance on sleep studies. Revisions to the hours-of-service regulation looked to sleep studies to help decide for how many hours a trucker can stay behind the wheel safely without a rest break/sleep in order to reduce fatigue-related vehicular accidents. The changes would put commercial vehicle drivers on a 24-hour schedule that coincides with circadian rhythms (biological sleep-wake cycles).

A fairly recent study, based on six years of data of commercial driver performance, added a twist by saying that sleep might be about more than circadian rhythms. The study reports on the effects of rest and recovery cycles and partial sleep deprivation on commercial driver performance. Major findings include that statistically there are significant relationships between daytime performance on several types of tasks and the amount of sleep the prior night. There is poorer performance among drivers with slightly less sleep than population norms. Studies also showed incomplete recovery of performance where continuous sleep was reduced, even after three consecutive nights of 8-hour sleep. The report concluded that daytime alertness and performance capacity is a function not only of an individual's circadian rhythm, but also time since the first sleep period and duration of the last sleep period, and sleep recovery history extending back for several days.

Fatigue Effects

California is so serious about fatigue, work-related performance, and safety, that under new labor regulations from the Industrial Welfare Commission (IWC), employees must be given state-mandated rest break or meal period, or the employer must pay a daily penalty equal to one hour's pay to each affected employee so deprived. It is believed that this will especially impact the health care industry where hospital understaffing has resulted in nurses regularly being unable to take rest breaks and meal periods. The concern is that more fatigued staff, when combined with mandatory overtime, can lead to increased medical errors and accidents and injuries to staff. While the IWC also adopted limitations on mandatory overtime, some say there are loopholes in the provision, which could allow employers to abuse the limitations.

Occupational Exposures

Two separate studies have reported associations between certain occupational exposures and unusual health effects. According to one study, Italian researchers reported that patients occupationally exposed in their jobs to hydrocarbon solvents were at risk for developing symptoms of Parkinson's disease. Nine jobs were identified as accounting for more than 91% of the hydrocarbon solvent exposure. The most common occupational exposures were found among petroleum, plastic and rubber workers. Others found to have frequent hydrocarbon exposure were painters, engine mechanics and lithographers.

In an unrelated study, researchers concluded that occupational exposure to lead could cause latent brain declines in workers nearly 16-20 years after exposures. According to the researchers, the declines have the effect of more rapid brain aging (five years of aging), resulting in progressive declines in memory and learning. The study compared 535 former chemical manufacturing employees exposed to lead at work to 118 non-exposed people from the same neighborhoods. This is said to be the first study to explore long-term problems caused by exposure to chemicals as adults. There is some suggestion that what we have been referring to as “normal aging” may in fact be due to past chemical/agent exposures that can affect the central nervous system.

Acts of God

While acts of God such as windstorms, tornadoes, exposure, lightning, floods, earthquakes, etc., would at first appear to be outside the employment risk, it is generally agreed that if one’s employment has enhanced or “increased” the risk of injury from these sources, the injury would be compensable. In addition to an *increased risk* approach to recovery, it may be possible to recover on the basis of *actual risk* or *positional risk* theories. The *proximate cause* or *peculiar risk* approaches would disallow compensation.

Imported Dangers

It is common for employees to be exposed to a risk of harm that they or their fellow employees have imported to the worksite. Examples of this would be matches, explosives, or firearms. Traditionally, risks imported by the injured employee were viewed as “personal” and outside of the scope of risk of employment. A danger imported by one’s co-employee, while it may appear to be a neutral risk, could give rise to recovery on the basis of increased, actual or positional risk theories. Even though compensation might be denied to an employee who was killed when his hunting gun accidentally discharged while he was getting a work uniform from his car, the court could indicate that recovery would have been allowed if the gun had belonged to another employee. An employee might be able to recover for the realization of a personal risk that the employee has imported, if it could be established that the employment had increased such a risk.

Assault

Assaults are considered to be within the scope of the risk and to arise out of one's employment when the nature of the employment increases the likelihood of such an occurrence, or if the assault has grown out of a controversy that is work related. Usually assaults are not within the scope of the risk if they have been prompted by malice or personal motives; however, even these assaults may be included if in some manner one's work has contributed to the occurrence. Assaults in some cases, such as those by stranger, lunatics, children, etc, may be viewed as neutral risks outside coverage. In the past the courts recognized the aggressor defense, which denied compensation to an aggressor in work-related assaults. The aggressor defense has been discredited today because it creates a fault-based defense in a no-fault system. A minority of jurisdictions by statute excludes from coverage those who have been harmed as a result of their willful intent to injure others.

Street Risk

In the past court decisions denied recovery to employees who were injured as a result of the risks associated with the use of streets and highways because these were viewed as common risks or hazards to the general public and not risks peculiar to one's employment. Today an employee who is subjected to a greater exposure to the risks of the street, despite the fact that such risks are common to the public, may be covered. Coverage in these cases can be provided on the basis of the increased risk approach, the actual risk, or positional risk doctrines.

Pre-Existing Injury or Disease

It is not uncommon for employees to bring pre-existing medical problems to the workplace. The difficulty posed in this area stems from the fact that pre-existing medical problems constitute personal risks, which would fall outside of coverage. However, if one is able to demonstrate that one's employment aggravated a pre-existing medical problem, recovery may be permitted. The obvious problem facing employees is that of factual cause and medical proof. One must establish through expert medical testimony the fact of aggravation and a causal connection between one's employment and the claimed injury. Some jurisdictions address this problem area through special provisions in their workers' compensation act.

Heart Cases

One of the most problematic areas in the law of workers' compensation is that of heart cases. Commonly these cases are approached on the basis of whether or not a personal injury "by accident" has occurred. This approach requires that "unusual" strain or exertion precipitate the heart attack. This is an impractical and unsatisfactory test for coverage in heart cases; distinctions between *usual* and *unusual* strains are practically impossible to make, and serve to confuse the issue.

It is better to approach this issue from a scope of risk perspective. If one's employment has contributed to the heart attack because of exertion or other work-related circumstances, the attack may be found to have arisen out of one's employment. Otherwise, heart attacks occurring on the job would involve personal risks. Because of the difficulties in this area, some jurisdictions have special provisions directed at heart and exertion cases.

Unexplained Accidents

Coverage questions arise in cases of unexplained deaths, unexplained falls, and idiopathic falls. A strict application of the neutral risk or personal risk theories could result in a denial of coverage, even if a fall or death occurred in the course of employment. An application of the

positional risk doctrine can result in recovery even if the cause of a fall or death is unknown, because of the employment relation that existed at the time. The positional risk doctrine could also permit recovery in idiopathic fall situations in which the fall was the result of a purely personal condition, if, for example, the fall occurred at work.

Intentional Injury

Another rule often invoked, as an exception to the exclusivity rule is that where an intentional injury has been committed. Several jurisdictions have refused to allow tort actions to be brought as exceptions to the workers' compensations' exclusivity provisions unless the plaintiff has established that the employer intended the injurious results of its actions as well as the intended actions themselves. Some cases have held that although the injured worker need not prove that the employer intended to cause the injury, there must have been a "substantial certainty" of the injurious result of the employer's actions.

Sexual Harassment

Depending upon the facts giving rise to a plaintiff's claim for sexual harassment, a defendant employer may be able to characterize plaintiff's injuries as "arising out of and in the course of employment" and successfully argue that the exclusive remedy injury lies under workers' compensation.

Safety Standards

The Occupational Safety and Health Act

In 1970, Congress passed the Occupational Safety and Health Act or OSHA that is a comprehensive law designed to reduce workplace hazards and to improve health and safety programs for workers. It broadly requires employers to provide a workplace free of physical dangers and to meet specific health and safety standards. Employers must also provide safety training to employees, inform them about hazardous chemicals, notify government administrators about serious workplace accidents, and keep detailed safety records.

Although there can be heavy penalties for not complying with OSHA, such penalties are usually reserved for extreme cases in which workplace conditions are highly dangerous and the employer has ignored warning about them. If one's workplace is inspected, OSHA will work with them to eliminate the hazards.

Usually, an employer must comply with the Act if his business affects interstate commerce. The legal definition of interstate commerce is so broad that almost all businesses are covered. OSHA does not apply to a workplace if one is self-employed and has no employees, one's business is a farm that employs only his immediate family members, or one is in a business such as mining, which is already regulated by other federal safety laws.

OSHA sets a general standard for all covered businesses. The employer must provide a place of employment that is *"free from recognized hazards that are causing or are likely to cause death or serious physical harm to employees."* Recognized hazards are not clearly defined, which can make it difficult for the employer to know how to comply with the law. The broad language covers an almost impossible large range of potential harm—from sharp objects that might cause cuts to radiation exposure.

In the Act, Congress created the Occupational Safety and Health Administration—also called OSHA---as a unit of the U.S. Department of Labor. Congress authorized this agency to set additional workplace standards, which it has done in great profusion. The specific standards cover a wide range or workplace concerns, including:

- worker training
- workplace temperatures and ventilation
- exposure to hazardous chemicals
- first aid and medical treatment
- noise levels
- protective gear—goggles, respirators, gloves, work shoes, ear protectors
- fire protection

Administration

The employer must post a notice called "Job Safety and Health Protection," which is available from the nearest OSHA office. If one's business is located in a state that has its own approved OSHA program, there may be a state form for him to post instead of the national version. The employer must notify OSHA within eight hours after learning that an employee has died from a job-related accident or that three or more employees have been hospitalized because of a workplace accident.

Unless his business is exempt from OSHA record keeping requirements, he must maintain several types of records. He must keep a log of all workplace injuries and illnesses, except minor injuries requiring only first aid. He must keep up-to-date medical records and records of employee exposure to hazardous substances or harmful physical agents. He must keep records of his safety training records and make them available for review by employees. He must maintain required records for specified periods of time – sometimes as long as thirty years.

Training

The employer is responsible for safety training under OSHA. He must make sure that all employees know about the materials and equipment with which they will be working, the known hazards in his business and how he is controlling those hazards. Special attention should be given to the use of chemicals, being sure to train employees in:

- methods of detecting the release of a hazardous chemical in the work area—for example, monitoring devices or appearance or odor of chemicals when being released
- physical and health hazards of the chemicals
- measures employees can take to protect themselves from the hazards---safe work practices, emergency procedures and protective equipment
- details of the company's labeling system and where employees can look at chemical safety data

No employee should start a job until he or she has received instructions in how to do it safely. The exact training that the employer offers will vary according to the nature of his business. Sometimes it is helpful to call in an OSHA consultant to recommend specific training for the workplace. It is very important to train existing employees who move into new jobs or start using new equipment. All employees need refresher instruction from time to time, since it is human nature to become complacent and forget the safety rules. The employer must maintain records of his safety training efforts and be prepared to show these records to OSHA inspectors.

Inspections

OSHA inspectors can inspect one's workplace at any time without advance notice or authorization by a court and, based on what they find, can issue citations and impose penalties.

It is unlikely that inspectors will make random inspections unless one is in a particularly hazardous business such as construction. OSHA has a limited number of inspectors, and must use its resources wisely.

If one has a workplace with ten or fewer employees and he is in an industry that has a low injury rate, he is exempt from random inspections by federal OSHA officials. State safety and health laws, however, may empower local inspectors to randomly inspect smaller business. If one's business is a small insurance agency, retail store, computer repair shop or similar low injury business, his chances of receiving a random inspection are remote.

Most small businesses are inspected only if:

- an employee has complained to OSHA
- a worker has died from a job-related injury
- three or more employees have been hospitalized because of a workplace condition

Even if an employer is at low risk of inspection, he is not free to ignore safety and health concerns. He is legally required to take the initiative in identifying and eliminating safety and health problems that can affect employees.

Penalties

Penalties ordered by OSHA depend on the seriousness of the violation. For willful or repeated violations, a company may have to pay thousands of dollars in penalties. If a worker has died because the employer violated OSHA standards, the employer could even be sent to prison. For less serious violations—problems that are unlikely to cause serious harm or death—the penalty may be up to $1,000. In assessing penalties, OSHA looks at several factors, including:

- the seriousness of the hazard
- one's history of violations
- whether the employer has made a good faith effort to comply with OSHA standards
- the size of the business

There is an appeal process through which one can challenge an OSHA citation against his business. If the federal OSHA issues the citation, the employer has 15 days to file a notice of contest with the agency. If a state OSHA issues citations in one's state, he should check with that agency to confirm the filing deadline. It is wise to consult a lawyer before embarking on an appeal. After the notice of contest is filed, an administrative law judge will conduct a hearing, giving the employer and others concerned a chance to present evidence. If an employer disagrees with the decision of the administrative law judge, there is an additional appeal process within OSHA. Fortunately, most OSHA disputes are resolved through a voluntary settlement

Workers' Rights

Workers have two basic rights under OSHA.

- Workers have a right to complain to OSHA about safety or health conditions without being penalized for doing so. Firing or discriminating against employees who have made such complaints is a violation of OSHA provisions.
- Workers have a right to refuse to work if they think the workplace is unsafe. The legal test is this: *Does the worker have a reasonable and good faith belief that there is an immediate risk of serious injury or death?*

If so, the worker can walk off the job and refuse to work. He can return after the problem has been corrected or investigated and it is determined that there is no imminent danger. While the problem is being investigated or corrected, the employer can place the worker temporarily in another job at equal pay. It is usually unwise to react by demoting or firing the complaining employee—which can be another violation of OSHA if the complaint is determined to be well founded.

If a state has a health and safety law that meets or exceeds federal OSHA standards, the state can take over enforcement of the standards from federal administrators. This means that all inspections and enforcement actions will be handled by one's state OSHA rather than its federal counterpart.

Hazardous Chemicals

The OSHA rules include a section called the Hazard Communication Standard. The standard requires employers to give information to their employees about the hazardous chemicals they handle. The requirements of informing employees vary somewhat from state to state. If one's business handles any chemicals, he must be sure to get a copy of his state's rules. Since most of the state laws are similar to the federal right to know rules, this discussion will focus on the federal law. If there are differences between the state and federal laws, it is wisest to follow the stricter standards.

The employer should become familiar with the Material Safety Data Sheets (MSDS) supplied by manufacturers of all hazardous chemicals. They contain a wealth of information, including:

- the physical hazards of the chemical such as flammability and explosiveness
- health hazards—the symptoms of exposure and the medical conditions that can be made worse by exposure
- how the chemical enters the body and the limits of safe exposure
- whether the chemical is known to cause cancer
- how to safely handle the chemical
- recommended protection methods including protective clothing and equipment
- first aid and emergency procedures should a chemical be mishandled

The law requires employers to keep the MSDS for each hazardous chemical and make it accessible to employees. He must also keep a list of all the hazardous chemicals used in his business and label all containers. He is required to train employees in the safe use of hazardous chemicals.

Tobacco Smoke

It is well established that second-hand tobacco smoke can harm the health of non-smokers. In many states and cities, employers are legally required to limit smoking in the workplace. A proposed OSHA rule would allow only two choices:

- completely prohibit smoking in the workplace
- limit it to areas that are enclosed and ventilated directly to the outdoors

The torturous effects of tobacco smoke on human health have been clearly established and even certified by the government. A recent report by the Environmental Protection Agency, for example, estimated that secondhand tobacco smoke kills about 3,700 Americans per year. Many other estimates put the number at several times that amount. So people who smoke

cigarettes, cigars or pipes at work increasingly find themselves to be an unwelcome minority--and many employers already take actions to control when and where smoking is allowed.

For example, a recent survey by Industry Week magazine found that nearly three-fourths of the 6,000 companies questioned either prohibited smoking in the workplace or restricted it to designated areas that nonsmokers can avoid. About 15% of the companies did not have a nonsmoking policy, but were considering adopting one.

Although no federal law directly controls smoking at work, a majority of states protect workers against unwanted smoke in the workplace. In addition, hundreds of city and county ordinances restrict or ban smoking in the workplace. In contrast, about half the states make it illegal to discriminate against employees or potential employees because they smoke during nonworking hours.

So the ongoing legal battle in most workplaces boils down to a question of what is more important: one person's right to preserve health by avoiding co-workers' tobacco smoke, or another's unfettered right to smoke. Because of the potentially higher costs of healthcare insurance, absenteeism, unemployment insurance and workers' compensation insurance associated with employees who smoke, some companies now refuse to hire anyone who admits to being a smoker on a job application or in pre-hiring interviews.

While most states now protect workers from unwanted smoke on the job, they follow different approaches. In several states--including California, Connecticut, New Jersey, Rhode Island and Vermont--the laws limiting smoking are aimed specifically at workplaces. A large number of other states have smoking control laws that apply to everyone in public places and specified private places. In these states, nonsmoking employees are protected only if they happen to work in a place that is specifically covered by the statute. A few state laws are all-encompassing--limiting or banning smoking in both public places and workplaces.

Where smoking is limited, some states prohibit it except in a designated area within the workplace. Other states take the opposite approach, requiring employers to set aside pristine areas for the nonsmokers in the work crowd. There are also common exceptions written into anti-smoking laws. Often, their protections do not apply to:

- places where private social functions are typically held, such as rented banquet rooms in hotels; presumably, even the most sensitive nonsmokers must brave the smoke when they frequent these places
- private offices occupied exclusively by smokers
- inmates at correctional facilities and hospital patients, who usually must comply with the rules of the institution
- employers who can show that it would be financially or physically unreasonable to comply with the legal limitations

Some workers who are irked and injured by smoke on the job have sued for their injuries under the Americans With Disabilities Act, which prohibits discrimination against people with disabilities. One is entitled to protection under this law only if he can prove that his ability to breathe is severely limited by tobacco smoke, making him physically disabled.

Workplace Violence

The workplace is becoming a dangerous place as increased violence is occurring against health care workers. A study done in Washington State found that more health care workers were being attacked at work than prison guards or police officers. The Occupational Safety and

Health Administration (OSHA) developed voluntary guidelines recently to protect health care workers and consumers in the workplace, but not all employers have instituted them.

Liability for the vast majority of workplace injuries, including those due to violence, is strictly limited to worker's compensation. The injured employee is entitled to receive lifetime medical care for injuries on the job, as well as a small stipend (paid by workers comp insurance) and perhaps job retraining. Employees are able to go around workers compensation and sue for money damages only if the employer engaged in serious and willful misconduct. Examples include situations like the following:

- The employer received direct threats of violence and didn't notify or protect the target.
- An employee had a history of violence which the employer knew about but did nothing to protect others. To date, there is no legal duty to check references or criminal records of employees for violent tendencies. However, if an employer acts as a reference for a former employee who he knows was violent, he may be liable to anyone that person injures at his or her new employment.

Over the last few years there has been a dramatic increase in the use of Employer's Liability Insurance (ELI) as protection from the high cost of defending and resolving claims brought under the civil rights laws and other employment laws.

The Ergonomic Standard

Work-related musculoskeletal disorders (MSDs) currently account for one-third of all occupational injuries and illnesses reported to the Bureau of Labor Statistics (BLS) by employers every year. These disorders thus constitute the largest job-related injury and illness problem in the United States today. Employers pay more than $15-$20 billion in workers' compensation costs for these disorders every year, and other expenses associated with MSDs may increase this total to $45-$54 billion a year. Workers with severe MSDs can face permanent disability that prevents them from returning to their jobs or handling simple, everyday tasks like combing their hair, picking up a baby, or pushing a shopping cart.

Thousands of companies have taken action to address and prevent these problems. OSHA estimates that 50% of all employees but only 28% of all workplaces in general industry are already protected by an ergonomics program, because their employers have voluntarily elected to implement an ergonomics program. OSHA believes that the proposed standard is needed to bring this protection to the remaining employees in general industry workplaces that are at significant risk of incurring a work-related musculoskeletal disorder but are currently without ergonomics programs.

A substantial body of scientific evidence supports OSHA's effort to provide workers with ergonomic protection. This evidence strongly supports two basic conclusions:

- there is a positive relationship between work-related musculoskeletal disorders and workplace risk factors
- ergonomics programs and specific ergonomic interventions can reduce these injuries

Taken together, this evidence indicates that:

- High levels of exposure to ergonomic risk factors on the job lead to an increased incidence of work-related MSDs
- Reducing these exposures reduces the incidence and severity of work-related MSDs
- Work-related MSDs are preventable

- Ergonomics programs have demonstrated effectiveness in reducing risk, decreasing exposure and protecting workers against work-related MSDs

As with any scientific field, research in ergonomics is ongoing. The National Academy of Sciences is undertaking another review of the science in order to expand on its 1998 study. OSHA will examine this and all research results that become available during the rulemaking process, to ensure that the Agency's ergonomics program standard is based on the best available and most current evidence.

Employers with companies of all sizes have had great success in using ergonomics programs as a cost-effective way to prevent or reduce work-related MSDs, keeping workers on the job, and boosting productivity and workplace morale.

A recent General Accounting Office (GAO) study of several companies with ergonomics programs found that their programs reduced work-related MSDs and associated costs. The study also found that the programs and controls selected by employers to address ergonomic hazards in the workplace were not necessarily costly or complex. As a result, the GAO recommended that OSHA use a flexible regulatory approach in its ergonomics standard that would enable employers to develop their own effective programs. The standard being proposed today reflects this recommendation and builds on the successful programs that thousands of proactive employers have found successful in dealing with their ergonomic problems.

Much literature and technical expertise already exists and is available to employers, both through OSHA and a variety of other sources. OSHA's state consultation programs will provide free on-site consultation services to employers requesting help in implementing their ergonomics programs; and OSHA is developing a series of compliance assistance materials and will make them available before a final ergonomics standard becomes effective.

Reporting Injuries

The workers' compensation system is designed to provide benefits to injured workers no matter whether an injury is caused by the employer or employee's negligence. But there are some limits. Generally, injuries caused as a result of an employee being intoxicated or using illegal drugs are not covered by workers' compensation. Coverage may also be denied in situations involving:

- self-inflicted injuries (including those caused by a person who starts a fight)
- injuries suffered while a worker was committing a serious crime
- injuries suffered while an employee was not on the job, and
- injuries suffered when an employee's conduct violated company policy

Most states require that the injury be reported within two to twenty days. If an injury occurs over time (for example, a breathing problem or carpel tunnel syndrome), one must report his condition soon after he discovers it. The injured worker should get the medical treatment he needs and follow the doctor's instructions exactly. This may include an off work order" or a "limited duties work order. Finally he should file a claim with his workers' compensation carrier. The employer must provide necessary forms.

In some states, one has a right to see his own doctor if he makes this request in writing before the injury occurs. More typically, however, injured workers are referred to a doctor or health plan recruited and paid for by their employer. One’s doctor's report will have a big impact upon how he is treated. While it is crucial that one tells the doctor the truth about both his injury and his

medical history (one's benefits may be denied based on fraud if he does not), he should be sure to clearly identify all possible job-related medical problems and sources of pain. In short, this is no time to downplay or gloss over the presence of a pain.

The injured employee needs to keep in mind that a doctor paid for by his employer's insurance company is not his friend. The desire to get future business may motivate a doctor to minimize the seriousness of the injury or to identify it as a pre-existing condition. For example, if the employee injures his back and the doctor asks him if he have ever had back problems before, it would be unwise to treat the doctor to a twenty-year history of every time he suffered a minor pain or ache.

State workers' compensation systems establish technical and often tricky rules in this area. Often, one has the right to ask for another doctor at the insurance company's expense if he clearly states that he does not like the one the insurance company provides, although there is sometimes a waiting period before one can get a second doctor. Also, if one's injury is serious, he usually has the right to a second opinion. And in some states, after an insurance company's doctor treats one for a certain period (ninety days is typical), he may have the automatic right to transfer his treatment to his own doctor or health plan with the cost being paid for by the workers' compensation insurance company.

One does not usually need a lawyer unless all or part of his workers' compensation claim is denied. If this occurs the claimant will probably want to do some research to familiarize himself with his rights and duties. For example, many claims are denied based on a doctor's report claiming that the claimant is not injured. If the injured employee disputes this, he may have a right to obtain a second doctor's opinion paid for by the worker's comp insurer.

The workers' compensation system was established as part of a legal trade-off. In exchange for giving up the right to sue an employer in court, the employee gets workers' compensation benefits no matter who was at fault. Before the workers' compensation system was passed, if one went to court, he stood to recover a large amount of money, but only if he could prove his employer caused the injury. Today, one may be able to sue in court if someone other than his employer (a visitor or outside contractor, for example) caused his injury or if it was caused by a defective product (such as a flaw in the construction of the equipment he was working with

Workplace safety and health laws establish regulations designed to eliminate personal injuries and illnesses from occurring in the workplace. The laws are primarily federal and state statutes. Federal laws and regulations preempt state ones where they overlap or contradict one another.

Employee Hiring

Negligent Hiring

The doctrine of negligent hiring is a broad doctrine that extends liability to employers for the injurious conduct of its employees even when the injurious acts are committed outside the scope of employment. Specifically, liability may be imposed when an employer places a person *with known propensities, or propensities that should have been discovered by a reasonable investigation, in an employment position in which, because of the circumstances of the employment, it should have been foreseeable that the hired individual posed of a threat of injury to others.*

Liability will not be imposed upon an employer who simply fails to investigate or adequately investigate the employee **unless** the investigation would have disclosed information that would have put the employer on notice that the prospective employee posed a risk of harm to others.

Legal Implications of Negligent Hiring

Litigating under the doctrine of negligent hiring may be advantageous in several circumstances. As already indicated, when the injurious activity of an employee is outside the scope of his employment, negligent hiring may permit recovery. Negligent hiring may save a case from being barred by a statute of limitations. In addition, certain defenses available under the doctrine of respondeat superior, such as guest statutes or assumption of risk, may not be applicable in a negligent hiring action.

Since negligent hiring alleges the employer hired a dangerous or incompetent employee, the person's character, reputation and criminal record may become important issues. The victim may introduce evidence of an employee's prior misconduct to illustrate the employer's failure of reasonable care.

With negligent hiring causes of action, victims may be able to seek punitive damages against an employer who was reckless or grossly negligent in the hiring of an employee. While punitive damages are generally unavailable in vicarious liability actions, punitive damages may be available in respondeat superior actions, but the victim may be required to prove the employer authorized, participated or ratified the employee's injurious conduct. However, in negligent hiring cases, some juries are quite willing to award punitive damages against employers.

Elements of Negligent Hiring

In a negligent hiring claim, courts look for a connection between the victim and the employment of the perpetrator. Essentially, the court needs to find that

- at the time of the injury an employment relationship existed between the employer and employee; the employee was unfit for the position
- the employer knew or should have known that the employee was unfit for the position
- the employee negligently or intentionally caused the victim's injury
- the employee's negligence was the proximate cause of the victim's injury

Most courts hold that the duty of the employer is to exercise reasonable care in hiring individuals who, due to the employment, may pose a threat of harm to others. The nature of the employment directly relates to the duty imposed upon the employer. In situations where the job provides access to property or homes or a special relationship exists between the employer and victim, such as customers, invitees, licensees, passengers, guests and others, the employer may have a duty to conduct a reasonable investigation into the employee's background. In addition, the employer's duty may extend only to victims within the sphere of foreseeable risks created by the employment.

Reasonable Investigation

In order to conduct a reasonable investigation, the employer must take into account the severity of the potential risk of harm the employee may pose in the employment position. Depending upon the nature of the work, employers should make an appropriate investigation into the background of the employee by going beyond the job application form and interview by making an independent background check on the employee by calling former employers and references. In addition, in some situations it may be appropriate to look at the employee's

driving record, criminal record, qualifications and character, especially when the job involves security duties or the use of weapons.

However, where risks to others posed by the employment are slight, an employer may only be liable if the employer had actual prior knowledge of an employee's propensity for violence. No single standard or formula has emerged to determine the employment situations where a heightened duty to investigate exists. Most authorities suggest that the important factor is that the victim was made vulnerable because an unfit employee was in a position that facilitated the commission of the injurious conduct.

The final determination on the liability for negligent hiring is a question of fact for the jury. But, when evaluating a case for viability as a negligent hiring claim, certain aspects of an employer's hiring decision should be scrutinized. While there are many specific steps that employers could use to cut down on their possible liability for negligent hiring, did the employer utilize them?

Following are questions that the jury will consider:

- Did the employer check the employment application carefully for any discrepancies or red flags?
- Did the employer obtain the employee's consent to contact previous employers and references?
- Did the employer contact listed references and the previous employers to find out whether the employee is an honest, trustworthy and reliable applicant?
- Did the employer inquire about any gaps in the employee's work history?
- Did the employer inquire about the employee's reasons for leaving previous jobs?
- If the employee was fired from previous employment, did the employer check the validity of the employee's answer?
- Did the employer determine whether the responsibilities of the position indicate a need to investigate any possible criminal conduct or driving infractions?
- Did the employer investigate appropriate areas of the employee's background as deemed necessary by the responsibilities of the position?
- If the employee sought to change positions, did the employer reevaluate the employee's suitability for the new job's responsibilities?
- Did the employer make a reasonable decision in hiring the employee in light of the responsibilities of the job and the totality of the information learned about the employee?

The Employee's Unfitness

The victim possesses the burden of proof in regard to the unfitness of the employee and risk of harm that the employee posed to persons who might come into contact with the employee due to the job. Thus, the victim must prove that the employer had actual or constructive knowledge that the employee is unfit; the employer knew or should have known of the employee's dangerous propensities. Actual knowledge exists when the employer personally witnessed such violent propensities in the employee.

On the other hand, constructive knowledge may be found when a reasonable investigation would have put the employer on notice of the employee's criminal or tortuous tendencies.

Example *~ A restaurant was held liable for negligent hiring when it failed to investigate an employee's background, and the employee, previously convicted of child molestation, sexually assaulted a young boy*.

Example *~ A court reversed summary judgment in favor of the employer whose employee who had violently attacked a customer when he was inside her home to pick up rental furniture. The court noted that an obvious discrepancy existed on the employee's application when the employee claimed to have worked in two different cities at the same time, and that discrepancy was a "red flag" which should have prompted the employer to contact previous employers and references. The court held that the employer was put on notice of the employee's recent discharge for drug abuse, should have conducted a reasonable investigation, and could not escape liability based on his lack of actual knowledge.*

Summary judgment in favor of a hospital was also reversed because the court found that there was sufficient evidence, by way of an affidavit, which demonstrated that the hospital could have discovered through reasonable diligence that a nurse, who repeatedly made sexual advances toward patients, had a criminal record.

A number of other factors are considered regarding the background an employer knew or should have known. Such factors include: the availability of such information; burden, cost and delay in obtaining background information; whether adequate sources exist which are sufficient to justify a finding of fitness; and, whether unanswered questions or negative indicators exist.

Proximate Cause

Not only must an employer have a duty to investigate the employee, the breach of that duty must be the proximate cause of the victim's injury. The victim must establish that his or her injuries were actually and proximately caused by propensities of the employee that the employer knew or should have known posed a risk of harm to others.

The proximate cause combines a necessary showing of cause-in-fact as well as a showing of foresees ability.

Example *~ In one negligent hiring case, the court held that negligent hiring of the employee was not the proximate cause of a victims' injuries when the employee, an appliance delivery man, broke into her home late at night and raped her. The court found the employee was on his own time, not utilizing a business vehicle, and had not entered the victim's apartment at the time of the injury under the authority of the employer. In that case, the employment relationship was not instrumental to the employee committing the crime.*

In the end, the responsibility for criminal acts lie with the perpetrator. Yet, when an employer puts that dangerous person in a position to harm others, the employer should be liable. The liability not only means monetary compensation to the victim, but also serves as a deterrent example to other employers when making hiring decisions. In the long run, successful recovery against employers under the doctrine of negligent hiring will greatly benefit individual victims as well as society at large.

Legal Liability

If an employer decides to hire or lease employees or use independent contractors, it is extremely important that he is aware of all the federal and state laws that can affect those relationships. Whether or not a business is subject to specific employment laws depends on how many employees that business has and for how long. There's a large array of federal and state laws and, in some states, it only takes one employee to make an employer subject to certain employment laws.

The legal liability as an employer involves four things:

- Understanding the definition of an employee
- Knowing his liability under federal employment laws
- Knowing his liability under state employment laws
- Structuring contracts for non-employees to minimize liability

Lots of business owners think that the way to get around all of the employment laws is to have no employees and instead to employ leased workers, temporary workers, or independent contractors. In some cases, this works, but how well it works depends on what the worker actually does and how the contracts are structured.

Most employers are required by the law to insure against liability for injury or disease to their employees arising out of their employment. The employer is responsible for their health and safety while they are at work. If one is injured as a result of an accident at work, or becomes ill as a result of his work, and if he believes his employer is responsible, he may seek compensation from them. In order for the employer to pay the compensation they must take out an insurance policy. This is employers' liability insurance.

Employers' Liability

Employers' liability insurance will provide compensation for injuries or illnesses caused on or off site. Any injuries or illnesses relating to motor accidents, which occur as a result of one's employment, may be covered separately by his employer's motor insurance.

Public liability insurance is different. It covers employers for claims made against them by members of the public or other businesses, but not for claims made by employees. While public liability insurance is generally voluntary, employers' liability insurance is compulsory. An employer can be fined if they do not hold a current employers' liability insurance policy, which complies with the law. All employers must have employers' liability insurance except the following:

- most public organizations including government departments and agencies
- local authorities
- police authorities and nationalized industries
- health service bodies including National Health Service trusts, health authorities, Family Health Services Authorities and Scottish Health Boards and State Hospital Management Committees
- some other organizations which are financed through public funds, such as passenger transport executives and magistrates' courts committees

If one works for one of these public sector organizations, he can still claim compensation if he is injured at work or becomes ill as a result of his work and his employer is to blame. Any compensation will be paid directly from public funds.

Family businesses are also exempt. One's employer will not need employers' liability insurance to cover him if he is closely related, that is if the employer is his husband, wife, father, mother, grandfather, grandmother, stepfather, stepmother, son, daughter, grandson, granddaughter, stepson, stepdaughter, brother, sister, half-brother or half-sister. However, this exemption does not apply to family businesses that are incorporated as limited companies.

Most employers are required by the law to insure against liability for injury or disease to their employees arising out of their employment. When thinking about workers' compensation insurance, most employers, agents/brokers, and insurers tend to focus on the fact that a

standard workers' compensation policy provides employer coverage for statutory benefits that an employee is entitled to for injuries that are sustained during the course of employment. This type of coverage is typically found in Part One of a standard policy. When purchasing a workers' compensation policy, however, an employer may also obtain Employers Liability ("EL") coverage, which is written under Part Two of the standard policy. EL insurance provides coverage for claims which arise from injuries suffered by employees in the course of their employment that are not otherwise covered by Part One under the policy.

In most cases, a workers' compensation carrier is not subject to a significant risk of loss arising from EL coverage. Stating the obvious, the overwhelming majority of claims arise under Part One of the policy. However, due to the erosion of the exclusive remedy doctrine in certain states, the frequency of EL claims has become more prevalent in such states.

The Exclusive Remedy Doctrine

Generally, once an employer's obligation to an employee to provide workers' compensation benefits is established, an employee (or his estate) cannot sue an employer based upon common law claims for damages sustained as a result of an injury or death that arose out of and in the course of employment (even if the damages result from the negligence or recklessness of an employer). This exclusive remedy also applies to situations in which an employee's injury or death results from the negligence of a co-employee.

Some state law does provide for three principal exceptions to this exclusive remedy doctrine:

- If an employer fails to provide coverage as required by the Workers' Compensation Law (WCL), an employee is allowed to either sue for damages that were sustained as a result of the injury or seek benefits provided under the WCL. Obviously, this exception does not implicate EL coverage since an employer has not procured a policy of workers' compensation insurance to cover its employees.
- If an employee's injury arises as a result of an intentional act, which *is perpetrated by the employer, or perpetrated by an employee at the direction or instigation of the employer,* then the employee has a common law right for damages against the employer. In order to prevail, an employee needs to prove that the employer's acts were deliberate and intentional, not merely reckless. Given this standard, EL coverage under Part 2 likely would be excluded for these claims. The standard policy form, upon which most companies policies are based, specifically excludes EL coverage for bodily injury intentionally caused or aggravated by the employee. In view of this exclusion, the loss exposure for these intentional-act based claims should be limited.
- A third exception has developed out of common law and appears to provide a significant risk exposure in connection with EL coverage, commonly referred to as the **Dole exception**. Originally, this exception allowed a third party, that was sued by an employee for injuries sustained in the course of the employee's employment, to implead the employer for contribution or indemnification if the third party was found liable for the employee's injuries. In 1996, however, this exception was limited through an amendment to Section 11 of the WCL. The amended Section 11 language now only allows a third party to implead an employer for contribution or indemnification when an employee suffers a "grave" injury (this term is defined to include death, permanent and total loss injuries, and brain injuries resulting in total disability). Even in view of the recently enacted limitation, the Dole exception could provide a significant risk of loss for a carrier providing EL coverage to the insureds as described below.

Example *~ An employee suffers a grave injury in the course of his employment due to actions or negligence of a third party. Although the employer was negligent in connection with the*

incident (for example, not providing proper safety devices or a vehicle was negligently maintained), the employee recognizes that his only remedy against the employer is workers' compensation benefits. However, the employee's attorney recognizes that the employee has a cause of action against the negligent third party for damages arising from the incident based upon common law principles. Under Dole, as limited by the amended Section 11 of the WCL, the third party will likely implead the employer for contribution or indemnification in the event the court or jury finds the third party liable for damages. Consequently, an employer could be subject to defense costs and ultimate liability to the third party, even though its liability to the employee is limited to statutorily defined benefits.

In spite of the recent limitation of the Dole exception to situations in which an employee suffers a "grave" injury, the implications of this risk are still significant with respect to an insurer's EL loss exposure. The first factor in this regard concerns the potential unlimited liability an insurer faces under EL claims. Assuming an employer is made subject to a third party action via the Dole exception, if the employer is found liable for contribution or indemnification, the loss exposure for the employer's insurer will therefore only be limited by the amount of damages found attributable to the employer.

Fire Loss Prevention

Each year more than 5,000 Americans die and more than 25,000 are injured in fires, many of which could be prevented. In less than 30 seconds a small flame can get completely out of control and turn into a major fire. It only takes minutes for thick black smoke to fill a building. In minutes it can be engulfed in flames. Fire uses up the oxygen a person needs and produces smoke and poisonous gases that kill. Breathing even small amounts of smoke and toxic gases can make one drowsy, disoriented and short of breath. The odorless, colorless fumes can lull one into a deep sleep before the flames reach them.

The U.S. has one of the highest fire death rates in the industrialized world. About 100 firefighters are killed annually in duty-related incidents. Each year, fire kills more Americans than all natural disasters combined. Fire is the third leading cause of accidental death in the home; at least 80 percent of all fire deaths occur in residences. More than 2 million fires are reported each year. Many others go unreported, causing additional injuries and property loss. Direct property loss due to fires is estimated at $9.4 billion annually.

Causes of Fires and Fire Deaths

Causes of fire ~ Cooking is the leading cause of home fires in the U.S. It is also the leading cause of ***fire injuries***. Cooking fires often result from unattended cooking and human error, rather than mechanical failure of stoves or ovens. Careless smoking is the leading cause of ***fire deaths***. Smoke detectors and smolder-resistant bedding and upholstered furniture are significant ***fire deterrents***. Heating is the second leading cause of residential fires and ties with arson as the second leading cause of fire deaths. However, heating fires are a larger problem in single-family homes than in apartments. Unlike apartments, the heating systems in single-family homes are often not professionally maintained. Arson is the third leading cause of residential fires and a leading cause of residential fire deaths. In commercial properties, arson is the major cause of deaths, injuries, and dollar loss.

Those at risk ~ Seniors and children under the age of five have the greatest risk of fire. The fire death risk among seniors is more than double the average population. The fire death risk for children under age five is nearly double the risk of the average population. Children under the age of ten accounted for an estimated 20 percent of all fire deaths. Children playing with fire start over 30 percent of the fires that kill young children. Men die or are injured in fires twice as often as women.

Causes of injury or death ~ A fire's heat alone can kill. Room temperatures in a fire can be 100 degrees at floor level and rise to 600 degrees at eye level. Inhaling this super hot air will scorch ones lungs. This heat can melt clothes to ones skin. In five minutes a room can get so hot that everything in it ignites at once. This is called flashover. Fire starts bright, but quickly produces black smoke and complete darkness.

Safety preventions ~ A working smoke alarm dramatically increases a person's chance of surviving a fire. Approximately 90% of U.S. homes have at least one smoke alarm. However, these alarms are not always properly maintained, and as a result might not work in an emergency. There has been a disturbing increase over the last ten years in the number of fires that occur in homes with non-functioning alarms. It is estimated that over 40% of residential fires and three-fifths of residential fatalities occur in homes with no smoke alarms. Residential sprinklers have become more cost effective for homes. Currently, they protect few homes.

Reducing Property Loss

According to the National Fire Protection Association, fires in the workplace cause more than $1.1 billion in damage and more than 1,200 injuries each year. An average of 78 deaths each year is caused by fires in the workplace. Fires can start in any number of ways -- faulty electrical wiring or equipment, unsafe storage of combustible materials, inadequate ventilation, human error and arson. Most of these fire hazards can be corrected. By following safety procedures and recognizing potential hazards, employers and employees can prevent fires in their workplace and save lives.

Prevention Guidelines

- Keep fire exits and escape routes clear and well marked.
- Periodically inspect premises to find and correct potential fire hazards.
- Have a qualified heating mechanic check all heating, air conditioning and ventilation systems annually.
- Maintain clearances around all heating equipment to avoid ignition of combustible material.
- Keep equipment and machinery clean and in good operating condition.
- Maintain an adequate number of fire extinguishers and inspect them monthly.
- Limit the quantities of flammable materials and store them in appropriate containers, away from heat sources.
- Dispose of flammable materials according to established safety procedures.
- Keep work and storage areas clean and free of debris.
- Limit smoking to designated areas equipped with appropriate receptacles, or prohibit smoking on ones premises.
- Use caution when operating welding or other spark-producing equipment.

Preventing the Risk of Arson

About 24% of fires in the workplace have suspicious causes. Many of these fires are set intentionally by vandals, disgruntled employees or burglars attempting to cover their tracks. Here are steps a company can take to reduce the potential for arson fires:

- Stay on alert for strangers on the premises, or disgruntled employees in areas where they have no business.
- Provide around-the-clock security patrols.
- Lock gates and exterior doors.
- Secure all entrances at the end of the business day.
- Assign responsibility for periodic checks of security systems such as alarms, locks, fencing and lighting.

- Lock all sprinkler control valves in the wide-open position using sturdy locks and chains.
- Keep ignitable materials away from windows.
- Keep grass and shrubbery trimmed low near buildings so they are not a fire hazard and can't be used as cover for an intruder.
- Secure windows or skylights with boards or heavy screening.
- Keep combustible storage to a minimum in a secure area that is a safe distance from buildings.
- If practical, lock access doors to storage areas.

Reducing Risk of Faulty Wiring

Faulty wiring is a leading cause of industrial fires. By following these guidelines an employer can reduce their risks of fire:

- Properly match fuses to the size of wire being used.
- Replace all temporary wiring with approved permanent wiring properly installed to code.
- Identify the circuits served by fuses, circuit breakers or disconnected switches and record them in the panel board directory.
- Protect flexible cords and cables from physical damage.
- Keep motors clean of dust, dirt and oil accumulation so they don't overheat and burn out.
- Maintain a clear space of at least thirty inches in front of all electrical panels.
- Have a qualified electrician check flickering or dim incandescent lights, since this could indicate a damaged or overloaded circuit.
- Make sure the insulating qualities of a splice are equal to or greater than the original cord.
- Make certain there are no obstructions limiting air circulation near equipment ventilating openings.
- Locate over-current protective devices (i.e., circuit breakers or fuses) where they can be reached easily and quickly.

Fire Sprinklers

Fire sprinklers operate automatically in the area of fire origin, preventing a fire from growing undetected to a dangerous size, while simultaneously sounding an alarm. Statistics show that in fully sprinklered premises:

- 99% of fires are controlled by sprinklers
- 93% of fires are controlled within the design area of operation of the system
- 60% of fires are controlled by four sprinklers or less

Only the sprinkler that is affected by heat from the fire will operate, and it is fed from a simple connection to the mains water supply. If there is water in the mains and the stopcock is open water will be delivered to the seat of the fire. All fire safety measures have a reliability factor. Walls, ceilings and floors may have barriers penetrated by ducts, conduits and cables. Exit doors may be blocked or locked to 'improve' security. Windows may be broken. Fire sprinklers are the most reliable active fire protection system known. Detailed fire records reveal a success rate of 99.5%.

A fire sprinkler is individually heat calculated and supplied with a calculated amount of water at a predetermined pressure through a network of small bore piping in much the same way as the domestic central heating system. When the heat from a fire raises the fire sprinkler operating element to its design temperature, usually 68C (155F) either a solder link will melt or a liquid filled bulb will shatter, thus actuating that single sprinkler and releasing water in a controlled pattern directly over the source of the fire.

Fire sprinklers place less reliance upon human factors such as familiarity with escape routes or the use of manual 'first aid' fire appliances. Fire sprinklers go to work immediately to reduce the danger. Fire sprinklers prevent fast-developing fires of intense heat and smoke from trapping occupants.

The Risk of Water Damage ~ Reports of water damage arising from fires in sprinklered buildings are often exaggerated, dwelling on comparisons with the resultant small fire loss. The amount of water which is used to extinguish a fire in an **unsprinklered** building is many tens of hundreds of times more than would have been used had a sprinkler system been installed. During a fire, only those sprinklers closest to the fire operate, thus limiting the amount of water needed.

Smoke Alarms

In the 1960's, the average U. S. citizen had never heard of a smoke alarm. By 1995, an estimated 93% of all American homes ~ single, multi- family, apartments, nursing homes, dormitories, etc. – were equipped with alarms. By the mid 1980's, smoke alarm laws, requiring that alarms be placed in all new and existing residences – existed in 38 states and thousands of municipalities nationwide. And smoke alarm provisions have been adopted by all of the model building code organizations.

Fire services across the country have played a major and influential public education role in alerting the public to the benefits of smoke alarms. Another key factor in this huge and rapid penetration of both the marketplace and the builder community has been the development and marketing of low cost alarms by commercial companies. In the early 1970's, the cost of protecting a three bedroom home with professionally installed alarms was approximately $1,000; today the cost of owner-installed alarms in the same house has come down to as little as $10 per alarm, or less than $50 for the entire home. This cost structure, combined with effective public education has caused a huge percentage of America's consumers, whether they are renting or buying, to demand smoke alarm protection. The impact of smoke alarms on fire safety and protection is dramatic and can be simply stated. When fire breaks out, the smoke alarm, functioning as an early warning system, reduces the risk of dying by nearly 50%. Alarms are the most common first line of defense against fire.

Professional Claims

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

Legal Disasters

Professional Liability insurance protects ones business from potentially catastrophic litigation caused by charges of professional negligence or failure to perform his professional duties. Whether the claim is baseless or not, mounting a legal defense can bankrupt a company. Professional Liability insurance protects a company and its future by responding to professional liability claims and helping the professional keep his business operating as potential law suits move through the courts. Without it, a company could be financially overwhelmed.

Professional Liability insurance is especially essential in today's legal environment where the boundaries and definitions of professional requirements and duties are largely legally undefined. Unlike lawyers and other professionals who have an established body of tort, or contract law from which to draw, computer professionals are often in legally uncharted territory. What this means for the professional is that he may be liable tomorrow for actions which are today

completely in line with present consulting expectations. Professional Liability insurance protects against the unknown and the unforeseeable. Professional liability insurance covers crucial aspects of ones business and his interactions with clients.

Alleged Negligent Acts

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

Claims Typically Excluded from General Liability

General Liability insurance policies cover claims of bodily injury and property damage only. They typically exclude coverage for claims related to the delivery of professional services. For example, if one damages a computer while performing his job (which might fall under General Liability insurance coverage), he may be responsible simply for the finite replacement cost of a damaged computer. The financial impact of the company's professional errors and omissions and negligence is usually greater than the types of damage covered by general liability insurance.

Damage to or Loss of Client Data

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

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

Importance of Communication

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

It is essential that the investigator gathers and corroborates information in a manner that can be presented in court if necessary. Factual details would include:

- the exact date, time, and place of the incident
- the complete factual details from all available sources
- the complete medical or other records that may be available, such as supervisory reports, police reports, medical records, etc. If medical or hospital malpractice in involved this investigation should cover the history of the incident, previous medical history, diagnosis,

treatment rendered, x-rays taken, operations performed, consultations made and an exact list of all visits
- an itemization of the professional bill
- statements from any associates, assistants, nurses, attendants, or anyone else involved in the incident

If applicable, he should

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

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

- Find out who referred the doctor, surgeon, hospital, etc. to the injured.
- If surgery was performed determine whether consent was obtained and, if so, how, when, and from whom. If consent was obtained in writing, obtain a copy. If no consent was obtained, find out why.
- Find out whether the injured followed the doctor’s, the surgeon’s, or the nurse’s instructions. Obtain complete details.
- Determine when the injured made the first complaint after the alleged malpractice and why such complaint was directed at the specific person or company.
- Determine what subsequent medical treatment was received and obtain complete medical reports from all available sources as previously outlined in making a medical investigation.
- Find out whether the injured received a settlement or was awarded compensation or a judgment as a result of an injury that necessitated the medical treatment presently being investigated. Obtain full details including copies of all releases, checks or drafts issued, court orders, or other records.
- Determine whether the injured ever made a previous malpractice claim, and, if so, obtain complete details.
- Determine the advisability of obtaining a physical examination by a specialist. Make a complete background investigation of the injured, including complete medical history as previously outlined.
- Determine if the person or company suspicion were accredited. Find out when the company /product was last inspected and get a copy of the report and recommendations. Check to see if all recommendations were complied with. Check to determine if the company’s own regulations were followed. Determine the company has had previous experience with similar incidents and equipment.

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

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

Courts routinely require expert testimony to establish the standard of care in malpractice claims against physicians, lawyers, dentists, accountants, and architects. Their line of reasoning is that there are few lay people who understand professional standards of care concerning the issue of negligence. Therefore the benefit of expert testimony is extremely important. For this same reason, courts are beginning to require expert testimony where an insurance agent's negligence is required to be shown.

Errors and Omissions (E & O) Claims

Errors and omissions insurance is a basic safeguard for a business. This insurance protects technology businesses against potentially catastrophic litigation involving professional negligence or charges of failing to perform professional duties. Errors and omissions coverage can make the difference between the survival and failure of a business when faced with these types of legal threats.

Errors and omissions insurance protects technology companies if they are faced with the two most common forms of liability risks:

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

Either one of these types of errors and omissions allegations can tie up company funds, personnel, and attention for years. E & O insurance is especially necessary in the new technology age where the law is still being formed. In many cases, courts are defining what a computer professional is and what the expectations are for services and contracts. The laws around computer consulting and contracting are too new to have established legal precedents. With no precedents, the legal waters are murky and dangerous for the company or consultant without E & O coverage.

Changing Tort Law

Tort law is established law covering contracts. It has had time to establish contractual expectations for most types of professionals and professional activities, but the cyber-service world is too new to be clearly addressed by existing law. This means that much of the tort law is still to be formed through court cases and judgments. What may not be actionable today could result in huge court awards next year. The upshot is that no one can protect against what may be decided in court cases in the near future, except with E & O insurance.

Massive software giants, multinational hardware producers, and individuals writing programs or servicing computers out of their homes are all equally at risk for E & O liability suits. Whether it is catastrophic software crash or network failure that ties up services for expensive hours, the

result to the consulting firm or individual can be an unforeseen lawsuit. Errors and omissions insurance protects against the financial effects of potentially disastrous court cases.

Many computer-consulting companies are becoming aware of these legal threats and, to protect themselves and subcontractors, are requiring their subcontractors (generally those workers receiving a 1099 instead of a W-2 at the end of the year) to carry Errors and Omissions Insurance. If a client company experiences what it perceives to be an actionable error or omission, even if the problem occurs months after the initial consulting activities, both the consulting firm and subcontractors can be held liable and met with law suits. Errors and Omissions insurance protects both parties as they face the legal battles.
Errors and Omissions insurance can be highly tailored to the needs of technology firms. For example, the Errors and Omissions insurance policy can include the persons covered, exclusions, length of coverage, definitions, professional responsibilities and other information pertinent to technology businesses.

Errors and Omissions Claims

The way in which claims are handled varies from insurance carrier to insurance carrier. Some policies include a clause stating one's consent to settle, while others give the insurer the sole right to determine when to settle. Some carriers also include a clause requiring the policyholder to consent to a common defense with any other defendant insured by the same company. While this has certain advantages, it also has certain risks, and the acceptance of any such clause should be given very careful consideration.

Most professional liability policies are written on a claims-made basis, though sometimes coverage is available on an occurrence basis. **Communication** between the agent and the client can be **absolutely critical** in preventing dangerous gaps in coverage. The agent needs to understand the needs of the client, and the client needs to understand exactly what claims-made liability coverage is. Professional liability coverage is sometimes offered on a claims-made basis.

Professional liability policy coverage is sometimes provided only for work produced during the policy period and, only those claims that are first made against the business owner and are reported during the policy period will be covered under the policy when a policy is written in this manner. Claims-made coverage is most common in the computer consulting industry.

Software Errors and Omissions Claims

In today's litigious society, companies are searching for every way possible to minimize the financial consequences of a lawsuit. Even a baseless lawsuit successfully defended can cost tens of thousands of dollars in legal costs. In some situations, a standard liability product simply doesn't offer enough coverage. While both General Liability and Errors & Omissions policies cover defense and settlement costs, the manner in which the suit is brought shows the difference between the two distinct coverages.

General Liability protects a firm against lawsuit costs stemming from *bodily injury* and physical property damage. ***Errors & Omissions*** coverage offers protection against lawsuit costs stemming from a *product's failure to perform* as specified resulting in a client's

- Loss of use of *physical* property without *damaging* it
- Injury to the claimant's reputation
- Damage to *intangible* property
- Loss of use of *intangible* property

The Software E & O insurance market continues to evolve as the technology industry moves forward. The impact of software technology in our world, results in the need for the insurance industry to keep pace with coverage to address potential claim situations. As reliance on computers continues, there will be claims when something goes wrong. Organizations are realizing that is critical for them to secure coverage to protect their company assets. Many insurance companies have developed special technology departments and have provided the underwriters with appropriate training to evaluate those companies requesting insurance coverage.

Since general liability policies cover only bodily injury and tangible property damage, they don't generally insure the damage brought about by software and tailored programming. Software, in and of itself, cannot cause bodily injury, and if it does not perform, it will not likely cause *tangible* property damage. In addition, the General Liability policy only provides coverage for an *occurrence* that is defined as an *accident* and not a failure to perform. With no clear coverage under the General Liability policy, software consultants and companies are looking to Software Errors & Omissions policies to provide the insurance protection.

Some states also require that the companies writing E & O insurance as a part of a package policy, and on an admitted basis, provide defense costs outside of the policy limit, similar to the manner in which General Liability policies are written. This is important for an entity when considering the limit of liability to purchase. Many insureds purchase E & O coverage primarily for the defense provision, and it aids in the selection of limits with knowledge that defense costs are in addition to the limit of liability.

Some insurance companies write coverage on a surplus lines basis. Because their forms do not have to be filed with the respective state insurance commissioners offices, the coverage grant can usually be modified quickly and underwriters have the ability to manuscript forms. In the fast paced technology market, the ability to react to market needs is vitally important. There is typically also flexibility in the premium calculation in the surplus lines market, as the rates are not filed with the respective state insurance departments. However, when insurance is written on non-admitted paper, the insured must also pay surplus lines tax. And, the insured cannot look to the state guarantee fund in the event of insurer insolvency.

There has been an increase in the premium volume for this class of business as companies in the software industry recognize the need to procure E & O insurance as a part of their risk management program. The increase in submissions has been seen by all of the companies. One company reports an increase of over 50% in premium written for technology accounts. For many insurers, this market is where they will experience the largest growth in underwriting. This increase in volume is very positive for the carriers from two standpoints:

- They can spread their exposure over a greater number of insureds
- There are more premium dollars from which to pay claims

For insureds, growth in this market means more competition and a focus by insurance companies ***to understand the exposures*** unique to their industry and ***to provide the necessary coverage.***

These type of claims are not only becoming more frequent, but also costly. Typical defense costs can run in the hundreds of thousands of dollars, not to even mention the settlements. Computer related claims continue to rise, as we are increasingly dependant on technology. However, just because there are allegations of errors or omissions, the software firm is not necessarily liable. There are frivolous claims, where damages are not proven. In these cases, however, the software entity must still address the allegation and provide a defense. Even with

a well-drafted license, service agreement, or contract, a company is vulnerable to lawsuits. Attorney fees alone can seriously impact a company. For the defense costs provision alone, many companies purchase Errors & Omissions insurance.

The loss exposures for the software companies include:

- software failures, resulting in lost time and production
- virus attacks, resulting in thousands of dollars in losses
- technicians fail to make back-ups of data, and erase a client's hard-drive
- software is corrupted and data is destroyed, resulting in lost business
- hackers, resulting in penetration of prominent sites
- failure of custom-designed software, resulting in client not being able to market their product on-line
- spreadsheet error, resulting in incorrect data
- incompatible software which was recommended to client by insureds representative

Communication Issues

All policies cover

- the individual named insured
- related named partnerships and joint ventures
- corporations including executive officers, directors, and stockholders, and employees while acting within the scope of their duties

Insurers differ in their position on covering *former* partners, directors, officers and employees. The insured must decide whether it is important to include these individuals. Employment contracts may require that certain individuals be provided coverage when they no longer work for the company as a claim may occur during the time of their employment or directorship, and may not be reported until some time after they leave.

All companies either include coverage for independent contractors within the policy language or can add it by endorsement. Typically the policy stipulates the extent to which coverage is afforded the contractor, and limits it to work performed for or on behalf of the named insured. Regardless of the coverage provided for the independent contractor, policies usually will protect the named insured for claims arising out of their actions, while working on behalf of the insured.

With the increasing reliance on independent contractors and computer consulting firms, it is important to determine the company position on providing coverage. This is a management decision that should be considered before entering into a contract for services.

The insurance issue should be addressed, and made clear as to which entity is responsible for the coverage. It is very important for the insurance agent to ask detailed questions on the use of independent contractors. He and the client should discuss whether the insured requires evidence of separate errors and omissions insurance. This will help them to have a clear picture of the exposure and to be sure they are not assuming unintended risk.

Workers' Compensation Fraud

High workers' compensation costs has led to more anti-fraud efforts. Some states have created special fraud investigation units in response to escalating workers' compensation costs. These units have discovered that the real drain on the system stems from employer and provider fraud.

Workers' compensation fraud occurs when a person knowingly or intentionally conceals, misrepresents, or makes a false statement to either deny or obtain workers' compensation benefits or insurance coverage, or otherwise profit from the deceit. The most common type of fraud discovered and investigated is injured worker benefit fraud. More cases involving health care provider fraud were referred to district attorneys for criminal prosecution than injured worker benefit fraud cases -- even though injured worker benefit fraud investigations outnumbered provider fraud investigations by more than four to one.

Investigators have found that health care provider fraud was often the most expensive type of fraud in the workers' compensation system.

Trickle-Down Effect

Stealing from large, faceless insurance companies seems harmless at first. One should consider the trickle-down effect of workers' compensation fraud. Insurance companies pass on the costs of fraud to employers as higher premiums. These employers in turn pass on the costs to consumers for goods and services. Employers who can't afford the costs are sometimes forced to move to a state with lower compensation premiums, taking their jobs and income with them. But employees aren't the only people committing fraud.

- Employers have neglected to carry workers' compensation coverage.
- Doctors have falsified bills to insurers.
- Attorneys have committed forgery.
- Insurance agents have neglected to send premiums to insurers, pocketing the money.
- Employers that don't carry workers' compensation coverage operate their businesses with a lower overhead, giving them the opportunity to underbid businesses with the proper coverage.
- Uninsured employers can run honest employers out of business, again resulting in a loss of jobs.
- Health care professionals, attorneys and insurance agents -- professions often regarded as being owned by individuals of high moral fiber -- are also under scrutiny.

If one is aware of someone who is abusing the workers' compensation system, he should realize that it does affect him and his community. While his neighbor next door sits home and collects fraudulently obtained benefits, he will be working harder to support his family. Those benefits are coming out of his pocket.

The Self-Insured

While vigilance against fraud by employees must be maintained as a deterrent to systemic abuse, and fraud prevention strategies should continue to be developed, it seems that the attention of insurers might be beneficially invested in other directions. Further lessons can be learnt from a section of the industry not contributing to the problem of premium non-compliance: **the self-insured.**

Study reports a "negligible" occurrence of workers' compensation fraud in a self-insured company. As a result of their strong prevention record they have 60% less claims than the rest of their industry. As a self-insurer they have management and ownership of all claims and they

can deliver benefits within twenty-four hours. The closeness of their involvement with the worker in terms of early post-injury intervention produces an environment not conducive to fraud.

While current regulations limiting self-insurance could be looked at more closely, it is not a realistically viable option across the board. Experts agree with arguments for self-insurance but believe the same positive principles can be applied to broader schemes.

The self-insurer certainly has the capacity to be closer to the worker but other employers can replicate that in the broader workforce by seriously practicing early intervention. That is the self-insurer's greatest advantage against fraud. Other employers should take the view that all injuries are legitimate on the first day and get the system intervening very quickly. If they can get people looked after and set on the road back to work straight away, thoughts of exaggerating incapacity fall away.

Home Safety

Someone once said that a person's home is his castle. If this is true, castles are very dangerous places. Approximately 24,000 individuals are killed each year in home accidents--an average of about 65 deaths per day. The National Safety Council reports that about 3.6 million people are injured in home accidents, which means that one person in 60 was disabled for one or more days in a home accident. About 100,000 of these injuries resulted in permanent impairment.

Although most loss control programs focus on commercial / professional elements, agents can help their personal lines clients reduce claims in the home with some education on a few simple concepts and procedures.

Positive Safety Attitude

You cannot oversee your client's activities at home, but you may share with him some ideas on developing a positive safety attitude. Let's see how this works. First, some examples . . .

Example: *A father making a plumbing repair in his kitchen finds that he does not have the correct tool for the next job step. He really needs a strong utility knife to cut the trim off a plastic pipe, but he left it back in the garage. There are only two choices: Should he improvise and use a substitute tool, like his small pocket knife? Or, should he take a little extra time and get the right tool? The father with a strong, positive safety attitude certainly will take the time and do the job properly and safely by going back to the tool shed and getting the correct tool.*

Here's another example . . .

A mother is running errands on a hot day with her baby. She needs to stop at a friends house to pick-up a pan she needs for a recipe. It will only take a minute or two to get the pan she needs. Does she park the car in the driveway with the baby inside? Maybe she can leave the motor and air conditioner running while she pops inside for just a minute. The mother who takes the time to remove the baby from the car is making the correct decision. It is the only way to guarantee that something won't happen (heat stroke, a stolen car, exhaust fumes, etc) to the baby while she is out of sight – even for just a minute.

In both of these examples, there was an easy way out . . . a short-cut . . . a quick solution. But, by adopting a ***positive safety attitude***, your clients can make better, more consistent decisions for greater safety. It may be a little harder this way, but at the end of the day, you and your clients will have peace of mind and a greater sense of accomplishment.

Parents have the unique opportunity to help their children develop a ***positive safety attitude*** at an early age by setting a good safety example? When they do jobs around the house, make kids see them wear safety glasses, gloves, protective clothing, etc. Make sure they see them handle household tools like knives, scissors, chemicals and appliances with extreme caution. Encourage them to take the time to explain to them that the reason for wearing safety gear and following safe procedures is to make sure that they are not injured.

Emergency Preparation and Procedures

In any emergency, clients should: [1]

1) Stay Calm.
2) Check for life-threatening situations (choking, severe bleeding, or shock). Do not move a seriously injured child.
3) Call 911 or your local emergency number if the child is seriously hurt. Have emergency numbers posted by the phone--police, ambulance (911), and poison control center.
4) Give CPR or first aid, if necessary (if you know what you are doing).
5) Know where the nearest hospital or urgent care center is located. Are they open 24 hours a day? Do they have an emergency room? (Not all hospitals or clinics have emergency services).
6) Keep consent forms for emergency treatment (in case someone else is watching your child when he is injured) and numbers for emergency contacts near the phone. These forms can save you child's life since they give the person in charge of your child the immediate right to authorize emergency medical treatment if you are not around.
7) Keep a fully stocked first aid kit in easy reach, but out of reach of children. Check the first aid kit regularly and restock it as necessary. (See box for what your kit should contain.) In addition to the supplies listed for your first aid kit, you should also keep ice cubes or ice bags in the freezer to use to reduce swelling of some injuries.
8) Place a stocked first aid kit in every vehicle used to transport your children. In addition to the items in first aid kit, your vehicle kit should also include a bottle of water, soap, coins for a pay telephone, and a first aid guide.

What A First Aid Kit Should Include

Box of nonporous disposable gloves
Sealed packages of alcohol wipes or antiseptic
Small Scissors
Tweezers (for removing splinters)
Thermometer
Adhesive bandage tape
Sterile gauze squares (2" and 3")
Triangular bandages
Flexible roller gauze (1" and 2" widths)
Triangular bandages
Safety pins
Eye dressing
Insect sting preparation
Pencil and notepad
Syrup of ipecac
Cold pack
Small splints
Sealable plastic bags for soiled materials

First Aid Procedures

There are many injuries where people in the home need some first aid right away. Encourage clients to go take a Red Cross class in first aid training to get this knowledge.

[1] The ABC's of Safe and Health Child Care, www.cdc.gov, 12/2000

Another part of managing risks at home is to do as much as possible to ***prevent them from happening*** in the first place. There are probably dozens of changes that anyone could make to their home or apartment to make them safer. You are not trying to be an authority here, but there are some good suggestions from some people who are considered experts.

Preventing Common Household Injuries

Here is a few simple precautions can help to prevent many common household accidents. Start today to make your home safe using these tips: [2]

- Make sure stairs are clearly lit.
- Install light switches at the top and bottom of stairways.
- Keep exits and passageways free of boxes, furniture and other tripping hazards.
- Regularly clear the floor of toys, games, magazines and other obstructions.
- Make sure you can see over the top of what you're carrying to avoid tripping.
- Make sure that all of your small rugs have slip-resistant backing.
- Put cut-to-fit rubber matting or two-sided tape on rugs that don't have their own backing.
- Mark sliding glass doors with decals or decorations. Someone could easily walk through what looks like an open door.
- Wipe up spilled water, grease or food peelings immediately to prevent slipping.
- Place a rubber mat or adhesive strip on the bathtub floor. This will reduce the possibility of slipping in the bathtub.
- Purchase bedroom night-lights for children and elderly people. Falls can happen easily in a dark bedroom.
- Wear shatter proof safety glasses when operating any power tool. If you wear eyeglasses, use safety glasses that fit over them.
- Never store inedible products in the same place as food. This may result in an accidental poisoning.
- Don't save medicine. Discard all leftover medications by flushing them down the toilet.
- Avoid using the basement, attic or utility room for a dumping ground, especially for combustible materials.
- The yard should be kept clear of broken glass, nail-studded boards, and other litter. Electric utensils or tools should be properly grounded if they are not of the "double insulated" type and should always be disconnected when not in use.
- You should always tag and identify your main gas and water valves and electrical cut-offs. Be sure that others in your family know where they are located and how to cut the supply in the event of an emergency.
- Fuses or circuit breakers should be labeled to identify outlets and fixtures they protect. Good lighting should be available for work areas, stairways, and in the bedrooms of children and elderly persons.
- Keep emergency phone numbers like police, fire, doctor, utilities, handy by your telephone.
- Falls are the greatest killers in the home. Always have non-skid backing on small rugs and avoid using them at the top of stairs.
- Use a step stool or utility ladder--never a chair or table--when reaching into high cupboards or shelves. Keep ladders in good condition by replacing loose rungs, worn ladder shoes, and frayed ropes on extension ladders.
- Replace cracked or frayed electrical appliance and extension cords.
- Don't use aerosols near open flames or while smoking.

[2] Farmers' Insurance website, *www.farmersinsurance.com*, Preventing Accident at Home, 12/2000

- Keep firearms secure in a locked rack or cabinet and ammunition stored separately from the firearms.
- As on the job, always use the right tool for the job and always get help from a neighbor or friend for heavy or difficult jobs.
- Prepare and practice a family escape plan in case of a fire that might occur during the day or night.
- This plan should include two ways out of every area and a pre-determined meeting place outside of the home.
- Smoke detectors of an approved type are a good investment to provide early warning of a fire in the home.
- Motor-vehicle accidents are the #1 accidental killers of our children ages 5 and under. Using a child safety seat is estimated to be 80 to 90 percent effective in preventing fatalities.
- Look for the UL label whenever you buy appliances.
- Wipe up liquid spills immediately.
- Turn hot handles away from the stove front so that they don't tempt little children, but don't place them over another burner.
- Keep in mind that water should never be poured on a grease fire.
- Washers and dryers should be electrically grounded.
- Always keep household cleaners, disinfectants, insecticides, drain openers, and medicines in their original labeled containers--separate from food--and preferably locked up and out of reach from small children.
- Read the label before taking any medicine.
- Keep emergency phone numbers like police, fire, doctors, utilities, handy by your telephone.
- Keep all tools properly guarded and out of reach of small children.
- Flammable paint thinners and solvents should be kept in metal cans. Their vapors will travel along the ground, so it is important to keep them stored away from gas hot-water tanks, heaters, or other sources of ignition.
- When operating a power mower, keep children and pets a safe distance away. Always shut off the mower and make sure the blades are stopped before adjusting the blade or emptying the grass catcher.
- Keep the garage door open while running the car engine inside to avoid asphyxiation.

Fire Safety & Prevention

If a fire broke out in the middle of the night, would your client's family be able to escape safely? Although most Americans believe they could get out alive, according to NFPA's 1997 Home Fire Escape Survey, only a small number (16%) have actually developed and practiced a home fire escape plan to ensure they could escape quickly and safely.

Some 4,000 fire deaths occur in U.S. homes every year, and too often it's because people did not, or could not, get out of a burning home in time. Developing and practicing a home fire escape plan is the key to survival.

According to the National Fire Prevention Association, the elements of an effective home fire escape plan include the following: [3]

- Working smoke alarms on every level of the home and outside all sleeping areas
- Two ways out of each room
- Unobstructed and easy-to-use exits

[3] Fire Escape Planning & Practice, *www.nfpa.org*

- A meeting place outside
- A posted emergency phone number for the fire department
- Practicing the plan at least twice a year with every member of the household

Everyone, including preschoolers, can be taught the basics of fire escape. If there are infants or family members with mobility limitations, someone in the household should plan to assist them. Also make sure that doors needed for escape can be opened easily, and that windows are not nailed or painted shut. The most important thing to remember is to react to the sound of a smoke alarm immediately and make getting out your top priority.

Some other tips helpful in fire safety include the following:[4]

- Once you are out, stay out! Call the fire department from a neighbor's home.
- If you must exit through smoke, crawl low under the smoke to your exit.
- If you are escaping through a closed door, feel the floor before opening it. If it is warm, use your second way out.
- If smoke or heat blocks your exit, stay in the room with the door closed. Signal for help using a bright-colored cloth at the window. If there is a phone in the room, call the fire department and tell them where you are.

One of the worst things that can happen, of course, is an emergency where you or your clothes catch on fire. Each year more than 15,000 people are seriously burned when their clothes catch on fire. In more than half of the incidents, flammable liquids or vapors were present on or around the person's clothing. But it can happen in many ways. A person's loose sleeve may catch fire on a hot stove. Someone may be working with gasoline or some other flammable liquid and then light a cigarette. They might spray lighter fluid on a smoldering barbecue fire and the resulting flames could catch their clothes on fire. When a person's clothing catches on fire, action must be instinctive and immediate. There is no time to think.

The one thing you should never do is run.

To minimize a burn injury when your clothes catch fire, ***STOP, DROP and ROLL***. Burns are among the most painful of injuries and the third leading cause of unintentional death in the United States. The hands, groin, face and lungs are at particular risk because they are delicate structures and easily injured. The healing process is slow and painful, resulting in enormous personal suffering.

Certain types of clothing are less flammable and resist flames more than other types of clothing. Heavier clothing and fabrics with a tight knit weave burn more slowly compared with loose knit clothing. Fabrics with a loose fit or a fluffy pile will ignite more readily than tight-fitting, dense fabric clothing. Synthetic fibers, such as nylon, once ignited, melt and burn causing severe burns. Natural fibers, such as cotton and wool, tend to burn more slowly than synthetic fibers. However, fibers that combine both synthetic and natural fibers may be of greater hazard than either fabric alone. Curtains and draperies can be sprayed with flame-retardants to reduce their rate of burning. However, these chemicals should not be applied to clothing.

The principles of STOP, DROP and ROLL are simple:

- Stop, do not run, if your clothes catch on fire.
- Drop to the floor in a prone position.
- Cover your face with your hands to protect it from the flames.

[4] Ibid

- Roll over and over to smother the fire. Don't stop until the flames have been extinguished.

If you are near someone whose clothing catches on fire, be sure to stop them from running and make them STOP, DROP and ROLL. Once the fire is out, you must treat a burn injury. Cool a burn with water. Then call 9-1-1

Earthquake Safety

Are your clients ready for an earthquake? Here's what the Red Cross says they can do to prepare. [5]

Prepare a Home Earthquake Plan

- Choose a safe place in every room--under a sturdy table or desk or against an inside wall where nothing can fall on you.
- Practice DROP, COVER, AND HOLD ON at least twice a year. Drop under a sturdy desk or table, hold on, and protect your eyes by pressing your face against your arm. If there's no table or desk nearby, sit on the floor against an interior wall away from windows, bookcases, or tall furniture that could fall on you. Teach children to DROP, COVER, AND HOLD ON!
- Choose an out-of-town family contact.
- Consult a professional to find out additional ways you can protect your home, such as bolting the house to its foundation and other structural mitigation techniques.
- Take a first aid class from your local Red Cross chapter. Keep your training current.
- Get training in how to use a fire extinguisher from your local fire department.
- Inform babysitters and caregivers of your plan.

Eliminate Hazards, Including--

- Bolting bookcases, china cabinets, and other tall furniture to wall studs.
- Installing strong latches on cupboards.
- Strapping the water heater to wall studs.

Prepare a Disaster Supplies Kit For Home and Car, Including--

- First aid kit and essential medications.
- Canned food and can opener.
- At least three gallons of water per person.
- Protective clothing, rainwear, and bedding or sleeping bags.
- Battery-powered radio, flashlight, and extra batteries.
- Special items for infant, elderly, or disabled family members.
- Written instructions for how to turn off gas, electricity, and water if authorities advise you to do so. (Remember, you'll need a professional to turn natural gas service back on.)
- Keeping essentials, such as a flashlight and sturdy shoes, by your bedside.

Know What to Do When the Shaking Begins

- DROP, COVER, AND HOLD ON! Move only a few steps to a nearby safe place. Stay indoors until the shaking stops and you're sure it's safe to exit.

[5] Are You Ready For an Earthquake?, *www.redcross.org*

- Stay away from windows. In a high-rise building, expect the fire alarms and sprinklers to go off during a quake.
- If you are in bed, hold on and stay there, protecting your head with a pillow.
- If you are outdoors, find a clear spot away from buildings, trees, and power lines. Drop to the ground.
- If you are in a car, slow down and drive to a clear place (as described above). Stay in the car until the shaking stops.

Identify What to Do After the Shaking Stops

- Check yourself for injuries. Protect yourself from further danger by putting on long pants, a long-sleeved shirt, sturdy shoes, and work gloves.
- Check others for injuries. Give first aid for serious injuries.
- Look for and extinguish small fires. Eliminate fire hazards. Turn off the gas if you smell gas or think it's leaking. (Remember, only a professional should turn it back on.)
- Listen to the radio for instructions.
- Expect aftershocks. Each time you feel one, DROP, COVER, AND HOLD ON!
- Inspect your home for damage. Get everyone out if your home is unsafe.
- Use the telephone only to report life threatening emergencies.

Hazardous Materials Awareness

Many people don't realize it but there are a lot of common household items that are considered to be hazardous materials. These include medications, paint, motor oil, antifreeze, auto batteries, lawn care products, pest control products, drain cleaners, pool care products such as chlorine and acids, and household cleaners. Some household cleaners may be harmful separately or when combined such as ammonia and bleach. In extreme cases, people and children have died when exposed to improperly mixed household chemicals.

How do clients manage this risk?

- Be alert
- Take the time to ask questions
- Look for labels

To help, most fire departments provide some very good pamphlets and other materials for identifying dangerous and hazardous materials, including potential health effects. Here are some examples of their advice: [6]

Arts & Crafts

A good percentage of your clients engage in some form of art or craft as a vocation or hobby. While art is a creative, individualistic pursuit, the materials used may pose a risk to individual health and the environment. Knowledge about the materials and processes is the best protection against the major and minor health effects of the art or craft.

A wide range of health effects are linked to materials used in the arts and crafts, depending on the substance, the dose, the duration of exposure, and the susceptibility of the person exposed. Many solvents affect the central nervous system and are skin and eye irritants. Most are flammable; many are linked to long-term adverse health effects such as liver damage. Several are known or suspected carcinogens such as benzene and toluene.

[6] Household Hazardous Materials, Eastside Fire Department, *www.esfd.org*

Dusts/fibers created from crafts are eye and respiratory irritants, and may aggravate asthma and provoke allergies. Specific hazards: ***silica in clay*** dust causes lung disease over years of exposure; ***talc (white clays)*** may be contaminated with asbestos a known carcinogen; some hardwood dusts lead to nasal and sinus cancers in woodworkers. ***Heavy metals*** are hazardous both as dusts and as fumes. Lead affects the nerves, digestive system, muscles and joints. Arsenic, cadmium and chromium are known carcinogens. Mercury, copper, cobalt, silver, manganese, selenium and zinc are all acutely toxic.

Basic Safety Rules For Arts & Crafts

1. Know the hazards of the materials you're working with. Read the labels, request material safety data sheets (MSDS) on new products, know what precautions, safety gear and clean up procedures are advised. When buying arts and crafts materials look for these key words or symbols:

- Non-toxic - item will not cause immediate poisoning.
- AP - approved product; item does not contain sufficient quantities of a material to be toxic or harmful to the body, even if eaten or swallowed.
- CP - certified product; meets AP standards as well as standards for product quality, color, etc. Be especially cautious using discarded materials such as wood (what chemicals might it be treated with?) or scrap metal (what alloy is it?).

2. Use the safest materials and procedures possible. Stay current on the new developments in your art or craft. Safer, less-toxic alternatives are being devised for many activities.

3. Use good ventilation at all times. Local exhaust is the best, such as a hood or spray booth that vents to the outside. Next best is to use exhaust fans that pull the contaminated air away from you and exhaust it outside (an air-conditioning system is not adequate, since it re-circulates most of the air). An open window usually does not provide adequate ventilation; toxins may be blown back into your face.

4. Use good hygiene and good housekeeping habits. Separate work and living areas; avoid eating, drinking or smoking in the work area; don't store materials in food containers; and wash and change clothes after working. Wet mop or vacuum for cleanup of dusts.

5. Special precautions are needed for children's art. In general, children over the age of 12 can understand and consistently follow safety instructions for the more toxic materials; younger children cannot and should use only the safest materials.

Acids are corrosive to skin and eyes. Acid vapors are irritating to the lungs and inhalation of small amounts may damage lung tissue. Concentrated acids can react with many other materials.

Gases generated from kilns, welding or sculpting with plastics are acutely toxic; some may lead to long-term lung damage with repeated exposure.

Pesticides

Pesticides are chemicals designed to kill rodents and insects. Herbicides are used to kill plants and micro-organisms. ***They can injure or potentially kill people by inhalation, ingestion and absorption through the skin***. Exposure can affect the respiratory and nervous systems, and cause skin and organ damage. If improperly used, these chemicals can also injure or kill plants or animals that are not intended to be controlled. Certain pesticides that don't readily break down can accumulate in the food chain.

Unless otherwise directed, don't water an area immediately after applying these chemicals to it. This might cause them to run off with the extra water into a storm sewer or stream. Don't throw pesticides or herbicides in the trash, or pour them on the ground or down a drain. Don't burn or bury them either. These methods of disposal can pollute groundwater, lakes, rivers, and water supplies.

The best way to get rid of these chemicals is to use them up unless they are banned. When mixing these chemicals, follow the directions on the label. Read the label to determine if

protective clothing such as wraparound goggles, gloves or a respirator are needed. When finished, wash protective clothing separately from other laundry in hot water.

If you can't use the chemicals, see if friends, neighbors, greenhouse, or city park departments need them. Don't give away pesticides or herbicides that are banned, damaged, or unlabeled.

After using all the pesticide or herbicide from a container wash it three times and use the rinse water as pesticides. Throw the rinsed-out container in the trash. Don't burn or reuse old containers. Safely store pesticides in their original container. Protect the label and make sure the word DANGER appears on the container. If the chemical is flammable, keep it away from heat, flames, and spark sources. Also, store it where it won't freeze. Always store chemicals out of the reach of children.

Before purchasing a pesticide or herbicide, make sure you need one. Contact the local agricultural extension service for information on when to use pesticides/herbicides. If you need to use these chemicals, buy only the amount you need. Try using up leftover pesticides/herbicides before purchasing more.

Automobiles

Automobiles consume vast quantities of gasoline, motor oil, antifreeze, car batteries, degreasing agents, windshield washing fluid, car waxes, and cleaners. While most of these products are necessary for proper operation and maintenance, they are all toxic.

Any oil that has been refined from crude oil and has been used is "used oil." The term "used oil" also applies to any oil that is no longer useful to the original purchaser as a consequence of extended storage, spillage or contamination with non-hazardous impurities such as dirt and water. Used oil is a hazardous waste. The hazards associated with used oil result from the various additives used in its manufacture and from the heavy metal contaminants picked up from use in the internal combustion engine.

Oil poured down household drains or directly onto the ground can reach the lakes, rivers and ground water. It can pollute the groundwater with contaminants such as lead, magnesium, copper, zinc, chromium, arsenic, chlorides, cadmium and polychlorinated biphenyl (PCBs). ***One quart of oil can pollute 250,000 gallons of drinking water***.

Used oil is recyclable. Two and one half quarts of lubricating oil is gained by re-refining one gallon of used oil. You can participate in oil recycling by draining the used oil into a clean container with a tight fitting cap. Do not mix the recovered oil with any other liquid and make sure the oil is free from dirt, leaves and other debris. Many auto parts stores will accept your oil for recycling. Check the Yellow Pages or contact stores such as Jiffy Lube or Auto Zone for used motor oil recycling.

Automobiles use lead-acid batteries. Lead-acid batteries contain lead and sulfuric acid. The lead can contaminate water and the acid can burn skin. These batteries have approximately 18 pounds of toxic metals and a gallon of corrosive acids.

If lead-acid batteries are improperly disposed of, such as dumped in a non-hazardous landfill or an empty field, the lead and sulfuric acid can seep into the ground, contaminating the environment and ground-water supply. Damaged, leaking batteries improperly disposed of in the regular trash also pose a danger to refuse collectors who can come in direct contact with sulfuric acid. They are also a fire hazard.

Symptoms of severe lead poisoning include coma, convulsions, irreversible mental retardation, seizures and even death. Even low levels of lead exposure can result in fatigue, impaired central nervous system functions and impaired hearing.

Lead-acid batteries are recyclable. Many places that sell batteries will take the battery. Also some garages and scrap metal dealers will take the battery. If you have a used battery at home, store it safely until you can take it somewhere to recycle. For safe storage, keep the battery in a dry place inside or a lead-proof container outside. Store batteries out of the reach of children and pets.

Nationwide, 70 percent of spent lead-acid batteries are recycled. After the lead is separated from the non-metallic components of the battery, it then is smelted to produce soft lead and lead alloys. Most of these lead products are used to make new lead-acid batteries.

Antifreeze is made up mainly of water and ethylene glycol and added to the radiator water in a car to lower the freezing point and raise the boiling point of radiator fluid. In other words, it keeps the water from freezing on very cold days and boiling over on hot days.

Auto maintenance experts recommend that radiators should be flushed every one to two years. This presents a question of what to do with the radiator fluid. You have to be careful not only to store new antifreeze safely, but also to dispose of used antifreeze properly.

Because ethylene glycol is a clear, colorless and sweet-tasting liquid, it is very attractive to pets and small children. Pets will lap up an antifreeze puddle because it tastes sweet. Young children are also at risk. If swallowed, ethylene glycol may cause depression, followed by respiratory and cardiac failure, renal and brain damage. It is often fatal.

Antifreeze that is carelessly disposed of, such as poured into a storm drain or ditch, a river or stream, onto the ground, or into the trash, presents a health threat to humans, animals and the environment.

Flush antifreeze down the toilet or sink with plenty of water if your house connects to a sanitary sewer system. The sewage treatment plant will break down hazardous chemicals in antifreeze. Used antifreeze can be recycled for use by the mining industry (sprayed on coal to keep it from sticking together) and the glycol industry (used for airplane de-icing solution). It also is used in cement grinding and brake fluid.

Gasoline is toxic and extremely flammable, and never should be used as a cleanser. Always store gasoline in a cool, well-vented area away from electrical sources. Gasoline should be kept only in a metal, stopper-topped container made specifically for gasoline.

Cleansers

Some chemicals in ***cleansers*** may be hazardous to your health during routine use even though exposure is only to small amounts in the air or on your skin. You can reduce the risk to your health by avoiding products containing toxic chemicals. Or, if you must use toxic chemicals, be sure to follow the manufacturers' directions.

Organic solvents affect the central nervous system, liver and kidneys. Many are flammable and a few are suspected carcinogens. Petroleum distillates in ***polishes and sprays***, perchloroethylene in spot removers, mineral spirits in paint thinner and p-dichlorobenzene in mothballs are all examples of organic solvents.

Strong acids or bases are corrosive to skin, eyes and mucous membranes, and can react with other household chemicals. ***Acids are found in tub, tile and toilet cleaners and in rust removers***. Lye in oven cleaners and hypochlorites in ***chlorine bleach*** are examples of high-pH corrosive substances. Phenols and alcohol are poisonous and flammable chemicals and active ingredients in most ***disinfectant products***.

Although not highly toxic, synthetic detergents are the household chemicals most frequently ingested by children. "Real" soaps made from animal fat or vegetable oil are less toxic. Cleansers also may contain added dyes, perfumes, fillers, aerosol propellants, and traces of ammonia and formaldehyde. Keep in mind that hazardous wastes are produced in manufacturing all the different chemicals contained in these elaborate formulas. They generate waste problems even before you buy them.

Paint

Leftover oil or solvent-based paint is a hazardous waste. Toxic, dangerous chemicals used in the production of oil-based paint can pose serious threats to human health and the natural environment if handled or disposed of improperly.

A Johns Hopkins University study found 300 toxic chemicals and 150 carcinogens that may be present in paint. Hazardous chemicals can be found in each of the four basic components that make up oil-based paint: resins, solvents, pigments and additives.

Resins that cover the surface may contain ethylene, which may cause headaches, dizziness and loss of consciousness. Ethylene also is flammable and can be toxic to aquatic wildlife. Urethane alkyds, which cause nausea, vomiting, and drowsiness, also may be present. Solvents that keep the resin liquefied contain aromatic hydrocarbons such as mineral spirits and toluene. Mineral spirits can be a skin, eye, nose, throat and lung irritant, as well as flammable. Very ***high air concentration may cause unconsciousness and death***. Toluene may irritate the eyes, respiratory tract and skin. Acute exposure results in central nervous system depression.

Pigments that provide the color may contain heavy metals such as cadmium and chromium. Cadmium irritates the respiratory tract while chromium is an eye and skin irritant. Pigments also may be made with zinc oxide, which can cause flu-like symptoms. Additives, such as thickeners and fungicides, may contain heavy metals such as mercury compounds, which can irritate the skin and mucous membranes.

If oil-based paint is thrown into the trash and ends up in a sanitary landfill, there is the potential health hazard of the chemicals seeping into the groundwater and possibly being consumed by animals or people. In addition, since oil-based paint is flammable, refuse workers may be injured and equipment may be damaged during trash collection.

If you must use oil-based paint, buy only the quantity needed. Measure the space you wish to paint and ask for help from the retailer to purchase the right amount.
Reuse or recycle leftover paint by giving it to someone who can use it, such as a neighbor or friend, theater group, school, or other community organization.

If possible, use latex or water-based paint instead because they are made up of less hazardous ingredients. Latex paint is easy to apply and can be cleaned with soap and water. Latex paint also is less harmful to the environment than oil-based paint, which contains more hazardous ingredients.

Carbon Monoxide Poisoning [7]

You can't see or smell carbon monoxide, but at high levels it can kill a person in minutes. Carbon monoxide (CO) is produced whenever any fuel such as gas, oil, kerosene, wood, or charcoal is burned. If appliances that burn fuel are maintained and used properly, the amount of CO produced is usually not hazardous. However, if appliances are not working properly or are used incorrectly, dangerous levels of CO can result. Hundreds of people die accidentally every year from CO poisoning caused by malfunctioning or improperly used fuel-burning appliances. Even more die from CO produced by idling cars. Fetuses, infants, elderly people, and people with anemia or with a history of heart or respiratory disease can be especially susceptible. Be safe. Practice the DO's and DON'Ts of carbon monoxide.

Know the ***symptoms of CO poisoning***. At moderate levels, you or your family can get severe headaches, become dizzy, mentally confused, nauseated, or faint. You can even die if these levels persist for a long time. Low levels can cause shortness of breath, mild nausea, and mild headaches, and may have longer term effects on your health. Since many of these symptoms are similar to those of the flu, food poisoning, or other illnesses, you may not think that CO poisoning could be the cause.

Play it Safe. If you experience symptoms that you think could be from CO poisoning:

- DO GET FRESH AIR IMMEDIATELY. Open doors and windows, turn off combustion appliances and leave the house.
- DO GO TO AN EMERGENCY ROOM and tell the physician you suspect CO poisoning. If CO poisoning has occurred, it can often be diagnosed by a blood test done soon after exposure.
- DO Be prepared to answer the following questions for the doctor: Do your symptoms occur only in the house? Do they disappear or decrease when you leave home and reappear when you return? Is anyone else in your household complaining of similar symptoms? Did everyone's symptoms appear about the same time? Are you using any fuel-burning appliances in the home? Has anyone inspected your appliances lately? Are you certain they are working properly?

Prevention is the Key to Avoiding Carbon Monoxide Poisoning

- DO have your fuel-burning appliances -- including oil and gas furnaces, gas water heaters, gas ranges and ovens, gas dryers, gas or kerosene space heaters, fireplaces, and wood stoves -- inspected by a trained professional at the beginning of every heating season. Make certain that the flues and chimneys are connected, in good condition, and not blocked.
- DO choose appliances that vent their fumes to the outside whenever possible, have properly installed, and maintain them according to manufacturers' instructions.
- DO read and follow all of the instructions that accompany any fuel-burning device. If you cannot avoid using an unvented gas or kerosene space heater, carefully follow the cautions that come with the device. Use the proper fuel and keep doors to the rest of the house open. Crack a window to ensure enough air for ventilation and proper fuel-burning.
- DO call EPA's IAQ INFO Clearinghouse (1-800-438-4318) or the Consumer Product Safety Commission (1-800-638-2772) for more information on how to reduce your risks from CO and other combustion gases and particles.
- DON'T idle the car in a garage -- even if the garage door to the outside is open. Fumes can build up very quickly in the garage and living area of your home.
- DON'T use a gas oven to heat your home, even for a short time.
- DON'T ever use a charcoal grill indoors -- even in a fireplace.

[7] Protect Your Family from Carbon Monoxide Poisoning, The environmental Protection Agency, *www.epa.gov*

- DON'T sleep in any room with an unvented gas or kerosene space heater.
- DON'T use any gasoline-powered engines (mowers, weed trimmers, snow blowers, chain saws, small engines or generators) in enclosed spaces.
- DON'T ignore symptoms, particularly if more than one person is feeling them. You could lose consciousness and die if you do nothing.

Pesticide Poisoning [8]

Although pesticides can be beneficial to society, they can be dangerous if used carelessly or if they are not stored properly and out of the reach of children. According to data collected from the American Association of Poison Control Centers, in 1995 alone, an estimated 79,000 children were involved in common household pesticide-related poisonings or exposures in the United States. An additional 19,837 children were exposed to or poisoned by household chlorine bleach.

A survey by the U.S. Environmental Protection Agency regarding pesticides used in and around the home revealed some significant findings:

- Almost half -- 47% -- of all households with children under the age of five had at least one pesticide stored in an unlocked cabinet, less than 4 feet off the ground (i.e., within the reach of children).
- Approximately 75% of households without children under the age of five also stored pesticides in an unlocked cabinet, less than 4 feet off the ground (i.e., within the reach of children). This number is especially significant because 13% of all pesticide poisoning incidents occur in homes other than the child's home.

Bathrooms and kitchens were cited as the areas in the home most likely to have improperly stored pesticides. Examples of some common household pesticides found in bathrooms and kitchens include roach sprays; chlorine bleach; kitchen and bath disinfectants; rat poison; insect and wasp sprays, repellents and baits; and, flea and tick shampoos and dips for pets. Other household pesticides include swimming pool chemicals and weed killers.

EPA regulates pesticides in the United States under the pesticide law (the Federal Insecticide, Fungicide, and Rodenticide Act). Since 1981, the law has required most residential-use pesticides with a signal word of "danger" or "warning" to be in child-resistant packaging. These are the pesticides which are most toxic to children. Child-resistant packaging is designed to prevent most children under the age of five from gaining access to the pesticide, or at least delay their access. However,
individuals must also take precautions to protect children from accidental pesticide poisonings or exposures.

Recommendations for preventing accidental poisoning include the following:

- Always store pesticides away from children's reach, in a locked cabinet or garden shed. Child-proof safety latches may also be installed on cabinets and can be purchased at your local hardware stores;
- Read the label first and follow the directions to the letter, including all precautions and restrictions;
- Before applying pesticides (indoors or outdoors), remove children and their toys as well as pets from the area and keep them away until the pesticide has dried or as long as is recommended by the label;

[8] Pesticides and Child Safety, The Environmental Protection Agency, *www.epa.gov*

- If your use of a pesticide is interrupted (perhaps by a phone call), properly reclose the package and be sure to leave the container out of the reach of children while you are gone;
- Never transfer pesticides to other containers that children may associate with food or drink;
- Never place rodent or insect baits where small children can get to them;
- Use child-resistant packaging properly by closing the container tightly after use;
- Alert others to the potential hazard of pesticides, especially caregivers and grandparents;
- Teach children that "pesticides are poisons" -- something they should not touch;
- Keep the telephone number of your area Poison Control Center near your telephone.

IN CASE OF AN EMERGENCY, try to determine what the person was exposed to and what part of the body was affected before you take action, since taking the right action is as important as taking immediate action. If the person is unconscious, having trouble breathing, or having convulsions, give needed first aid immediately. Call 911 or your local emergency service.

If the person is awake, conscious, not having trouble breathing, and not having convulsions, read the label for first aid instructions and contact your local Poison Control Center, physician, 911 or your local emergency number -- remember to act fast because speed is crucial! In most cases, the pesticide products label provides you with a "Statement of Treatment" to follow in emergencies.

Lead Poisoning [9]

Lead has long been recognized as a harmful environmental pollutant. In late 1991, the Secretary of the Department of Health and Human Services called lead the "number one environmental threat to the health of children and others in the United States." There are many ways in which humans are exposed to lead: through air, drinking water, food, contaminated soil, deteriorating paint, and dust. Airborne lead enters the body when an individual breathes or swallows lead particles or dust once it has settled. Before it was known how harmful lead could be, it was used in paint, gasoline, water pipes, and many other products.

Old lead-based paint is the most significant source of lead exposure in the U.S. today. Harmful exposures to lead can be created when lead-based paint is improperly removed from surfaces by dry scraping, sanding, or open-flame burning. High concentrations of airborne lead particles in homes can also result from lead dust from outdoor sources, including contaminated soil tracked inside, and use of lead in certain indoor activities such as soldering and stained-glass making.

Health Effects: Lead affects practically all systems within the body. Lead at high levels (lead levels at or above 80 micrograms per deciliter (80 µg/dl) of blood) can cause convulsions, coma, and even death. Lower levels of lead can cause adverse health effects on the central nervous system, kidney, blood cells. Blood lead levels as low as 10 µg/dl can impair mental and physical development.

Steps to Reduce Exposure:

- Keep areas where children play as dust-free and clean as possible.
- Leave lead-based paint undisturbed if it is in good condition; do not sand or burn off paint that may contain lead.
- Do not remove lead paint yourself.
- Do not bring lead dust into the home.

[9] Lead, The Environmental Protection Agency, *www.epa.gov*

- If your work or hobby involves lead, change clothes and use doormats before entering your home.
- Eat a balanced diet, rich in calcium and iron.

The effects of lead exposure on fetuses and young children can be severe. They include delays in physical and mental development, lower IQ levels, shortened attention spans, and increased behavioral problems. Fetuses, infants, and children are more vulnerable to lead exposure than adults since lead is more easily absorbed into growing bodies, and the tissues of small children are more sensitive to the damaging effects of lead. Children may have higher exposures since they are more likely to get lead dust on their hands and then put their fingers or other lead-contaminated objects into their mouths.

Get your child tested for lead exposure. To find out where to do this, call your doctor or local health clinic. For more information on health effects, get a copy of the Centers for Disease Control's, Preventing Lead Poisoning in Young Children (October 1991).

Secondhand Smoke [10]

Secondhand smoke is a mixture of the smoke given off by the burning end of a cigarette, pipe, or cigar, and the smoke that is exhaled from the lungs of the smoker. Secondhand smoke is also called environmental tobacco smoke (ETS); exposure to secondhand smoke is often called involuntary smoking or passive smoking.

Why Should Homeowners Be Concerned About Secondhand Smoke?

- Effect on Lungs...people who breathe secondhand smoke are more likely to suffer from pneumonia, bronchitis, and other lung diseases.
- Ear Infections...people who breathe secondhand smoke can have more ear infections.
- Asthma...people who breathe secondhand smoke can have more asthma attacks and the episodes can be more severe. In fact, secondhand smoke is believed to cause thousands of healthy children to develop asthma each year. Infants and very young children who breathe secondhand smoke are more likely to get lung infections, resulting in thousands of hospitalizations each year.

What Can I Do to Reduce Health Risks from Secondhand Smoke?

- Choose not to smoke in your home and don't permit others to do so.
- Choose not to smoke if children are present, especially infants and toddlers. They are particularly susceptible to the effects of passive smoking.
- Don't allow baby-sitters or others who work in your home to smoke in the house or near your children.
- Choose not to smoke in your car.
- Find out about the smoking policies of the day care providers, pre-schools, schools, and other care-givers for your children. Help other parents understand the serious health risks to children from secondhand smoke. Work with parent/teacher associations, your school board and school administrators, community leaders, and other concerned citizens to make your child's environment smoke free.

Indoor Pollution [11]

Indoor pollution sources that release gases or particles into the air are the primary cause of indoor air quality problems in homes. Inadequate ventilation can increase indoor pollutant levels

[10] Secondhand Smoke, The Environmental Protection Agency, *www.epa.gov*
[11] What Causes Indoor Air Pollution?, The Environmental Protection Agency, *www.epa.gov*

by not bringing in enough outdoor air to dilute emissions from indoor sources and by not carrying indoor air pollutants out of the home. High temperature and humidity levels can also increase concentrations of some pollutants.

Pollutant Sources

There are many sources of indoor air pollution in any home. These include combustion sources such as oil, gas, kerosene, coal, wood, and tobacco products; building materials and furnishings as diverse as deteriorated, asbestos-containing insulation, wet or damp carpet, and cabinetry or furniture made of certain pressed wood products; products for household cleaning and maintenance, personal care, or hobbies; central heating and cooling systems and humidification devices; and outdoor sources such as radon, pesticides, and outdoor air pollution.

The relative importance of any single source depends on how much of a given pollutant it emits and how hazardous those emissions are. In some cases, factors such as how old the source is and whether it is properly maintained are significant. For example, an improperly adjusted gas stove can emit significantly more carbon monoxide than one that is properly adjusted.

Some sources, such as building materials, furnishings, and household products like air fresheners, release pollutants more or less continuously. Other sources, related to activities carried out in the home, release pollutants intermittently. These include smoking, the use of unvented or malfunctioning stoves, furnaces, or space heaters, the use of solvents in cleaning and hobby activities, the use of paint strippers in redecorating activities, and the use of cleaning products and pesticides in house-keeping. High pollutant concentrations can remain in the air for long periods after some of these activities.

Ventilation

If too little outdoor air enters a home, pollutants can accumulate to levels that can pose health and comfort problems. Unless they are built with special mechanical means of ventilation, homes that are designed and constructed to minimize the amount of outdoor air that can "leak" into and out of the home may have higher pollutant levels than other homes. However, because some weather conditions can drastically reduce the amount of outdoor air that enters a home, pollutants can build up even in homes that are normally considered "leaky".

Outdoor Air

Outdoor air enters and leaves a house by: infiltration, natural ventilation, and mechanical ventilation. In a process known as infiltration, outdoor air flows into the house through openings, joints, and cracks in walls, floors, and ceilings, and around windows and doors. In natural ventilation, air moves through opened windows and doors. Air movement associated with infiltration and natural ventilation is caused by air temperature differences between indoors and outdoors and by wind. Finally, there are a number of mechanical ventilation devices, from outdoor-vented fans that intermittently remove air from a single room, such as bathrooms and kitchen, to air handling systems that use fans and duct work to continuously remove indoor air and distribute filtered and conditioned outdoor air to strategic points throughout the house. The rate at which outdoor air replaces indoor air is described as the air exchange rate. When there is little infiltration, natural ventilation, or mechanical ventilation, the air exchange rate is low and pollutant levels can increase.

Indoor Air

Health effects from indoor air pollutants may be experienced soon after exposure or, possibly, years later.

Immediate effects may show up after a single exposure or repeated exposures. These include irritation of the eyes, nose, and throat, headaches, dizziness, and fatigue. Such immediate effects are usually short-term and treatable. Sometimes the treatment is simply eliminating the person's exposure to the source of the pollution, if it can be identified. Symptoms of some diseases, including asthma, hypersensitivity pneumonitis, and humidifier fever, may also show up soon after exposure to some indoor air pollutants.

The likelihood of immediate reactions to indoor air pollutants depends on several factors. Age and preexisting medical conditions are two important influences. In other cases, whether a person reacts to a pollutant depends on individual sensitivity, which varies tremendously from person to person. Some people can become sensitized to biological pollutants after repeated exposures, and it appears that some people can become sensitized to chemical pollutants as well.

Certain immediate effects are similar to those from colds or other viral diseases, so it is often difficult to determine if the symptoms are a result of exposure to indoor air pollution. For this reason, it is important to pay attention to the time and place symptoms occur. If the symptoms fade or go away when a person is away from home, for example, an effort should be made to identify indoor air sources that may be possible causes. Some effects may be made worse by an inadequate supply of outdoor air or from the heating, cooling, or humidity conditions prevalent in the home.

Other health effects may show up either years after exposure has occurred or only after long or repeated periods of exposure. These effects, which include some respiratory diseases, heart disease, and cancer, can be severely debilitating or fatal. It is prudent to try to improve the indoor air quality in your home even if symptoms are not noticeable.

While pollutants commonly found in indoor air are responsible for many harmful effects, there is considerable uncertainty about what concentrations or periods of exposure are necessary to produce specific health problems. People also react very differently to exposure to indoor air pollutants. Further research is needed to better understand which health effects occur after exposure to the average pollutant concentrations found in homes and which occurs from the higher concentrations that occur for short periods of time.

AGENT CLAIMS

Our claims course would not be complete without addressing claims that occur against agents. It is estimated that one in seven agents face an errors and omissions claim each year. Conflicts of this gravity challenge your reputation, waste enormous time and could threaten your financial well-being. ***Basic measures*** to limit exposure 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.

MANAGING CONFLICTS

Following are some steps to consider in managing the risk of selling insurance:

Step 1
Know your basic legal responsibilities as an agent and only exceed them when you are absolutely sure what you're doing. Pull out your agency agreement right now and ***read it***!!! When you decide that you want to be more than an agent, i.e., ***a specialist or expert***, 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.

Step 2
Learn from other agent mistakes. The best school in town is the one taught by agents who have already had a problem. Study their errors, learn from them and make sure you don't repeat them.

Step 3
Be aware of and avoid current industry conflicts that could develop into problems for your agency. There are hundreds of professional industry publications and online sources that will help you keep abreast. Once you are aware of a potential problem, take action to make sure it doesn't end up at your doorstep.

Step 4
Maintain a strong code of ethics . As you will see from our discussion of ethics, you don't need a list of degrees or designations to be ethical. Simply be as honest and responsible as possible.

Step 5
Be consistent in your level of "due care". Adopt a code of procedures and create an operations manual that forces you to treat client situations the same way every time. 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.

Step 6
Know every trade practice and consumer protection rule you can and act within standards of other agents. The violation of "unfair practice rules" is a really big deal to lawyers. They will

portray you as something short of a “master criminal” for the smallest of violations, especially if they are outside the standards of others working in your same profession.

Step 7
Use client disclosures whenever possible. There is nothing more convincing than a client’s own signature witnessing his knowledge of the situation or a note in an application offering an explanation.

Step 8
Spend more time with client applications (at least 50% more time than you do now). The information provided in an application is serious business. Mistakes, whether intentional or not, can void a policy or reduce benefits and lead to a lot of trouble for your client and you. Use mini-disclosures to evidence your position and reasoning.

Step 9
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 not “hearsay”.

Step 10
Maintain and understand your errors and omission insurance. This policy is your “first line of defense”, but know its limitations and gaps.

Now let’s expand on some of these steps:

Know Your Agent Responsibilities

The Agent & Client Duties

An agent generally acquires only those duties normally found in any agency relationship. Unfortunately, many assume more duties by working outside the scope of these agreements.

Your agency contract is a good source of basic duties. Overall, the basic duty of agents is to select a company and a coverage and bind it (if you have binding authority -- casualty agents). Where clients have come to you and requested coverage, you need to decide whether it is available and if the client qualifies.

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

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

The 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***. They include Duty of Care and Skill, using standard care and skill; Duty of Good Conduct or acting so as not to bring disrepute to the principal; Duty to Give Information by communicating with the principle and clients; Duty to Keep Accounts by keeping track of money; Duty to Act as Authorized; Duty to be Practical and not attempt the impossible; 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 incompetency or untrustworthiness in the conduct of any business, or has exposed the public or those dealing with him or her to danger of loss. In **Goldberg vs Barger (1974)**, an application for an insurance license was denied by one state on the basis of reports and allegations in other states involving the applicant's violations of laws, misdealing, mismanagement and missing property concerning "non-insurance" companies.

Activities Circumventing The Law

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; or (4) fails to perform a duty or act expressly required of him or her by the insurance code. In **Hohreiter vs. Garrison (1947)**, the Commissioner revoked a license because the agent misrepresented benefits of policies he was selling and had entered false answers in applications as to the physical condition of the applicants. In **Steadman vs. McConnell (1957)**, a Commissioner found a licensee guilty of making false and fraudulent representations for the purpose of inducing persons to take out insurance by misrepresenting the total cash that would be available from the policies.

Agent Dishonesty

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

disciplinary action against the persons he or she aided or abetted. In **McConnell vs. Ehrlich (1963)**, a license was revoked after an agent made a concerted effort to attract "bad risk business" from drivers who 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, RICO (criminal) violations, etc.

License Responsibilities

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

License Authority

A person or employee shall not act in the capacity of an agent/broker without holding a valid agent/broker license. This becomes the "age-old test" of what activities constitute an insurance producer. It is generally assumed that anyone quoting premiums or terms of an insurance contract should be licensed. However, insurance departments across the country have pushed to constantly expand the definition of who in an agency should be subjected to licensing as an insurance producer. To avoid unintentional noncompliance, many agency principals have licensed almost all staff members, regardless of how limited and passive the functions they perform. By contrast, the staff of ***insurance companies are exempt*** from producer licensing for a wide variety of service functions such as collecting premiums, mailing and delivering insurance policies and taking additional information requested by the agent or the insurer concerning and applicant or other transaction over the phone.

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

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

Recent controversy has surfaced concerning the granting of producer licensing and special privileges (exemption from licensing) 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. One state (Texas) has strictly prohibited agents and firms from entering to solicit property/casualty insurance business (life and health sales are permitted) without forming a corporation or agency and physically opening a Texas office. Soliciting is defined as direct mail, telephone or any other form of communication, 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 insureds. Many states require proof of continuing education credits for non-resident agents in those lines of insurance they are licensed or physically go to the state and pass a test before renewal or relicensing.

Display of License

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

Records

Agents, should maintain a record-keeping system that will provide a sufficient "paper-trail" to identify specific insurance transactions and dates. At a minimum, such record systems should track the name of the insurer, the insured, the policy number and effective date, date of cancellation, premium amounts and payment plans, dates premiums are paid and forwarded or deposited to a the insurer or trust account, commissions (and who gets them). Where an agent trust bank account is used, agents should maintain all bank statements, deposit records and canceled checks. Most records should be kept for a total of 5 years after the expiration or cancellation of the policy. Some states require that records be maintained"on-site" for one year after expiration or cancellation or stored off-premises but available within two business days.

Agent Files

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

Agent Business and Marketing Practices

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

Applications

Proper attention to the completion and submission of applications cannot be stressed enough. Spend at least 50% more time than you do now on applications. Mistakes by you or a client can

void, decline or reduce coverage. Be accurate, timely and explain to clients the serious nature of misrepresenting information they provide. ***Tip***: Use mini-disclosures in applications to note the source of suspicious information or to justify your reasoning, e.g., if you are basing an exchange on an IRS code, include the code section in the application.

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

False Claims

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

Unfair Business Practices

It is a violation in most states for agent/brokers to fail to act promptly and in good faith regarding an insurance claim, fail to confirm or deny coverage applied for within a reasonable time, dissuade a claimant from filing a claim, 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 ***(Certain states)***
Agents must clearly disclose in writing, signed by the client, their intention to replace insurance with a new policy and that the existing insurance will lapse, be forfeited, surrendered or terminated, converted to a paid-up or reduced paid-up contract, etc. A copy of this "replacement notice" shall be sent to the existing insurer (by the new insurer). Additional requirements typically include the completion of specific sections of the insurance application where the agent must acknowledge that he or she is aware of the replacement.

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

Agent Ethics

It is difficult to discuss matters of agent responsibility and reducing liability without exploring ethics. As it relates to insurance agents, ethics go beyond the maintenance of "moral standards". ***Insurance ethics involves the maintaining of honest standards and judgments that place the client first.*** To keep it simple, just remember the old adage "the customer is king".

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, i.e., you are a person with good ethics. Take the case of **Grace vs Interstate Life (1996).** 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", few, if any, "Ethics & Due Care" certificates.

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.

Instilling ethics is a process that must start long before a person chooses insurance as a career. It is probably part of the very fiber that is rooted in lessons parents teach their children. So, preaching ethics in this book may not be incentive enough to sway agents to stay on track. It may be easier to explain that honesty and fair play could mean cleaner sales and lessen the possibility of lawsuits.

Disclosure

Client Disclosure

Without a proper disclosure of facts and terms, it will be impossible for your clients to make informed decisions. Not surprising, failure to disclose important policy or product information is a major area of conflict leading to denied claims and lawsuits involving agents and insurers alike. What can you do to minimize disclosure conflicts? First off, make sure you tell the truth; the whole truth; and nothing but the truth when selling product. To make sure that you clients have understood what you said, develop a standard procedure (backed up in writing) of asking the ***3 closing questions:***

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

In addition to this, 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. The sample on the next page was composed by an agent's association and is provided for educational purposes only. ***Before using any disclosure letter speak to an attorney for approval***. Also, know that specific products may require different wording.

Additional ***attachments*** to this letter could disclose options ***the client chose to refuse***, such as: The opportunity to seek tax, legal or business advice prior to making any insurance purchase or the availability and cost of various options or riders to a policy that were available and suggested at time of purchase (waiver of premium, higher deductible options, exclusions, etc).

Also, you should consider using ***mini-disclosures*** in your applications. For instance, if you were basing the exchange of two policies on a specific IRS Private Letter Ruling, why not cite it in the application?

Agents have successfully used disclosures to qualify a promise of coverage as in **T.G.I. East Coast Construction vs Fireman's Fund Insurance (1985)**. Here, 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.

In **Eddy vs Sharpe (1988)** an agent proposal included the following disclosure: "This proposal is prepared for your convenience only and is not intended to be a complete explanation of policy coverage or terms. Actual policy language will govern the scope and limits of protection afforded." While this seems to cover any omission the agent might make in his proposal, he was found liable for client losses because his proposal also listed eight specific exclusions of the policy. Unfortunately, the one he left out was the peril that damaged the client's policy.

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

Insurer Disclosures

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

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

- Loss of insurer indemnification if there is ***any*** wrongdoing by the agent.
- Forfeit of all agent profit-sharing and override payments earned if the agent is terminated.
- Agent indemnification of the company even if the insurer was the significant contributor to the liability.

Clearly, you would have a difficult time defending your position if you have signed documents with this wording . . . ***read your agency agreements!***

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

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 ***indemnification policies.***

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

Exclusions

Aside from the primary limits of the policy ($1 Million seems to be the limit of choice for most agents) the ***cost of defense*** is the most important exclusion to watch. Does your errors and omission policy ***include defense costs as part of the limit***? If so, the amount of money available to pay monetary or punitive awards will be significantly reduced. Defense costs can also be ***limited to a percentage of policy limits***. Here, when the number is reached, ***you*** start paying for the balance of defense costs. Obviously, the best errors and omission plan will pay for all ***defense costs in addition to policy limits***.

The ***claims made*** exclusion is the next consideration. If you have one, you will be covered for only the claims that occur while the policy is in force. If so, how will you handle a claim problem that occurs down the road, say at retirement, when you have dropped your policy? Actually, you may have little choice in the matter since most policies today are written on a claims made basis versus an ***occurrence basis***. However, there are endorsements, 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); 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; judgements -- some policies only pay if a judgement is obtained against you; some exclude contractual obligations in the form of "hold harmless" clauses (watch them); outside services like the sale of securities, real estate or notary work.

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

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

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

E&O Claims

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

Generally, it is in your best interest to cooperate fully with the company by assisting in any evidence gathering and witness lists. However, this same spirit of cooperation does NOT always extend to your client. Most errors and omissions insurers do NOT want you or any staff member to make any voluntary admission of guilt to the client. Never blame the insurance company in any way or make any statement that might lead them to believe that the situation will be cured. While you can be cordial and calm in dealing with the client, be careful NOT to give any advice, legal or otherwise. If you are absolutely positive the claim is wrong, you can deny it, but never offer to settle.

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

Cooperation also extends to any settlement offer proposed by your errors and omissions company. If your E&O insurer suggests a settlement offer that you do no agree with, and the case ended with a higher judgement that 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 coverages or records that show a clients 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.

Put It In Writing

The legal purpose of documenting client transactions is to establish evidence. Evidence can be ***parol 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, e.g., You offer a special endorsement coverage to everyone and log their acceptance or denial in the client file.
- Instead of “post-it” notes and scattered comments in client files make a point to transfer the content of these notes to a formal log kept in every client file.

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. We use a program called “Maximizer” which allows a quick location of a client file and fast entry of the conversation. Retrieval is a snap.

Applications For Insurance

Complete and legible copies of the original application for coverage are extremely important. They presumably show the "intent" of the insured when he took out the policy, what he communicated to the agent regarding his wishes, whether the agent followed his wishes as to coverage requested and whether the insurance company followed the wishes of the agent who requested a policy of insurance pursuant to the wishes of the insured. Also, a material misrepresentation of fact by the insured in his application may cause the policy to be declared void (American Family Mutual Insurance Co vs. Bowser - 1989)

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. In **State Farm Fire & Casualty vs. Gros (1991)**, lack of notation regarding a client conversation three years before the loss was evidence upon which a jury concluded that the agent misrepresented the terms of the policy to the insured.

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

As the industry edges closer to “paper less” 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 can't say there was nothing inside since the address was on the letter showing through the envelope window.

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 plaintiffs vantage, non-compliance of policy procedures that you establish may work against you.

Your operations manual should cover procedures for dealing with client applications, claims, policies and certificates, insurance companies and any special services you plan to offer. 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. Chapter 2 discusses many routine questions concerning agent due care and client needs.
- 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, etc.
- 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.
- As mentioned above, all oral agreements and binders should be reduced to writing and dated in the file.
- Policies received should be checked against "specimen policies" to be sure it is the same contract and against the client application to be sure it meets client needs
- Endorsements should be processed as soon as possible. Make notes that show the policy has been endorsed and create a follow-up system that compares any endorsement papers mailed with the endorsement received from the insurance company.
- Cancellation procedures should comply with state regulations and policy provisions. Notices to client should be tracked and posted in the client file. Also, be sure that the client does

NOT continue receiving a bill after cancellation.

- Renewals should be sent within a specified time before expiration of the policy (usually 60-90 days). Experts agree that if you can't reach the client you should order the renewal anyway. Posting and tracking any notices to file is very important.
- Expirations should comply with state and policy provisions. Always notify client of any expiration.

The Agent Call Center

Some of the biggest conflicts with customers occur over communication or lack thereof. And, the problem compounds as the world finds more ways to communicate. The insurance client of the new millennium may wish to reach you in several ways . . . phone, cell phone, PDAs, voice mail, fax, mail, e-mail, internet text chat, and voice over Internet protocol. Truly, this is an era of the "multi-channel" customer experience. As an agent who wants and needs to serve his customers, there is little you can do to keep from participating in some or all of these communication systems. However, there is much you must do for proper loss control.

Collectively, the system you establish to receive client communications is referred to as the ***agent call center***. The call center concept was built on the premise that customers initiate contact, and that whatever they need can either be handled in real time by the agent, or handed off to an automated system. In the past, a typical agent call center consisted of a telephone and an answering machine. However, with the growing communication options now demanded by clients, these call centers are upgrading to the status of ***call plus***. Telephones aren't going away, but the alternative channels are now so numerous, and becoming more heavily used, that a mixture of communication methods is now needed to serve customers.

Your call center or call plus can be a vital link to serve your clients better, but it can also be vulnerable to problems or even legal exposure. Let's discuss some of the ways to improve it and minimize the obvious problems that surface with multiple modes of communication.

Principles of Communication

Whatever mode of communication used by your or your clients, there are certain general principles you need to follow to make sure you are meeting client needs and eliminating potential confusion.

Clear communication is always your goal. For instance, when handling an instruction or request, it would be wise to ***repeat your understanding*** to the other person. Let's say that Mr. Dean called your office and advised you drop coverage on a boat. You might respond by saying . . . "Mr. Dean, as I understand it, you want to drop the coverage on your boat . . . "

If you are making a recommendation, you need to thoroughly explain the client's ***options and consequences***. For example . . . "Mr. Brighten, we recommend that all our customers buy high-deductible medical coverage. Even though you will being paying a portion of costs, you premiums and total out-of-pocket costs will be lower. But the lifetime coverage is the same as your previous policy . . . "

Always confirm that you are ***meeting client needs***. "Mr. Smith, have I given you all the information you need to make a decision?" Does this policy make sense to you"? "Is there anything else I can answer for you to assure you that this is the right solution based on your needs?"

Be sure that your client always understand his ***current insurance coverage status***. "Mrs. Johnson, do you understand that you will not have coverage until the company approves your application and issues a policy?"

When you and your client are satisfied that you are BOTH communicating on the same wavelength you still need to ***document what was said, what was done and what needs to be done***. For instance, it would be smart to follow-up a phone conversation about dropping a certain coverage with a letter outlining your understanding of the matter. Likewise, you would want to have a client sign-off on a rejection of coverage, the establishment of certain coverage limits, coverage NOT provided by your agency, important limitations of a policy, etc.

Telephones

For the not-too-distant-future, it is unlikely that the telephone will be totally replaced with alternative forms of communication. Instead of complicated e-mail, Internet or fax transmissions, a healthy portion of your clients will always prefer to simply dial you up with their problems and needs

One of the most important things to remember about phone calls is that they are not a permanent record of your communication with a client like letters, e-mail or faxes. There are countless lawsuits, and as many judgement awards against agents, where there were no "notes to the file" to verify the basis of a client/agent discussion. Your ***standard operating procedure*** should include a system to immediately document client phone calls, inbound and outbound, between you, clients and your staff. Every call should be logged into the client's file or, better yet, a ***contact management system*** to document what was said and the result of the conversation. Where needed, a follow-up letter documenting the basis of the phone call can be sent to the client.

As far as improving your phone calls consider the following advice:

- Call your company and ask for yourself or have someone do it for you. Try different times of the day and listen closely to the general demeanor of your employees. Are they courteous, helpful, enthusiastic, accurate?
- Call your company and pose as an existing customer or pose as a new one. Ask for different departments, voice a complaint or leave a message for a call back. Being passed from one wrong person to another can make a client feel unimportant and frustrated. Th initial contact should determine who best to handle the call and solve the problem.
- Make sure that all incoming calls are answered before the third ring. Always ASK if it is OK before you put someone on hold before you do. A good phone system will let you know if the caller has been on hold too long. Offer to call ask if necessary and find out when this will be convenient.
- Take complete and accurate messages. Incomplete phone messages or lost scraps of paper are not acceptable procedures.
- Return all messages within one business day or less. If you promise to call someone back by a certain time make sure you do . . . even if you still don't have an answer for his question. It is important to do what you say you are going to do every time.
- If your company has a menu of options, listen to it carefully. Does it make sense. Does it work?
- Try NOT to use a speaker phone unless you really need to because a caller may feel as though their conversations are less than private.
- Call new clients to make sure that their policy or information you sent them arrived.

- Call existing clients on a regular basis, just to say hello, or tell them about a new offering.
- If you leave a voice mail message for someone, speak slowly and clearly. Give the purpose for the call and a good time for them to call you back.
- If calls are taken at home, make sure family members understand the rules on message taking.
- Unlicensed people in your office need to know the proper procedures and what they can and can't say to clients.
- Hire customer service people who have insurance knowledge and a pleasant phone voice. Clients are more likely to trust a friendly, confident person on the other end of the line over one who is abrupt, uninterested or combative.

Cell Phones

Cellular phones are a modern-day marvel and a potential E&O tragedy. There are concerns about privacy and the basic inability to reach the intended party when needed. Equally important is the fact that calls are taking place outside the office where it is much more difficult to document the conversation.

Automated Messaging

Answering machines and voice mail systems are inexpensive methods to take calls in your absence. Newer systems are capable of documenting the time and date a call was received. However, all such systems are capable of breaking down when you most need them and/or distorting a message. Answering machines in an agency should not take messages. They should be limited to listing agency hours and an emergency number if needed. If you use one, your outgoing message should clearly state that your machine does not take messages. Claims and coverage issues must ONLY be handled during normal business hours with a "live" person.

Fax Messaging

Your fax machine is an incredibly useful part of your call center. One of the most important issues in handling faxes is to make sure they are delivered to the appropriate person and responded to in the same manner as a letter.

Is it a good idea to leave your fax on 24/7? What if a client faxes a request for coverage at 3 AM on Saturday and has a claim on Sunday? While the fax may constitute a legal request by the insured, there is no acceptance of that offer. In other words, leaving a fax machine on after hours does not necessarily bind an agent.

Here are some more things to keep in mind concerning faxes:

- Most states accept fax signatures and documents as good as the original. However, the paper on some fax machines (thermal paper) is know to fade over time. For this reason and others, it is always a good idea to not rely solely on faxes. Try and get the original in your file as soon as possible.
- Faxes are not a 100% reliable delivery system. For unknown reasons, they sometimes don't get to their destination even when your machine shows a confirmation that the message was received. For important documents, it is always wise to call and confirm delivery.
- Confidential information should not be faxed without the approval of the parties involved. It is best to call the intended receiver before the fax it sent.
- Faxes you receive should be date stamped and filed.

Online Communications

The Internet is a rich component for customer service. The challenge for agents is to bring the same level of excellence they have placed on traditional call center systems to their websites.

Online communications are evolving rapidly. Unfortunately, customer care is moving at a much slower pace. Recent studies, for example, have found that only a small percentage of customers who sent an e-mail regarding an inquiry or purchase receive a follow-up e-mail. The same customer who telephoned their agent would be outraged to NOT receive a return call. To avoid this, your ***e-mails should be treated like a phone call.*** Check them often and return them promptly.

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. For the best protection, use software that requires passwords.

Online customers today are expecting more from e-commerce sites than just e-mail. Those who use the Internet often like the control it gives them. They can seek information, contact you and even complete transactions without ever speaking to a single person. The question of whether large numbers of customers will actually buy "end-to-end" policies online is yet to be determined. Still, it is important that any information you provide them be accurate and clear. Important terms, conditions, options and disclaimers should be as visible and noteworthy on any website as they are on paper. For example, if your site is primarily being used to advertise your services, it is recommended that you advise customers that they will have to call or write you to receive coverage.

As technology in this area progresses, it is likely that when consumers start purchasing insurance online they will be prompted through each phase of the transaction, perhaps with "live" assistance from an agent. Online delivery, e-signatures, witnessing and servicing of policies will eventual be available. For now, this appears to be a few years from being commercially successful. Until then, traditional call center systems -- phone, fax and mail -- will continue to play an important role in supplementing and serving online customers effectively.

Customer Handling For Fewer Claims

Clients may have very complex needs and you may be the best agent around at anticipating them, but, it means nothing if you don't also ***meet their needs.*** In fact, how clients are handled after the sale is as much a legal responsibility as disclosure and ethical practices before and during a policy transaction.

Established as such, agents must understand the importance of customer service and customer retention.

A recent survey of 46,000 businesses (InfoQuest, 2001) concluded the following about customer service:

- A ***totally satisfied customer*** contributes 2.6 times as much revenue to a company as a *somewhat satisfied customer*.
- A ***totally satisfied customer*** contributes 17 times as much revenue as a *somewhat dissatisfied customer*.
- A ***totally dissatisfied customer*** decreases revenue at a rate equal to 1.8 times that contributed to the business by a *totally satisfied customer*.

The point of this survey is quite obvious . . . create as many ***total satisfied customers*** as you can.

When it comes down to it, insurance customers do not buy products or services -- they buy ***satisfaction***. They do not buy policies from you; they buy the benefits and satisfaction they produce. And, customer service is how you create satisfaction.

Unless you have clients who are satisfied and happy and who keep coming back, you have nothing. Always remember that it is more difficult and costlier to find new customers than retain old ones.

Too many businesses, look to simply reduce prices or provide other give-aways when, in fact, a focus on giving top service would be an easier path. Discounts are one thing, but real customer service is an opportunity to create a "customer for life".

Every involvement with a customer should be looked at as an opportunity to serve. This could mean something as simple as answering the phone in a more courteous manner or returning phone calls promptly. ***Good customer service*** involves getting to know your customers and their needs by building relationships for the future. ***Excellent customer service*** means going beyond what is normally expected; maybe even *thrilling your customer* with service that is a complete surprise. Examples might be returning a customer's call on the weekend, delivering a policy in person, instant account information, a monthly free newsletter, e-mail reminders about important due dates and so on.

What Is Customer Satisfaction

Almost everything you do in your business has an impact on your customers. A satisfied customer is someone who believes that the service you provided was something worthwhile, done in the way he or she likes it to be done. Generating satisfied customers, then, is a process of consistently doing something of value for customers in the way customers want it done, or more simply, always doing the right things right!

Why should you practice good service? Good service leads to customer satisfaction, which leads to customer loyalty, which leads to better profits. Good service is good business.

Customer satisfaction should be a goal because if you're doing it right, it makes it easier for customers to do business with you. Not only that, they'll ***want*** to do business with you.

How will you know you're doing it right? Customers will come back to do more business and they will refer their friends.

Better Service

There are a thousand ways to make your service better. Here's a few of the more important ones you need to know:

- Always be positive. This means always trying to create a situation where your customer can be satisfied. If you don't handle a particular coverage, go the extra mile and find someone who will. Take the attitude that nothing is impossible and that no effort is too much.
- Keep your word. Don't make promises you can't keep.
- Don't argue. If a problem develops between you and your customer, always remember, the customer is "king". It doesn't make sense to debate an issue to death. Even if you are right, it doesn't matter. It is the customer's perception that you are wrong that counts. In his mind, you goofed. It is better to look at it as an opportunity to fix the problem and satisfy the customer. As we saw earlier, a dissatisfied customer can cost you a lot of money and time. And they're sure to complain to ten other people. Just give him some attention and assure him it will be fixed. Then make sure you do it!
- It's ok to acknowledge your mistakes. Unless a lawsuit is at risk, don't be too proud. Let the customer know that a mistake has been made. Apologize and set in place a solution to fix it.

Handling Tough Customers

No matter how you try, you will encounter tough customers who always believe they are right and you are wrong. Here are a number of ways to handle them:

- Negotiate. Always try and find a middle ground.
- Keep you cool. Make sure you and your employees understand that it is not personal. It's business. Keep a soft tone of voice and solve the problem.
- Listen to the customer. Since they usually think they are right and you are wrong, make sure you let them know that you are aware of the problem and you are concerned that it be solved as soon as possible. You can diffuse the situation somewhat by actually taking the customer's side and agreeing with them (to some extent).
- Set a policy. While there is never an excuse for poor behavior or lack of manners, you need to develop a policy for handling problem customers and stick to it. If you are too soft, then customers can easily pick up that you are an easy mark and they will always complain. Using a database or contact manager, you can document conversations with clients to ferret the chronic complainers. As long as you are fair, you can be firm with these customers. They may not win every time, but at least they may come to respect you.

If Customers Leave

Everyone loses a customer now and then. Some move out of the area, others find someone closer to them or just like to spread their business around. You can't beat yourself up over every lost customer, however, when they leave it is a good idea to try and find out the reason and keep it from happening again. Here's what to do:

- Find out what made them leave. Were they unhappy or just what?
- Ask their advice and suggestions on how you could improve your service to keep their business. You may not get them back, but they might really appreciate that you are concerned enough to make amends.
- Try and keep in touch with customers who have left by letting them know if you have a new product or made changes in your business that might encourage them to come back.

Never Say . . .
To keep your customer satisfaction as high as possible, never find yourself or an employee saying this . . .

"Sorry, I don't know where you can find that type of coverage . . . "
"Once you buy it, you are stuck . . . "
"I don't really care about . . ."
"Sorry, you will have to talk to the company about that . . . "
"I don't know . . . "
"I'm sorry, it's closing time (or lunch). You'll have to call back another time . . ."

Elements of Good Service
Following are the elements of good service.

- Reliability. Consistent service the customer can rely on.
- Quality performance. Make sure you do things well.
- Worthwhile outcome for the customer.
- Overall service. The ability to provide good service in ***all*** your dealing with clients.

Poor Service
You already know that poor service will drive your customers away. The trouble is that you may not even know about until it's too late. Why? Because a lot of people will never complain about poor service, they'll just move on to the next agent. Worst yet, when they have the chance, they'll complain to friends, family and others that your service was poor.

It is also important to realize that good service extends to everyone you deal with, not just paying customers. Providing poor service to people because they are not paying customers is a definite way to ensure that they will not want to do business with you in the future. Like others, they will also probably complain to their friends.

Best Practices

In any given industry, someone is compelled to document the strategies and tactics employed by highly admired companies. These companies are not particularly the "best-in-class" in every area -- such a company may not exist at all. Rather, due to their nature of competition and drive for excellence, the practices they have implemented and honed place them among the most admired, the most profitable and the keenest competitors in the business.

In the early 1990's the Independent Insurance Agents of America began researching ways to reverse tough market conditions present at the time. They formed a commission to identify the most successful agencies and find out what they were doing that set them apart. A series of interviews, on-site visits and conversations among 800 offices revealed a set of common practices consistent with the most successful agencies. These common business methods became known as the basis of ***Best Practices***.

In reality, best practices may not be revolutionary or new ideas; they are just good, sound business practices. They may be things you already know, but having them broken down helps to bring attention and use them easier.

The IIAA Best Practice survey resulted in nine guidelines to maximize potential, improve agency operations and minimize claims against agents.

1. ***Focus on customer service and satisfaction***. This means not only providing good service but looking into what the customer needs and expects.
2. ***Maintain good customer contact***. Best Practice agencies use customer contacts to educate the customer, serve as the client's advocate and problem solver, and make every transaction as easy as possible. They also tend to be pro-active on pricing and introducing new products
3. ***Valued staff***. Agencies' staff are continuously provided education, training and tools to do a good job. The expectation of high performance and professional growth is often rewarded with recognition, better salaries and better benefits.
4. ***Participatory management***. Top managers are very active in day-to-day operations. Managers regularly seek employee input, especially about planning and budgeting processes. Fiscal information is not a secret and profit expectations are clear.
5. ***Vision***. Best Practice agencies have a very clear vision of where they are and where they intend to go in the future.
6. ***Win/Win supplier relationships***. Successful agencies seek to do business with companies that have a vision and embrace values like theirs. A Best Practice agency engages in joint planning.
7. ***Efficiency***. Though not all agencies are completely automated, use of efficient processes and systems is common. Bets Practice agencies strive to improve work flows t add value for their customers.
8. ***Total account development***. Best Practice agencies seek to grow through total account development. They are looking to develop a larger share of the customers' accounts.
9. ***Continuous improvement***. These agencies constantly work to improve themselves. They measure and compare themselves to peers and their own past performances.

Agents who follow best practices typically use them as a benchmark to see how they measure up with other agencies -- where they excel and where they can improve. Benchmarking is a common practice among many industries. The mission is simple: observe, learn and copy practices that lead to success. As the old adage goes: ***Success breeds success***. Product or the type of agency (life, casualty, health, etc) is irrelevant. The bottom line is that these are tools and skills the agent can use to change or improve his practice.

Customer Retention

The end result of meeting customer needs and good customer service should be a certain degree of customer loyalty. And, loyalty breeds fewer complaints and reduced claims against you – loss control at its best!

Agents, like everybody else, tend to rest on their laurels by thinking that a customer who is satisfied with his services will be loyal. This is not necessarily true. Some come and go no matter what you do. Others, stick around even when they are unhappy. And, one interesting study discovered that *the number of years the customer had been with a company was a better predictor of loyalty than satisfaction*.

So, the question becomes . . . Why bother with customer service and the meeting of needs if some of my customers are going to leave anyway? The answer is that it can cost you five times or more to get a new customer than retain an existing one. And, a lot of claims against agents arise form new clients rather than longstanding, loyal clients.

To keep more of your customers sticking around longer, with fewer complaints, you need to invest in a system of ***customer retention***. This goes beyond simple customer servicing or a monthly newsletter. It means building a relationship with clients and giving them the

encouragement to remain active in choosing your business. The ultimate goal is keep them happy and involved long enough that their devotion to you is ingrained. Who would think of leaving a trusted advisor or friend?

Instead of resigning yourself to the fact that customer attrition is normal for any business, why not try and manage it. Be proactive. You worked hard to get them, so why let them slip through your fingers. The key to retention is to ***know your clients and communicate with them often***. By conducting customer satisfaction surveys, you can determine the various levels of satisfaction and potential "mobility" of your clients. In doing so, you will be able to identify those who are likely to leave at the drop of a hat as well as the true blue "loyals". With this information, you can establish a system to keep as many customers as possible for the longest period you can.

How do you get to know customers and what do you do with the results? Conduct a customer satisfaction survey and compare the results with the length of time each customer has been with your agency. Ideally, you may also some information in their file as to how long they were with their previous agent as well. Once gathered, you should be able to use this information classify your clients into specific categories as follows:

- Safe customers are considered such because they are satisfied and not likely to change services or complains even when their satisfaction drops. Just keep what you are doing with these folks!
- High risk customers are both unhappy and more likely than others to move on or complains. Even if they satisfied, they are still prone to leaving. There may be little you can do here.
- Unhappy but static customers deserve your attention. Whether they are just lazy or fear change, they are not too interested in moving. A little more effort on your part to help improve their satisfaction can motivate them to stay longer.
- Happy but mobile people are satisfied but tend to always shop around for new deals. You need to monitor them closely for any signs of switching. A much higher degree of communication is needed here to help keep them around.

In essence, you will develop different levels of communicating with each of these groups with the ultimate goal of improving long-term satisfaction and customer retention.

Communicating and Keeping Customers Involved

Customers want to win. They like to feel they are in control and smart about the choices they make. If you are successful, you make them feel this way when they originally buy your policies and throughout the time they remain with you.

As we said before, customer retention is the process of building a relationship with them and giving them the encouragement to remain active in choosing your business. How do you foster this relationship and action? In his book Drilling Down, Jim Novo describes the steps as ***action -- reaction -- feedback -- repeat***. In a nutshell, the idea is to communicate with your customer and invoke some kind of action. You want him to "raise his hand" and say "yes" to something. Once he does, you respond with more information. The entire process is repeated on your next contact. Customers are involved and your reaction and feedback makes them feel valued and ***value*** creates long-term loyalty!

Let's discuss a few examples of how you can get clients involved:

- When it comes time for renewal of a policy, get the customer involved in the process by keeping him abreast of the companies you have shopped and the rates you found. A little back and forth conversation or correspondence will keep the client involved.
- Conduct a customer satisfaction survey and share the results with your customers. Better yet, ask them for input on the results and how they can help improve his service. When you think about it, it's hard to define the changing needs of customers without input from customers!
- Customers could become more loyal to you if you make yourself more familiar. Most agents see their customers once a year or less. Studies show, however, that the most effective plans call for at least five contacts per year. E-mails, new product offerings, birthday cards, calendars and newsletters are just a few of the ways to become more familiar. When possible, include fill-in forms for them to get some special information or local coupon.
- Asking clients for referrals is another way to get them involved. Once received, send a thank you note (reaction) and tell them how much you value their business (feedback).
- Instead of just sending your client a proposal for a new product, get him involved by ask him when he will be ready to make a decision.
- Send a "Customer Bill of Rights" outlining the services your customers can expect to receive from you. Include a feedback form and follow-up with a thank you.

In conclusion, customer retention depends on more than a process of continually improving satisfaction. It also requires dealing with the attrition that occurs even when the best service is in place.

Matching Client Needs With Product

When you are comfortable that you know your client needs and have asked the client himself, it's time to match these needs with an appropriate product.

Much has been written . . . and as much litigated . . . on the perils of matching the wrong product to a perceived client need. This is an area where agents need to exercise extra due care for the client's sake and their own financial well-being.

Questionable market conduct in the 1980's and early 1990's created new demands for today's agent. Past agent abuses have centered around twisting, wholesale replacement, deceptive advertising, misleading illustrations and other unethical acts. Regulators have responded with replacement policy forms, insurer fines, agent reprimands, and in some cases, revocation of licenses. To compound the problem, the industry's image has been occasionally tarnished by solvency problems. Further, stiffer competition, declining interest rates and thinner profit margins have impacted how insurers and agents work together -- less support in marketing and support materials. The bottom line in either case is that agents are forced to work harder and smarter. In lieu of sitting back and waiting for the market to improve, industry forecasters say that agents must accept new roles to survive.

Repeat business, referrals and long-term rewards must center more around client needs, rather than the products agents wish to sell. The trend toward "agent as counselor" is the most obvious path. Putting oneself out to be knowledgeable in many financial matters, however, will come with a price tag as you will see in this chapter. Both regulators and clients will hold insurance professionals to ever higher standards. Agent due care and sales conduct will be more important than at anytime in our industry's history. This will involve a commitment by agents to polish skills and acquire a systematic approach to filling client needs. Following are

some basic due care discussions which may help the agent get started. Of course, every situation will vary and require constant refinement:

AGENT BLUNDERS & CLAIMS

Selling and agent market conduct are the root of many insurance claims today. A few years ago, no one knew what market conduct meant. Today there are class action suits and negligence claims filed against insurers and agents alike amounting to millions of dollars for sales and legal conduct violations. Of course, agent conflict is nothing new. Our research into "blunders" found cases dating back to the early 1800's. What is different between cases of today and the ones that occurred years ago is the trend toward fiduciary responsibility. In essence, the courts are viewing agents as ***more than mere salesmen***.

Agent responsibility, in the past generation, has evolved from contractual compliance to ethical duty. Recent cases, for example, lean toward the precedent that agents, as insurance professionals, ***should have known*** something was wrong compared to years ago where agents were generally held liable for ***outright negligence*** in a matter. There ***is*** a world of difference between the two that is best explained by the ***legal precedent theory*** discussed in the preface. In a nutshell, this theory claims that because our legal system makes legal decisions based on precedents it is destined to constantly expand. Each decision in the chain sets the stage for the next step of expansion. This chain reaction is demonstrated in some recent court cases. In **Southwest vs Binsfield (1995)** the agent ***should have known*** that a specific coverage option was important to the business he insured. In **Brill vs Guardian Life (1995)** the agent ***breached his fiduciary duty*** by not using an optional conditional receipt. Clearly, the expansion of agent liability from decades-old "negligence" issues to these types of fiduciary duties is a trend. In the next chapter, we discuss these controversies and other potential conflicts which may be the next expansion phase, i.e., ***sales and legal conduct issues of the future.***

In reviewing the following court cases, keep in mind that issues in the past that did NOT result in agent liability might indeed represent exposure today, mostly because of the legal precedent theory and the fact that courts and juries in more recent years show a willingness to sanction this expansion. Further, an agent who escaped liability in a conflict may not have escaped the huge cost of a trial or legal fees. A lot of agents fail to insure for this contingency and errors and omissions carriers can also refuse to cover the claim. Also, ***don't assume that a casualty court case has no application to you if you sell life insurance and vica versa. Many legal matters concerning duties are fully portable and transferrable between classes of agent.*** Finally, be aware that some court decisions appear to "clear" the agent of wrongdoing. These decisions can result from issues extraneous to the case or a technicality

A.G. Edwards vs Drea (1998)
Plaintiff Drea claims that the agent's quote for a company medical plan was a policy that contained an "active-at-work" provision, but the policy issued excluded coverage for claims be employees who were not actively at work on the first day of the policy period. The suit forced the agent to obtain a policy with active-at-work provisions at this own expense.

Aetna of the Midwest vs Rodriguez (1988)
Based on a conversation, an agent believed his client was seeking insurance on a conditional sales contract when, in fact, client had purchased a home secured by a mortgage. A claim resulted in lack of coverage and a lawsuit commenced. The courts determined that even though the client used words that could have been interpreted two ways the agent should have investigated the "real" coverage and not simply wrote the policy in a manner that was most legally advantageous to the insurance company.

Alaniz vs Simpson (1998)
An agent owes duty not to mislead an applicant for insurance into believing he is insured when he is not. This duty also inures to the benefit of innocent third parties. In this case, the agent was not liable because he used proper procedure when he faxed a letter to the applicant that he was uninsured several hours before the applicant's employee drove a company vehicle and caused an accident. The victim of the accident (a third party) unsuccessfully tried to sue the agent on the basis that he was liable to third parties for misleading the applicant to believe he was insured. The courts disagreed and the agent was cleared of any responsibility.

American Pioneer Life vs Sandlin (1985)
An agent sold annuity policies to mostly retired clients where the average purchase was about $20,000. The agent typically represented that the principal was available at anytime and the accumulation value of the contracts were guaranteed to grow to certain levels. Both representations were so false so as to prove a fraudulent scheme for which agent was liable.

Ahern vs Dillenback (1991)
In 1982, clients were visiting California and purchased an automobile policy which agent said would cover them on an up and coming trip to Europe. Client requested "the best policy available" and agent assured client that she and her husband would receive full insurance coverage with policy limits that would safely protect them. In 1984, the client was driving in France and was seriously injured in a hit-and-run accident with an unidentified and uninsured motorist. Claims by the client were denied since the following coverages were not in the policy: collision, medical payments and uninsured motorist. Client's lawsuit against the agent was not successful in this case because the courts felt that the general duty of reasonable care that an agent owes a client does not include the obligation to procure "complete liability protection". Further, there was NO special relationship with client that held agent to a higher standard of care.

Bayley Et All vs Pete's Satire (1987)
In an unusual case a client owned a bar/lounge and was assured by the agent that his business was "fully covered" for alcohol-related lawsuits. In fact, the policy obtained for client contained an exclusion for such lawsuits. The bar was eventually sued for negligence by permitting a minor to leave the lounge while intoxicated and causing an accident. The insurance company cited the exclusion and refused to pay. The client sued both the insurance company and agent for full reimbursement of his costs to settle the accident case. The courts concluded that the insurance company was NOT liable but the agent WAS. Further, because the error was rooted in complete negligence, the agent was held liable for all future alcohol related lawsuits the client might incur.

Bedford vs Connecticut Mutual Insurance (1996)
Client purchased a whole life policy from agent under the assumption that coverage would be fully "paid-up" in six years. When it became apparent that the policy would not be paid-up in six years client sued and the courts determined that the special relationship between agent and client was a factor in determining agent's fraud.

Bell vs O'Leary (1984)
Agent took an application for flood insurance but failed to notify client that his mobile home was located in unincorporated areas that were ineligible under the National Flood Insurance Plan. A loss occurred and agent was sued. The agent tried to assert the client could NOT have purchased flood insurance from anyone and he could have known coverage was not available because the Code of Federal Regulations regarding flood coverage availability was public information. The courts did not agree rendering that agent has superior knowledge and failure

to notify clients that coverage was unavailable takes precedence over the fact that coverage was not available from any source.

Benton vs Paul Revere Life (1994)
Agent sold a disability policy to his client on basis that coverage could be extended for life for an additional premium, when in fact, the policy and rider required a higher level of disability occur before life benefits are awarded. The court was clear to point out that any agent who does not understand the differences between two products he is selling is subject to liability for fraud.

Bitz vs Knox (1998)
Agent Ed Knox was sued by Plaintiff Bitz saying he (Knox) inadvertantly submitted erroneous financial information on Dr. Bitz's disability insurance application. A subsequent disability occurred but the insurance company refused the claim based on false information in the application. Bitz had to sue the insurance company to get the full coverage he was entitled to receive, but after attorney fees he was left with 1/3 less than he needed. This led to a suit against agent Knox who won the first round in the lower courts on the basis that the insurance company didn't rely on the wrong financial data. A higher court reversed this decision making Knox liable for the coverage Bitz did not receive.

Blumberg vs Paul Revere Life (1998)
An agent was found to be liable when he marketed "guaranteed disability insurance" to a group / association regardless of previous medical history. The courts felt that the agent exceeded his authority in making new members of the association, as opposed to existing members, eligible for the guaranteed plan. The courts rules that an agent who fails to obtain insurance coverage promised is personally liable as an insurer. In this case, new member claims may fall in the agent's lap to pay.

Born vs Medico Life (1988)
A client purchased a new health insurance policy from agent with a typical six-month pre-condition waiting period. Client then canceled his old policy but soon developed health problems that were waivered by the precondition waiting period of the new policy. Client sued agent for "gaps in coverage" but court decided that agent did not have a duty to advise client about maintaining his old policy until the six-month waiting period of the new policy had expired. Also, it was discovered that agent advised client specifically about the six-month waiting period.

Brill vs Guardian Life (1995)
A client expressed a desire to obtain life insurance coverage as soon as possible. Agent took client's application but failed to advise client his option to pay a small fee for a conditional receipt which would have provided immediate, although temporary life insurance. Upon client's sudden death, his widow sued the agent and company for negligence in failing to recommend use of the conditional receipt. The court sided with the widow by determining agent's negligence was a breach of duty.

BSF Inc vs Cason (1985)
An agent met with a client and filled out an application for homeowner's coverage. Client supplied information that indicated he had previous claims and was canceled by another carrier. A loss resulted and the insurance company refused the claim upon learning the true experience of client which was not disclosed on application filled out by agent. The courts determined that the agent was liable for acting outside his scope of authority by failing to record the client's claim and cancellation experience.

Boothe vs American Assurance (1976)
Client requested flood insurance coverage. Agent accepted a completed application and advance premium payment and led client to believe he was protected. The application was not sent and the insurance company refused coverage which client discovered when he submitted a claim for a flood loss. Agent was sued and found liable for neglecting to follow up on application and notify clients that they did not have coverage.

Campbell vs Valley State Agency (1987)
The client was a founder and director of a bank that owned and operated an insurance agency. The agent was also manager of the agency and knew that client was a millionaire. Agent obtained automobile coverage for client in the amount of $100,000 per person and $300,000 per occurrence. A major accident occurred which exceed the limits of the policy. The client sued agent for these additional damages. Although the case was scheduled for a new trial the original court found that a jury could have found the agent had a duty to advise the client about his liability coverage needs due to the special relationship that existed. Thus, the agent was potentially liable for the damages that exceeded policy limits.

Cartwright vs Equitable Life (1996)
Multiple clients purchased life insurance policies from an agent on the strength that policies were "self-supporting" after only three premium payments. When clients learned that automatic premium loans were reducing face values agent again reassured clients he would "take care of the problem". The courts sought $6.1 million in punitive damages from insurance company for failure to curb agent after his conduct was first reported. Agent was fined $30,000 for fraud even though he was retired at the time of the trial.

Commissioner vs Grossman (1986)
Plaintiff Charlin says she never signed a waiver on uninsured motorist coverage. After her policy was issued she was involved in an accident with an uninsured motorist. She says agent Donovan failed to advise about the uninsured motorist coverage and did not obtain a waiver. Courts concluded that Donovan was not agent of the insured and was acting within scope of his duties. Agent and insurance company found not liable.

Crobons vs Wisconsin National Life (1984)
Agent sold client a life insurance policy. Client later became very ill and lapsed into a coma. Agent, who was fully aware that client was in a coma, "witnessed" a change in beneficiary signature that led to a dispute in determining the proper beneficiary of the proceeds. Agent was responsible for his damages by his fraud.

Cuismano vs St Paul Fire (1981)
Client clearly informed agent of the need for a specific coverage. The face page of the policy suggested that the client was furnished this coverage. A claim for loss, however, proved otherwise. The court held that the ambiguity of the policy did not require the client to verify coverage, especially in light of agent's assurance. Negligence here resulted in agent liability.

Cunningham vs PFL Life (1999)
Agents held themselves to be professionals with superior knowledge, were found to have misrepresented life insurance policies as investment vehicles. The insured's sued on breach of fiduciary duty leading to claims against the insurance company which was found liable for reckless and wanton failure to train and supervise its agents.

Daniel vs Florida (1998)
The plaintiff set out to help his son obtain a loan for a home in which he would own but his son and new wife would reside. The mortgage agent faxed a request to agent defendant asking him to cover the property. A note to the agent said that the "son is going to live there'. After the policy was issued a fire and theft of the property caused substantial damage. The father filed a claim for property damage and the loss of the son's personal property. The son's personal property claim was denied by the insurance company as they were not insured. The plaintiff filed a claim against the agent for negligently failing to obtain adequate coverage. The courts are still deciding this one but are leaning to the plaintiff since the original request for mortgage included a note about the son's intention to reside at the property.

Dahlke vs John Zimmer Agency (1997)
The importance of obtaining and reading a specimen policy is underscored by this case. Here, an agent was insulated from liability where the policy contained clear and unambiguous descriptions concerning the insured's deductible. The agent prevailed because of this clear language and the fact that the insured did not read his own policy, choosing instead to rely on the agent to make sure he was covered.

Durham vs McFarland Et Al (1988)
Agent handled most of client's insurance needs for approximately 15 years. Client purchased a new residence boathouse and met agent to discuss transferring the coverages on the old residence to the new boathouse. Ten months after the meeting the boathouse was damaged by a flood and the client submitted a claim. The insurance company did not list the flood peril and denied coverage. The agent was sued and the courts agreed that he had a duty to advise the client about flood insurance on the new residence, especially since it was a covered event for the old residence.

Eddy vs Sharp (1988)
Client owned multiple rental buildings requested coverage from new agent similar to old coverage. The agent prepared a proposal describing his coverage as "All Risk" subject to a list of eight exclusions. Additionally the proposal contained the following disclaimer: "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". Client relied on the proposal letter and decided it met his needs. When the policy arrived he did not read it. Client losses resulted from the back up of water through drains and sewers (due to a clogged city drain). This was not covered by the policy but was not listed as an exclusion in agent's proposal. The court held that the agent owed his clients a fiduciary duty, a duty of care under agency principals, and a statutory duty to accurately describe the provisions of their policy. Further, when agent described proposed coverage as "all risk" and clients accepted same, there was a binding contract obligating agent to obtain the promised coverage.

Employers Fire Insurance vs Speed (1961)
Agent agreed to obtain fire and extended coverage on client's soon-to-be constructed building. Client was led to believe he was covered but agent failed to do so. Client relied on agent but did not request the name of agent's principal (insurance company). Upon a claim for loss, the court ruled that there was no contract for insurance, even though the same client was already

insured with six of the eight companies carried by agent on other projects. The agent incurred big legal fees and lost a good client. (Compare this result to Julien vs Spring Lake Agency - 1969).

Europeon Bakers vs Holman (1985)

After handling the client's insurance needs for approximately six years the agent proposed that the client change its business interruption coverage to a policy that included a coinsurance provision. The insured accepted the proposal but found that it covered only 28 percent of his loss caused by the interruption of business when an oven accidentally exploded. The agent was sued for negligence by the bakery which was seeking the full amount of the lost business production it suffered. The court held that the agent was responsible since he had a duty to advise the client about its business interruption needs, especially since agent held himself to be an "expert" in this area and client had relied on him in the past.

Evanston Insurance vs Fred A. Tucker (1989)

The client paid agent almost $75,000 for fishing vessel coverage. Agent requested coverage and sent premiums to intermediary broker who failed to obtain coverage and refused to return premium money. Agent's E&O carrier refused to pay claim since his E&O policy excluded any claim for premiums lost. Agent was found liable.

Eyerly vs Gregary (1999)

The plaintiff became seriously ill eating contaminated food at a hotel-lodge. The hotel was owned by a Florida Corporation which immediately filed for bankruptcy to avoid huge damages. Plaintiff attorneys, however, found a DBA for the hotel under the name Anthony Connor. Both Conner and the Florida Corporation were insured by Bill Eyerly.

The insurance company denied any liability claiming that it never received notice of the plaintiff's claim as Eyerly failed to forward the original complaint and summons. The courts didn't agree and awarded a large judgement against Connor and the defunct Florida Corporation for $317,000. The insurance company paid the policy limits of $300,000 but the agent was found liable for the excess based on negligence.

Fitzpatrick vs Hayes (1997)

An agent's brochure promoted a "family insurance checkup". These words did not, according to the courts, establish assumed duty by the agent to advise the plaintiff insured about the availability and need for personal umbrella protection. This duty would only be imposed if 1) the agent misrepresented the scope of coverage, 2) the insured made a specific request for a particular coverage, 3) if the agent assumed additional duty by holding himself out to be an expert.

Flattery vs Gregory (1986)

Agent had previous business with client where he purchased "optional" coverage on his automobile. A new policy was purchased, but nothing was said about adding the optional coverage. Naturally, the client's loss involved optional coverage damages which were not included in the new policy. The court ruled that the agent's "promise" to procure optional coverage was ***implied*** from the earlier transaction. He was responsible to provide this coverage at his own expense.

Foster vs American Deposit Insurance (1983)

Agent sent client a letter indicating that client's automobile policy was paid for 90 days. A loss occurred 89 days from client letter and client submitted his claim. The insurance company denied coverage since 90 day coverage had expired days earlier. Agent was responsible for damages due to his error in calculating coverage.

Free vs Republic Insurance(1992)
Since 1979 agent provided client homeowner's coverage and assured same that the policy limits were sufficient to rebuild his home. In 1989 client's home was destroyed by fire and insurance proceeds were found to be less than needed to rebuild. The client brought an action against agent and insurance company in that they failed to inform him of the inadequate limits of coverage despite years of assurance. The courts held that the agent was under NO general duty of care to advise client about the sufficiency of coverage to replace his home, but once he elected to respond to his inquiries he acquired special duty to use reasonable care. Due to some extraneous issues a new trial was to set to establish liability.

Gabrielson vs Warnemunde (1988)
The particulars in this case are not as important as the result. It was found that an agent's duty to inform the client that he had appropriate coverage is greatest at the time of purchase. Agents do not generally have a duty to ferret out, at regular intervals, information which brings a client within provisions of a policy exclusion or waiver. Agents typically acquire this duty by their own admission (refer to Free vs Republic -1992 and Grace vs Interstate Life - 1996).

Gauntt vs United Insurance Co of America (1994)
A client requested insurance company pay the accumulated cash value in her life policy. The company refused because the policy had already been converted to another policy without a current surrender. As a result of the dispute, the agent refused to turnover the client's policy. The courts found that even though the policy was rightfully converted, the agent's wrongful detention of the policy effectively denied the client the ability to know her policy rights and thus constituted a conversion for which the agent could be liable.

Glenn vs Leaman & Reynolds (1983)
An independent agent obtained coverage for client in the past and was asked to do so again. An application and advance premium payment was made and coverage obtained. Shortly thereafter the insurance company was declared insolvent and client's coverage was prematurely terminated. The courts in this case established that a fiduciary relationship existed between the agent and client and that he did NOT fulfill his obligation to inform client of the premature termination even though he mailed an unregistered letter to client's last known address. For the most part, the court was disturbed that this letter was sent more as a "courtesy" and not out of any course of action designed to notify client of the insolvency and the procedure to be followed in obtaining a refund of his unearned premium. Agent was liable for losses client incurred.

Goebel vs Suburban (1997)
An insured brought a "frivolous" claim against an agent regarding negligence in procuring coverage. The claim was quickly dismissed by the courts but the agent wanted reimbursement based on a clause in his agency agreement whereby the insurance company would indemnify agent against certain liability cased by the insurance company's acts of omission.

The lower court agreed that the agent could be reimbursed, however, on appeal, the higher court reversed this decision based on an additional clause in the agency agreement where agent and insurance company agreed to abide by common law. Unfortunately for the agent, common law in this state does NOT require insurance companies to indemnify agents against meritless claims.

Grace vs Interstate Life (1996)
Agent obtain a health insurance policy for client who kept it going for almost ten years. Benefits of this policy were substantially replaced by Medicare after age 65 but agent continued to collect

premiums. The courts determined that the special relationship that existed between agent and client created a duty for agent to disclose this fact and his silence made him personally culpable in a second potential lawsuit.

Great American Insurance vs York (1978)
Agent accepted an application from client's wife without client's knowledge. In addition, a business was operated on the residential property but agent failed to make a personal inspection to discover this. Shortly after submitting for coverage a fire destroyed the home but the insurance company refused the claim since insufficient information was obtained on the application. The agent was responsible for client's damages because he had failed to follow insurance company instructions to submit a completed application, including all signatures.

Greenfield vs Insurance Incorporated (1971)
Client requested business interruption coverage including mechanical breakdown of an automobile shredder. Agent assured client this coverage was in place but a claim for lost production went unpaid as uncovered. The courts ruled that even though the client failed to read the policy, he had a right to rely on agent's representations as well as years of agent/client relationship. The agent was liable.

Gulf Insurance vs The Kolob Corporation (1968)
For various reasons, an insurance company decided to cancel all of an agent's business policies. The agent was asked to collect and send any remaining premiums and cancel policies. Because agent had a large volume of clients to cancel and find replacement coverage, this process was delayed. Cancellation for one client did not occur for six weeks, during which time a claim occurred. The major task before the court was determining what is "reasonable" time to cancel these policies. Despite evidence of the agent's tremendous workload and possible "contributory negligence" by the insurance company in not following up sooner, the insurance company was forced to pay the client and the agent was ultimately liable to the insurance company for not taking quicker action.

Hardt vs Brink (1961)
Client owned a metal products company and leased space for which agent obtained a comprehensive liability policy. Although the agent never saw client's lease, it included language that excluded the tenant client from any benefits of the building owner's coverage. Thus, when a major fire damaged the building, the client was uncovered. In fact, agent's coverage specifically exempted the insurance company from liability for damage to the leased property. The agent was sued and the court ruled that even though agent was unaware of the lease provisions, he had breached his duty to advise the client to obtain sufficient coverage under the lease. This duty was solidified through previous dealings with client where client followed all agent recommendations. Agent was liable for damages.

Heritage Mutual vs Stevens (1996)
Insurance company sued its own agent saying he negligently requested reduced uninsured motorist coverage even though insured did not sign the UIM waiver. A subsequent accident with an uninsured motorist resulted in damages beyond the insured's $50,ooo UIM limit but the insured said he was entitled to up to his full $300,000 limit since no UIM waiver was signed.

The insurance company paid the claim but sued the agent for indemnity. An appeals court determined that the agent was responsible to pay the difference between the premiums paid and the premiums that would have been paid if the issued policy had included the UIM overage agreed.

Honeycutt vs Kendall (1982)
Client requested automobile coverage by tendering an application and premium payment. Before policy was issued, the insurance company discovered an undisclosed traffic violation and asked for an additional premium payment. Client was not aware of this demand and the policy was shortly canceled. Client's loss claim was denied and the agent was sued. The courts determined that the agent had a duty to provide notice to the client that coverage was not available.

Hutchins vs Hill Petroleum (1993)
Client owned a maintenance company specializing in oil refineries. Client requested that agent name a refinery as additional insured under his existing policy. An employee of client was witness to the phone conversation where agent was orally instructed to accomplish this. When the agent failed to add the refinery, the client's maintenance contract was terminated resulting in business losses. The agent was sued and the court agreed that the contract termination was, for the most part, the agent's failure to add the refinery.

INCO Express vs Marketing Insurance (1984)
This case involved a non-admitted insurance company that eventually became insolvent. When the client incurred losses, the agent and the surplus line broker he used were initially found liable because the agent failed to investigate a low-rated carrier and disclose to client that they were a non-admitted company. On appeal, the surplus lines broker was determined to have ultimate responsibility.

Independent Life vs Peavy (1988)
The specifics of this case are not as important as the lesson. An agent attempted to cheat a client out of $412 in policy benefits. The court was so enraged with this deception that it awarded the client punitive damages in the amount of $250,000 -- that's 606 times the compensatory damages of $412!

Jarvis vs Modern Woodmen of America (1991)
Agent encouraged client to drop an incontestable policy and purchase a new policy even after being advised about client's certain mental and financial problems. Policy was later canceled when these facts were found missing from application. The courts awarded $500,000 punitive damages against the insurance company based on acts of its agent and agent's gross, reckless and wanton negligence. Further action by the insurance company against the agent was contemplated.

Johnson vs Illini Mutual Insurance (1958)
An insurance broker was requested to insure the client's home at a specific address. The agent "misdescribed" the house number and the building and contents were subsequently destroyed by fire. The insurance company refused to pay the claim and the courts ruled that the broker was liable to his principal (client) for failure to follow instructions.

Julien vs Spring Lake Agency (1969)
The client was a builder who dealt with agent regularly among a variety of properties. Client requested agent cancel a specific policy and add two others. Although agent noted the request to add two policies, only one was issued. As luck would have it, the uncovered property incurred damages. Since the claim went unpaid the client sued both agent and insurance company. The courts found for the client but denied the insurance company claim for reimbursement from agent on the basis that agent had binding authority and all previous business policies were written with the same insurer. In essence, the courts felt that the principal was adequately known to the client even though coverage was never obtained. (Compare this case to Employers Fire vs Speed).

Karam vs St Paul Fire (1973)
Client owned a Laundromat and requested agent obtain "as much property damage liability insurance as possible". Agent said that $100,000 was the most he could get. Client approved but through agent error only $10,000 was written. A water heater exploded causing $20,000 of damage. Agent was sued and found liable for the difference between damages and policy limits. The courts felt that the client had no responsibility to read the policy or the bill sent by agent which stated "$10,000 of coverage".

Kioutas vs Life Insurance Company of Virginia (1998)
This court case establishes some specific rules on the broker vs agent controversy. Following are parameters which may determine status: 1) who set the agent in motion (who called the agent), 2) who controlled the actions of the agent, 3) who paid the agent and 4) whose interest does the agent represent.

In this case, an independent insurance agent, with no fixed relationship with any insurance company, represented the insured to obtain the most suitable and affordable life insurance from among various insurers. The courts determined that he was an "insurance broker" and he had prior knowledge of the insured's cancerous condition which was not imputable to the life insurer.

Kurtz, Et Al vs Insurance Communicators (1993)
In 1985, client obtained group medical, life and accident coverage for its employees. Client was not knowledgeable in this area of insurance and relied on agent, who held himself out as an "expert" in the field. Agent advised client to sign a Certificate of Non-Applicability which essentially exempted client from certain Medicare provisions of TEFRA. In fact, this exemption does not apply to companies with more than 20 employees. Agent informed insurance company that client had only 12 employees when, in fact, he knew they had 30. A serious illness with client's employee was the source of major claims in 1987. The insurance company paid for some of the claims, then informed client that is was not required to pay for the employee's treatment because client had violated the above TEFRA provisions. Late in 1987 the insurance company canceled the policy and then demanded that client reimburse it for amounts already paid. A lawsuit was commenced in 1989 by insurance company which believed its coverage to be secondary to Medicare coverage. Client filed a cross complaint against insurance company and agent alleging breach of contract, breach of implied covenant of good faith, fraud, negligent misrepresentation and unfair business practices. The complaints between the client and insurance company were a "wash", but on appeal, the agent was found to be liable for negligence and negligent misrepresentation.

Lazzara vs Howard Esser (1986)
Client requested $1,000,000 automobile coverage. Agent purchased two policies: A primary with $300,000 maximum and an extended policy covering claims in excess of $250,000 up to $1 million. A few years later, the primary coverage was issued for split limits of $100,000 per person and $300,000 per occurrence, i.e., a $150,000 gap occurred but client was not notified. Upon a loss client sued agent for the gap in coverage. Client prevailed because agent "had a duty to act in good faith with reasonable care, skill and diligence".

Levine vs Allmerica (1999)
Levine purchased universal life from an agent who assured him that his initial lump sum premium would be the full extent of his out-of-pocket premiums. This was not the case since the insurer eventually called for additional premiums, Levine sued for misrepresentation saying agent Seymour Prell was a "dual agent". The case was referred back to the California courts to determine this status.

Lewis vs Equity National Life (1994)
Client was injured in a car accident and had many heart-related treatments which the insurance company refused to pay after learning that client had a preexisting condition that was NOT disclosed on the original application. Client alleged that agent was the one who filled out the application and failed to list the condition even though it was disclosed to him. The courts awarded contract and punitive damages to client because agent misrepresented information disclosed to him.

Life Investors vs Young (1999)
Life company sued its own agent to recover $26,000 indemnity for negligent failure to indicate an insured's pre-existing condition on a credit life application. The agent allegedly wrote life coverage on a vehicle purchased by the insured knowing that a he had pre-existing heart condition. The insured died and the claim was paid but the courts agreed that the agent must reimburse his insurance company for his misrepresentation of known facts.

Lott vs Metropolitan Life (1993)
Client's employees were sold life policies through a "cafeteria plan". Agent mistakingly represented to employees that they ***must*** buy life insurance in order the plan to be granted tax savings. Agent and company found liable for undisclosed damages and fines.

MacGillivary vs W. Dana Bartlett (1982)
Agent obtained insurance on client's boat which was later stolen. Insurance company failed to pay claim since it was declared insolvent. Client also found out that this company was not licensed to do business in state. The courts determined that the agent's failure to apprise himself of the non-admitted status of insurance company was gross negligence.

Magnavox Co of Tennessee vs Boles & Hite (1979)
The agent set out to provide a construction company "complete" liability coverage. Agent had done business with client for over seven years and had in his possession the construction contracts used by the client which required client to "indemnify" his customers damages occurring in connection with his performance. An employee of client's subcontractor died in an accident and all parties were sued for damages, including agent. The courts held that the agent had a duty to advise the client of the need to be covered for the peril and was negligent in failing to investigate this need based on the client contracts he had in his files.

Mate vs Wolverine (1998)
The courts determined that in this case the agent had a special relationship with the insured. As additional support, the plaintiff's attorney produced notes from the agent's file showing personal knowledge of the insured and her family. As a result of this special relationship and knowledge, the courts believed that the agent had a duty of care to know that the insured's son was an uninsured motorist driving a car that was owned and covered by the insured.

Metropolitan Life vs Haney (1999)
An agent used software provided by an insurance company to develop policy illustrations. When policies were issued, however, differences between the original illustration and the policy caused several insureds to rescind. The agent sued the insurance company for loss earnings due to the stress this caused. The courts did not agree saying that policy illustration software was a benefit to the agent which was only incidental to the goal of increasing sales. The agent got to keep his commissions but paid legal fees for his lost case.

Moss vs Appell (1998)
Agent represented himself as a pension consultant and sold annuities to client. The insurance company ultimately became insolent and the courts determined that a fiduciary relationship

existed between the agent and client since they had been doing business for several years. Plaintiff contended that agent knew of pending problems with the insurance company when he received a letter from them indicating they needed to find capital to bolster reserves. In the end, the courts narrowed the case to liability for a breach fo fiduciary duty pending the outcome of the insolvency.

Naijmias Realty vs Cohen (1985)
Client builder asked agent to obtain "replacement cost" coverage for his rental property. Agent instead procured "actual cash value" coverage. A fire to the building and requirements to meet updated building codes resulted in damages exceeding policy limits. Agent was sued for deficit and the courts awarded same to client due to agent's breach of duty to obtain the correct coverage as instructed.

Nationwide Insurance vs Patterson (1985)
A trial court concluded that an agent was liable for misrepresentation for not advising client about the "stop loss" payment feature of his policy when he accepted a revised group health policy proposal. Agent was responsible for the stop loss damages.

Osendorf vs American Family Insurance (1982)
Agent handled ALL client's farm insurance business for 10 years. Agent had visited the operation many times during this period but failed to advise client that he needed liability coverage for his employees. An on-the-job injury caused uninsured damages which the agent was liable to cover.

Pacific Insurance vs Quarlls Drilling (1988)
Agent and client agreed that "crew and employee injuries" would NOT be covered under a hull and indemnity policy because it was already covered by another liability policy. Somehow the crew and employee coverage was "bound and written" with the hull and indemnity policy. Meanwhile, the insurer for the "other" policy became insolvent and an employee-related client loss occurred. The client filed his claim with the hull and indemnity company which denied it upon learning that agent and client agreed NOT to include it. Because the agent produced documentation that proved this arrangement, the courts sided with the hull and indemnity company and agent. The client's higher level of sophistication was also a factor in this decision.

Padeh vs Zagoria (1995)
An investment advisor/agent recommended client invest the proceeds of an investment into a pension plan and purchase additional life insurance for the same purpose. Client launched a lawsuit for reasons that the pension plan was ill-suited for their financial goals and life insurance was inappropriate inside this plan. The courts established that the agent misrepresented claims of the potential benefits and offered negligent advice. Where results of the plan are negative, the agent has a potential liability.

Parlette vs Parlette (1991)
Agent sold a life insurance policy to a client, the primary purpose being to benefit the mother of the client if he died prematurely. Despite this knowledge, agent failed to see that the mother was properly designated as beneficiary. Upon the client's death, the mother proved she was the intended beneficiary and sued agent for his negligence in failing to see that it was accomplished.

Perelman vs Fisher (1998)
A broker procured a disability policy that did not provide a cost-of-living adjustment. The plaintiff sued the agent for breach of duties. Agent prevailed in the lower courts based on the evidence that the plaintiff was advised in writing to review the policy. The appellate court, however, held

that the insured's failure to read and understand the terms of the policy was not an absolute bar to recovery.

R-Anell Homes vs Alexander & Alexander (1983)
Client advised agent that a new telephone system would be part of his building. Agent indicated that the phone system would automatically be covered under the building's blanket policy. Damages that occurred to the phone system were denied by the insurance company since it was NOT covered under terms of the policy. The courts found the agent liable for negligently conveying false advice.

R.H. Grover vs Flynn Insurance (1989)
Client requested a Certificate of Insurance from agent. Agent's new employee issued the certificate, however no coverage was ordered. A claim was presented and denied. The courts held the agent liable to client for his negligence in supervising his new employee.

Reserve National Insurance vs Crowell (1993)
Client requested Medicare supplement information from agent and disclosed certain preexisting health problems. The agent told client he could receive better coverage under a new policy. After policy was issued, a claim developed which was denied by the insurer upon learning of client's preexisting condition. The courts awarded client contract damages and punitive damages totaling 600 times the out-of-pocket expenses based on the agent's intentional misrepresentations about the preexisting condition.

Rieger vs Jacque (1998)
Agents should be concerned about referring their clients to other professionals who do not do their job. In this case, the agent was not liable for referring a client to a trust attorney. The client suffered injuries from a defective trust but the agent escaped liability because the attorney created the trust and personally asked the client about his goals. In essence, the attorney did not rely on any statements made by the agent.

Saunders vs Cariss (1990)
In 1986 client obtained an automobile policy from agent. The policy included uninsured motorist coverage with $100,000 in limits. The policy was in effect in 1988 when client was seriously injured in an accident caused by an uninsured motorist. When client submitted his claim the insurance company produced "Reduction Agreements" consenting to reduce uninsured coverage down to $25,000. The agreements purported to bear the signature of Client although he denied signing them. Client sued claiming that agent signed his name without authorization. The court held that the agent was liable where his intentional acts or failure to exercise reasonable care in obtaining or maintaining insurance resulted in damages to the client.

Seascape vs Associated Insurance (1984)
Agents held themselves out to be "professional insurance planners". They had served client for several years. Client came to them to get specific advice regarding "seawall insurance". Agents advised client that this type of insurance was NOT available to them. Later, a storm damaged client's seawall and clients learned that seawall insurance could have been purchased. Clients sued agent alleging that their relationship was such that agent owed a duty to exercise reasonable care in rendering advice on insurance matters. The courts agreed.

Small vs King (1996)
The specifics of this case are not as important as the result. Client requested "full coverage". In response, agent obtained additional coverage, but the wrong kind. Client losses were attributable to the insurance company who sued agent for reimbursement. The court in this

case ruled that the agent's duty to provide correct coverage cannot be triggered by a client's request for "full coverage" because that request is not a specific inquiry about a specific type of coverage.

Smith vs Dodgeville (1997)
The insured sued agent for failure to procure coverage alleging agent's failure to ask if the insured had been cancelled (which he had). This is a standard question on the application that was not answered. A fire caused $370,000 to the insured's property and the insurance company refused to pay based on misrepresentations in the application. The courts forced the insurance company to make good on the claim on the basis that their own agent failed to ask the cancellation question. The case against the agent was dismissed, but only after legal bills were incurred.

Smith vs National Flood Insurance Program (1986)
Agent filled out a flood insurance application dated March 31. As typical with this type of insurance, coverage only becomes effective the day after the application IF the payment and application are received within 10 days of application or if mailed "certified" within four days of application. Agent used regular mail and application was received April 11 (after the deadline). Clients claim for loss that occurred after application mailed was denied. Agent was sued and the courts determined that he was negligent for using regular mail rather than certified mail, the only sure method of fulfilling his duty under provisions of the coverage. Agent was liable for the flood damage of client's home and contents.

Sobotor vs Prudential Property & Casualty (1984)
Client requested the "best available" auto insurance package from agent. Coverage options for uninsured motorist were NOT discussed and this coverage was NOT included in the policy as issued. Subsequent client losses prompted a lawsuit. The courts sided with the client by determining that even though this was a single insurance transaction between agent and client, a fiduciary relationship existed because the agent held himself out to have special knowledge in insurance and client, who knew nothing about the technical aspects of insurance, placed his faith in agent. Also, by asking agent for the "best available" package client put agent on notice that he was relying on agent's expertise to obtain desired coverage.

Soho Generation vs Tri City Brokers (1998)
The broker failed to accurately disclose on the application the client's prior loss history, including a $205,000 loss within the last two years. The courts deemed this a material misrepresentation which relieved the insurance company of its obligation to pay a claim but subjected the broker to full liability.

Southland Lloyd's Insurance vs Tomborlain (1996)
Agent made application to insurance company to cover property he personally owned. The property was later destroyed by fire but the insurance company denied coverage based on misrepresentations by agent concerning the property's age, purchase price and condition. The court held that an agent's fiduciary duty to its principal (insurance company) is highest when agent writes his OWN contract insurance.

Southwest Auto Painting vs Binsfield (1995)
Client requested coverage for his auto painting business indicating his reliance on the advice and ability of agent to obtain appropriate coverage. At no time was employee dishonesty coverage mentioned and it was NOT included in the policy as issued. Later, one of client's employees embezzled over $150,000 of company money. The insurance company refused the claim and agent was sued. Agent was found liable, contrary to previous court cases where agents, who had no special relationship with client, had no duty to advise or recommend a

specific coverage. In this case, however, expert testimony helped the court determine that the agent was duty bound to advise client about the relevant types of coverage where this coverage is ***widely available for this type of business at a relatively low cost.***

Speir Insurance Agency vs Lee (1981)
Agent agreed to bind comprehensive collision and liability coverage on client's vehicle. Insurance company canceled policy prior to date of collision but agent failed to obtain replacement coverage upon learning of the cancellation. The court felt that the agent acted in bad faith and committed fraud on the client. As such, punitive damages were authorized.

State Farm vs Gros (1991)
Client built a home on the side of a hill and carried a standard homeowners policy. The policy contained a common exclusion landslide damage. However, client alleged that agent told him "if a landslide made contact with your home, you're covered". Three years later, client filed a landslide claim. Agent advised client he was NOT covered for landslide. Lack of notes in agent's file to support earlier conversations with client forced court to hold that the policy was misrepresented when purchased. The insurance company was liable and bound by the agent's action.

Steadman vs McConnell (1957)
Agent sold multiple life contracts called "Bank Loan Life Insurance Plans" where clients paid the first annual premium on a ten-payment life insurance policy. The policy is subsequently assigned as collateral a bank loan. Proceeds of the loan are applied to payment of the second annual premium. On each anniversary date, a new note is executed in the amount then outstanding. The result of this process was that after ten years the cash values of the policy would be substantially less than the premiums paid. Knowing this fact, agent continued to promise clients that cash values, sufficient to meet their financial planning needs, would be available. They were not. The insurance commissioner accused the agent with misrepresentation, dishonest conduct and other counts which resulted in the suspension of the agent's license for one year.

Stuart vs National Indemnity (1982)
Client requested coverage and tendered initial premium. Agent represented that client had "full coverage" even though agent had NO binding authority. A loss occurred before application was approved but insurance company denied coverage. The court ruled that an agent who advises client that coverage is bound, with knowledge that the intended insurance company has not yet agreed to accept such coverage, ***acts as the insurance company until coverage is accepted***. The agent was liable for client losses.

Tillman vs Short (1973)
Client owned a business and purchased a group medical plan. Client sold business but continued to pay his portion of premiums with full knowledge of agent. A subsequent car accident caused client to submit a medical claim which the insurance company denied upon learning he was no longer a full-time employee (a requirement for coverage). Even though the agent seemed to be doing the client a favor client sued agent, but the court ruled that BOTH agent and client were equally at fault. It doesn't pay to "cross the line".

Todd vs Malafronte (1984)
Client maintained a business insurance policy through agent that did NOT include worker's compensation coverage even though the agent knew that client hired a part-time summer employee. The agent had assured client that it was not necessary to cover this employee who was later injured. The client sued the agent for the damages and the courts agreed that it was the responsibility of the agent to be sure the client had proper coverage for this condition.

United Farm Mutual Insurance vs Cook (1984)
Agent and client had a long-standing relationship where the agent exercised broad discretion to serve client needs. Client explained a new project that he wanted agent to insure. Despite having sufficient information to know that he could NOT obtain this coverage, agent said nothing and did not procure coverage. The courts determined that agent was liable for losses of the client since he had the duty to exercise reasonable care to inform client he could not provide coverage.

Wal-Mart Stores vs Crist (1988)
Client (Wal-Mart) asked for bids on worker's comp coverage. Agent submitted a $3.5 million premium offer which client accepted. After issuance, the high claims experience did not seem to match the payroll. Then it was discovered that a Wal-Mart employee intentionally misrepresented the payroll amounts to secure a better insurance bid. Thereafter, the insurance company refused to pay claims and demanded Wal-Mart pay premiums that matched it's actual payroll. Just about that time, the insurance company became insolvent. A lawsuit followed that involved the agent. Through testimony, the courts determined that the agent and insurance company were equally at fault as Wal-Mart. In essence, all parties had sufficient information to know that the premium deal was "too good to be true". No one was liable to the other, but all parties incurred huge legal bills.

Ward vs Durham Life Insurance (1989)
Client purchased a life insurance policy from agent and later died. The insurance company denied benefits because certain health history information was left out of the application. The client's widow sued on the basis that the agent told her and her husband that the missing information did not need to be disclosed on the application. The court ruled a new trial indicating possible collusion between agent and the client where no agent notes of the conversation could be produced.

Watts vs Talladega Savings & Loan (1984)
For years agent worked with client by sending notice of payment due for real estate fire insurance coverage. The mortgage company would then draw a check from the escrow account and pay agent. The policy would automatically renew upon payment. For some reason, agent failed to send premium notice and the policy was canceled, despite a call to the agent by the mortgage company regarding coverage. A claim caused client to sue agent. The courts felt that agent had a duty to notify client that premium was due as he had in the past. A phone call from the mortgage company was further proof of agent's negligence.

Westrick vs State Farm (1982)
Client maintained insurance with agent since 1964. The agent's office was run by a father and son team. Both shared an office but had different clients. Since they had no employees they would answer the phone for each other when one was out. In early 1977 client inquired about insuring a jeep-type vehicle to be used in his agricultural business. Agent son gave client impression that said business vehicle would automatically be insured for 30 days. Client did not purchase this vehicle. In late 1977 client ***did*** purchase a welding business for his son which included a six-wheel welding truck. The day client called the insurance office the father agent was alone. Client asked for son agent and then explained that he purchased the business with two vehicles for which he wanted coverage (client's automobile coverage provided for 30 days of automatic coverage for any newly acquired auto if it replaced an auto already insured with company). Client said he offered the father agent serial numbers but the agent said his son would be in the next day. Client assumed he had coverage and that night the welding truck was involved in an accident. Father agent believed that the truck was NOT insured because client wanted to talk to son agent. Further, it was a commercial vehicle not covered by his policy.

Client, however, assumed this type of vehicle was insurable based on his earlier conversation with son agent regarding the jeep-type vehicle (in court the son agent did not remember this conversation). The court originally found in favor of the agents but this was reversed on appeal because it felt that a jury would have ruled negligence on the part of agent. The case was recommended for retrial.

White vs Calley (1960)

Client maintained a "builder's risk" policy covering a rental home that was set to expire on April 16. In March, client requested that agent increase the insurance limits of the rental. Agent verbally agreed that she would "take care of increasing the insurance". A few days later the agent delivered to client a routine rider that contained a mortgage clause to be endorsed on the new policy which commenced April 16. When the building was destroyed by fire on March 30, the insurance company paid ONLY the old value. Client's lawsuit to obtain the new value from agent was successful even though agent testified that the client's real intent was to increase limits for the new policy.

Williams Agency vs Dee-Bee Contracting (1984)

Agent discovered that client's apartment building was underinsured. Unable to reach client about this situation agent left on a trip and took no further action. During agent's absence, the client also learned about the valuation problem but was unable to reach agent. Agent's secretary indicated that "the matter would be taken care of". The client took no further action but a major fire destroyed his building. Agent was sued for failure to fully insure the property and the courts determined that agent was negligent.

Wood vs Newman Agency (1995)

A client maintained a comprehensive business policy with agent for her marina complex. The insurance company notified agent that this policy would no longer cover ice and snow damage but agent failed to advise client of this fact when the policy was renewed. When the next storm hit the area, the client lost 18 covered wooden docks which collapsed under the weight of snow and ice. The insurance company denied coverage and the client sued all parties. The courts determined the agent was negligent and liable for not advising client of this lost coverage even though her knowledge of same might not have changed the outcome, i.e., she would have suffered loss from the damage anyway because NO snow and ice coverage was available from any source.

Wright Bodyworks vs Columbus Agency (1974)

Client requested business interruption insurance from agent. Agent agreed to adequate coverage based on agent's yearly inspection of client's books to determine premium. Coverage was placed but agent calculated premiums based on client's "gross profits" rather than it's "gross earnings". When a major loss occurred the client was underinsured in a big way. The courts determined that the agent assumed a "dual agency" role because of his special arrangement to audit the books and the fact that agent advertised himself as an expert in this field of insurance. The insurance company paid their limits and the agent was liable for any deficit.

PERSONAL AUTO CLAIMS

PERSONAL AUTO POLICIES

Almost 50 percent of all liability-property insurance underwritten in the United States involves insurance on vehicles, including private automobiles, station wagons, vans, panel and pickup trucks, and jeeps. A typical policy will cover personal and most business uses. Vehicle insurance covers liability, collision loss of the vehicle, comprehensive losses and medical expenses occasioned by the driver, passengers or other persons. Coverage typically applies to anybody who is driving the car at the time of the loss with the express or tacit permission of the owner of the vehicle. Endorsements can be added to cover a number of options, to afford liability coverage for additional circumstances and to provide insurance for special accessories and equipment. Vehicle liability coverage is mandated by law in most states up to a particular monetary limitation. Coverage may be excluded when a vehicle has been driven in a foreign country. Following are some of the more important aspects of a vehicle insurance policy:

- ***Property damage liability***—When a policyholder's vehicle causes damage to property of another, claims and legal costs arising from such damage are covered under this provision. Lamp posts, buildings, telephone poles and other forms of stationery property are also covered. The policyholder and resident family members are included within coverage when driving a vehicle of the insured or of another with that owner's permission. In some states, if an insured lends his or her vehicle to a second person who entrusts the vehicle to a third person, the insured may be liable for damages caused by such third person under the "negligent entrustment theory," on the basis that he or she should have reasonably foreseen that the borrower of his or her vehicle might let a third person use it.
- ***Bodily injury liability***—If an insured causes bodily injury or death to another while using his or her vehicle, he or she is protected from losses by this type of coverage. Expenses for hospital and medical care, rehabilitation, legal fees, pain and suffering, lost wages and potential future earnings may be covered. Unless required otherwise by state law, an insurer is not required to pay any claims under this type of coverage unless a driver has been negligent. When litigation or claims are filed against a policyholder, bodily injury liability insurance offers protection in the form of legal defense, and the insurer will pay damages or losses stated in the policy up to the limits of coverage if the policyholder or another named insured is legally liable.
- ***Underinsured motorist coverage***—In the event a party who is responsible for an accident does not have enough insurance to pay medical expenses, this type of coverage will make up the deficit, subject to policy limitations. This feature is included automatically in some states when extraordinary amounts of uninsured motorist coverage are obtained.
- ***Uninsured motorist coverage***—If a person is hit by an uninsured driver or a hit-and-run motorist, he or she can recover expenses for bodily injury or property damage under this part of a policy. Coverage is also available when the insured is injured by a motorist whose insurance carrier has become insolvent. Coverage extends to family members and nonpaying passengers.
- ***Medical payments insurance***—This type of coverage extends to medical expenses of the insured and of any passengers that are incurred as a result of an accident. Payments are made without regard to the fault of any of the parties involved. Generally, this coverage

applies to invited guests and family members who are residents of the insured as well as to the policyholder. If the policyholder or his or her immediate family members are injured while in another car or by a vehicle while walking or running, coverage is also available.

- ***Personal injury protection***—This kind of coverage is sold mostly in states that have no-fault insurance laws. Generally, personal-injury coverage is mandatory.
- ***Collision insurance***—damage to an insured's vehicle is covered without regard to which party caused an accident. An insurer may pay a claim to the insured, and then seek to recover from the insurer of the other party when the latter is at fault. This type of coverage ordinarily has a deductible ranging from $100 to $1,000 dollars. The insurer will pay for repair costs of the policyholder even if another driver is at fault, and will then seek reimbursement from the other driver's carrier.
- ***Comprehensive coverage***—Losses from damage to a vehicle attributed to a cause other than a collision are protected against under comprehensive coverage. Comprehensive insurance typically covers situations where theft, fire, breaking of glass, vandalism, flood, explosion, earthquakes, hail and malicious mischief are the cause of the damages.

Exclusions

Following are some of the more common exclusions from a personal vehicle insurance policy:

- Intentionally causing bodily injury or property damage—One who uses a vehicle to intentionally inflict injury to the person or property of another is not included within coverage, because such activities are of a criminal character and it is against public policy to insure such behavior.
- Damage to property owned or being transported by an insured—Liability coverage is provided for damages to property owned by others.
- Damages to property of others in the possession of the insured—While an insured has custody and control of the property of another, he or she is treated as the constructive owner of such property and coverage is not available.
- Injuries to an employee of the insured while working for the insured—It is against public policy to allow an employer to thwart his or her responsibility to carry workers' compensation by acquiring liability insurance.

No-Fault Insurance

Under "no-fault" auto insurance, a policyholder recovers from his or her own carrier losses, such as medical and hospital expenses and lost income. Generally, a policyholder is required to waive his or her right to sue the party at fault, except in the case of death, permanent disfigurement or injury. Some states require no-fault policies to include coverage for property damage.

Financial Responsibility Laws

Such laws require drivers of vehicles to produce evidence of financial responsibility as a condition to obtaining and keeping a drivers' license. Financial responsibility provisions are an alternative to acquiring personal liability insurance, and evidence of such responsibility can be demonstrated by a cash deposit or by the acquisition of a surety bond.

Responsibilities of an Insured Following an Accident

A personal vehicle insurance policy imposes responsibilities on an insured, such as:

- ***Personal injury***—The first order of business at the scene of an accident involving a vehicle is to see that treatment is provided for personal injuries. The insured should make a mental note of injuries in the event one of the parties to an accident later attempts to stage an injury. Photographs can be useful.
- ***Witnesses***—A thorough search for witnesses should be conducted.
- ***Notification to the insurer***—Most policies require an insured to report any accident to an insurance company, even though the insured may be at fault. An insured should follow the notification procedure provided by the policy or in other written instructions from his insurer, which usually requires information, such as the location and time of the accident, the names, addresses and telephone numbers of parties involved in and witnesses to an accident, the make, model and license number of any vehicles involved, the nature and amount of damage to all vehicles and the location where the vehicles were taken, the name of the police department that responded to the accident and the name of the insurance company of any other driver involved.
- ***Notifying the police***—Not only does a standard insurance policy include provisions concerning notification to the police, but state laws ordinarily require that the police must be informed under certain circumstances. An accurate statement of the accident should be provided. Coverage may be denied if the police are not notified under some policies. If a civil or criminal charge may be filed against someone under the policy as the result of a loss or injury, the police should be made aware of such possibility.
- ***Protection from further damage***—An insured must take all reasonable steps to protect a wrecked vehicle from further damage.
- ***Inspection***—An insurer must be permitted to inspect a vehicle before repairs are undertaken.
- ***Cooperation during an investigation***—A policyholder must cooperate with his or her insurer during an investigation of the conditions surrounding a collision. If anyone has been injured, it will be necessary for such person to undergo a physical examination.
- ***Legal proceedings***—If any party involved in a collision institutes legal proceedings, copies of the complaint and any additional papers filed with the court must be provided to the insurer. Every effort must be made by the insured to submit to depositions and answer interrogatories and requests for production of documents.
- ***Notification to lien holders***—If there is an outstanding note on the vehicle, the lien holder should be notified.

Following is a typical provision in a personal vehicle insurance policy regarding the duties of the insured:

We have no duty to provide coverage ... unless there has been full compliance with the following...

1) We must be notified promptly of how, when and where the accident or loss happened. Notice should include the names and addresses of any injured persons and any witnesses.
2) A person seeking coverage must:
- *a. Cooperate with us in the investigation, settlement, or defense of any claim or suit.*
- *b. Promptly send us copies of any notices or legal papers received in connection with the accident or loss.*
- *c. Submit, as often as we reasonably require:*
  - *i) To physical exams by physicians we select.*
  - *ii) To examination under oath.*
- *d. Authorize us to obtain:*
  - *i) Medical reports.*
  - *ii) Other pertinent records.*

e. Submit a proof of loss when required by us.

3) A person seeking uninsured motorist coverage must also:

a. Promptly notify the police if a hit-and-run driver is involved.

b. Promptly send us copies of the legal papers if a suit is brought.

4) A person seeking coverage for damage to an auto must also:

a. Take reasonable steps after loss to protect "your covered auto" or any "nonowned auto" and its equipment from future loss. We will pay reasonable expenses incurred to do this.

b. Promptly notify the police if "your covered auto" or any "nonowned" auto is stolen.

c. Permit us to inspect and appraise the damaged property before its repair or disposal.

SPECIAL AUTO COVERAGE ISSUES

Rental Cars

Agents disagree on whether clients should purchase the Collision Damage Waiver from car rental companies. Although the cost of this coverage is sometimes outrageous and seems like a duplication in protection, following are reasons why your clients should still buy it:

Loss Valuation

The Personal Auto Policy covers the lesser of the "actual cash value" of the vehicle and the mount necessary to repair it. Some rental agreements obligate your client to reimburse the rental company for "full value".

Loss Settlement

PAP policies typically give the insurer the right to "inspect and appraise the damaged property before it is repair or disposed". The rental care companies, however, are under no such obligation. They may decide to immediately repair the vehicle which could forfeit your own coverage.

Loss of Income and Expense Costs

The rental car contract may make your client responsible to pay for their loss of rental income. Your coverage may have very specific limits here.

Also, the rental contract may obligate your client to pay various administrative expenses or losses related to towing, appraisal, claims adjustment, storage, etc. Your PAP may not cover these.

Excluded Vehicles

Client rented vehicles that are NOT private passenger autos, pickups, vans or trailers may not be covered by your PAP.

Uses and Drivers

Your PAP may not cover certain drivers of a rental car or cove the use for which they were rented. Rental insurance can specify coverage for these drivers and uses.

Excess Coverage

Your PAP covers your client for any "excess" over the coverage provided by the legal owner of any auto they drive. Can you see where someone may try to argue that no primary insurance is in place?

Premium Increases
Your PAP policy premiums will most certainly include deductibles and if a claim is filed, premiums will likely increase. Rental car contracts may have few deductibles and will not effect your client's premiums

Cars for Kids

There is much discussion in the industry as to the handling of cars for children. Some feel that the car should be titled in the name of the parents and fall under their coverage. Others believe that a separate policy, with minimum coverage and lower premiums, should be issued in the child's name.

While there is no correct answer, consider the following claim problems that can develop when minimum coverage is requested:

Minor / Dependent Status
If a child is under 18 and/or living at home with his parents, he will probably still be classed a minor or dependent falling under his parents liability exposure. Thus, a major claim exceeding his policy limits would likely fall to the parents to satisfy.

Car Swapping
The parent's policy will cover the parents and other family members but not the child with his own policy. So, let's say the family's 17-year old daughter (covered under the parent's policy) decides to drive her brother's car (covered under his own, minimum coverage policy). Since PAP policies exclude coverage for resident family members insured separately, the daughter must rely solely on the brother's low policy limits. Any excess may fall back on the parents to cover personally.

Also, there is the risk that the brother, like many teenage boys, has not made his premium payment last month. He may be already cancelled!

State Requirements
Some states require parents to sign financial responsibility contracts which obligate them to pay for any damages or liability regardless of whether the car is in the child's name or parent's name.

Umbrella Gaps
If an umbrella policy can be tapped in a claim, it responds AFTER the underlying limits have been reached. If the parent's primary policy has a limit f $300,000, but the kid's separate policy is only $100,000, a potential gap of $200,000 exists. This assume, that the umbrella policy would pay ***anything*** against a child's separate policy

In summary, kids are expensive to insure because they are risky drivers. Trying to put a "pretty" face on this issue by recommending cheaper, lower limit policies for child drivers is likely to result in a faulty claim. This, in turn, can come home to roost at the agent's door in the form of a malpractice suit. It is best to always advice your clients (in writing) of the gaps and coverage deficiencies possible when applying for separate policies for their children.

Trusts & Autos

Since a lot of clients have personal trusts these days there is more opportunity for titling problems to develop into claims. Traditional PAP policies are designed for individuals. So, if

the named insured is a trust, not an individual, there could be potential coverage gaps. For this reason, vehicles owned by a trust are technically supposed to be covered by a Business Auto Policy. Be sure to question the underwriter on how the insurer's criteria and the application of certain language -- especially "you" and "family members" will be interpreted when covering trusts. Another possible solution is to have the trust, as the legal owner, execute a written lease of at least six months to the persons having custody of the vehicle, so they can insure it under their own PAP and additionally insure the Trust as if they were a lien holder.

LAWS AND AUTO CLAIMS

Comprehensive Laws

Comprehensive coverage protects the insured against fire, theft, vandalism and other potential perils. Surprisingly, a collision with a deer typically falls under comprehensive coverage rather than collision coverage. Since comprehensive coverage is usually written with a lower deductible than collision, insurance people joke that insureds are quick to blame deer as the source of their collision rather than revealing how it really happened.

There will be unusual instances where no deductible is applied. Suppose the insured is driving along the road and another vehicle kicks up a stone which damages the windshield. This damage would be covered by his or her comprehensive coverage. The insured would be able to file a claim under the comprehensive coverage in his or her automobile policy. Normally there will be a deductible under that coverage, but on occasion the insurance carrier might waive the deductible if the insured agrees to have the windshield repaired rather than replaced.

If the ***damage to the windshield*** is in the driver's line of vision, a repair is usually not permitted. The windshield must be replaced. The cost of replacing it runs from $200 to more than $1,000, depending on the make and model of the car. The windshield replacement is covered by the comprehensive coverage and is subject to the deductible. In some states such as Florida, no deductible will be charged even if the windshield has to be replaced.

Automobile liability insurance policies ordinarily contain a provision requiring immediate written notice of the occurrence of an accident or of a claim for damages resulting therefrom. This requirement is not limited to the named insured, but applies to any person insured under the policy who seeks its protection. The purpose of this notice is to enable the insurer to receive prompt information concerning the accident, so that he or she may investigate the circumstances, prepare a defense, or be advised whether it is prudent to settle any claim arising from it. Because of its apparent necessity, such a provision generally has been held to be a reasonable and valid one. Ordinarily if the policy expressly makes the insured's failure to give timely notice a ground of forfeiture, or compliance a condition precedent to liability, no recovery can be had where timely notice has not been given.

In an automobile liability insurance policy requiring immediate notice of the occurrence of an accident, the word "accident" means an undesigned and unforeseen occurrence of an afflictive or unfortunate character, resulting in injury to the person or property of another. The word "loss," in an automobile indemnity insurance policy, means the injury or damage caused by the accident for which the insurer may, under the provisions of the policy, be liable, though at the time, the extent of the loss may not be known.

The provisions in the policy as to the time within which notice must be given to the insurer are of very great importance. They may take on a variety of forms such as "immediate," "prompt," "forthwith," "as soon as practicable," and "within a reasonable time." The exact phraseology used seems to make very little, if any, difference, and it is well settled that none of these expressions require an instantaneous notice but rather they call for notice to be given with reasonable dispatch and within a reasonable time in view of all the facts and circumstances of each particular case.

By the terms of a clause, the notice of an accident is to be given by "the insured." This does not mean that the insured must personally give the notice; it may be given by another acting as his or her agent and representative in the matter. Thus, it has been held that notice given by a mortgagee of the vehicle, by the injured person, or by an additional insured, is sufficient to satisfy the requirement of the policy as to giving notice of an accident. Where the insured is a corporation, such notice may be given by and through its officers and agents. Upon the death of the insured, the duty to give timely notice devolves upon his or her personal representative.

In some of the earlier automobile liability insurance policies, clauses requiring notice of an accident did not specify in what manner or by what means the notice should be given. Now, the clause ordinarily requires written notice. As a general rule, such a requirement that notice must be in writing is not satisfied by an oral notice, such as notice given by telephone. However, the requirement of written notice is one which the insurer may waive or be estopped to set up. Telephoning the state automobile association through which the policy was obtained, a day or two after an accident, and following that with a detailed written report several days later, satisfies the policy requirement of an immediate written notice.

In the case of liability insurance policies in general, the standard motor vehicle liability insurance policy contains a provision giving the insurer the right to investigate, negotiate, and settle any claim or suit as he or she deems expedient. Motor vehicle liability insurance policies also usually contain a clause which prohibits the insured from voluntarily assuming any liability, settling any claims, incurring any expense, or interfering in any legal proceedings or negotiations for settlement, except with the consent of the insurer. The purpose of this provision is to prevent collusion and to invest the insurer with the complete control and direction of the defense or compromise of suits or claims.

In the Basic Standard Automobile Liability policy, the insuring agreements entitled "Coverage," concerning bodily injury and property damage liability, state:

"To pay on behalf of the insured all sums which the insured shall become legally obligated to pay for damages caused by accident and arising out of the ownership, maintenance or use of the automobile."

The word use is further delineated in the declarations of the automobile policies as follows:

"Use of the automobile for the purposes stated includes the loading and unloading thereof."

In the Family Automobile policy, the word "use" is specifically defined as including the loading and unloading thereof.

In attempting to delineate the scope of loading and unloading, we are not only concerned with coverage that may or may not be extended to an insured under certain circumstances, but also with the controversy between insurance carriers. One carrier may have the automobile coverage and the other the general liability coverage on the premises on which the loading or unloading occurred. The first question which must be determined is whether there was any

causal relationship between the act of loading or unloading, and the accident. If there was some definite intervening cause that contributed to the accident, most decisions have held that such intervention takes it outside the scope of coverage.

Some of the decisions on this subject have been based merely on interpretation of what constitutes maintenance or use of the automobile. Most of the decisions however, have based their reasoning on two separate theories:

- The "coming to rest" rule, prevalent in most of the earlier decisions, confines "loading" to that period of time which begins when the object is first picked up and kept in motion, without interruption, pause, or rest of any kind, until it is placed on the truck. "Unloading," according to this theory was held not to extend beyond the point where the object was first set down, so that again, movement from the time unloading began had to be continuous and uninterrupted. This rule is also known as the "Continuous Passage Rule" in some jurisdictions, and is identical in that it requires continuous and uninterrupted movement without any breaks or pauses in order to establish coverage.
- The Complete Operations Rule is the majority view and the more prevalent trend today. This doctrine holds that the scope of loading and unloading covers the movement of the operation from the time the insured receives possession until possession is turned over to the receiving party upon whom delivery is to be made.
- If the trends and decisions were clear-cut and definite on the Complete Operations Rule, we would have some demarcation line. It is impossible to guess how far the courts may go in extending this coverage. A sticky situation arises when a motor vehicle is being unloaded on premises owned by someone else. These cases normally involve pickup and delivery.

Omnibus Clause

The Omnibus Clause applies only to the automobile policy and creates as an additional insured "any person while using the automobile and any person or organization legally responsible for the use thereof, provided the actual use of the automobile is by the named insured or said spouse or with the permission of either." This means that if employees of the firm owning the premises where a delivery or pickup is being made are helping the insured's driver to unload, they are using the automobile with the permission of the insured and are hence additional insureds.

In addition, there is the complication that the general liability policies exclude automobile exposure away from the premises but do include such exposure if the accident occurs on the premises. However, it must be noted that since the general liability policies do not contain an Omnibus clause, employees of the insured are not additional insureds under these policies. The claim associations tried to set up some guidelines for the settling of disputes between the automobile and the general liability carriers.

Before considering the general principles, statutory provisions, and particular matters pertaining to "representations," "misrepresentations," "warranties," and "conditions," in the law of automobile insurance, it will help to reflect upon the meaning of these terms.

Representation

A "representation," in the law of insurance, is an oral or written statement by the insured or his or her authorized agent made prior to the completion of the contract, giving information as to some fact or statement of facts with respect to the subject of the insurance. A representation is intended or necessary for enabling the insurer to determine whether he or she will accept the

risk and at what premium. Representations are either affirmative, as to facts then existing, or promissory, as to what is to happen during the existence of the insurance. A "misrepresentation," in insurance, is a statement of something untrue, which the insured states with the knowledge that it is untrue and with an intent to deceive; or, a misrepresentation is a statement that the insured states positively as true without knowing it to be true, and which has a tendency to mislead.

Warranty

A "warranty," in the law of insurance, is a statement, description or undertaking on the part of the insured, appearing in the policy or in another instrument properly incorporated in the policy, relating contractually to the risk insured against. The warranty must appear on the face of the policy; or, if in another part of it, it must appear that the statements were intended to form a part of the policy.

If in another paper, the statements must be incorporated or referred to in the policy to clearly indicate that the parties intended them to form a part of the warranty. Warranties are either affirmative or promissory, and either expressed or implied, and there may be several warranties of different kinds in one policy.

Types of Conditions

"Conditions" in insurance policies are of two kinds—precedent and subsequent. The term "***condition precedent***" is commonly understood and technically used. It means a condition precedent to the consummation of the insurance contract, and is one that is to be performed before the contract becomes effective. "***Conditions subsequent***" are those which pertain, not to the attachment of the risk and the inception of the policy, but to the contract of insurance after the risk has attached and during the existence thereof. The terms "warranty" and "conditions precedent" are often used interchangeably or synonymously, although there is a distinction between the two. A warranty does not suspend or defeat the operation of the contract, and a breach of warranty affords either the remedy expressly provided in the contract or that furnished by law. A condition precedent is one without the performance of which the contract, although in form executed by the parties and delivered, does not spring into life. ***Promissory warranties*** are usually regarded as conditions subsequent to be performed after the policy has become a valid contract, a nonperformance of which will work a defeasance.

As a general rule, an insurer who has issued a motor vehicle insurance policy may, in accordance with the principles applicable to insurers generally, void the policy or liability thereon if, in procuring the insurance, the insured misrepresented a fact material to the risk and the falsity of the representation, unknown to the insurer, or if the insured is guilty of a breach of an affirmative or promissory warranty or condition contained in the policy.

However, if a combination policy, such as one insuring against fire "and" theft, is in legal effect two separate policies, a breach of a condition which renders only one void does not prevent recovery on the other. As indicated in the definitions, the distinction between a representation and a warranty in an insurance contract is that the former precedes and is not part of the contract and need be only materially true, while the latter is part of the contract and must be strictly fulfilled or the policy is void. However, this distinction between representations and warranties has been abrogated in whole or in part by statutes in many states. Where an applicant for automobile insurance gives correct information to an insurance agent who, without knowledge of the applicant, records the answers incorrectly, the acts of the agent under such circumstances are binding upon the insurer.

Named insureds are those persons or legal entities whose names are actually on the policy. There are many others, however, who qualify as "insureds" under the automobile policy. The Basic Standard policy defines "insured" in part as "any person using the automobile and any person or organization legally responsible for the use thereof, provided that the actual use of the automobile is by the named insured or such spouse or with the permission of either."

Problems Involving Permissive User

In addition to individuals who may be driving the automobile with the permission of the named insured, those legally responsible for its use can be as broad a class as an agency relationship can make it. For instance, any organization whose business is being furthered by the activities of the driver of the automobile may be legally responsible for its use under the law of agency. The organization would be covered under this broad provision if we assume that permission to drive had been obtained from the named insured.

No problem is presented when direct permission is given to the driver, as long as his or her acts remain within the scope of the permission granted. However, if some limitation of time, place, or purpose for driving has been placed by the named insured, a definite problem is presented when an accident occurs outside the scope of the driving authority given. Most courts have held that deviation by the driver from the authority granted must have been material in order to take it out of the scope of permissive use. A few minutes over the time specified, or a few blocks outside the normal route of travel, would ordinarily not be sufficient to permit the company to disclaim coverage.

On the other hand, if the driver was sent on a definite business mission. Before returning the car, decided to go on a long distance joyride that had no connection whatsoever with the purpose for which the car was put in his or her charge, he or she would have made a material deviation sufficient to deny himself coverage in most jurisdictions.

Cases involving a second permittee present another problem when a driver receives permission from the named insured, then allows someone else to drive the car and an accident occurs while said second permittee is driving. Again, if the initial driver has been given direct authority to permit someone else to drive, there is no question, because the second driver obviously has the named insured's permission to drive. Also, if the insured is present in the car at the time the second permittee is driving and makes no objection, the permittee obviously has the named insured's tacit permission to drive.

What is the situation, however, when the named insured is not present in the car and there has been no discussion whatsoever concerning anyone else driving the car? Sometimes the decision can be reached from previous conduct under similar circumstances. For instance, if the named insured has entrusted his or her car on previous occasions to an individual without objection, it can be assumed that implied permission was granted at the time that the accident occurred.

What Is Permission?

There is a good deal of controversy about what actually constitutes permission. Some authorities have stated that permission can only be given if one also has the authority to refuse permission. Others have said that it need only be apparent authority to grant permission. It has been held that the use must be legal to be permissive. It is commonly agreed that a former owner of a car can no longer grant permission to a new owner or to anyone else driving it, since he or she no longer has any legal control over the vehicle.

An Exception to the Omnibus Clause

As has been stated many times, the policy must be read as a whole because there are many sections which are interdependent and many exceptions which affect other parts of the policy other than the one directly referred to. For instance, although there is a specific section of the policy dealing with exclusions, there is an exception in the provision with which we are dealing which has the same effect as an exclusion. "Definition of insured" goes on to state:

The insurance with respect to any person or organization other than the named insured or said spouse does not apply to any person or organization or to any agent or employee thereof, operating an automobile sales agency, repair shop, service station, storage garage or public parking place, with respect to any accident arising out of the operations thereof.

This provision does not apply to a resident of the same household as the named insured, to a partnership in which such resident or the named insured is a partner, or to any partner, agent or employee of such resident or partnership. To any employee with respect to injury to or sickness, disease or death of another employee of the same employer injured in the course of such employment in an accident arising out of the maintenance or use of the automobile in the business of such employer."

Multiple claims occur when several persons are injured as a consequence of negligent conduct by someone who is covered by liability insurance. For example, suppose a negligently driven car covered by a liability insurance policy with a liability limit of $20,000 per accident collides with another driven car and results in serious injuries to the driver and five passengers in the second car. If the damages sustained by those six persons as a consequence of the accident substantially exceed the insurance policy liability limit of $20,000, the individuals injured in such an accident will have sharply conflicting interests because each of the injured persons seeks compensation from the available, but inadequate, liability insurance. The question of how a limited amount of liability insurance would be allocated when the claims exceed the available coverage has long been recognized as a vexing problem when there are multiple claims arising from an insured event.

Whenever the amount of insurance for any insured event is less than the total losses, the persons sustaining losses may have divided interests. In such situations, if the insurance company exhausts the applicable liability insurance by settling with one or more of the claimants, the interest of the person(s) receiving compensation has, in essence, been preferred over the interests of the others. Depending on the circumstances, the specific settlement(s) with the individual claimants may not be in the best interests of one or another of the claimants.

Ordinarily, when tort claims exceed the applicable liability insurance, the insured's interest is best served by use of the available insurance coverage as to minimize the insured's risk of liability in excess of policy limits. This is especially true if the insured's resources may be subject to claims by the other injured persons. Therefore, when there are multiple claimants, the insured have interests that may be adversely affected by the settlements if even more of the claimants receive settlement payments—in exchange for an agreement that releases the insured from any additional liability obligation—while others do not.

Compulsory Liability

Compulsory liability insurance law is principally designed to protect travelers and to provide compensation to persons injured as a result of the negligent operation of a motor vehicle. Vehicle registration is conditional upon a showing by the registrant that he or she has liability insurance coverage on that vehicle. The purpose of financial responsibility acts is to protect the

public and to provide compensation for innocent persons injured through faulty operation of motor vehicles, to secure solvency of operators upon highways, and to provide funds for payment of claims of those injured in an accident. Without the requirements of such laws, negligent vehicle owners and operators often might be unable to compensate their innocent victims.

Further, a provision in a compulsory insurance act requiring a nonresident whose car is registered in another state to have insurance with an insurer who can be served in the state and who complies with the requirements of the act has been held not to constitute a discrimination against nonresidents denying them equal protection of the law since it merely puts nonresident owners upon an equal footing with resident owners.

Compulsory motor vehicle insurance is a remedial statute and is broadly construed to carry out its benefit purpose of providing compensation to those who have been injured by automobiles. Well-settled principles covering the interpretation of an ordinary policy of insurance will be disregarded in determining the scope and extent of a compulsory motor vehicle policy where necessary to accomplish the legislative aim. A liability policy which expressly states that it was issued to meet a statute requiring motor vehicle liability insurance must be stated in connection with such statute, public policy, and principles.

No-Fault Laws

A no-fault insurance plan which provides for compulsory personal injury protection benefits, and which modifies traditional civil liability, does not violate the due process clause of the Fourteenth Amendment to the Constitution of the United States or corresponding provisions of state constitutions.

In a compulsory motor vehicle insurance act which deals with indemnity for personal injury arising out of the ownership, operation, maintenance, control, or use "upon the ways of the commonwealth" of the motor vehicle, the quoted words mean public ways within the commonwealth or a way laid out under the authority of statute. Where an ordinance imposes as a condition of conducting a car-rental business the securing of liability insurance covering vehicles "rented, leased, operated, or used in the city," the policy applies to a vehicle rented in the city and involved in an accident outside the city boundaries. But a statute requiring persons engaged in the car-rental business to take out insurance or to be personally liable on failure to do so does not apply to a business conducted in another state even though a vehicle rented in such other state is operated within the state at the time of the injury.

The primary objective of the No-Fault Act is the prevention of duplicate recovery. Thus, where the insured sustained personal injuries in a one-car automobile accident, medical payments received by the driver from the driver's own no-fault insurer were deductible from a private or civil wrongdoing (tort) recovery against the township which negligently placed traffic control signs at the location of the accident. No-fault laws typically require that an individual buy personal injury protection (PIP). No-fault is a system in which the insured’s coverage pays for his or her injuries, regardless of who caused the accident. This is why the required personal injury protection is sometimes called no-fault insurance.

In states that do not have no-fault laws, the insurer of the person who was at fault is the company that pays for injuries. If an individual did not cause the accident, it is the other driver's coverage that pays, which means that to collect, an individual will sometimes have to sue that other driver and establish in court that the accident was his or her fault.

Lawsuits typically take a long time to settle. In Los Angeles County, for example, it takes an average of five years for a civil case to come to court. Often, a victim must be very well-off to afford the luxury of waiting for his or her day in court. A poor family could become bankrupt waiting that long for money to pay the medical bills and for the loss of income resulting from a serious auto accident.

Lawsuits also cost a lot of money—and a large chunk of it goes to pay lawyers rather than to compensate victims. As much as one-third to one-half of compensation paid in the fault system goes to lawyers and other legal expenses.

The basic principles behind no-fault insurance are to get accident victims' bills paid promptly, regardless of who caused the damage; to lower the cost of auto insurance by reducing the number of lawsuits; and to channel more of the premium dollar toward paying for losses rather than litigation expenses.

No-fault insurance is also an attempt to solve a dilemma at the heart of the auto insurance system. As a responsible person, an individual spends money for coverage to make sure that anybody he or she injures will be compensated—without causing bankruptcy. But an individual's life savings are at the mercy of less responsible drivers. The savings could be wiped out paying his or her own medical bills as a result of an accident caused by a person who has no coverage. No-fault lets the premiums work to pay for the insured's injuries.

In exchange for getting speedy reimbursement of their medical expenses and lost wages, drivers in no-fault states typically forfeit the right to sue except in the most serious cases. Several federal studies have found that under no-fault, accident victims get higher compensation, and receive it much more quickly than in fault states. And more victims get paid too. A recent insurance industry study by the All-Industry Research Advisory Council, for example, found that about one-third of the people who received no-fault benefits would not have been eligible for payment on a fault basis.

In some "fault" states, how much a victim collects depends on the degree to which he or she was at fault. If a judge or a jury find the insured 20 percent responsible for the collision, for example, and the other driver 80 percent responsible, the insured will get 80 percent of the damage award. In others, if the insured bears any responsibility for the accident, he or she will collect nothing. But the effectiveness of no-fault also depends on which no-fault law you are talking about. Fourteen states and Puerto Rico currently have some form of no-fault law—but no two have the same law. No-fault laws vary primarily in two areas: the breadth of coverage they require and how they define an injury serious enough to warrant a lawsuit for additional damages.

Generally speaking, the toughest no-fault laws—the ones that give the most generous no-fault benefits in exchange for the strictest prohibition against lawsuits—have been the most effective, both at compensating victims and at holding down the cost of insurance. The system does not work nearly as well in states that have mandated very generous insurance benefits regardless of fault, while also making it easy to sue for additional damages, even for minor injuries. This is the most expensive combination of no-fault and fault systems.

Michigan has the strongest no-fault law of the states with such laws. It requires very generous insurance benefits—unlimited medical and rehabilitation coverage and three years' worth of wage loss benefits—and includes coverage for property damage as well as bodily injury. But Michigan's law also has very tough restrictions on the right to sue. Lawsuits are limited to situations in which a victim dies or suffers serious disfigurement or the serious impairment of a bodily function. If the insured lost both legs in an auto accident, for example, he or she would

feel entitled to compensation above and beyond the no-fault policy limits—and he or she would be able to sue for it. People typically sue for their pain and suffering to provide for future compensation. It is left to the courts to decide if they should receive higher awards for their injuries.

The Michigan law has a verbal threshold that must be passed before a person can go to court; that is, it gives a verbal definition of "serious" injury. Some other states have dollar thresholds; they define as "serious" any injury resulting in a specified amount of medical costs. Clearly, a verbal threshold reduces the number of permissible lawsuits more effectively than a low dollar threshold, or even a relatively high one, given the rapid escalation of medical costs today.

There is a compulsory personal insurance protection coverage with some restrictions on lawsuits in these states: Colorado, Connecticut, Georgia, Hawaii, Kansas, Kentucky, Massachusetts, Michigan, Minnesota, New Jersey, New York, North Dakota and Utah.

There is compulsory personal insurance protection coverage and optional liability insurance and also some restrictions on lawsuits in these states: Florida and Puerto Rico.

There is compulsory personal insurance protection and liability insurance and no restrictions on lawsuits in these states: Delaware, Oregon, Pennsylvania and Maryland.

There is compulsory liability with optional personal insurance and no restrictions on lawsuits in these states: Arkansas, South Carolina, Texas and the District of Columbia.

There is insurance protection (but not compulsory and optional personal insurance protection) with no restrictions on lawsuits in these states: New Hampshire, Virginia, Wisconsin, South Dakota and Washington.

Kentucky, New Jersey and Pennsylvania allow consumers to chose between a no-fault option and the liability system.

No-fault insurance statutes have been upheld against a variety of objections. It has been held that the provision of a no-fault statute exempting a negligent person from liability up to the statutory limit as a result of an automobile accident caused by the driver's own negligence does not deprive the injured party of any property rights. However, compulsory provisions included in a no-fault statute have been held to violate the state constitutional guaranty of the right to trial by jury. A no-fault insurance statute does not violate the due process requirements of the Constitution merely because it compels unlimited medical expense payment without guaranteeing the insurer the right to recover that payment by way of subrogation and reimbursement.

Mandatory arbitration provisions of no-fault laws do not violate the constitutional right to due process. On the other hand, a noncompulsory no-fault system has been held unconstitutional and void in regard to the due process clause of the Fourteenth Amendment to the United States Constitution and of similar provisions of a state constitution because the classifications in the statute were discriminatory and arbitrary.

The fact that all persons are not treated the same under no-fault laws does not mean that such laws invalidate the equal protection clause of the Constitution. Such a law is not invalid on the basis that it creates two groups of motor vehicle accident victims, one with tort remedies and one without. A no-fault law which grants immunity from most tort liability to a person who is involved in a private or civil wrongdoing (tortfeasor) insured as required by the law, while denying such immunity when the tortfeasor is uninsured, does not violate equal protection

principles. A no-fault law does not violate equal protection rights. Although it does not permit a nonresident to recover, it permits him to maintain a civil tort action against a resident tortfeasor subject to the limitations of recovery which would apply if benefits were to be paid under the no-fault law. The nonresident injured party's recovery is subject to the threshold limitations applicable to residents with respect to recovery of nonpecuniary damages. In this case, the injured party's rights are violated. Since the nonresident's right to sue for pain and suffering is limited when he is non-negligent, he obtains the counterbalancing effect of being protected from comparable claims where he has been negligent.

No-fault provisions limiting recovery for nonpecuniary damages such as pain, suffering, mental anguish, and inconvenience to persons injured in motor vehicle accidents having medical expenses in excess of a reasonable specified threshold value, do not violate equal protection rights. Medical costs vary geographically, and the poor normally receive medical care at lower costs than do those of financial means, and are therefore less likely to reach the medical threshold.

Nor is the right to equal protection denied by the fact that the statute requires some vehicles to carry no-fault insurance and not others, thereby making an injured person's remedy depend upon the nature and use of the vehicle causing the injury. A no-fault insurance statute which requires a reduction of benefits to the insured by the amount of benefits received from governmental sources for the same injury is not a violation of equal protection principles.

A provision of the Florida no-fault insurance act allows recovery of intangible damages in cases in which medical benefits do not exceed the threshold amount of $1,000, and in which no death or permanent injury results, but in which injury or disease consists in whole or in part of a fracture to a weight-bearing bone or compound as a displaced or compressed fracture.

The Michigan no-fault insurance act was held to be constitutional insofar as it provided insurance benefits to victims of motor vehicle accidents as a substitute remedy; however, the mechanisms contained therein for controlling the rate-making procedure were found to be constitutionally inadequate in certain respects.

The South Carolina Automobile Reparation Reform Act requires automobile insurance carriers doing business in the state to write or renew policies for all insurable applicants, whether or not they are good or poor insurance risks. This does not violate the insurer's rights to equal protection and due process, since the act bore a reasonable relation to the state objective of guaranteeing adequate coverage for all drivers.

The Kansas No-Fault Act provides certain benefits to injured employed persons and their survivors and not to unemployed persons and their survivors. This does not violate equal protection clauses of the Constitution.

The New Jersey No-Fault Act provides that the resident's relatives seeking recovery for personal injury protection benefits were bound by the cost containment option selected by the insured. This does not violate equal protection rights.

Financial Responsibility Laws

Financial responsibility laws are designed not merely to regulate the rights of operators and owners of motor vehicles but also the rights and obligations of insurers issuing policies to comply with those statutes. It has been suggested that although public policy prevents the indemnification of one who intentionally causes damage, the financial responsibility law is itself

declaratory of public policy and supersedes any rule of public policy applicable to ordinary insurance law, so that it is not against public policy for the insurer to be held liable for the intentional act of the insured. Such a result is for the protection of the injured party and to insure that he or she is compensated for is injuries; it is not intended to benefit the intentional wrongdoer, so that a policy with such a requirement may have a provision for reimbursement of the insurer for any payments which the insurer might not have been obligated to make except for this statutory requirement. A financial responsibility statute is designed to subject insurers to absolute liability only where they are aware of the status of the applicant as a member of the statutory class.

When an automobile liability insurance policy is issued to satisfy the requirements of a financial responsibility law, the resulting situation closely resembles that which exists when a compulsory liability insurance law is in effect and a policy is issued pursuant to the requirements of that law. As may be expected, the construction and application of financial responsibility laws and liability policies issued in compliance with those laws closely parallel the construction and application of compulsory liability insurance laws and policies that have been issued.

An insurance policy, issued for the purpose of enabling the insured to comply with a financial responsibility act, must comply with the requirements of the act, and if any provisions of the policy are inconsistent with those statutory requirements, the provisions of the act will prevail, and the nonconforming provisions of the policy will be held to be invalid. A specific provision put into an insurance contract by force of a financial responsibility statute, should be interpreted according to the intention of the legislature, irrespective of how the contractors understood it.

Under a financial responsibility law providing that every motor vehicle liability policy shall insure the named person and any other person using or being responsible for the use of a specified motor vehicle with the express permission or implied permission of the insured, an insurer cannot limit coverage in a liability policy to the insured and the insured's immediate family.

Although provisions of a liability policy are invalid where they are inconsistent with the terms or intent of the financial responsibility law to which the policy was issued, the coverage of the policy will not be expanded beyond its terms where such expansion is not reasonably required to satisfy the statutory provisions or legislative intent. An insurer does not, under the financial responsibility law, become an insurer of all owned automobiles merely by issuing a policy on one automobile that he or she owns.

An insurer will be estopped from denying that liability for injuries sustained is covered by a policy it issued to one who negligently caused such injuries, where, knowing that the insured had been previously involved in an accident which brought into operation the statutory obligation of the insured to submit proof of financial responsibility, the insurer issued a policy so limited as to circumvent the statutory policy of protection for innocent persons injured by the operation of the insured vehicle, or where the insurer has failed to notify the motor vehicle commissioner of the fact that a previous accident was not covered by the insured’s policy, which excluded coverage of motor vehicles owned by the insured.

A financial responsibility law may provide that violation of the terms of an insurance policy shall not defeat or void the policy. However, where such a statutory provision exists, care must be exercised to distinguish between violation of the terms of the policy and circumstances which merely reflect a use outside the scope of the coverage of the policy.

The Arizona Financial Responsibility Act requires that a motor vehicle liability policy provide specified coverage, and exclusions or conditions which dilute that coverage are void and of no effect. An exclusion in a motor vehicle liability policy certified under the Safety Responsibility Act

concerning an automobile owned by the insured, or any resident of the same household is in conflict with the act and invalid.

Under the financial responsibility law, the omnibus clause is a part of every policy regardless of whether the policy states it or not. The statute relating to civil liability and financial responsibility of owners and operators of vehicles is incorporated into every vehicle operator's insurance policy.

The requirements of a financial responsibility law cannot be avoided through a separate agreement, not incorporated into the insurance policy, which would limit the coverage of a policy in a way which would contravene the requirements of the law.

A financial security law requires the maintenance of certain minimum levels of insurance, but it does not prevent the insurer and the insured from agreeing to coverage in excess of the statutory requirement. Either the insurer or the insured may limit the coverage provided under some parts of the policy to the statutory minimum required by the financial responsibility law, while having a higher limit of liability apply under other parts of the policy.

Although a financial responsibility law may be in effect, such an act has no effect upon automobile insurance which is not required, and the terms of such other coverage need not comply. Since the mandatory provisions of financial responsibility laws come into play only after an accident has occurred, such laws normally have no effect upon an insurance policy voluntarily obtained at a time when the person obtaining that policy was under no obligation to demonstrate financial responsibility, at least where the policy does not satisfy the requirements of the law. Thus, a policy may contain an enforceable provision, even though such provision would be rendered invalid by the financial responsibility law if it fell within the provision of that law. However, with the widespread adoption of financial responsibility laws, many insurers began including in their policies a provision that such policies should comply with the terms of applicable financial responsibility laws.

Claim Investigations

Some states have adopted regulations which impact upon an insurer's handling of claims under a vehicle insurance policy. For example, in 1993 the California Insurance Commission adopted a number of rules designed to facilitate the processing of claims, including requirements that:

- Within 15 days of receipt of notice of a claim from a policyholder, a carrier must provide written notification of receipt of the claim. Within that same time frame, the carrier must commence investigation of the claim.
- Within 40 days after receiving a proof of claim, the carrier must affirm or deny both the claim and liability, or, in the event the carrier finds that forty days is not sufficient, it must notify the claimant, specifying why a longer period is necessary and delineating what further information is needed.
- If there is a partial or complete denial of a policyholder's claim, the claimant must be notified in writing, specifying under what provisions of the policy and the factors upon which coverage is denied. The claimant must be advised of his or her right to have the denial reviewed by the insurance department and of the address and telephone number of the department.
- Carriers must disclose to their policyholders any time limits, benefits, coverage or other material provisions of any policy the carrier has issued and sold that may apply to the facts underlying the claim. If a policyholder sends any other communication which reasonably

suggests a reply is expected in regard of a claim not the basis of a lawsuit, the carrier must respond within fifteen days of receipt of the same.

HISTORY OF AUTO CLAIMS

In the early days of auto insurance, almost all auto policies were written by agents. The agent could be an employee of a certain company, or he or she could be an "independent agent." The independent agent could represent many companies, and could offer the customer a "laundry list" of carriers from which he or she obtained the most favorable premium price for his or her customer.

Today if you ask a person with whom he carries his or her auto insurance, most of the time the answer will be the name of an insurance agency. Seldom does the policyholder know the name of the company which actually wrote the policy.

Therefore, most of the time when a driver is involved in an auto accident, if in the driver's judgment the accident is deemed to be serious enough to report, he or she will report the occurrence to his or her insurance agent.

Let us assume that the other driver was insured and has reported the accident to the agent. What next? The bureaucratic wheels will begin to turn. In due course—several days or even weeks—an adjuster will be in contact. The insurance adjuster will either be a staff adjuster (an employee of the involved company) or an independent adjuster. The independent adjuster, much like the independent agent, represents a number of casualty companies which—by reason of size, choice or accident locale—do not have staff adjusters available.

In 1960, an on-the-scene adjuster was involved in every claim, be it a fender bender or a multiple fatality accident. If an individual had a collision claim, he or she might simply be instructed to "get three estimates" and send them in; however, an adjuster was involved.

In the case of a more serious accident, the adjuster visited, diagrammed and photographed the scene. He searched for and obtained statements from witnesses. He interviewed the investigating law enforcement officers and all involved parties. He even visited the hospital rooms of the accident victim, if for no other reason than to leave his or her business card. This "hands on" treatment of claimants persisted for years until the paranoia of the elevated loss adjustment expense became paramount in the minds of casualty company senior management. Consequently, a new era was born.

The independent adjusters, because of extreme pressures from companies to hold down expenses, began utilizing the telephone more. They found they could handle more claims less expensively by telephoning to take statements, tracking down leads on additional witnesses, and a multitude of other investigative functions which were previously done "on the street."

Companies have made wide usage of the "drive-in" claims service concept. The modus operandi is that the insured or third party claimant is requested, if the auto is drivable, to make an appointment at a staff or independent drive-in claims facility where they are assured prompt service and quick payment.

In most cases, good service is provided and prompt payment is made. The insured or claimant leaves the drive-in facility with an estimate of damage written on a company form and a draft or check. This sometimes provides a truly happy ending to the always traumatic experience of an

auto accident. But this is not always the case. The only problem is that the insured or claimant must find an auto repair facility which is willing to do the work for the sum of money the appraiser has decreed. Many times there are no problems, but in a number of cases there are. The repair facility of choice will not agree to repair the car for the sum of money the appraiser has allowed, additional damage is discovered after repairs are commenced or the work is done improperly. Guess who winds up in the middle?

Despite these minor inconveniences to the insurance consumer, the direct handling of physical damage losses was hailed as a great success. Inspired by this success, it has been decided by many companies to expand this technique to the handling of "minor" bodily injury, PIP and med pay claims. The BI direct handling claims person should be an individual who is reasonably experienced in the determination of liability, has a pleasant telephone personality, is articulate and has a fair command of medical terminology.

Most companies place time constraints on the number of months a file can remain in a BI direct handling unit. These mandated time constraints are largely ignored; however, it would be in the best interest of both the agent and client to assemble the settlement documentation as quickly as the client's medical recovery permits and relay that documentation.

Procrastination may result in the client's file being referred to a higher level, to a more experienced claims person who is even more overworked than the lower level person, the end result being that a second opinion by a more experienced person may well change the company's outlook on the clients' claim and kill an advantageous opportunity for settlement.

PERSONAL AUTO CLAIMS

First Party Claims

Simply defined, a "first party" claim is a claim for indemnification made by the policyholder against his or her own coverage. The most elementary examples of such claims should be under the auto policy claims for damage due to collision, theft or fire. Under a property policy, a simple example would be a claim made for a loss due to fire, hail, windstorm, etc. All of these types of claims usually involve a clearly defined amount of dollar damages. About the only dispute which can arise is a difference of opinion as to whether the compensation offered is adequate.

An often misunderstood auto coverage is "comprehensive" coverage. As the name implies, this coverage is designed to cover risks which produce damage " other than by collision." It is supposed to protect the owner of an insured auto against any "direct and accidental" loss other than those "losses" which are excluded, such as mechanical breakdown and normal wear and tear.

Comprehensive coverage has some peculiar traits, covering certain "collision" occurrences, such as accidental breakage of glass, with breakage usually occurring as a result of a "collision" by some object with the auto's glass. Another unusual example is the damage to an auto caused by a hood accidentally flying up while driving. Obviously, there was a collision between the hood and passenger compartment of the car; yet such claims are paid under the comprehensive coverage based upon the rationale that an auto or a part thereof cannot collide with itself.

Probably more unique and complicated coverage questions arise under the comprehensive coverage of the policy than any other, yet casualty companies usually start their rookie claims people adjusting losses under this coverage. After all, the companies reason, what is so tough about handling a broken antenna and stolen hubcap losses?

At the other end of the spectrum is the rock-punctured oil pan of a $60,000 Mercedes Benz, which results in oil loss and the replacement of a very expensive engine. The standard procedure is to attempt to pay for the damaged oil pan and deny the claim for the engine, based upon the "insured's failure to protect the vehicle after loss and subsequent mechanical failure."

This is a very common type of claim and each must be judged by its own particular circumstances. The final test is whether the insured acted prudently after becoming aware of the loss of engine lubricant and, if not, were there additional extenuating circumstances which induced the insured to act other than in a prudent manner. There are no inexpensive engines, so one should not be surprised if he or she is consulted on a claim such as this. In the many states which have adopted the California doctrine of "bad faith" or "outrageous" conduct, the denial of a simple and small first party loss can be tremendously expensive to the company.

Mundane coverages account for $.70 of every loss dollar spent. Next on the list is medical payments or Personal Injury Protection Coverage. In the agent's representation of clients, he or she should be totally familiar with these coverages.

Under the old Family Auto Policy, there was no Personal Injury Protection (PIP) Coverage, only Medical Payments Coverage. This coverage provided for 100 percent reimbursement for medical expenses, up to the specified dollar limit, due to accident or illness while occupying the insured auto. "Occupying" was defined as "in, upon or alighting from." It also protected the insureds under the policy against medical expense resulting from being struck by a motor vehicle while a pedestrian. The period of coverage was one year. Some litigation occurred as a result of this coverage.

Dental and scarring injuries were particularly troublesome as their treatment usually lasted much longer than the one year time period. Some innovative insureds actually entered into contractual agreements with dentists and physicians, thus claiming that the future expenses were "incurred" within one year. The success rate in the courts was about 50 percent depending upon the expertise of the author of the contract and the amount of consideration exchanged and when it was exchanged. "In, upon or alighting from" the insured auto also created business for the courts. The condition alighting from caused much controversy. Is a person with one foot on the ground "alighting from"? The answer is clearly "yes," but what about five feet or ten feet away from the car? Exploding batteries and tires can also create some problems. Enlightened companies generally made decisions based upon common sense rather than a pure technical interpretation of the policy. All of these problems still remain despite the birth of the "Easy Read" policy.

Personal Injury Protection

Personal Injury Protection coverage (PIP) was the solution adopted by many states when the pressure for enactment of "No Fault" coverage was at its peak. In the final analysis, all PIP did was to add income loss reimbursement to the old med pay coverage. Disability coverage has been on the market for years, but not as a part of the auto policy. PIP also extended the time period of the coverage from one to three years.

There is a wide variation from state to state as to whether a provider of Med Pay or PIP coverage can subrogate against a responsible tort feasor or deducts such payments from Uninsured Motorist or Underinsured Motorist settlements. Many jurisdictions have held that such subrogation and setoffs are void as against public policy. Recent "bad faith" litigation involving attempts to subrogate these coverages has also dampened the subrogation efforts of many carriers.

The U.S. government, under the Medical Care Recovery Act and case law relative thereto, does have the right to claim against either the responsible third party's liability coverage, UM/UIM Coverage or MP/PIP coverage. However, the government is entitled to be reimbursed only once. It is important to remember that in cases of even minor hardship, the government is usually willing to compromise or even waive their entire claim.

Enforcement of the government's right of subrogation is the responsibility of the Justice Department. This type of litigation is usually at the bottom of their priority list. When a client's recovery depends solely upon the amount of the liability limits available, it will be in the best interest of both agent and client to attempt to obtain a compromise or waiver of the government's claim, especially if damages are great and the limits are low.

MP/PIP coverage in many states will "stack" or pyramid even with a policy pronouncement to the contrary. It will generally stack when a client is injured while he or she is an occupant of an auto owned by some other person or entity.

Uninsured Motorist Coverage

A form of coverage which is finally coming into more and more prominence is that of Uninsured Motorist protection. This coverage was first presented to the various state insurance departments as a substitute or alternative to compulsory liability insurance. For many years, the coverage was only offered in limits of $10,000 per person and $20,000 per accident or an amount equal to the financial responsibility coverage law limits of a particular state. From its very inception, the policy provided that disputes between insured and coverage would be resolved by arbitration under the auspices of the American Arbitration Association.

In the early years of uninsured motorist coverage, it proved to be a huge financial boon for the industry even though the premium charge was typically very cheap. In the past, contributory negligence was an absolute bar to recovery, physical contact with the uninsured auto was a universally enforceable requirement, and guest statutes were the order of the day.

The greatest fear of a company—then and now—is that a case would actually be decided by AAA arbitrators. An arbitration award of less than the policy limit was considered an absolute victory. The reason for the horrible results from the industry point of view regarding the AAA is that most of the arbitrators were plaintiffs' attorneys. Insurance defense counsel did not have the time or the inclination to serve as arbitrators and would not volunteer their names to the AAA.

In some states—Texas for example—arbitration of a UM claim is not allowed and suit must be brought against the uninsured and the company providing the uninsured motorist coverage. While the companies may fare somewhat better than AAA arbitration, they are still disadvantaged as the company is named defendant in a suit by a policyholder. In recent years, things have changed insofar as the coverage itself is concerned. The changes have been dramatic and have completely altered these coverages. All changes benefit the injured party, yet this coverage remains much misunderstood by plaintiffs' counsel as well as the insured.

In most jurisdictions, the coverage is no longer Uninsured Motorist Coverage. Secondly, if requested, it must be written in the same coverage amounts as the Bodily Injury Liability Coverage. For example, an insured who carries $300,000/$500,000 BI liability limits, upon request, can carry the exact same UM/UIM limits. This is a giant step from the days of 10/20 UM. Again, the premium difference between 10/20 UM/UIM and 300/500 UM/UIM is a few dollars a year. It is probably the best insurance buy in the market today. When reviewing their insurance policies clients should do two things: (1) if indicated, raise their BI limits and (2) buy equal UM/UIM limits.

Underinsured Motorist coverage is a relatively new form of coverage. The specific application of this coverage varies by state and it would be in an agent's best interest to find out how it works in his or her jurisdiction. Some of the variations are as follows:

- The company is entitled to offset or take credit for the amount of coverage carried by the responsible tort feasor. Example: If the claimant has $10,000 in coverage, the insured's UIM coverage is $100,000. Total exposure to the UIM carrier is $90,000.
- Some states allow no offset of the tort feasor's coverage. Thus, in the example above, the insured would be entitled to claim the full $100,000. Typically, this is the better rule because the insured paid a premium for $100,000 UIM coverage, not $90,000.
- In some states, if the claimant's coverage is equal to or exceeds the UIM coverage, there is no UIM claim.
- Some states allow "stacking" of both UM and UIM coverage.

There is generally a right of subrogation under the UM/UIM coverage and a policy condition that any settlement against the responsible party must be with the permission of the company.

The auto policy covers every relative residing in an insured's household. Consider, for example, the aged lady who resides with her son, daughter, brother or uncle. She has not driven a car for 20 years and does not own an auto, and is struck while taking her morning walk by a hit and run driver. Is she covered? Yes—under the UM/UIM coverage(s) on the relative's auto(s).

Consider a case where an individual is badly injured in a multiple car accident while a passenger in a friend's car which is not insured or has low BI liability limits. If the combined limits are not adequate to compensate for the injuries sustained, the individual would make a UIM claim under his or her own auto policy or that of the relative with whom he or she resides.

"Stacking" is another opportunity for a client to apply additional coverage. Some years ago, the industry wrote the "single car" policy regardless of the number of vehicles insured by a single individual. The courts, however, almost universally "stacked" all of the coverages, especially the UM coverage. Consequently, for the sake of efficiency and service and to hold down rates, the multi-car policy was born. It became much more difficult to "stack" the coverages of all autos listed on the multi-car policy.

A UM/UIM claim cannot be made against the combined limits of all autos in the multi-car policy. Only the coverage of the car actually being driven at the time of the accident will apply. With more and more people carrying higher limits, both BI and UM/UIM, probably the UIM coverage will shortly become as important a source of compensation for injured claimants as has been the traditional BI liability coverage carried by negligent claimants.

It is important to remember that numerous states have recognized the bad faith clause of action in claims by insureds against numerous insurance contracts such as auto, health and accident, homeowners, etc. Many other states are on the brink of recognizing punitive damage actions

predicated upon "bad faith" handling by a casualty company. The point is that a claim by an insured under his or her UM/UIM coverage, while based upon tort liability and personal injury, is nevertheless a first party claim against a person's own insurance company. Therefore, the company is placed under a much greater duty to properly handle and negotiate in good faith as compared to the duty placed upon a liability carrier in the handling of a claim by an injured third party against its insured.

It should also be remembered in regard to UM/UIM coverage, that most states now require this coverage to also cover damage to the insured auto. Collectibility under this type of policy is based upon claimant liability of the uninsured motorist and generally provides for a $250 deductible. Therefore, in the absence of collision coverage on a client's auto, consideration should be given to a claim under the UM/PD coverage. In this day of comparative negligence, unless the client is totally at fault, the chances are good that the insured will be able to recover for all or most of the damage to his or her car.

Claim Handling Procedures

There are five general phases to good claim handling procedures:

1) Proper preparation.
2) Prompt and thorough investigation.
3) Decision and action.
4) Adequate reporting.
5) Self-discipline.

Proper preparation enables the claims person to plan an orderly investigation without loss of time or effort. Such preparation avoids the necessity for callbacks to the insured, claimant or witnesses. Callbacks are not only a waste of time, but are bad public relations as well. An additional interview gives the impression that the company is uncertain, and is looking for an "out." A thoroughly planned initial interview makes it more likely that the adjuster will obtain correct and complete information. Claimants and witnesses become suspicious when a callback is made to get additional information which should have been obtained in the initial contact. Not only does the adjuster run the risk of losing control of the case, he or she greatly lessens the chances of getting the entire truth in the form of a signed statement.

Proper preparation should begin at the very inception of a case—that is, at the receipt of the first report. It requires prompt and thorough analysis of the problems involved. Such an analysis must be based upon the facts at hand, the coverage information, and the applicable law. It cannot be based upon guess and surmise.

Incredible Auto Claim Stories

The following are actual statements found on insurance forms where car drivers attempted to summarize the details of an accident in the fewest words. These instances of faulty writing serve to confirm that even incompetent writing may be highly entertaining.

- Coming home I drove into the wrong house and collided with a tree I don't have.
- The other car collided with mine without giving warning of its intentions.
- I thought my windows was done but I found out it was up when I put my head through it.
- I collided with a stationary truck coming the other way.
- A truck backed through my windshield into my wife's face.
- A pedestrian hit me and went under my car.

- The guy was all over the road. I had to swerve a number of times before I hit him.
- I pulled away from the side of the road, glanced at my mother-in-law and headed over the embankment.
- In my attempt to kill a fly, I drove into a telephone pole.
- I had been shopping for plants all day and was on my way home. As I reached an intersection, a hedge sprang up, obscuring my vision and I did not see the other car.
- I had been driving for 40 years when I feel asleep at the wheel and had an accident.
- I was on my way to the doctor with rear end trouble when my universal joint gave way causing me to have an accident.
- As I approached the intersection, a sign suddenly appeared in a place where no stop sign had ever appeared before. I was unable to stop in time to avoid the accident.
- To avoid hitting the bumper of the car in front, I struck the pedestrian.
- My car was legally parked as it backed into the other vehicle.
- An invisible car came out of nowhere, struck my car and vanished.
- I told the police that I was not injured but on removing my hat, I found that I had a fractured skull.
- I was sure the old fellow would never make it to the other side of the road when I struck him.
- The pedestrian had no idea which direction to run so I ran over him.
- I saw a slow moving, sad faced old gentlemen as he bounced off the hood of my car.
- The indirect cause of the accident was a little guy in a small car with a big mouth.
- I was thrown from my car as it left the road. I was later found in a ditch by some stray cows.
- The telephone pole was approaching. I was attempting to swerve out of its way when it struck my front end.

AUTO CLAIM INVESTIGATIONS

The investigation, once started, becomes a constantly shifting picture with new leads and new avenues of inquiry opening up as it develops. The claims person will need some imagination and inquisitiveness, and a lot of determination and persistence. For instance, sometimes a witness cannot be located unless a neighborhood investigation is made, which can only be effectively done by ringing doorbell after doorbell. The investigator may not get the signed statement from the policeman who investigated the accident but the chances are certainly in his or her favor that the police officer will discuss the accident, and supply some pertinent information. This certainly would not happen if he or she decided it was useless to attempt to see the officer in the first place.

Purposes of Investigation

There are only three purposes involved in every investigation of casualty claim: (1) to determine the facts, (2) to establish liability and (3) to obtain and preserve the evidence. A claims person cannot be content with guesswork. All allegations should be thoroughly checked for accuracy and must either be corroborated or denied by evidence which can be presented in court. An attitude of alert skepticism is healthy. An investigation is made to determine the truth as closely as possible. No useful purpose is served by philosophizing on the nebulous quality of the word "truth." The new claims person will learn, within the period of his first few months, that four people can see an accident and give four different versions of how it happened and each witness will be convinced that he is telling the truth. Do not start an investigation with any preconceived notions or prejudices. Let them speak for themselves. There are specific areas of investigation that will involve the special coverages. These will be discussed later.

Principles of Investigation

Following are general principles involved in handling casualty claims:

- ***Review the Report***—Review the initial report carefully and make notes on the information contained therein. These notes should be made in the form of a worksheet which the investigator should have for every claim that he handles. Some companies have preprinted work sheets which outline the investigation to be made and leave space for the insertion of important information such as the file number, names of the insured, claimant and witnesses, coverage information, facts, etc. If such preprinted sheets are not available, it is easy to make them.

  If the original report of an accident is incomplete, a telephone call to the insured will usually provide sufficient details to enable the adjuster to arrange an orderly plan of action. Such a call may also serve the purpose of arranging for an appointment with the insured, since it will be necessary to obtain a detailed signed statement from him on any serious claim. Quite often, drawing a rough diagram from the facts at hand will help to clarify the picture.

  Not all claims will demand the same kind of investigation. The insured's first report may indicate that the matter is of minor importance and may contain sufficient information to avoid the necessity of further contact with him. Again, the matter may be important enough to warrant a phone call for additional information without personal contact. Each company has its own policy concerning the degree of investigation necessary, depending upon the importance of the case involved, and the supervisor will soon inform the adjuster concerning the company's attitude in this respect.

- ***Examine the Coverage***—Over the years, a mystique has developed concerning coverage problems. In many companies the new adjuster is not required to do any policy reading as to matters of fact, and is even occasionally discouraged from doing so. However, instruction in coverage problems is of prime importance and will be as long as the adjuster is involved in claim work. This instruction should begin as soon as possible. If an insured is expected to know what is in his policy, the adjuster should at least be just as familiar with it. It cannot be expected that a new claims person will be able to interpret a policy which is complicated or needs legal interpretation, but he or she should at least become familiar with the major problem areas as soon as possible.

  He should examine the coverage carefully in the light of the facts at hand on all important cases involving anything other than the ordinary, uncomplicated accident report. The application and all endorsements should be "pulled" and examined. If the adjuster recognizes a coverage problem, he or she should immediately consult with the supervisor concerning it and make a careful outline of the investigation needed for a proper determination of the problem involved. All of the facts connected with the problem should be obtained. Specific coverage questions will be discussed in detail subsequently.

- ***Outline the Projected Investigation***—After the facts and the coverage information have been reviewed, a complete outline of the projected investigation should be made. Here is where a worksheet becomes invaluable. Enough space should be allocated so that the claims person can list everything that has to be done in the order of its importance. One may get the impression that he or she does not have the time to do this, but in the long run the time spent in outlining the projected investigation will be more than made up by the time saved in wandering around aimlessly. Where necessary, use all available technical aids such as textbooks, articles on related subjects, and the policy itself.

- ***Outline the Interview***—Some sort of an outline should be made of the points that are to be covered in each interview. While the interview is progressing, it is impossible to remember everything about a complicated claim. The use of proper notes reduces the possibility of overlooking an important point and avoids the necessity for callbacks.

- ***Consultations***—If there is any doubt or confusion about the direction of the investigation or the facts to be obtained, a claims person should discuss the matter with his or her manager or supervisor to get additional ideas or clarification of the objectives. To consult with someone else on a complicated problem is not an admission of weakness. The very act of talking over the situation will help to clarify the objectives. The old adage that "two minds are better than one" has been proven time and again in claims work.

- ***Make an Itinerary***—If an adjuster were handling only one claim at a time, it would be relatively easy to make an itinerary that would be efficient and productive. Unfortunately, the economics of the situation are such that this is impossible since every adjuster is required to handle a sizable workload. Accordingly, it is essential that the following factors are considered in planning the itinerary for the day.

  1) The order of importance of the claim itself—the claims person may have an important case that is going into suit where it is absolutely essential for him to obtain some information as soon as possible.
  2) The location of the stops that he or she is to make—it is important for him to try to arrange the itinerary so that he or she does not have to backtrack any more often than is absolutely necessary. If backtracking is required, it might be more efficient to arrange to make several stops in different areas on different days.
  3) Where possible, he or she should make advance appointments which will have to be fitted into the itinerary. It is not always necessary to make appointments. There will be instances where it will be advisable to try to surprise a witness or a claimant and not give him any advance notice that the claims person wants to interview him. However, where the element of surprise is not involved, appointments will save a lot of time.
  4) Finally, in making an itinerary, the claims person will have to consider the likelihood that the individual he is seeking will be at home or at his or her place of business at the time when he or she will be there. Give consideration to this factor before making up the itinerary.

  It is impossible to make up a perfect itinerary; however, if the above factors are taken into consideration in making up the itinerary, it will certainly be much more advantageous than to start making calls blindly without any advance planning. On an individual important case there can be no set formula. If sufficient facts have been obtained from the insured in the first report, or in a telephone conversation, it may be better to see the claimant personally on the first call. On the other hand, if the claims person is ready to start the investigation, and he or she does not have sufficient facts to form a fairly clear picture of what happened, he or she may consider it advisable to see the insured first. Where "ambulance chasing" is prevalent, it is usually more practical to make an attempt to see the claimant immediately. Seeing the insured is usually wise when coverage questions are involved, since a determination of the coverage problem may make it inadvisable to contact the claimant at all. If the scene of the accident is on the way to the insured or to the claimant, the claims person might wish to examine the scene before he or she interviews the principals.

It is important that a decision be made as promptly as possible on whether or not a case is one for settlement of declination. To do so is not only good business practice, but good for the reputation and public relations of our industry as well. A claimant has the right to know the attitude of the insurance carrier and its decision, so that future actions may be guided

accordingly. If the investigation is complete and the case is one to decline, the claims person should do so courteously and promptly, and give proper explanation for the decision. The claimant then knows where he stands and the company will know all the sooner whether he intends to press the matter further.

Prompt decision is especially important in compensation cases where the claimant is disabled and depends upon indemnity payments for living expenses. Such payments are scrutinized very closely by most states and the time element involved in making them is of the utmost importance. If the claim is compensable and properly covered, be sure that the payments are made on time.

Advance payments are not at all unusual, making it essential to determine as soon as possible what the ultimate decision is going to be in any particular case. However, there is a diversity of opinion. Some companies feel that where the injury warrants control, and where this factor is of utmost importance, they may decide to make advance payments even though the liability picture is not altogether clear. This is a matter for each individual company to decide.

Evidence

In motor vehicle accident cases, the general rule is that hearsay evidence is inadmissible. The usual reason given for the exclusion of hearsay evidence is that it is not subject to the tests which can ordinarily be applied for the ascertainment of the truth of testimony; the evidence if admitted would derive its value, not solely from the credit to be given to the witness upon the stand, but in part from the veracity and competency of some other person. It is upon such considerations, and not because of its irrelevancy and immateriality, that hearsay evidence is generally condemned. Accordingly, the rule followed in most jurisdictions is that hearsay testimony admitted without objection may properly be considered and given its natural probative effect, although the weight of hearsay evidence is minimized by the same inherent weaknesses which are grounds for its exclusion when objection is made.

Normally, a witness in a motor vehicle accident case must testify to the evidentiary facts and not to conclusions, opinions, or inferences—that is, he or she must state what was witnessed or observed and not opine or draw conclusions based on such observations. It is necessary that testimony be composed of facts and opinions, and exceptions to the general rule that witnesses must testify to facts have been found to be necessary to the due administration of justice.

Admissions

Despite the general rule of exclusion of hearsay evidence, there are many exceptions to this rule, perhaps the most important of which, in motor vehicle accident cases, are those relating to admissions against interest, and to statements, exclamations, or conduct admissible in evidence. Admissions made by one of the parties involved in the case may be used against him, and such admissions may be shown in evidence without laying a foundation in the nature of impeachment. Pleadings containing allegations inconsistent with subsequent pleadings made by the party in the action may be admissible in evidence.

An admission by one injured in a collision with a motor vehicle that the accident was due to his or her own fault is acceptable as an explanation. A statement by the driver of an automobile that he or she was responsible for an accident in which a guest was killed, that it was caused by his or her recklessness and disregard for the safety of others, and that he or she was engaged in driving at the time with an indifference to consequences, is—in light of undisputed testimony that the accident was due to a mere lapse of attention to the road—a mere conclusion on the part of the driver as to the legal effect of his or her conduct, and therefore not properly taken into

consideration as evidence on a motion, in an action for the death of the guest, to set aside a verdict for plaintiff and to enter a judgment for the defendant.

It is often difficult to distinguish, in the testimony of a witness, facts within his or her knowledge from observations or opinions regarding the facts. A question asked of the owner of the motor vehicle which struck the plaintiff concerning whether the vehicle was being used in connection with his or her business is not objectionable as calling for a conclusion from the witness, and a witness may testify as to the method by which defects in the wheel of a motor vehicle could be ascertained. Testimony that a motor vehicle, when struck by one motor vehicle, was headed right into another, is a conclusion of fact which the driver of the first vehicle is permitted. But the witness must be qualified to give an opinion, and the rule, fundamental to the law of opinion evidence in general, that the knowledge of the witness must be shown, and that he or she must testify to the facts upon which conclusions are based, applies to testimony by observers of a motor vehicle accident. Furthermore, the necessity for opinion evidence exists only where the facts in controversy are incapable of being detailed and described so as to give the jury an intelligible understanding concerning them. ***Opinion evidence*** is not as a rule admissible when facts can be reproduced before the jury so as to show the conditions upon which the opinion is desired.

It is generally true that an eyewitness to a motor vehicle accident may describe it in terms that import a conclusion as to the cause, if the conclusion is but incidental to the description. For example, a witness may say that a truck was "zigzagging across the street and appeared to be out of the control of the driver," or a passenger in a bus may testify, from the action and feel of the bus, that it "was skidding." However, if the witness includes in the description something that goes beyond the mere objective portrayal of the facts and resorts to what is argumentative opinion, the answer or that part of it will not be accepted as evidence.

An eyewitness of a motor vehicle accident cannot be asked, after having described the whole circumstances of the collision, to say, on that basis, who was at fault or to issue blame for the collision. In testifying regarding the cause of a pedestrian being struck by a motor vehicle, a witness stating that the pedestrian was drunk is inadmissible without preliminary testimony by the witness relating to what he observed about the pedestrian’s appearance or manner which led to that conclusion.

Opinions of experts who observe the conditions after a motor vehicle accident are usually based on either an observation of the tire or skid marks at the scene of the accident, or an observation or inspection of the vehicle involved in the accident. Sometimes the opinion of a person who did not observe the accident or the conditions after the accident, but who knows how the type of vehicle in the accident performs and handles, is offered in evidence as the opinion of an expert and admissible as expert testimony.

Proof which is addressed directly to the senses, generally characterized as real or demonstrative evidence, while comprising a comparatively small proportion of the evidence ordinarily produced in the trial of a motor vehicle accident case, is a most convincing and satisfactory class of proof, and its importance in the determination of controversies is relatively great. Evidence of this character includes objects brought into court and exhibited to the court and jury, the exhibition of injured persons, the use of maps, plats, and diagrams concerning some fact in issue, the use of photographs, moving pictures, X-ray pictures and the conducting of experiments and tests.

Photographs

Photographs are evidence in motor vehicle accident cases when they appear to have been accurately taken and are proved to be a faithful and clear representation of the subject, which

cannot itself be produced, and of such nature as to throw light upon a disputed point. For example, photographs of the locale of an accident, and of skid marks or tire marks, are admissible in evidence. This evidence is based upon tire or skid marks at the scene of an accident relating to the speed of a motor vehicle involved in the accident. Such evidence must be based upon skid marks made prior to the accident rather than after, and the calculations upon which the opinion is based must be made by the witness.

Opinions of experts based upon the observation of skid marks have been held admissible in regard to evidence other than speed, such as opinions as to how certain tire marks of the vehicle were made, where such evidence tended to show the position of the vehicle and the effect of the collision upon it. Furthermore, a witness qualified as an expert with respect to knowledge of motor vehicles and how they operate under certain conditions may express an opinion as to the operation of the car based on his observation of photographs of brake or skid marks at the scene of an accident.

Even a nonexpert witness, from observation of tire or skid marks at the scene of an accident, may properly be allowed to give an opinion concerning the identity of the vehicle making the marks, or in regard to the position of the vehicles on the highway at the time of the accident. Indeed, in some cases, although there is authority to the contrary, statements of witnesses based on their observation of tire marks at the scene of the accident, regarding whether the motor vehicle went in a certain direction, whether it skidded, how far it went after the collision, or whether the wheels of the vehicle were braked at the time of the accident, are admissible as evidence within the personal observation of the witness and not objectionable as far as being considered merely the opinion of the witness.

In order for photographs to be considered as evidence, it must be proved that they were taken at or near the time of the occurrence of the event before there had been any change in the condition or position of things; otherwise they will be inadmissible. A photograph of the scene of an automobile accident which is obscure and indefinite in its details and was taken when the foliage, shrubbery and lighting conditions were different from those existing at the time of the accident, is normally not admissible.

Classification of Photographs

Photographs can be divided into two general classifications:

- ***Snapshots***—For the most part, these are to be used merely for the transmitting of information from the investigator to the file. They are not ordinarily used in a trial because in many jurisdictions, photographs are not admissible unless taken by a qualified expert. The average investigator does not have the experience to qualify as an expert; furthermore, it is usually advisable to avoid having the investigator for an insurance company testify at a trial. Snapshots should be taken in those cases in which the scene or object is difficult to describe or to draw in detail. Snapshots taken for this purpose require only the use of a simple camera that can be operated with a minimum of technical ability.

- ***Commercial Photographs***—Commercial photographs are taken primarily to be used as evidence at a trial. It is therefore important that the photographer not only be well qualified professionally, but that he or she have the necessary characteristics for a good and convincing witness. Accordingly, it is important that all photographs be properly identified on the reverse side or by an attached tab. In view of the large number of cases that require the use of a commercial photographer, cost, in the average case, should be a definite consideration. Not only must the claims person have a definite understanding about the price before engaging the services of a commercial photographer, he or she must specify the number of photos desired. This should not be left to the discretion of the photographer.

The commercial photographer whose services are engaged should definitely understand that any photographs he or she takes belong to the company that ordered them, and that no prints are to be made available to anyone else. Commercial photographs can be important in the defense of a case not only by showing the entire scene of an accident, but by illustrating the point of contact through pictures of both vehicles that show the damage to them.

The claims person must remember that he or she is trying to show the condition as it existed at the time of the accident. He or she should see that the photographs are taken not only at the same time of year, but even at the same time of day or night, so that the shadow formations and lighting conditions will be similar. It is also important that the weather conditions be the same.

Everyone has seen examples of trick photography, and photographic distortions made either intentionally or by accident. The angle of a shot, the type or combination of filters, the direction of the lighting, and the like, can so distort a picture that it bears little resemblance to the actual object represented. Such distortions should be guarded against not only in taking photographs but in examining those taken by others who are trying to present a different point of view.

Superimposed Photographs

Some commercial photographers are also qualified to testify concerning surveys and measurements. They usually specialize in superimposed photographs. These photographs consist of a thin sheet of transparent paper, placed over the photograph, with measurements drawn on the paper sheet.

In some instances, photographers specialize in marking a scene of an accident with rulers, chalk or other objects to indicate measurements shown up on the actual photograph itself. Care must be used so that the effectiveness of the photograph is not lost because of the markings and changes made by the photographer. Superimposed photographs can sometimes serve a very useful purpose. Where the importance of a case warrants their use, the claims person should make sure that the person who does the work is well qualified and has a previous history as an expert witness.

Aerial Photographs

An investigator will not often have use for aerial photographs. For the most part, he will be interested in a detailed study of a small area, not an aerial shot of a vast area. In the exceptional case, it may sometimes be advisable to take an aerial photograph to show the general contour of a road or area over a considerable distance. Even though this should be kept in mind as a possibility, its use should be kept at a minimum.

Panorama Shots and Enlargements

Use of panorama shots and enlargements should be limited to use in important cases that are definitely pointed for defense, because these photos are expensive. They are very effective in courtroom cases in which a detailed study of the scene is important to the defense of a case. Skilled commercial photographers can make overlapping photographs that will represent a considerable area. Though there is a certain amount of unavoidable distortion in such photographs, it may be unimportant if the extent of the area to be covered is of prime importance.

Stereoscopic Views
Stereoscopic photography is valuable when it is important to present a three-dimensional picture. While the photography itself should not present any great problems for the commercial photographer, the finished prints must be viewed in a special viewer or through special glasses. Consideration should be given to the taking of stereoscopic views when dealing with the defense of claims involving steps, curves and inclines that would, in the ordinary photograph, blend into the background. These photographs can also be important when it is desirable to highlight a dent in a car that might be almost invisible in the ordinary flat-plane photograph.

Color Photographs
Color photographs are very effective for showing personal injury. It is, however, one thing to show an actual injury honestly, and quite another to highlight blood and gore for the sake of inciting the jury's sympathy. Many of our courts have become more conservative in the admission of color photographs because of abuses by some attorneys who have, without purpose, taken progressive photographs during the course of an operation, or who have photographed undressed wounds. The tendency today is to permit only the part of the body that is essential to a proof of injury to be shown.

Color photography has an important place when color is a vital factor in an accident. For instance, a full-color photograph of a stop sign is far more effective than the same photograph in black and white. If it is desirable to show that damage to a vehicle was long-standing and that rust was encrusted in the damaged areas long before the accident occurred, color photography can be extremely valuable.

Slides and Projections
Occasionally, detail of an object or an area is so important that it is advisable to project a picture of it onto a screen. Both black and white and color projection can create a dramatic and impressive effect.

However, the claims person must realize that it may be difficult to have a slide admitted in evidence and to obtain the judge's permission to project it onto a screen. When problems of admissibility arise, it may be necessary to use a highly qualified expert who can, among other things, testify that a projected image can show gradations in tone and color that are impossible to reproduce in a print on paper.

Police Photographs
Very often the police or detectives who make the investigation of an accident will take their own photographs. These shots are important because they have been taken by an impartial agency, usually very shortly after an accident. Many jurisdictions will release copies of such photographs on payment of a fee. The claims person should always determine whether such photographs have been taken and whether copies are available to him.

Newspaper Photographs
Occasionally, a news photograph of a scene of an accident or vehicles involved in it is advantageous to the defense of a case. Ordinarily, copies of such a photograph are made available upon payment of a small fee. In many instances photographs may have been taken by a free-lance photographer from whom not only the prints but sometimes the negatives can be bought.

Motion Pictures / Videos
The view generally followed by the authorities is that motion pictures are evidence, under a proper exercise of discretion by the trial court, where their relevancy, authenticity, and accuracy of portrayal are established by the laying of an adequate foundation. But the motion pictures

must be authenticated and verified, and their accuracy or correctness shown before such pictures may be admitted in evidence.

The taking of motion pictures/ videos is a specialized art, requiring professional competence if the movies are to be effective. Again, the claims person must remember that the pictures themselves have no value as evidence unless the person who took them can qualify as an expert. Those who have had experience in this field have the equipment such as trailers, telephoto lenses, and the necessary know-how to take pictures of claimants without revealing the fact that the subject is being photographed. The use of motion pictures in claim work is usually confined to checking on the activities of a claimant in order to refute an allegation of disability.

Ordinarily, it is not necessary to incur the expense of motion pictures unless some element of fraud is involved.

Diagrams

It is a well-established rule that diagrams and maps illustrating the scene of an accident and the relative location of objects, if proved to be correct, are evidence used to understand and apply the established facts to the particular case, and to illustrate the position of the automobile involved. Accordingly, maps or diagrams indicating tire or skid marks or their location at the scene of a motor vehicle accident are admissible under certain circumstances.

A diagram made by an investigator need not be a work of art, nor need it have the precision of a draftsman's blueprint. However, since its main purpose is to dispel confusion, not compound it, enough care and effort should go into its composition to make it understandable.

Diagrams drawn by the investigator have many advantages:

- A visual drawing of the scene of an accident is mentally absorbed much more quickly than a word description.
- It is very often much easier to draw a diagram illustrating what occurred than it is to describe the occurrence in words.
- A diagram will help the reviewer of the file, whether he be the local manager or the home office examiner, to understand the factual situation much better and arrive at a determination of liability more quickly.
- The drawing of a diagram will force the investigator to make a closer than ordinary observation and help impress the physical facts that much more firmly in his or her mind.
- Studying a complete diagram will often suggest leads for additional investigation that might uncover as-yet-unknown witnesses.

The method of drawing diagrams varies with the individual. Some investigators can make a complete and finished diagram at the scene of the accident without having to redo it later. Others are so meticulous that they are not satisfied with a diagram drawn under adverse conditions on the spot; they redo it subsequently at home or in the office. Several aids can be purchased that are helpful in making diagrams. They range from cutouts designed into rulers or celluloid squares, to elaborate diagram kits which include rubber stamps to represent all types of transportation equipment, traffic signals, and even human beings in various positions.

Properly used, these aids can be very helpful. However, effective diagrams can be made without any of them. A diagram need not be elaborate to be effective. Although it should be complete, clear and understandable, a diagram drawn by an investigator is not made to be presented in court as evidence.

The quality of a claims person's work can usually be judged by the diagram he or she draws, and by whether one is drawn at all. The essential information in all diagrams should include:

- All of the details of the physical facts, including the surrounding area, the makeup and general condition and composition of the streets or roads, lighting, defects, obstructions, points of vantage from which witnesses could have viewed the scene, traffic controls, and all other details which will be further itemized in discussions of investigations of automobile and other types of accident claims.
- Position of the vehicles involved in an automobile accident before, during and after the accident.
- All measurements that have a direct bearing on the investigation, including distances from lighting, skid marks and street or object measurements.
- A compass indication at the top of the diagram, showing north to be the top of the page.
- If the diagram is done to scale, key to the scale in the lower right hand corner.
- A legend at the bottom of the diagram giving label to all objects or vehicles involved and including the date and time when the diagram was drawn, as well as the date and time of the accident.
- The signature of the diagram's maker.
- In motor vehicle accident cases, as in other cases, it is proper in some instances to conduct, or show the results of, tests or experiments concerning the operation of a motor vehicle involved in the accident, or the operation of a motor vehicle at the locale of the accident. For instance, testimony showing tests and experiments relating to the speed or control of a motor vehicle involved in an accident, or concerning the visibility of persons or objects, or the line of vision of the operator of a motor vehicle involved in an accident, has been admitted.

Such basic factors as testing the adequacy of brakes or steering on an automobile that has been involved in an accident, products and professional liability coverages have proven the need for many kinds of laboratory tests that might be helpful in trying to determine liability. Testing can determine the reason for the failure of structural material including metal, wood and rope; the breaking point of glass objects; the reason for malfunctioning of appliances and other mechanical and electrical equipment; the contamination of foods and drugs; and the allergenic qualities of contact materials such as chemical fabrics, detergents, cosmetics, etc.

The admissibility of such experimental evidence rests largely in the discretion of the trial court. If the essential conditions under which the experiment or observation is made are substantially the same as those surrounding the accident which is being investigated, any departure or minor variation goes to the weight rather than the admissibility of the evidence. Experimental evidence has also been held admissible for the purpose of showing the control of a damaged motor vehicle, or to determine the performance of a motor vehicle when "freewheeling."

Police reports made by various departments of the state and municipal governments can be exceedingly helpful in the investigation of an accident case. Most of these reports are a matter of public record and are available for a small fee. Others may not be available when criminal prosecution is involved, and still others are confidential reports that can only be obtained through confidential sources or by discovery processes.

A police report is usually made when an accident of a serious nature occurs. Depending on the jurisdiction, it may be made by state troopers, local municipal police, or the sheriff's office. These reports are becoming more and more inclusive and contain much of the following information:

- Date, time and place of the accident.
- Traffic details, usually including a small diagram.
- Names of all parties and witnesses involved in the accident, including the owners and drivers of vehicles, or the owners of the premises involved in an accident.
- A description of the driver, including his age and license number.
- The names and addresses of all injured parties, and a digest of their injuries including the place where they received medical attention.
- Description of the accident, ranging from brief to detailed.
- Names of witnesses to the accident.
- Weather, lighting and road conditions.
- Description of motor vehicles involved in the accident.
- Property damage sustained.

Occasionally, police reports will furnish even more detailed information, in the form of questions requiring check-mark answers. These reports are ordinarily available in photostatic form or can be copied. In some cases, a small fee is charged.

Police officers often have more information in their notes than appears on the actual report. Sometimes this information is hearsay that can lead to profitable avenues of additional investigation. Therefore, it is always advisable for the investigator to see the police officers personally if the magnitude of the case warrants it.

Most states have a motor vehicle department that is separate and distinct from the police department. This department usually requires each involved party to an accident that involves a certain minimum of property damage, ranging from $50 and up, or that involves any bodily injury, to submit a report promptly. The forms are available, usually in photostatic reproduction, for a nominal fee. Although these motor vehicle accident reports cover much the same ground as the police and state troopers' report, their importance is greater because they are usually made out by the drivers involved in the accident and often include admissions against interest.

Within the motor vehicle department, some states will provide a certified abstract of a driver's operating record for a nominal fee. This record usually contains the type of license the operator holds (private passenger, junior license or truck), the number and type of accidents in which the driver was previously involved, a record of any traffic convictions, and a record of any suspensions, revocations, or restorations of a driver's license.

A coroner's report may be available in cases involving the possibility of criminal prosecution as a result of a death. Most of the larger municipalities automatically conduct a coroner's inquest in a case where death has resulted from an accident.

Ordinarily, for a small fee, a certified copy of an abstract of the coroner's report can be obtained and usually contains at least the following information:

- Date, time and place of the examination.
- Name, age, occupation and personal description of the deceased.
- A detailed description of his injuries.
- A history of the incident or the accident taken from police information.
- Probable cause of death.

Occasionally, an important bit of information can be obtained from newspaper accounts of an accident. The investigator, however, should read all newspaper reports with an extremely jaundiced eye. After comparing newspaper accounts with the results of his own investigation, he

sometimes begins to wonder if it is the same accident. There are, however, occasions when such articles do reveal names of witnesses or other information not previously obtained.

Some claims persons may find it surprising or unnecessary to discuss the subject of self-discipline in dealing with handling claims. Self-discipline can be the most important attribute of a successful claims person. One of the most desirable features of claim handling is the fact that it is one of the fields that is freest of rigid outside discipline. Most companies, particularly in rural areas, do not require the claim adjuster to report in to the office every day as long as the job is done properly and on time.

Accident Reports

The report of a motor vehicle accident, made to a public official by the operator of a motor vehicle involved therein, in pursuance of a statutory duty, is generally not admissible evidence in an action to recover damages of injuries sustained in such accident. When such report is introduced on behalf of the party who made the report, it is not admissible for the reason that it is a self-serving declaration. It is provided by statute in some jurisdictions that an accident report required by the statute may not be used as evidence in any trial arising out of an accident, except that the proper department shall furnish upon demand of any person who has made or claims to have made such a report, or upon demand of any court, a certificate showing that a specified accident report has or has not been made to the department, solely to prove a compliance or failure to comply with the requirements that such a report be made to the department. However, while accident reports made to public officials are generally not admissible, such a report has been held admissible where it is offered by the plaintiff to show material inconsistencies between the defendant's statements in the report and the evidence introduced by him at a trial.

Notwithstanding the rule that records and reports made by public officers or employees are admissible in evidence, the courts usually exclude statements contained in automobile accident reports concerning the cause of, or responsibility for, an injury to the person or damage to property. However, while the accident report of a highway patrol officer is not admissible evidence, the patrol officer himself is free to testify regarding the accident and the statements made to him, even though such statements are substantially the same as the contents of the report.

The matter of accident reporting by a field claims person in the handling of a casualty claim is by no means complete when he or she has progressed through the investigation or even the disposition of a claim. The information obtained and the work done must be shown in the file so that his or her decision will stand scrutiny by anyone. Since the claims professional has nothing to conceal, he or she should welcome the most critical investigation of his or her files. Letters and other file material should be well-worded and show exactly what he or she means. Careless wording can inadvertently create a false or distorted picture. Claims files are confidential; however, a claims person should not record any statement that could not be brought before any court, insurance department or other official body, without fear of embarrassment or criticism.

Pertinent material of a confidential nature definitely belongs in the file, but unnecessary or derogatory (as distinguished from descriptive) reference to race, religion, national origin or even appearance has no place in the files. Every file must speak for itself. There should be no unanswered questions, or at least as few as possible. Why settlement was made, what amount was paid or why the claim was denied should be shown and fully explained in the report.

Finally, the field claims person should try to anticipate the needs of the home office. Reports should be accurate and thorough enough to avoid (as much as possible) correspondence from

the home office correcting errors or calling for clarification. He or she should use proper English grammar, write legibly, send readable copies, and try to be clear and logical in his or her thinking and reporting.

The Statement

A statement is a report provided to an insurance carrier that describes the underlying event or accident for which insurance coverage is sought. The statement will be analyzed and evaluated for details by an insurance examiner. A statement can be provided in one or more of four ways, including the following:

- ***A verbal statement***—This is the least used form of a statement and is generally reserved for a situation in which there is little or no question about liability.
- ***The insurance company form***—This is a standard form prepared and used by an insurer. During the initial examination of an incident, it may become obvious to an examiner that a more detailed account of the underlying transaction is necessary. In the case of an accident involving a vehicle, the company form may be substantially similar to the one provided to the state department of motor vehicles.
- ***Recorded statement***—This is a verbal statement taken from the claimant which is typically in a question and answer format. It is necessary for an adjuster to provide the claimant with a written copy of the transcript of a recorded statement, and the claimant should be provided with an opportunity to review and sign the statement before it becomes an official part of the record. Recorded statements are especially useful to a staff adjuster who is employed by a carrier. Recorded statements are also useful if a claimant lives a long distance from the offices of an adjuster. Generally, a recorded statement will not be legal unless the adjuster obtains the permission of the claimant or another party involved.
- ***Written statement***—This is the most frequently used type of statement, and is typically taken by an adjuster in a surrounding familiar to the other party, such as a home or an office. One of the advantages of a written statement is that it allows the adjuster and the other party to discuss the underlying events on an informal basis before the written statement is obtained. Like the transcript of a recorded statement, the person providing a written statement should be allowed to review it and make any corrections, if necessary, before signing. A written statement is used by an examiner to evaluate the facts underlying the accident and to determine if any injuries resulted. Written statements are usually not admissible as evidence in a court of law. If a party refuses to give a written statement, an examiner may conclude that coverage is available based only upon scanty evidence.

Contents of a Statement

In investigating a claim, an insurance adjuster or examiner will first seek to ascertain that the statement contains the required amount of information. Depending upon the type of accident and the nature of the coverage involved, a written statement may include the following information:

- The name of the claimant or witness.
- The marital status and number of children of a claimant.
- The permanent residence and business addresses.
- Social Security number.
- Driver's license number.
- Date of birth.

- General information about the insured's property, such as location, the existence of liens, condition of the property before the accident and the location of any personal property if it was moved after the accident.
- The immediate events leading up to an accident.
- Weather conditions at the time of an accident.
- Location of an accident.
- The existence of potential witnesses.
- The occurrence of any personal injury or death.
- A detailed description of the events surrounding the loss or accident.
- Diagrams or sketches of the underlying events.
- Any other facts which the parties involved feel may be pertinent or material.
- The signature of the person providing the written statement.

In the event of a vehicular accident, whether involving personal injury, death or property damage, the following factors must be taken into consideration by an examiner, especially if the question of fault is at hand:

- ***Speed limit***—Compliance with applicable speed limits may determine the extent and amount of settlement.
- ***Tailgating***—The distance between the claimant's vehicle and those in front are frequently determinative of whether the claimant or the driver allowed for sufficient space to brake properly. The required distance increases in harsh weather conditions.
- ***Traffic lights***—Running a red light or entering the intersection on an yellow light may be indicative of negligence.
- ***Seat belts***—In some states, failure to use a seat belt is presumptive negligence. In others, the use or failure to use a seat belt may not be a crucial or material factor in determining fault or the amount of damages.
- ***Maintenance of a vehicle***—An adjuster might investigate the maintenance history of a vehicle with an eye to whether improper maintenance or a lack of maintenance may have contributed to an accident. Items such as the windshield wipers, horn, headlights, tires, brakes, transmission and turn signals are frequently considered.
- ***Driving under the influence***—Under the terms and conditions of some policies, coverage may be negated if a driver is violating the law while an accident occurred. Even if driving while intoxicated or under the influence of drugs was not the proximate cause of an accident, coverage could nevertheless be avoided in such cases.
- ***Turn signals***—An adjuster may seek to determine if an accident was caused by the failure of any of the parties involved to use a turn signal.
- ***Last clear chance***—In those states in which liability under the negligence doctrine can be avoided if the claimant had the "last clear chance" to avoid an accident, an examiner will be looking for signs of whether the claimant took proper precautions to minimize or eliminate an accident. For example, a driver sitting at an intersection in which there is a traffic light cannot pull into the intersection when the light turns green if he or she sees an oncoming driver running a red light, and then recover when he or she could have avoided the accident by waiting for the negligent driver to clear the intersection.
- ***Use of an insured's vehicle by another***—An adjuster must ascertain if a person other than the insured was using the vehicle with the "permission" of the insured. In a number of policies, the "insured" may be defined to include "any other person while using such car if its use is within the scope of consent of you or your spouse . . ." One court has held that once permission is implied, it will be given a very wide and liberal meaning in determining coverage. If the initial use of a vehicle received the implied or express consent of the insured, subsequent changes in the scope or character of use will not demand the consent of the insured, and coverage will be denied only in the event later usage is tantamount to

theft or the display of other conduct showing utter disregard for the return or safekeeping of the vehicle.

Evaluation of a Claim Involving a Personal Vehicle

The evaluation of a claim surrounding a vehicle may involve property damage as well as personal injury or death. Carriers usually do not assign adjusters to evaluate a claim for damages to a vehicle. Rather, material damage appraisers are used to assess the amount of loss. Some of the larger carriers that issue personal vehicle insurance have facilities into which a claimant can drive his or her vehicle to get an estimation of the amount of damage. The appraiser or the adjuster will assess the damage on the spot and offer the claimant a check in settlement of the claim. The amount of money that a claimant may recover for property damage depends on an appraisal of the damages done by an insurance adjuster after he or she has made a visible inspection of the damaged vehicle and has reached an agreement with the repair shop. If an appraiser determines that any repairs were undertaken before authorization on the carrier's part, the extent of the damages may be questioned by the adjuster.

Determination of Value

There is always the possibility that a vehicle may be determined to be a total loss. In such case, the actual cash value to be paid by a carrier is based to a large extent on the value of the vehicle set forth in the National Dealer's Association publication or the "Red Book," another trade publication. Certain items, such as the existence of air-conditioning, type of transmission, airbags, anti-lock brakes, mileage and a sunroof, are all factors which an examiner may use to determine the actual cash value. An adjuster should get the claimant to sign a written appraisal.

Deciding Which Party Is at Fault

Evaluating what dollar amount to assign to a claim is frequently difficult because of the fact that more than one person may have contributed to the accident. In such case, it becomes necessary to allocate the extent of coverage and the amounts of the settlement among various parties. Three types of liability may apply in such a situation:

- Contributory negligence—There are a few states in which a claimant can collect nothing if he or she in any way contributed to the accident or loss.
- Absolute comparative negligence—Under this doctrine, claimants can collect the amount of their damages minus any costs which are attributable to their own negligence.
- Partial comparative negligence—Under the laws of most states, a claimant can collect from another party's carrier if such other person has contributed to less than half of the damages. Anyone who has contributed more than 50 percent of the losses can collect nothing under this doctrine.

Disparity Between a Body Shop Estimate and a Carrier's Appraisal

Frequently, there is a significant disparity between the estimates secured by the insured from his or her body repair shop and those provided by a carrier's appraiser, because of an unwillingness on the part of many repair shops to use reconditioned parts. In evaluating the cost of repairs, a carrier is usually bound to pay no more than the prevailing rates in a given area.

AUTO CLAIM DISPOSITION

Personal Property

A claim for a loss arising from a lost or stolen vehicle is settled by a carrier by payment of funds, repairs or replacement of the vehicle. Stolen property may be returned to the insured, in which case the carrier will pay for any damages resulting from the theft. The property may be retained by the carrier at an agreed-upon or appraised value. If a loss is paid in cash, the carrier may be required to pay an applicable sales tax for the damages to the stolen vehicle. If a vehicle of the insured is stolen from a garage or a repair shop or if the shop burned to the ground, the carrier will not pay for any repairs or body work that may have been done to the vehicle. If there are any other sources of recovery on the loss, such as physical damage coverage provided by a lender, the carrier will pay no more than its share of the loss.

Totaled Vehicle

When a claimant comes to terms with a carrier on a claim involving a totaled vehicle, the carrier will take possession of the vehicle after obtaining the keys and a properly endorsed certificate of title.

In the event a claimant settles with a carrier other than his or her own, the claimant must dispose of the vehicle after the other carrier deducts the salvage value from the actual cash value of the vehicle in question. The claimant is then free to dispose of the vehicle as he or she deems fit, including selling it for parts.

When a claimant settles with a carrier, the adjuster should provide the claimant with a tax credit letter stating the amount and nature of the settlement. The amount of the tax credit may be added to the amount of the settlement.

In the event of a settlement involving a stolen vehicle that is either never recovered or is damaged beyond rehabilitation, a total loss is applicable in determining the amount of the settlement. In many instances involving a stolen vehicle, a carrier is required to wait thirty days before settlement to make certain the vehicle is not recovered. Personal items inside a stolen and never-recovered vehicle may figure into the amount of the settlement.

Liability

Personal vehicle liability insurance imposes on the carrier a duty to pay third party claims against an insured as well as an obligation to provide legal representation if the insured is sued by a third party. Known as a "duty to indemnify" and a "duty to defend," an ordinary policy usually provides as follows:

The company will pay damages and losses which the insured becomes legally responsible for because of bodily injury or property damage...from an accident. The company may investigate or settle any claim or suit for damages against the insured. If the insured is sued for damages, the company will provide a defense...even if the allegations are fraudulent, false or groundless.

Usually, a third-party claimant will attempt, through his or her attorney, to negotiate a settlement with the insured's carrier. If the claim is excessive or frivolous, the carrier may allow the claim to go into litigation so it can obtain more detailed facts through discovery. If the case cannot be

settled, it is likely the claimant will file suit against the insured. The carrier is entitled to notification of any summons and complaint against the insured. Following that, the insured is not entitled to pay any money to the claimant or agree to settlement or to incur any expenses on behalf of the claimant without the prior written permission of the carrier. If the claimant is awarded a judgment against the insured, the carrier will pay the claim to the extent of the amount of coverage.

There are times when a carrier may settle against the wishes of the insured. Insurers have wide latitude in resolving third-party claims, including settling if it is deemed expedient to do so. Homeowners and vehicle liability policies do not usually require the insured's consent to settle a third-party claim.

HOMEOWNER CLAIMS

HOMEOWNER POLICIES

Intended to cover residential and personal property of a mainstream policyholder, homeowners insurance is a comprehensive mix of liability and property coverage. A homeowners policy is typically issued to extend coverage to premises used principally as a private residence that contain no more than two-family living units. Separate units on the premises, such as garages, sheds or guest houses, are covered separately. For condominium owners and apartment dwellers who do not have a need to cover their dwelling, there are separate policies available that extend coverage for liability and for personal property.

Homeowners policies are designed to cover owner-occupied residences only. A policyholder can lose coverage if he or she rents property to a tenant and does not take out a rider to cover the changed situation. An ordinary homeowners policy is divided into two sections and includes the following coverage:

- Living Expenses—If damage to an insured's primary residence is covered by a homeowners policy and the home is rendered uninhabitable by such damage, a policy may pay for the costs of lodging and food in excess of what the insured would normally pay.
- Personal Property—Coverage is extended to general classes of personal property, such as furniture and clothing, which are located within the insured's dwelling. Personal possessions that are kept in temporary quarters, such as a motel or a college dormitory, may also be insured against loss.
- Primary Residence—The actual dwelling and any attached structures, such as a garage or a sun-porch, are protected against loss.
- Approximate Structures—Unattached, freestanding structures, such as a detached garage, are included.
- Medical Expenses—If a guest is injured, whether on or off the insured premises, a nominal amount of coverage is provided for medical expenses.
- Personal Liability—If an insured or a protected member of the insured's family accidentally inflicts bodily injury upon or damage to the property of another, coverage will extend to damages and legal costs.

All homeowners policies include a loss deductible that applies to almost every type of covered loss. A deductible applies one time to each occasioned loss. The deductible is subtracted from the amount of the loss rather than the amount of the settlement.

Risks of Loss Covered in a Homeowners Policy

A standard homeowners policy includes coverage for losses due to:

- An explosion.
- Damages attributable to vehicles not owned by the insured or any covered person.
- Theft.

- Ice, snow and sleet.
- Hot water heaters and home appliances.
- Lightning and fire.
- Riots.
- Smoke damage.
- Window breakage.
- Collapse of the structure.
- Injury to electrical parts and wiring.
- Hail and windstorm.
- Frozen pipes, from heating and air conditioning.
- Aircraft.
- Falling objects.
- Vandalism.
- All other perils, excluding flood, earthquake, nuclear accident and others specifically excluded in the policy.

Whether an insured is covered against some or all of the above risks depends on what type homeowner policy has been purchased. Basically there are six standard homeowners policies from which a consumer can select. One type of policy is a renter's policy, and another is specifically for insuring a condominium. The most basic, known as "homeowners policy-1," covers only about half of the risks specified above. At the other end of the spectrum is "homeowners policy-5," which extends coverage against all of the listed potential losses. All policies provide the same amount of coverage for medical payments and personal liability, and additional amounts can be purchased for an increased premium. There are, of course, limitations on the amount of coverage for damages resulting from any of the specified hazards and exclusions of certain types of risks.

Certain hazardous situations are excluded from coverage under a normal homeowners policy. Bodily injury or property damage arising from or connected to the following items or activities may be excluded from coverage:

- Business or commercial activities—If one uses a primary residence to conduct a full- or part-time trade, profession or occupation, business-related property may either be excluded from coverage or there may be severe limits on the amount that will be paid for damages. Also, there is no liability coverage for a professional who engages in malpractice.
- Property in transit—Extends to personal property and effects being moved from one location to another.
- Floods and mudslides—Water damage occasioned by either event is excluded.
- Possessions of a boarder—Personal property of a renter, if the primary residence is used in part as a boarding facility.
- Cooling and heating systems—Unless a loss occurs as a result of physical damage to such facilities located on the insured's property.
- Nuclear radiation—Losses incurred in a situation such as the Chernobyl incident.
- Earthquake losses—Damages due to an earthquake, tremor or an aftershock occurring in any location.
- Property—Servicing equipment items, such as a lawnmower or a ladder, that are not used to service and maintain the primary residence.
- Secondary damage—When due care is not taken to protect injured property from subsequent or secondary damage.
- Rental property—Any leased or rented property which is stored in a primary residence, shed or garage.

- Off-premises injury from motorized vehicles—The only exception is a golf-cart.
- Outdoor apparatus—Antennas and outdoor carpeting.
- High-risk areas—Locations where an increase in a specific risk of loss has been designated, such as a high-crime area.
- Loss of personal property from unlocked Cars—Unless it can be shown that the vehicle was locked and entry was forced.
- Construction—Tools used during renovation, remodeling or construction of a primary residence, garage or freestanding structure.
- Other coverage—Property which is insured under another policy, such as damage to a car parked in a garage which is covered by comprehensive automobile insurance.
- Household staff—Workers, babysitters, maids or gardeners who incur an injury or damage to the property while on the job.
- Pets—Only injury caused by a pet to a third person is included. If an insured kept an exotic pet, such as a boa or an alligator, at his or her residence, there would be no coverage since protection does not extend to injuries caused by animals other than normal pets that are kept legally on the premises.
- Other injuries—Those covered by workers' compensation laws.
- Many of these exclusions can be covered under an extension to a homeowners policy or through the purchase of special insurance referred to as a "floater policy."

Floater Policy

Insurance carriers offer coverage known as a floater policy, which is either a separate policy or an endorsement to a homeowners policy designed to cover specific items of property. A need for a floater policy arose out of a practice of the insurance industry to write homeowners policies to cover "unscheduled" personal property, subject to limitations and exclusions. Specifically, a floater endorsement or policy applies only to scheduled items. Coverage provided is on an all-risk basis, and is therefore quite extensive. Insuring scheduled items is less expensive if handled through an endorsement to a homeowners policy than by the use of a floater policy. Limitations in a standard homeowners policy are not applicable to scheduled items, although ordinarily there are exclusions for damages resulting from vermin, nuclear reactions, acts of war, wear and tear, insects, government regulations and confiscation of property by government officials under the provisions of eminent domain. Additionally, there may be exclusions that relate only to a given type of property. With respect to fine arts, such as antique furniture or paintings, there is no coverage for losses arising from the repair, restoration or retouching, or by breaking of fragile and glass items, unless occasioned by lightning or fire, aircraft and vehicles, windstorm, earthquake, flood, explosion, vandalism or derailment or overturn of a vehicle of conveyance. To cover property on exhibit, the location would have to be named specifically in the floater policy or rider.

The "personal articles floater" is the most common form of policy used to insure personal property, covering such items as jewelry, furs, cameras and related equipment, musical instruments, stamps, coins, fine arts, golfers' equipment and silverware. A separate premium is 8charged for each item. Many of the items may be covered for a percentage of the actual listed value or a specific dollar amount, whichever is less.

Flood Insurance

Prior to the 1960s a homeowner could not obtain any flood insurance, since then, as now, it was excluded from a standard homeowners policy. Congress established a federal plan, known as "The National Flood Insurance Program," which offers flood insurance to residents in flood-

prone areas at subsidized rates. Not every loss that would at first blush appear to be a flood is covered under flood insurance. Losses covered by the backup of sewers are not covered items. Flood coverage is available only if a local community agrees to participate in the federal program. Insurance can be purchased through any private insurance company that has been designated to make it available. Following are some of the more significant features of flood insurance:

- Waiting Period—Once a consumer signs up for flood insurance, there is a thirty-day waiting period before coverage is effective.
- Structure—The property to be insured must have walls and a roof and cannot be located either underground or completely over water.
- Coverage—The amount is limited.
- Deductibles—A standard deductible of $500 is applicable to both structural damage and personal effects.

Guaranteed Replacement-Cost Policy

A number of carriers issue guaranteed replacement-cost policies which offer to pay the entire amount necessary to replace a residential dwelling, such as a house or townhouse, as well as all of the contents, although the replacement costs may be in excess of policy limits. Some insurance companies set limits on coverage, paying 120 or 150 percent of the face value of the policy. There may also be a ceiling for coverage of the contents, which is ordinarily established at 75 percent of the replacement cost of the dwelling.

Condominium Insurance

Under a deed, declaration or bylaws which govern a condominium development, a homeowners association is usually required to insure the buildings. A condominium owner should determine if coverage is only to the bare walls or includes built-in items, such as cabinets and appliances. Individual condominium owner's insurance extends coverage to personal property of a homeowner. A condominium policy usually includes coverage for fixtures, alterations and improvements, up to a nominal limit, which can be raised for an additional premium. A condominium owner may purchase an individual policy from the same company that insures the entire structure. In the event of damage to the structure as well as to the personal property of an insured, there would only be one company to deal with in filing claims, proving losses and collecting insurance proceeds.

Dwelling Policy and Personal Property Insurance

A dwelling policy and personal property insurance policy covers a policyholder's dwelling, certain other surrounding structures on the same ground, specific types of use of loss such as additional living expenses or rental value, and personal property owned by the insured and his or her family members. Dwelling insurance is sometimes used synonymously with fire insurance. Similar in many ways to a homeowners policy, a dwelling policy does not cover theft or personal liability unless separate coverage is provided in an endorsement or a supplement to the policy. The most compelling reason to buy a dwelling policy is in a situation where a consumer owns two residences and does not need the more extended coverage of two complete homeowners policies. Also, it is usually easier to qualify for a dwelling policy than it is for a homeowners policy. Dwelling policies can be written to extend coverage to up to a four-family dwelling.

Managing Homeowners Personal Property and Liability Risks

Individuals and families must manage risk in their lives in a fashion similar to a business. Individuals have property risks, such as loss or damage to a home and personal property, as well as liability risks and are subject to liability claims related to home ownership or driving an auto. Insurance agents may assist individuals and families to manage these important risks, as well as others that may arise in an individual's specific life circumstances, with the result that the individual and family is more financially secure and less likely to suffer a loss from which they cannot recover.

Basic Coverage

Homeowners insurance provides property insurance protection against damage or loss to the home itself (the *home* is referred to as the *dwelling* within homeowners insurance forms), to structures attached to the dwelling, such as a garage, to other structures not attached to the dwelling, to personal property and to other items on *the residence premise*, such as trees and shrubs. The dwelling is generally insured against damage due to fire, windstorm, hail, theft, vandalism, and other perils such as falling objects, weight of ice, snow or sleet, freezing, and even volcanic eruption. ***Other structures*** covered under homeowners policies include gazebos, detached garages, sheds, mailboxes, satellite dishes and other such structures on the premises. Usually the amount of coverage for other structures is limited to 10% of the total coverage on the dwelling.

Some of the landscaping around the home is also covered under homeowners policies through *trees, plants and shrubs* provisions. Generally coverage for these items is limited to 5% of the coverage on the dwelling. Trees, plants and shrubs are covered against many of the same perils as the home, but normally excluded from this coverage is damage due to windstorm. Since windstorm damage occurs with frequency to landscape items, windstorm insurance is too expensive for the average homeowner to purchase as part of trees, plants and shrubs coverage.

Personal property is also covered under homeowners policies. The coverage limit for most personal property is 50 – 70% of the amount of coverage on the house. However, policies include special limits of liability for certain items, such as coins, precious metals, valuable papers, watercraft, business property and other items. If more coverage is needed, liability limits may be increased through riders or endorsements, or by purchasing separate policies.

Personal property is also generally covered under homeowners policies against loss away from home – even when outside of the US. Many policies provide this *worldwide coverage* against property damage. Additional insurance can be purchased to protect property from theft away from home as well.

Another coverage offered under homeowners insurance is *loss of use* coverage. Loss of use coverage pays for additional expenses incurred because a covered loss makes all or a portion of the home not fit to live in. Included are such expenses as hotel bills and meals away from home. The normal expenses that the insured would have incurred were there no loss or damage to the dwelling are not include in the amounts payable under the coverage. The loss of use coverage is generally limited to about 20% of the amount of coverage on the dwelling.

Liability Coverage

An important component of homeowners insurance is liability coverage. For example, if someone stumbles down a homeowner's steps and injures himself, liability insurance will pay

for the injury done and for the medical care the injury necessitated. The liability coverage pays for both the covered damage or injury and the costs of defending an insured against a claim or suit arising from the damage or injury, even if the suit is groundless, false or fraudulent. Medical expenses to others are paid if the injury occurs on the homeowner's premises and the injured party has permission to be on the premises (or the *insured location*, as the residence premises may be referred to within the policy).

Homeowners Forms

Standardized forms have been created for the use of insurers offering homeowners policies. A service agency for the property-casualty industry called ISO, or Insurance Services Office, has written and filed with the states many standardized homeowners forms and endorsements. Insurers use the standardized forms as the basis for their policies, but, unless state regulations prohibit, an insurer may change some of the provisions in the standardized forms and add special features to them.

There are six ISO forms used for homeowners policies. These are HO-1, the basic form, HO-2, the broad form, HO-3, the special form, HO-4, the tenants form, HO-6, the condominium form, and HO-8, the modified coverage form. Each form has its own special features and uses.

HO-1

The HO-1 basic form is not available in all areas because some state regulators have not approved its limited coverage for sale in their respective states. It is also not purchased by consumers as often as other forms in areas where it is approved because of its limited coverage. Protection against damage due to falling objects, the weight of ice, snow or sleet, accidental discharge of water or steam from household appliances, freezing, volcanic eruption and other perils covered in the other HO forms are not insured against through the HO-1 form.

HO-2

The HO-2 broad form is a *named peril* form. A named peril form is one that names each peril it protects against. Seventeen perils are named within the HO-2 form, including those listed above as not covered under the HO-1 form and the perils of fire, lightning, windstorm, hail, riot, vandalism and more.

HO-3

The HO-3 special form is an *all risk* form and provides dwelling and other structure coverage against all perils except those specifically excluded from coverage. The personal property coverage is the same broad coverage provided through the HO-2 form.

HO-4

The HO-4 tenants form is a form used by renters. It does not cover the dwelling, since the renter does not own the dwelling. It covers personal property against basically the same perils as the HO-2 and includes essentially the same liability coverage.

HO-6

The HO-6 condominium form includes limited dwelling coverage. Its personal property and liability coverage is similar to that found in the HO-2 and HO-3 forms.

HO-8

The HO-8 modified coverage form is used to cover older homes. It includes valuation provisions not found in the other HO forms because the older homes it was designed to cover often have replacement values that far exceed the home's market value. Some state regulators are not comfortable with the limits placed on the coverage due to the form's valuation provisions and so have not approved the HO-8 form for use in their states.

The homeowners forms that include dwelling coverage have the following sections and coverage types:

- Section I – Property Coverages
  - Coverage A – Dwelling
  - Coverage B – Other Structures
  - Coverage C – Personal Property
  - Coverage D – Loss of Use
- Section II – Liability
  - Coverage E – Personal Liability
  - Coverage F – Medical Payments to Others

Coverage A – Dwelling

The dwelling coverage applies to the dwelling on the residence premises and also to the structures attached to the dwelling, such as a garage or carport. Materials and supplies located on or next to the residence premises that are used to construct, alter or repair the dwelling or the other structures on the residence premises are also covered through the provisions of Coverage A.

Coverage A is not found in form HO-4, the tenants form. HO-6, the condominium form, provides one thousand dollars of dwelling coverage. Generally, the condominium association should have insurance that covers the buildings the association owns.

The Coverage A under HO-6 also covers alterations, appliances, fixtures and improvements in the part of the building that contains the residence premises. It covers real property pertaining to residence premises, property that is the responsibility of the insured under a condominium association agreement and other structures solely owned by the insured at the insured location.

Coverage B -- Other Structures

Homeowners policies cover the other structures on the residence premises that are set apart from the dwelling by clear space. The coverage also applies to structures connected to the dwelling by only a fence, a utility line or similar connection.

The other structures coverage does not apply to structures used in whole or in part for a business or rented to anyone who is not a tenant of the dwelling, unless it is used solely as a private garage.

Generally, the other structures coverage amount is limited to 10% of the limit of liability that applies to Coverage A.

The other structures coverage is not found in the HO-4 form.

Coverage C – Personal Property

Personal property is generally covered while anywhere in the world. Property away from the residence is normally covered for 10% of the personal property coverage limit. If the insured requests, the personal property owned by others while on a residence premises that is occupied by the insured can also be covered. The insured can also request that the personal property owned by a guest or residence employee be covered while in any residence occupied by an insured.

Excluded from personal property coverage are:

- Animals, birds and fish
- Motorized vehicles, other than certain trailers, off-road recreational vehicles, golf-carts, motorized lawn mowers, tractors, electric wheelchairs and other similar vehicles
- Property owned by boarders (who should cover their property through their own HO-4 coverage)
- Property owned by renters of an apartment owned by or rented out by an insured (like boarders, renters should purchase their own insurance to cover their personal property)
- Business data and records, although the cost of blank recording or storage media and packaged software is covered
- Property rented to others off of the residence premises

Certain personal property items are subject to special limits of liability. Additional coverage for many of these items can be obtained through personal article floaters.

Coverage D – Loss of Use
Loss of use coverage pays for additional living expenses related to maintaining the insured's normal standard of living if the residence premises, which must be the insured's principal place of residence, is uninhabitable due to a covered peril.

Additional Coverages
The homeowners forms include some additional coverages. Some of these additional coverages have a specified limit of liability and others are paid as a part of the property's applicable policy limit. Unless specifically stated, these additional coverages are found in all the homeowners forms.

Debris Removal
Reasonable expenses are paid for the removal of debris of covered property if a peril insured against caused the loss, and for ash, dust, or particles from a volcanic eruption that has caused direct loss to a building or to property contained in a building.

Reasonable Repairs
The reasonable repairs coverage pays the reasonable costs incurred by the insured to take necessary measures to protect covered property against further damage

Trees, Shrubs and Other Plants
Trees, shrubs and other plants on the residence premises are covered if damaged by the perils of fire, lightning, explosion, riot or civil commotion, aircraft, vehicles not owned or operated by a resident of the residence premises, vandalism or malicious mischief or theft.

Fire Department Service Charge
The policy pays up to $500 for fire department charges if the insured must pay them due to an agreement or contract with the fire department.

Property Removal
If covered property must be removed in order to protect it against a covered peril, it is protected against direct loss from any cause. The maximum time frame this coverage applies to property removed is thirty days.

Credit Card, Fund Transfer Card, Forgery and Counterfeit Money
There is an additional $500 limit of liability available to cover the legal obligation of the insured to pay due to:

- The theft or unauthorized use of credit cards or fund transfer cards
- Loss caused by forgery or alteration of any check or negotiable instrument
- Loss through the acceptance in good faith of counterfeit US or Canadian currency

Loss Assessment
If a named insured is charged a loss assessment by a corporation or association of property owners, and the loss is a direct loss to the property caused by a covered peril (other than earthquake, land shockwaves or tremors before, during or after a volcanic eruption), standard homeowners policies will pay up to $1000 for the insured's share.

Glass of Safety Glazing Material
Also covered is the breakage of glass or safety glazing material that is part of a covered building, storm door or storm window. Damage to covered property by glass or safety glazing material that is part of a building, storm door or storm window is also covered.

Collapse
Under the HO-2, HO-3, HO-4 and HO-6 forms, additional coverage for collapse is included. Collapse coverage pays for direct physical loss to a building or any part of a building caused by:
- Perils insured against under the personal property coverage
- Hidden decay
- Hidden insect or vermin damage
- Weight of contents, equipment, animals or people
- Weight or rain that collects on a roof
- Use of defective materials or methods in construction, remodeling or renovation if the collapse occurs during construction, remodeling or renovation.

Landlord's Furnishings
The HO-1, HO-2 and HO-3 forms include coverage for appliances, carpeting and other household furnishings in an apartment on the residence premises that is regularly rented or held out for rental to others by an insured. The coverage applies only if loss is caused by any peril insured against except theft.

Building Additions and Alterations
The HO-4 form includes additional coverage for fixtures, installation and improvements made or acquired at the insured's expense.

Perils Insured Against
The forms vary somewhat regarding the perils insured against. Form HO-4 has no dwelling coverage, so the perils insured against within the form apply only to the personal property coverage. The perils insured against under the HO-6 form, which like the HO-4 form is a named peril form, apply to the limited dwelling coverage that is within the HO-6 form, and to the personal property coverage. Personal property under both the HO-4 and HO-6 is covered with the same perils insured against as the HO-2 form, except that the HO-6 form has expanded coverage under the peril of accidental discharge or overflow of water or steam.

HO-3 provides *all risk coverage*, also known as *open peril coverage*, which applies to the dwelling, but the personal property coverage within the HO-3 form is named peril coverage, and provides coverage for the same perils as those found in the HO-2 form. The HO-2 form has the broadest coverage, and so includes perils insured against not found in forms HO-1 and HO-8. The HO-2 form also has expanded coverage provisions related to the perils of vehicles and smoke. The HO-8 form includes many of the same perils as the HO-1 form and uses special loss valuation provisions that serve to limit coverage.

Perils Insured Against by Form - Dwelling Coverage

(Note: Form HO-3 provides *all risk* coverage on the dwelling, so covers all perils except those specifically excluded. All other homeowners forms discussed provide *named peril* coverage for the dwelling. Form HO-8 uses special loss valuation clauses that differ from the other forms. The HO-6 form has limited dwelling coverage.)

Peril	Form
Fire or Lightning	HO-1, HO-2, HO-6, HO-8
Windstorm or Hail	HO-1, HO-2, HO-6, HO-8
Explosion	HO-1, HO-2, HO-6, HO-8
Riot or Civil Commotion	HO-1, HO-2, HO-6, HO-8
Aircraft	HO-1, HO-2, HO-6, HO-8
Vehicles	HO-1, HO-2, HO-6, HO-8 (HO-2 contains expanded coverage)
Smoke	HO-1, HO-2, HO-6, HO-8 (HO-2 contains expanded coverage)
Vandalism or Malicious Mischief	HO-1, HO-2, HO-6, HO-8
Theft	HO-1, HO-2, HO-6, HO-8
Falling Objects	HO-2, HO-6
Weight of Ice, Snow or Sleet	HO-2, HO-6
Accidental Discharge or Overflow of Water or Steam	HO-2, HO-6
Sudden and Accidental Tearing Apart, Cracking, Burning or Bulging	HO-2, HO-6
Freezing	HO-2, HO-6
Sudden and Accidental Damage From Artificially Generated Electrical Current	HO-2, HO-6
Volcanic Eruption	HO-1, HO-2, HO-6, HO-8

Exclusions
All the forms include the following exclusions. The HO-3 form includes additional exclusions related to the Dwelling and Other Structures coverages.

- Ordinance or Law: Loss caused directly or indirectly by the enforcement of any ordinance or law regulating the construction, repair or demolition of a building or other structure is excluded from coverage.
- Earth Movement: Excluded from coverage is loss caused directly or indirectly by earthquake, including land shock waves or tremors before, during or after a volcanic eruption, by landslide, mine subsidence, mudflow, or earth sinking, rising or shifting, unless as a result of the earth movement, loss from fire, explosion or the breakage of glass or safety glazing material which is part of a building, storm door or storm window, ensues.
- Water Damage: Water damage arising from items such as flood, water which backs up through sewers or drains, and water below the surface of the ground hat exerts pressure on or seeps or leaks through a building is excluded.
- Power Failure: Loss due to the failure of power or other utility service is excluded from coverage if the failure takes place off the residence premises.
- Neglect: Neglect of the insured to use all reasonable means to save and preserve property at and after the time of loss, is not covered.
- War: Loss due to war is not covered.
- Nuclear Hazard: Loss due to nuclear hazard is generally excluded. I
- Intentional Loss

Coverage E - Personal Liability
If a claim is made or a suit brought against an insured for damages because of bodily injury or property damage caused by an occurrence covered by the insurance, the insurer will pay, up to the limit of liability, for damages for which the insured is legally liable. Damages include prejudgment interest.

The insurer will provide a defense for the insured, even if a suit is groundless, false or fraudulent. The insurer may investigate and settle any claim or suit that the insurer decides is appropriate. The insurer's duty to settle or defend ends when the amount paid for damages reaches the applicable limit of liability.

Coverage F - Medical Payments to Others
Under the medical payments coverage, the insurer will pay the necessary medical expenses that are incurred or medically ascertained within three years from the date of an accident causing bodily injury. Medical expenses include reasonable charges for medical, surgical, x-ray, dental, ambulance, hospital, professional nursing, prosthetic devices and funeral services. The medical payments coverage does not apply to the named insured, a covered spouse, or regular residents of the insured's household except residence employees.

Exclusions from Personal Liability and Medical Payments Coverage
Exclusions from the personal liability and medical payments coverage include the following:

- Expected or Intended Injury or Damage
- Business Liability: Business liability should be covered through professional, commercial or businessowners liability forms.
- Rented Premises: Generally, bodily injury or property damage that arises out of the rental or holding for rental of any part of any premises by an insured is excluded.
- Professional Liability: Professional Liability should be covered through professional liability and errors & omissions insurance forms

- Uninsured Location: Also excluded is bodily injury or property damage that arises out of premises that are not an insured location.
- Motor Vehicles: Most damage, injury and liability related to motor vehicles is excluded.
- Watercraft: Most bodily injury or property damage that arises out of large watercraft is excluded.
- Aircraft: Most bodily injury or property damage that arises out of aircraft is excluded.
- War
- Communicable Disease: Also excluded is bodily injury or property damage arising out of the transmission of a communicable disease by an insured.
- Abuse: Bodily injury or property damage that arises out of sexual molestation, corporal punishment or physical or mental abuse is also excluded.
- Drug Use

Summary

The homeowners forms can be used to cover most of the property and liability insurance needs of the homeowner. A home, its outbuildings, landscaping and contents can all be protected from most perils. Special coverages for certain types of property can be purchased and higher limits can be added to the forms to create a coverage package that fits the needs of individual homeowners.

Inland Marine Coverage – Personal Property Floaters

One of the gaps homeowners insurance may leave is insufficient coverage for valuable personal property. This gap may be filled by inland marine insurance personal property floaters

Inland marine personal property floaters apply to many types of property that is mobile. A "floater" is a policy that follows the property. Property that may need floater coverage includes construction equipment, personal property taken on vacation, clothes being cleaned at a dry cleaning establishment, sculptures on loan to a museum and many other types of property.

Inland marine coverage for personal lines may generally be issued only to cover property of an individual or of spouses who reside together, or members of the insured's family of the same household. Policies may also be issued to unrelated individuals residing together, as long as they are legally co-owners of the property. Policies may also be issued to an executor or administrator of a decedent's estate to cover estate property eligible for coverage.

The most common personal property floaters include the Personal Jewelry Floater, the Personal Fur Floater, the Camera Floater, the Musical Instrument Floater, the Silverware Floater, the Golfer's Equipment Floater, the Fine Arts Floater, the Stamps and Coins Collection Floater and the Personal Property Floater.

Personal Jewelry Floater

The Personal Jewelry Floater covers jewelry owned by an individual. The coverage may be added to a homeowners policy, or through a separate policy. In order to determine the coverage amount of the policy, the jewelry must be appraised, or other suitable documentation verifying the jewelry's value must be submitted to the insurer. Exclusions to coverage include (1) wear and tear, gradual deterioration, insects, vermin or inherent vice, (2) loss arising from nuclear radiation or radioactive contamination and (3) loss due to war.

Personal Fur Floater

The personal fur floater covers fur articles owned by an individual. Items that may be included in this coverage include fur coats, items consisting mostly of fur, garments trimmed with fur and imitation fur items. Each fur item must be listed or scheduled along with the applicable amount

of insurance for each article. The exclusions to this coverage include wear and tear, nuclear radiation and war. Coverage may be provided through endorsement to a homeowners policy or through an individual floater policy. The coverage applies on a worldwide basis.

Camera Floater

Coverage for cameras and similar equipment is available through camera floaters. In addition to cameras, equipment that may be covered includes projection machines, motion picture recording equipment, films, binoculars and telescopes. Each item is scheduled and assigned a value. The exclusions to this coverage are also wear and tear, nuclear radiation and war. Coverage may be purchased through an endorsement to a homeowners policy or through an individual floater form.

Musical Instrument Floater

Musical instruments may be covered through either an individual policy or scheduled under a homeowners policy endorsement. Use of the covered instruments for remuneration is not allowed unless specifically provided for through an endorsement. Excluded from coverage of immobile instruments is damage or loss caused by repairing, adjusting, servicing or maintenance operations, or any mechanical or electrical failure.

Silverware Floater

Silverware, silver-plated ware, goldware, gold-plated ware and pewterware, including flatware, hollowware, tea sets, trays and trophies made of or including silver, gold or pewter can be covered under a silverware floater or under a homeowners policy floater endorsement. Each item must be scheduled. Coverage is offered on a worldwide basis. Exclusions include wear and tear, nuclear radiation and war.

Golfer's Equipment Floater

Under the golfer's equipment floater, golf equipment, including clubs, golf clothing and other clothing kept in a locker at a building used for golfing, is covered. Loss of watches and jewelry is excluded under this coverage. Most golf equipment can be covered on a blanket basis, but some items may require scheduling. This coverage may also be provided under a homeowners endorsement.

Fine Arts Floater

Collections of paintings, antique furniture, rare books, glasses, ornamental knick knacks and manuscripts may be covered under a fine arts floater or homeowners endorsement. Typically, the insurer requires an appraisal in order to determine value. Excluded from coverage is damage caused by repairs, restoration or retouching. Breakage is generally excluded for fragile items such as art glass objects, statuary, marble, bric-a-brac and porcelain, unless caused by fire, lightning, explosion, aircraft, collision, windstorm, earthquake, flood, malicious damage, theft or derailment or overturn of a conveyance. Unlike the other personal property floaters discussed, the fine arts floater ***does not provide coverage on a worldwide basis***. The coverage territory is limited to the United States and Canada.

Stamps and Coin Collection Floater

Stamps and coins must be part of a collection to be covered under a stamp and coin collection floater or homeowners endorsement. Depending on the property covered, either scheduled or blanket coverage is available. Besides exclusions for wear and tear, nuclear radiation and war, this coverage excludes loss due to fading, creasing, denting, scratching, tearing, thinning, transfer of colors, inherent defect, dampness, extremes of temperatures, depreciation, and theft from an unattended automobile. Damage due to being handled or worked on is also excluded.

Personal Property Floater

A personal property floater is generally used in circumstances when an insured does not own a home, and therefore has no homeowners policy, but needs coverage for his personal property. It provides coverage for all personal property owned, used or worn by the insured. It is typically used by wealthy insureds that need high limits of insurance.

Summary

Personal property floaters provide individuals with insurance for special types of property. It provides higher limits of insurance than found under unendorsed Homeowners forms. Coverage is generally provided on a worldwide basis, so those who travel with valuable property can benefit from personal property floater coverage. Personal property floater coverage also provides protection for an individual's property while being used locally or stored for safekeeping.

Title Insurance

Title insurance protects against the risk of financial harm that arises from claims against the rights of ownership of real property. Examples of items that could cause such claims include forgery, improper transfers of title, mistakes, fraud, and unknown heirs with rights to the property.

Title insurance is issued on the basis of a close examination of all records and property related to the title. The title insurer is responsible for this examination. In addition to insuring against claims against the title, the insurance provider insures the accuracy and sufficiency of the title examination and of the abstract, which is a summary of the results of the examination, and in some cases also insures the accuracy and sufficiency of items found in a survey or site inspection of the property. Title insurance is purchased to protect the interests of owners, lenders and leaseholders in real property.

Types of Title Insurance Policies

There are several different title policy types available because there are many different title transfer situations which necessitate the various policy forms. Some involve mortgages, others reflect owners in fee simple, still others involve leaseholders or construction loans. Many endorsements also are available to meet many situations. There are those that add coverage excluded by basic policy forms and those that provide for special circumstances, such as certain mortgage types.

Owner's Policies

One type of title insurance policy is the owner's policy. Owner's policies insure estates of ownership, occupancy and possession. Since the policy insures the full amount of the property owned, the liability of the insurer remains constant over the life of the policy. Owner's policies generally exclude unmarketability of title and mechanic's liens from coverage.

Mortgage or Loan Policies

Loan policies insure lenders' interests in title. Loan policies provide broader coverage than do owner's policies because lenders will not purchase policies that do not provide full coverage.

Under a loan policy, liability of the insurer decreases over time, since the loan amount decreases. If an open-ended loan is involved, a revolving credit endorsement can be added to the policy so that newly borrowed amounts are also covered.

Loan policies include provisions that, should foreclosure occur, the policy becomes an owner's policy. This is because, under a mortgage or deed of trust arrangement, the lender takes possession of the property upon foreclosure.

Leaseholder Policies

Leaseholders do not have an owner's interest in property. However, if the lease is for a specified period of time, state laws require that the Leasehold interest be recorded. This is because the states recognize that although not an owner of real property, a leaseholder can be harmed if title is passed improperly, or if the property is misrepresented in the deed. A leaseholder, especially one with a long lease, pays consideration for the use of the real property. In some cases, a lease arrangement will even allow the lease to be continued by heirs should the leaseholder die. The leaseholder has a valuable consideration in the real property leased. Because of this interest, title insurers developed policies to cover such title interests of leaseholders.

Construction Loan Policies

Construction loan policies include many of the same provisions as a loan policy, but include conditions and stipulations applicable only to construction loans, such as providing for coverage for mechanic's liens based on the laws of the sate in the policy issued.

Summary

Title insurance cannot protect a title holder from the potential harm arising from every potential problem related to a title. However, it can, along with the processes involved in providing title assurance, greatly reduce the exposure to the risk of loss and damage related to these problems.

SPECIAL HO COVERAGE ISSUES

Ordinance and law

Older homes might be restricted as to repairs and replacement for "up to code" issues pertaining to wiring, plumbing, sewer, etc. Consider the case where three layers of roof (the maximum the city allows) have built-up over the years. If the home is damaged by hail and needs to be replaced the cost to re-proof the home is covered. However, the cost to tear-off all three layers of roofing material is NOT and this is a considerable expense. Of course, ordinance and law endorsements are an option.

Adequate Limits

Remember the Oakland, California fires? Many homes destroyed by the fire were greatly uninsured or exceed replacement cost limits. "Guaranteed replacement cost" is an option. Of course, the insured might incur a replacement cost appraisal and inform the insurer of any significant changes after the endorsement is made.

Other Structure

The 10% limit usually covers most additional structures. However, remember that fencing, or rentals may not apply. Consider endorsements.

Riding Mowers

Old ISO Homeowner policies provide property and liability coverage as follows:

Vehicles or conveyances not subject to motor vehicle registration which are used to service an "insured's residence".

From this verbage it seems clear that if the mower were stolen it would be covered. Similarly, if a son or daughter were using the mower to cut their yard and injured a neighbor, there would be liability protection. All that is required is that the mower be used to service the residence.

Consider, however, when the mower is driven off the residence property, say to visit a neighbor to cut his lawn while he is on vacation. The policy does not seem to limit coverage here because there is no requirement that at the time of "an occurrence" the mower must be used to service the residence.

The ISO Homeowners 2000, however, changes all this

We do not cover "motor vehicles not required to be registered for use on public roads or property which are used solely to service an insured's residence.

The word "solely" has made a huge difference. Now, the ONLY thing the riding mower can be used for is serving the insured's residence. If the homeowners uses it to cut the neighbors lawn again and injures someone in the process, he is NOT covered. Even joyriding the mower on his own property seems to exclude protection.

Renting The Primary Residence

There are times when a homeowner may be away from his primary residence for an extended period of time. Say, for instance, they move out and rent their home "full-time" while it is up for sale.

The ISO HO3 policy clearly states that liability coverage extends only to occasional rentals (a few days, or only a portion of your home to a boarder). The question becomes; does the homeowner have clear intentions to return to the house? If not, the dwelling is clearly no longer the insured's true residence. That means there is no "residence premise" and no Coverages A, B or D – dwelling, other structures and living expenses. Coverage C may still be intact since it is extended on a worldwide basis.

Of course, court cases have interpreted this differently. Some, like Hill vs Nationwide Mutual (1994) have found that where someone "resides" is merely a description and not a warranty of occupancy. Here, the homeowner was supported because the courts felt that he should not suffer a catastrophic loss on a mere "technicality". Others, however, like Bryan vs United States Fire (1970) disagreed even though the homeowner testified that he had only temporarily relocated and planned to move back at some point.

Clearly, renting one's residence for any length of time is an issue that should not be "pushed". As long as the insured maintains an insurable interest in a property, coverage may need to switch from homeowners to a dwelling fire program.

Property in Storage

What happens when your client places items in a self-storage facility for an extended period of time? Does the homeowners policy cover them?

Consider the following verbage under Coverage C protection:

We cover personal property owned or used by an insured while it is anywhere in the world.

For most homeowners, this seems to say that they will be covered. However, there are limitations; such as . . .

Our limit of liability for personal property usually located at an insured's residence, other than the residence premises, is 10% of the limit of liability for Coverage C, or $1,000, whichever is greater.

Of course, coverage can be increased with an HO 04 50 endorsement.

"Special limits of liability" to Coverage C should also be considered. They usually read something like this:

This peril does not include loss caused by theft that occurs off the residence premises of:

Property while at any other residence owned by, rented to, or occupied by an insured, except while an insured is temporarily living there. -- Property of a student who is an insured is covered while at a residence away from home if the student has been there at any time during the 45 days immediately before the loss. – Watercraft, and their furnishings, equipment and outboard engines or motors. – Trailers and campers.

Insureds who use a mini-warehouse to store watercraft and equipment, or trailers and campers have no theft coverage for such property.

Similar limitations exist for business property:

$2,500 on property, on the residence premises, used at any time in any manner for any business purpose.

$250 on property, away from the residence premises, used at any time or in any manner for any business purpose.

Again, increased coverage is available under a HO 04 12, but limits are placed on business property used for samples or delivery after sale or for business property pertaining to a business actually conducted on the residence premises.

Valuation is yet another issue to analyze. Some policies disallow Replacement Cost coverage for items in storage or articles considered "outdated or obsolete". Said another way, "junk in storage" is not eligible for replacement cost.

What about liability? What happens, for instance, if an insured stores a propane gas grill or gasoline container negligently and they injury or damage a third party? Insureds and their attorneys would claim that the "premises" where they were stored were controlled by the insured and therefore covered. However, Section II in most policies exclude claims "arising out of a

premises that is not an insured location". Still covered? Probably, because the definition of an "insured location" is any part of a premises occasionally rented to an insured for other than business use. However, what about long-term storage? Check with an underwriter or declare the facility an "insured location".

College Students Living Away From Home

Most homeowner policies cover any personal property owned or used by an insured if it is lost or damaged in a covered peril. The term "insured" includes resident relatives and courts have consistently found that a dependent child away at school is still a resident of the insured's household. The usual limitation that is placed on this coverage is 10% of Coverage C or $1,000 if greater. 10% of Coverage C is usually enough to cover losses like a computer, although there is a deductible to contend with. In addition, limitations say that any losses be reported to the police. It is assumed that "campus police" is adequate here, but not 100%

The HO 2000 definition of an "insured" has changed somewhat:

A student is enrolled in school full time, as defined by the school, who was a resident of your household before moving out to attend school, provided the student is under the age of 24 and your relative or 21 and in your care.

The problems presented by this new definition are several. Now the student must be "full-time". This can vary from school to school, but it usually means 12 credits per semester. So, a child who could not get a full "load" for a given semester may not be fully covered.

The age restriction poses problems for graduate students or those taking a little longer to get their degrees. Technically, they are not covered. The student, under this definition, would have to get his own HO4 and umbrella.

ISO, however, created an "additional insured" endorsement – student away at school – for use by those who are over the age limit or not considered full time. Even here, potential problems lurk because kids move a lot. You sign them up for the endorsement at one address and when they move, they are essentially uncovered.

Few courts have interpreted policies so literally as to be highly concerned because it can usually be proven that the student has not moved away permanently. They usually still have a key to mom and dad's house or stop by to do laundry. However, the endorsement may still be a good idea.

Personal Trusts

Over the last several years, huge numbers of people have created family trusts to help avoid probate and save on estate taxes. Most of the time, the trust will take ownership of homes, autos and other property. A lot of agents have simply been adding the trust as an "additional insured".

While trusts have increased in popularity, older ISO policies are still designed for individuals. The trust is not a "family member" or natural person, so how can it own and occupy a dwelling?

The HO2000 has addressed this problem with a "residence held in trust" endorsement designed for this exposure. The policy is written in the name of the trustee, grantor or beneficiary. The

trust gets the benefit of all Section I and II coverages and the party that resides on the premises – the grantor or beneficiary – gets the benefit of all coverages except Section IA and B (dwelling and other structures).

A residence owned by a corporation would not qualify for the endorsement. As always, it is best to check with each carrier to learn any specific requirements.

Earth Movement

Most policies contain some form of ***exclusion*** for damage to buildings caused by the shifting movement of the ground beneath it. Typical wording might read as follows:

We do not insure for any loss to the property which consist of, or is directly and immediately caused by . . . Earth Movement, meaning, the sinking, rising, shifting, expanding or contracting of earth, all whether combined with water or not. Earth movement includes but is not limited to earthquake, landslide, mudflow, sinkhole, subsidence and erosion.

Of course, there are many claim controversies that develop when interpreting this kind of language.

In Strubble vs United Services (1973), for example, an insured's home was situated on a cliff. Prior to 1967 a slight landslide occurred which destroyed the home's patio. In 1967, an earthquake caused a crack and shifted the earth under the house, precipitating a very slow landslide. Over the next few months, the crack became wider and the insureds took steps to shore up the property. Unfortunately, in a short time, two-thirds of the house collapsed and the house was abandoned. Disputes quickly arose as to whether the earthquake, which was a covered peril under this particular policy, caused the landslide. Experts disagreed, so the appeals court held that the burden was on the insurer to prove that the earth movement exclusion applied, i.e., the earthquake was the culprit. Because the insurer could not prove it, the loss was covered.

Other claims were not so cut and dry. Consider:

Henning Nelson vs Fireman's Fund (1985). The courts held that the earth movement exclusion applies only to natural disasters.

Government Employees Ins vs Dejames (1970). The earth movement exclusion did not apply to damage caused by crushing of a foundation by the pressure of the outside earth load against it.

Bergeron vs State Farm (1967). The earth movement exclusion applied to the damage caused to a plaintiff's house by the failure of a nearby dam, even though the dam failed due to faulty construction. The damage was the "resulting loss" from the earth movement within the dam, and therefore it came within the exclusion.

Rankin vs Generali (1999). An insured's basement wall was twisted due to heavy machinery parked near the building which placed pressure on the earth abutting the basement wall. The court held that the earth movement exclusion precluded coverage.

Murray vs State Farm (1998). Several large boulders and rocks fell off a quarry's high wall and onto the houses owned by the plaintiff. Engineers determined that what occurred was a "rock fall" and not a "landslide". The courts originally decided in favor of the policyholder, but on

appeal, they reversed themselves on the basis that a question still remained as to whether the loss was caused by negligence of a third party or by the excluded natural event. This case is yet to be determined.

Water Line Access

Most policies include a "tear out" provision that covers the cost to remove and repair portions of a home to access broken or leaking water pipes. "Risk exclusions", however, might exist concerning normal wear and tear, deterioration, inherent vice, latent defect, mechanical breakdown, settling of pavement, animals, etc. And, a special endorsement might protect the inured as follows:

If any of these cause water damage not otherwise excluded, from a plumbing, heating, air conditioning or automatic fire protective sprinkler system or household appliance, we cover the loss caused by the water including the tearing out and replacing of any part of a building necessary to repair the system or appliance. We do not cover loss to the system or appliance from which the water escaped.

The dispute that is sometimes raised concerns the phrase "water damage" or "building".

For instance, what if there is no actual water damage now, but it will occur if the insured flushes his toilet one more time. Is the loss of the toilet considered a physical loss caused by the water? What about a case where there is no physical damage to a building, but the insured is "losing water"? Is that "water damage"? Probably, because once the water passed through the insured's water meter, it became personal property, a covered loss.

The word "building" is a whole other issue. What if it is not necessary to tear out a wall to get to a leaking pipe, but it IS necessary to tear out a *detached* driveway? Now, it becomes a matter of whether the policy broadly interprets this as "building". An abutting driveway might be easier to consider part of the building. However, the cost of tearing out *land* is not generally regarded as a covered building tear-out. It's a gray area for sure!

Other special claims may surface where repairs must be made "solely" to protect the covered property. Covered or not? It depends on the interpretation. Again, however, additional coverage is available to cover "reasonable repairs and costs" taken "solely" to protect against further damage (HO 00 03 04 91).

Replacement Cost Holdbacks / Timely Notification

Many homeowner policies contain loss settlement ***holdback provisions*** stating the insurers right to *pay no more than the actual cash value of the damage until actual repair or replacement is complete*. Typically, the insured can recover full replacement cost after he has repaired or replaced it, provided he notifies the insurer within 180 days after the loss his intention to rebuild.

Claim disputes have developed, however, when notification was not timely. In Lucero vs Smith (2000), for example, the insured waited six years to notify the insured of the intention to replace his home. Keep in mind that the insurer did not require the insured to actually complete, or even start, rebuilding within the 180 day timetable. He only needed to give notice of his intention.

In another case, the insured's decision to rebuild was delayed (beyond 180 days) due to the fact that he learned he could not rebuild the house on the same lot because of local ordinances

pertaining to sewerage treatment. The insurer denied the claim, but the court awarded in favor of the insured.

A time limit for actual replacement or completion of repairs is not typically specified in policies. And, when contracts are silent, the courts imposes a "reasonable time" limit. The facts and circumstances will be different for each case. However, it seems reasonable that "years" is unreasonable, while normal delays due to weather, legal issues, etc are ok.

Minor Exclusions

Watch for exclusions found in many homeowner and umbrellas regarding minors. For example, if a minor operates a boat, you may have a potential claim in waiting.

Intentional Acts

Changes are evident between older policy forms and HO 2000. There is little doubt, that this new form intended to create a ***true intentional acts exclusions***. Let's look at the modification of the exclusion:

Expected or intended injury exclusion:

Bodily injury or property damage which is expected or intended by an insured even if the resulting bodily injury or property damage:

a) Is of a different kind, quality or degree than initially expected or intended; or
b) Is sustained by a different person, entity, real or personal, than initially expected or intended

This exclusion does not apply to bodily injury resulting from the use of reasonable force by an insured to protect persons or property.

In the 1991 ISO, the exclusion is for damage simply "expected or intended" by an insured. The insured original action or intent are not the guiding determination. In the 2000 form, however, the word "initially" changes the context radically. For instance, what if an insured fired a gun at a person in his living room and the bullet goes through the window and strikes a neighbor? 1999 will probably pay on the basis that the insured did not originally intended to strike a neighbor. Under ISO 2000, a single word makes a big difference. The insured clearly "expected or intended" the injury or damage -- putting a bullet into someone. But, the fact that he is a lousy shot isn't going to make the insurer feel any better about paying the claim. It is clearly excluded in the newer policy making it a true intentional acts modification.

HOMEOWNER CLAIMS & SETTLEMENT

Responsibilities of an Insured Following a Homowner's Loss

When a loss is occasioned by the owner of a home or a condominium, there are a number of steps involved surrounding the responsibilities of a homeowner, including the following:

- Notification to the carrier—An adjuster will determine whether a claimant complied with the provisions of a policy requiring the policyholder to notify the carrier of a loss.

- Notification to the police—In the event a crime was committed during the occasion which gave rise to a loss, it must be determined if the police were notified. A copy of the police report may be useful evidence about the nature and extent of the loss. Under some policies, claims can be denied if law enforcement authorities were not notified.
- Theft of credit or ATM cards—If credit or debit cards were stolen, the issuer of such cards must be timely advised.
- Covered property—An adjuster will seek to determine if a claimant took steps to protect the underlying property from additional damages.
- Records—Records of the costs of repairs, which must be kept by a claimant, will be examined by an insurance adjuster.
- An inventory of damaged property—Most policies require the policyholder to prepare an inventory of damaged property, including such items as the cash value, the amount of losses, costs of repairs and a description of the property.
- Renters—If there are tenants living in the underlying property, and the owner secured a rider to cover renters, the policyholder must notify the carrier if the negligence of a renter contributed in any way to damages to the property.

Investigation of a Claim Under a Homeowners Policy

Having concluded that there were no misrepresentations or omissions on either the application for a policy or within the policy and that the policyholder complied with all of his or her requirements under the policy, a claims adjuster will review the applicable policy during the investigation stage to determine if coverage applies or it can be denied. Following are some of the more significant terms that could affect the nature and extent of insurance coverage for losses under a homeowners policy:

- ***"Named Insured"*** — Early in the investigative stage, a claims adjuster will review the status of the party or parties which suffered damages to real or personal property, and if such persons do not come within the definition of the "named insured," coverage may be denied. Many policies contain a provision substantially similar to the following:
  - The provisions of this policy impose joint obligations on the person designated on the declaration page of this policy as the Insured and on the resident spouse of such person. Such persons, for purposes of this policy, are defined as "you" or "your," meaning that the responsibilities, acts and failures to act of such persons specified as "you" or "your" shall be binding on another individual specified as "you" or "your."
  - If a homeowner decided to rent a vacant bedroom to a friend and failed to take out a renter's policy, any damage to the personal property of the tenant located on the homeowner's premise would probably not be covered, since renters would not be included within the definition of "named insured."
  - There may be other definitions or use of the word "insured" in a policy which may lead a claims adjuster after investigation not to recommend coverage. Some policies provide that with respect to any animals or water craft of the insured, any person or entity having custody or control of such animals or water craft is also to be considered as one of the insured only so long as that other person or entity does not use the water craft or animals in his or her business without the consent of the insured. Thus, if Ed left his pet German Shepherd, Fletcher, in the care and custody of the Canine Club, a dog kennel, while he went to Easter Island for two weeks, and the dog bit the night watchman, there might possibly be coverage under Ed's homeowners policy, since the Canine Club would be considered as an additional insured under Ed's policy. However, if the staff of the Canine Club sponsored a dog show for the public, using the dogs that were boarded at their facility, and Fletcher clawed an elderly man in the audience, there may be no coverage under Ed's insurance policy.

- ***"Insured Location"***—A typical homeowners policy contains a definition of an "insured location," which includes:
  - The "residence premises."
  - The part of other structures, grounds and premises used by the named insured as a residence and (i) which is shown in the Declarations, or (ii) which is acquired by the named insured during the period of the policy for his or her use as a residence.
  - Any premises used by the named insured in connection with premises specified under "residence premises or any part of a premises (i) which is not owned by an insured and (ii) where an insured is temporarily residing.
  - Any land owned by or rented to an insured on which a one- or two-family dwelling is being built as a residence for an insured.
  - Any part of the premises occasionally rented to an insured for other than a business use.
- ***"Covered Event"***—An "occurrence" is typically defined as an accident or exposure to substantially the same conditions over a length of time which produces (a) "bodily injury" or (b) "property damage." An adjuster must pay particular attention to a policy to see if the accident or injury comes within the definition of "occurrence." Underlying the definition of occurrence are two other terms. "Property damage" may be defined to include a "physical injury to, destruction of or loss of use of tangible property." Tangible property means real or personal property. Some items which relate to the covered premises, such as a floor plan, have no insurable value.
- ***"Residence Employees"***—An adjuster is reviewing a claim for medical expenses under a homeowner's policy involving a situation where the insured's maid tripped over a bottle of cleaning solution and hit her head on the edge of the wet bar. Coverage would only apply if the maid was a "residence employee" within the meaning of the policy — "an employee of an 'insured' whose duties are related to maintenance or use of the 'residence premises', including domestic services," or "one who performs similar duties elsewhere not related to the 'business' of an 'insured.' "
- ***"Other Structures"***—If a claim is filed seeking coverage for damages to a garage, the claims adjuster must determine if the garage is within the policy definition of "other structures." Typically, "other structures" are those set apart from a dwelling by clear space, including "structures" connected to the dwelling by a fence, utility line or similar connection. In addition to a garage, other covered structures might include a pool cabana, guest house or a gazebo. The more questionable structures might involve either a heated greenhouse or an environmentally-controlled doghouse. If an insured rented his or her garage to a neighbor to park his or her car, coverage might apply, but a loft over a garage rented to a college student probably would not fall within the definition of an "other structure."
- ***"Personal Property"***—An ordinary homeowners policy covers "personal property" owned or used by an 'insured' while it is anywhere in the world. "Personal property includes such items as household goods, furniture, linens, drapes, clothing appliances and paintings. Policy limits on electronic apparatus and software may be limited.
- ***"Faulty Planning, Construction and Maintenance"***—No investigation of a claim brought under a homeowners policy for damages resulting from flooding or a faulty structure would be complete without determining if such losses were due to faulty, inadequate or defective planning, zoning, development, surveying, design, specifications, workmanship, repair or materials used in repair, construction, renovation, remodeling, grading, compaction, or maintenance, since such losses are expressly excluded from coverage in most homeowners policies. If a county flood drainage ditch running behind the house of a policyholder became clogged with debris, causing flooding to the insured's house, there would be no coverage if the county had failed to remove the debris.

Examination Under Oath

The standard homeowners insurance policy allows a carrier to demand an "Examination Under Oath" from a claimant. Such provision is typically as follows:

The insured...shall exhibit to any person designated by the company all that remains of the property herein described, and submit to examinations under oath by any person named by the company...and shall produce for examination all books of account, bills, invoices and other vouchers...at such reasonable time and place as may be designated by this company...
An examination under oath ordinarily is not required except in circumstances in which a carrier suspects fraud or abuse on the part of a claimant, after an investigator has uncovered suspicious circumstances such as financial difficulties on the part of an insured, a dearth of records, similar losses prior to the claimed loss at issue, domestic difficulties or onerous demands for payment or excessive coverage.

Once the procedure has been set in motion for an examination under oath, a carrier will ordinarily engage the services of an attorney to conduct the examination. A court reporter will be present for the questioning. Misrepresentations or lies on the part of the claimant can lead to perjury charges.

Evaluation of a Claim

Under the loss settlement provisions of a policy, valuation methods for different types of property are provided. Personal property and structures that do not constitute buildings are valued at actual cash value, and the typical basis of settlement for buildings is the replacement cost.

Replacement Cost

This type of coverage, found in virtually every homeowners policy, applies mainly to dwellings and other buildings or building structures with a roof and four walls. Structures attached to a dwelling, such as a patio, are also covered. A replacement cost provision requires an insured to purchase insurance coverage that amounts to at least 80 percent of the replacement cost of the property. The average homeowners policy excludes from the 80 percent calculation excavations, foundations, piers or supports below the undersurface of the lowermost basement floor or below the surface of the ground inside the foundation walls if there is no basement, as well as flues, pipes, wiring and drains that are underground.

The purpose of an 80 percent clause is to deter a policyholder from being underinsured. If an insured acquires less than 80 percent, there will only be partial coverage equaling the amount of insurance purchased divided by 80 percent, and the result will be multiplied by the measure of the loss to arrive at the amount of settlement. This requirement is imposed to keep the calculation of insurance premiums uncomplicated, since premiums are based on a nonwavering cost of $100 worth of insurance.

The expense of building homes is typically calculated on a cost per square foot and varies according to the type of construction and the geographical area. Such cost information is obtained from data that is constantly changing. The replacement cost of a house is a relative issue. A policyholder is not bound by contract or by law to accept a carrier’s determination of the replacement cost of his or her property. If the insured suffers a loss and the carrier determines that the policyholder failed to comply with the 80 percent provision, a penalty is attached to a homeowner’s claim in which the amount of the settlement will equal replacement cost less the penalty specified in the policy or the actual cash value of the repairs, whichever is less.

Actual Cash Value

Conceptually, actual cash value is more difficult to determine than replacement cost. With respect to personal property, the actual cash value is based upon replacement cost less depreciation. As to real property, actual cash value is based on any number of factors, including physical condition, obsolescence, age, market value and the worth of any improvements on the property. Generally, in homeowner's policies, valuation is at actual cash value unless the policy provides for valuation at replacement cost.

Costs of Repairs

Once the parties agree on the scope of the repairs to be done and have a detailed itemization of the work to be included within the estimate, the next step is to arrive at an agreed cost for repairs. It is customary for a carrier to use the estimate that it obtains as a basis for establishing the cost of the repairs. Carriers always retain the right to repair the property, but invoking the clause seldom happens because a carrier does not want to be placed in a position of having to warrant the work of the contractor. Claims representatives frequently take an active part in ascertaining the expense of repairs. An adjuster may obtain an estimate from a company that does a sufficient amount of work for his or her carrier and invite the policyholder to obtain a competitive bid. Estimates can vary depending on whether a large or small company is used, if the contractor subscribes to workers' compensation and if the contractor's workers belong to a union. Many carriers insist upon a licensed contractor to do the repair work.

Generally, an adjuster will select two or more contractors to make an estimation of the costs of repairs and will advise a claimant to obtain one of his or her choosing. After repair bids are made, an adjuster will go over the estimates with the homeowner. Frequently the bids are for the cost of an entire job without breakdowns for the expenses relating to each item. Some estimates are offered in the form of a "lump sum" bid, one that does not include individual items of repair. The itemized bids are compared. Customarily, the settlement amount is the equivalent of the lowest bid. Once an agreement is reached, an adjuster will ask the claimant to sign a work authorization sheet. If items of personal property are found to be no longer usable, the adjuster will total them and pay the claimant the actual cash value of such items. Items that are damaged but are not a total loss will be adjusted and handled by a cash settlement in the amount of the loss. Once the cost of the repair is established, a determination of the amount of the claim is rather easy.

Valuing Personal Property

Ordinarily a policyholder establishes the cost of every item of personal property included in a homeowner's claim. When that has been done, the claims adjuster will review the insider's assessment and dispute items, if necessary. The final step is to determine the actual cash value amount of the claim, which in most cases is the replacement cost. Depreciation of the property is factored into the replacement cost.

Valuing Structural Damage

The evaluation of structural damage is complicated in a situation in which the extent of the damage may not become obvious until after work has begun on restoration of the damaged property. An adjuster should encourage a contractor to overbid to include the expenses of hidden damage, provided such increases are based upon his or her experiences. Adjusters involved in appraising the amount of damage to a structure of a building should be experienced

in such matters. Once the adjuster authorizes the work, the responsibility for paying is that of the claimant.
If there is a dispute between the claimant and the adjuster, the claimant may demand advance payments that cannot be conditioned on the claimant's acceptance of the carrier's valuation of the loss. Deductions for the settlement of structural damage for "betterment" of the property on the theory that a claimant would receive a windfall because the repaired property would be left in a condition that was better than before the loss are not proper in some instances.

Extraordinary Items

If a claim involves the theft, destruction of or damage to special items such as furs, jewelry or antiques, an insurance examiner may evaluate inventories and pictures of such items for proof of existence. Police reports will be reviewed for consistency in the items reported missing or damaged. If the item of property was a gift, an examiner may interview the person who gave the gift for details about the item. Verification of the purchase through a receipt, credit card or canceled check may be considered.

Determining the Meaning of "Reasonable"

The term "reasonable," which usually appears many times in a homeowners policy, gives rise to another aspect of the evaluation of a homeowner's claim by an insurance adjuster. In one context, a homeowners policy covers "reasonable repairs" to property damaged by an applicable peril. A carrier may pay the "reasonable costs" incurred for necessary measures taken to protect the underlying property against further damage. Reimbursement for "reasonable living expenses" may be allowed. Frequently a carrier may implement a predetermined notion of what is "reasonable" by including limitations for the amount of a covered item within the policy. In instances where "reasonable expenses or costs" are not scheduled, the criteria employed to determine what is "reasonable" may be subjective. For example, an insurance claims adjuster may conclude with "reasonable repairs" that only the lowest bid will suffice.

Evaluation Under a "Floater" Policy

Determining the value to be placed on property insured under a floater policy is usually the responsibility of a policyholder. Pursuant to the provisions of most floater policies, the amount of insurance coverage is a ceiling on the total amount a carrier will need to pay an insured. Insurance companies frequently have the opportunity to repair the property if that factor is less than the replacement cost. The savings is not passed to the policyholder. Rarely, a floater policy specifies that valuation be based on actual cash value rather than cost of replacement. Valuation may be illusory in cases where an insurance company has a number of avenues available to replace property.

Because of the frequency of repairs and restorations, an insurer may have a number of businesses that specialize in replacing property for insurance companies, and as a result, a carrier may realize substantial discounts beyond the reach of the general public. Replacement or repair items might be purchased by a carrier at an auction. The cost of the item may be considerably less than the amount paid on settlement. This dilemma can be circumvented by the purchase of an "agreed value" policy or a "valued" contract which stipulates a value that is accepted by both the policyholder and the carrier. When a loss is sustained, that amount is paid on settlement.

Consequential Losses

Most homeowners policies provide insurance to cover physical losses. Remote or consequential losses that are not physical in nature and that were not caused by damage to tangible property are not within the limits of coverage, and, as a result, are rarely the subject of a settlement. If a policyholder's refrigerator was destroyed by fire and the insured had to store his or her food in a neighbor's freezer, his or her carrier would not be liable to the neighbor for storage charges, because the loss of the refrigerator is a loss of physical property, but the loss of use of it for storing food is not. Additional living expense coverage may be an indirect way of covering the loss of storage space that was provided by the refrigerator.

Settlement of Claims Under a Homeowners Policy

Replacement Cost Claims

Before a construction contract is signed, an adjuster should be certain that all of the required work is set forth in detail. The adjuster should go over the scope of the work in detail with a policyholder, making sure that the estimate describes exactly what repairs are to be completed. If both the adjuster and the policyholder are satisfied with the proposed work, the policyholder will be required to sign a document known either as a "payment assignment," "direction to pay," "payment authorization" or an "authorization to pay," which allows a carrier to designate the contractor as the named payee on the payment draft. Without such an authorization statement, a carrier cannot assign payment to the contractor, since the contract is between the carrier and the policyholder. The payment draft cannot be executed by the contractor without the co-signature of the policyholder.

When claims are settled under a replacement cost provision of a policy, if the losses exceed a minimal amount, typically several thousand dollars, a policyholder must finish the repairs before he or she can collect the entire amount of the replacement cost. An insurance company must pay the actual cash value of the repairs, and after the policyholder furnishes evidence that the repairs have been completed, the insurer must pay the balance of the settlement.

In cases where the estimate of repairs exceeds the amount of the money actually spent on the repairs, a carrier is not liable for payment of the excess amount. Generally, repairs must be made within 180 days of the date the loss was occasioned. Under replacement-cost coverage, a carrier must pay complete replacement costs on every loss under several thousand dollars when a claim is adjusted without regard to whether repairs were completed. A policyholder in this situation cannot be compelled by his or her carrier to demonstrate the amounts actually spent on repairs.

Generally, replacement cost is the actual cost to replace ravaged property with like type that is substantially similar in function, quality and style. Replacement costs are not to be used interchangeably with "reproduction costs," since, typically, the latter is considerably higher than replacement costs. A carrier is not required to pay for work that enhances the value of the property. In a few states, damaged property does not have to be reconstructed at the same location to satisfy the carrier's obligations.

Disposition of a Claim Under a Floater Policy

The amount of a settlement payable under a floater policy varies according to the classification of property covered by a policy. Settlement under a floater policy may depend on the amount of the insurance that is applicable. In other cases, disposition of a claim will depend on the market value of the property at the time of the loss of the items involved, subject to a maximum limitation. In other instances, the amount of damages recoverable by a policyholder may be

limited to the lowest of either (1) the actual cash value at the time of the loss, (2) the cost of repair or restoration of the property, (3) the amount of coverage under the insurance policy or (4) the cost of replacement. If there is a "pair and set" provision in a floater policy, a carrier will have the right to replace or repair the damaged items or to pay the disparity between the remaining part of the set and the value of the complete set before the loss.

Proof of Loss

When a contractor has completed all the repairs and the amount of personal property losses has been determined, an adjuster will finalize the claim. Repair and reconditioning costs are added to outside living expenses, and cash allowances are made for items that could not be renovated or restored. After all items are agreed upon, a claimant will be asked to sign a "Sworn Statement in Proof of Loss," which will fulfill a part of the insurance policy. The specific amount that a carrier must pay on a claim will be shown on the proof of loss. Any payments made in advance are deducted from the total amount of settlement.

Homeowners insurance policies uniformly contain a proof of loss provision substantially in conformance with the following:

Within___days after the loss, unless such period of time is extended in writing by the company, the insured shall provide the company a proof of loss... stating...the time and origin of the loss, the interest of the insured and all others in the property, the actual cash value of each item thereof and the amount of loss thereto...all encumbrances, all other contracts of insurance...covering any of said property...any changes in the title, use, occupation, location, possession or exposures...since issuance of the policy, by whom and for what purposes any building...was occupied at the time of loss...and...verifiable plans and specifications of any building, fixture or machinery destroyed or damaged...

Courts have held that if an insured fails to supply a proof of loss but supplies other documents to a carrier such as a sworn statement and other requested documentation, the claimant has met the requirements of filing a proof of loss.

In situations where a carrier and a claimant cannot agree on the amount of the loss, an adjuster may provide a claimant with a blank proof of loss, asking him or her to fill in the amount which the claimant thinks is owed. In that case, the carrier can either pay the amount claimed by the claimant, take exception to such amount or deny the claim if he or she finds the policy does not cover the loss or damage in question. Exceptions to a proof of loss cannot be frivolous, but must be founded on a substantial basis.

Settlement Checks

Settlement checks are usually mailed within a week or two by the carrier. Such checks may be made payable to the claimant, the contractor or the lender that holds a mortgage on the property if the lender is named as a loss payee. A carrier does not normally have a right to include the contractor on the settlement check unless the contractor and the claimant agreed to do so. To avoid a mechanic’s lien being imposed by a contractor, a lending institution will normally insist on some arrangement with the claimant that settlement funds will be used to repair the property.

Settlement With a Mortgagee

If a mortgagee is named in a homeowners policy, any loss payable will be made to the named insured and to the mortgagee according to their respective interests in the damaged property. A denial of a claim made by the policyholder does not automatically mean that a claim filed in reference to the transaction by the mortgagee will automatically be denied too, provided the mortgagee has notified the carrier of any change in ownership, substantial risk or occupancy of

which it is aware, pays any premium on demand that the policyholder has neglected to pay and submits a sworn statement of loss within 60 days after notification by the carrier that the policyholder failed to do so.

Denial of a Claim Under a Homeowners Policy

If a claim for losses under a homeowners policy is denied, an adjuster must take time to explain the reasons for such denial to a claimant. A claimant may engage the services of a public adjuster to whom he or she has given a power of attorney to pursue the claim. Arbitration may be requested through the filing of a proof of loss by the claimant. Each party to the arbitration process generally selects an appraiser. Both in turn choose an umpire. The decision of the umpire may be reviewable in a court of law. Frequently, a carrier may choose to avoid arbitration by taking the matter directly into litigation.

Litigation

If the settlement process fails and a policyholder intends to sue his or her carrier, there may be provisions in the insurance policy which govern when and how suit can be brought. Some policies provide that suit cannot be instigated against the carrier unless the policy provisions have been complied with and the suit is commenced within one year from the date of loss.

PERSONAL UMBRELLA CLAIMS

As the number of outlandish civil cases and awards of punitive damages increased dramatically over the past two decades, umbrella policies have gained a tremendous amount of popularity. An umbrella policy is a personal liability policy sold in units of $1 million or more as a supplement to vehicle coverage and homeowners policies and is typically suitable for a person whose assets are substantially in excess of the liability limits of either a homeowners or vehicle policy. Umbrella policies provide coverage for accidents and other situations that can give rise to personal liability when basic coverage under other policy liability provisions is not sufficient to cover losses. Insurance carriers require substantial amounts of underlying coverage for known exposure as a condition to writing an umbrella policy. Typically, such coverage also extends to other types of situations not covered by a homeowners or personal vehicle policy, such as slander, libel, false arrest, invasion of privacy, defamation of character, damage to property in the care or custody of the insured, or claims against the insured resulting from serving as an officer or director of a not-for-profit organization. Liability coverage under an umbrella policy comes after the standard liability policy limits have been exceeded.

All known substantial exposures of an insured must be covered by an umbrella policy, and each exposure must be declared and a premium shown on the declaration page before coverage will apply. Even if a type of property is covered by an underlying policy, an absence of specification in the umbrella policy will result in no excess coverage in the event of a covered loss.

UMBRELLA POLICIES

Individuals may purchase umbrella liability coverage in order to provide higher limits of liability against many personal liability risks. Just as a business is required to have some basic liability coverage, such as General Liability coverage, before being covered by an umbrella policy, individuals must have basic liability coverage, such as that found in automobile and homeowners insurance, before they can be covered by a personal umbrella liability policy.

Umbrella coverage provides excess limits of insurance over the coverage from automobile or homeowners policies. The underlying policies would be the first to be tapped should an applicable liability claim occur. Once the limits of liability are expended from the homeowners or automobile policy, the umbrella policy's limit of liability is utilized.

Umbrella coverage also provides broader coverage than do personal automobile and homeowners policies. If a claim occurs to which an underlying policy does not apply, the umbrella policy will pay, after the deductible or self-insured retention requirements.

Exclusions to Umbrella Liability Coverage

Umbrella liability coverage generally includes the following exclusions:

- Owned or leased aircraft
- Most large watercraft
- Business use

- Professional services
- Liability to which workers compensation or similar benefits apply
- Intentional acts
- Property damage to property owned by the insured

Summary

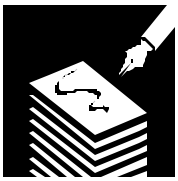
Umbrella Liability Coverage can be an important coverage to fully protect against personal liability risks. The umbrella policy can be coordinated with existing coverages to help ensure liability risks are adequately protected against.

UMBRELLA CLAIMS

Under an umbrella policy, the ceiling on a carrier's liability for loss assessments and damages resulting from a "single occurrence" will not exceed the liability limits of the policy. The limit is fixed notwithstanding the number of claims made by an insured, assessments of losses, persons involved, vehicles involved in an accident or the number of exposures or amount of premiums included in the policy.

Umbrella coverage is applicable only on a per-occurrence basis. One occurrence includes loss assessments, bodily injury and property damage resulting from either one accident or repeated exposure to substantially the same general harmful conditions and personal injury resulting from one or a series of related offenses.

If the underlying insurer becomes insolvent or the policyholder cannot pay the deductibles on a primary policy, the policy remains applicable only to the excessive coverage. It does not become a primary carrier in that event. In the case of litigation, if an insured or a carrier providing the underlying insurance chooses not to appeal a judgment exceeding the retained limits of the umbrella policy, the umbrella carrier can do so, provided it pays the expenses of such appeal. If the last party to contribute to a loss is the umbrella policy carrier, it has the first right to recover the full amount of its payment in the event subrogation rights are applicable.



BUSINESS CLAIMS

BUSINESS POLICIES

Business and commercial risk management may include the purchase of commercial and business insurance. Forms of insurance that may be purchased include property insurance, liability insurance, automobile insurance and surety and bond coverage. This chapter will briefly explain each of these forms of insurance, along with important related legal concepts.

Commercial Property Insurance

Commercial property may be insured through commercial property forms. As with other property casualty forms, Insurance Services Offices, Inc. has developed standardized commercial property insurance forms. These forms are generally issued as part of a Commercial Package Policy. Commercial property forms developed and filed by ISO include:

- Building and Personal Property Coverage Form
- Glass Coverage Form
- Builders' Risk Coverage Form
- Business Income Coverage (and Extra Expense) Form
- Business Income Coverage (Without Extra Expense) Form
- Extra Expense Coverage Form
- Legal Liability Coverage Form
- Leasehold Interest Coverage Form
- Mortgage Holder's Errors and Omissions Coverage Form
- Tobacco Sales Warehouses Coverage Form
- Condominium Association Coverage Form
- Condominium Commercial Unit Owner's Coverage Form

Building and Personal Property Coverage Form

The most commonly used commercial property form is the Building and Personal Property Coverage Form. It provides direct damage coverage on business buildings and structures and business personal property. It does not cover buildings in the process of construction.

The Building and Personal Property Coverage Form includes three coverage parts: Building, Your Personal Property and Personal Property of Others. Under the Building coverage, the business structure described in the policy, along with permanently installed fixtures, machinery and equipment, outdoor fixtures, personal property used for maintenance of the building and materials and supplies used for additions, alterations, or repairs of the insured structure are all covered. Under the Your Personal Property coverage, furniture, fixtures, machinery and equipment, stock and all personal property owned by the insured and used for the business are covered. Certain other personal property is also covered, such as the insured's interest in tenant's improvements and betterments. Under the Personal Property of Others Coverage, property that is in the care, custody and control of the insured and which is located in or on the business building as described in the policy is covered. Coverage also includes such property

on the premises but not in the building or on a vehicle within one hundred feet of the insured premises.

Builder's Risk Coverage Form

Buildings under construction may be covered by the Builder's Risk Coverage Form. This insured under this form may include the building owner, the general contractor and subcontractors. The coverage applies until the building is completed and occupied.

Glass Coverage Form

The Building and Personal Property Coverage form covers glass that is part of the building structure, but excludes coverage for vandalism and malicious mischief. The Building and Personal Property Coverage form also has a limit of coverage for glass of $100 per plate and $500 per occurrence. The Glass Coverage Form can be utilized to provide broader coverage with higher limits. Coverage under this form includes most causes of loss other than fire, war and nuclear damage. All glass covered under this form must be listed, or scheduled, in the declarations.

Business Income Coverage (and Extra Expense) Form

The Business Income Coverage (and Extra Expense) Form is one that covers indirect or consequential loss. It is a form of Business Interruption Insurance. It pays for loss of income while business property is being replaced or restored due to covered property damage. The insured can choose coverage based on a fifty percent, sixty percent, seventy percent, eighty percent, ninety percent or one hundred percent coinsurance provision, using the business' annual earnings over the one-year policy period. There is also available a one hundred twenty-five percent coinsurance option, used when reparations or restoration could take over a one-year period.

"Income" may be defined to include business income including rental value, business income excluding rental value or rental value only, depending on the type of business income to be covered and the insured's choice. If rental value is used, it is calculated based on the anticipated rent from tenants for the insured business, less expenses that do not continue and less the rental value of any part of the insured business occupied by the insured.

Business income is determined to be the net profit that would have been earned, plus any necessary expenses that continue during the restoration period. The amount that would have been earned is calculated based on the insured's actual experience before the loss.

Business Income Coverage (Without Extra Expense) Form

The Business Income Coverage (Without Extra Expense) Form provides generally the same coverage as the other Business Income Coverage Form, except that it does not cover extra expenses that arise due to the interruption of business.

Extra Expense Insurance

Extra Expense Insurance is used when a business would be able to continue operations in another facility should an insured place of business be damaged or destroyed. Extra Expense

Insurance pays for additional expenses incurred by the business when other facilities must be used due to damage or destruction covered by property insurance.

The ISO Extra Expense Form provides a scheduled method of payment. Generally, the business may collect up to forty percent of the form's coverage limit in the first month following the loss, up to eighty percent through the second month, and up to one hundred percent through the third month and following. The business has the option of choosing different schedules, such as one allowing ten percent the first month, twenty percent through the second month, and so on. The latter arrangement is likely to be used if the business expects that restoration of the destroyed or damaged property will take longer than three months.

Leasehold Interest Insurance

Leasehold Interest Insurance is used when a business has a lease that may be terminated due to fire or other damage to the leased property. Leasehold Interest Insurance would be useful for example if a business has a lease, a fire occurs, the lease is cancelled, and the business could not find similar other space for an amount equal to or less than the terminated lease. Under such circumstances, Leaseholder Interest Insurance will pay an amount, less a specified discount of five to fifteen percent, equal to the difference between the amount the insured would have paid had the original lease continued and the amount the insured must now pay. This difference is known as the *leasehold interest*. The insurance pays this amount based upon the period remaining in the original lease.

Important Concepts in Property Insurance

Certain concepts are fundamental in property insurance. Insurable interest, subrogation, indemnity and coinsurance are examples of concepts already discussed that are important in property insurance. A few more are detailed below:

Covered Property

Property insurance contracts carefully define which property is covered by the policy, and which property is not. Depending on the policy, property covered by the insurance may include property owned by the insured, property occupied by the insured, property rented by the insured, and property in the care, custody and control of the insured. Not all policies cover all types of property. It is important to understand the terms of the policy carefully in order to make sure the appropriate property coverage is selected to manage the specific property risks identified.

Covered Perils

Property policies also define the perils causing damage to the property that are covered. There are two general types of property policies: named or specified peril policies, and open peril policies. Under a named or specified peril policy, each covered peril is listed and defined within the policy. Under an open peril policy, the policy promises to pay for damage caused by any peril except for perils excluded from coverage.

Another type of property policy is a limited peril or limited coverage policy. Such policies cover only certain risks, such as pollution or rain.

Excluded Perils

War, pollution and nuclear hazards are all commonly excluded perils in property damage policies. Other policies may exclude items such as damage due to ground movement, or damage due to weight of snow, sleet and ice.

Limits of Insurance
Typically, the property coverage includes a limit of liability based on either actual cash value or the replacement or repair of the property.

Reporting Form Coverage
Some property policies require that the insured make regular reports to the insurer in order for the insurer to determine the coverage amount in force on the policy at any given time. Reporting form coverage is generally used for policies that cover inventory or merchandise that fluctuates in value over the year. Retail establishments may have more merchandise for the holidays than in late spring, for example, and therefore need higher amounts of coverage during the holidays, and lower amounts in the spring.

Reporting form coverage generally requires monthly reporting on the part of the insured, and gives the insurer the right to business records having to do with the insurance. If a report is missed, the insurer will use the last report received as the basis for calculating loss. If an insured fails to report the full value of the property insured (thereby resulting in lower premiums), the insurer will not pay any more for a loss than the value reported bears to the amount that should have been reported.

Conditions
The common conditions that are included in property policies include items such as:

- changes to the policy,
- fraud on the part of the insured,
- legal action against the insurer,
- subrogation,
- appraisal,
- policy period and territory,
- cancellation and renewal terms,
- assignment, and
- other insurance.

Commercial Liability Insurance

Liability insurance is an important tool in risk management. Financial loss due to liability has the potential to devastate a business. And, there may be no other time when the need for protection against liability litigation has been greater. Newspapers and the television news discuss high profile lawsuits almost daily. Employers, businesses, municipalities, the media, professionals, and common citizens are all targets. It appears that one can sue or be sued for just about anything. The number of liability suits filed has grown tremendously in recent years. Liability insurance may be used to help protect businesses, individuals and professionals against financial ruin due to liability claims.

Why Lawsuits Have Increased

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

befalls an individual is not seen as happenstance – it could have been avoided if some party had not failed to do the right thing.

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

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

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

Lawyers and Advertising

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

The Amount of Money in Litigation

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

Joint and Several Liability

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

also thought that joint and several liability rules may encourage bringing parties into lawsuits who previously would have been excluded because their liability was negligible.

Application of Contract Law

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

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

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

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

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

Liability and the Law

Because liability insurance is so important today, the legal concepts applied to liability are important to understand. Liability insurance provisions spring from statutes relating to legal liability and from insurance contract law.

Common Law

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

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

Tort Law

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

A tort is not a breach of contract. Contract law provides the remedy for acts that are considered to be a breach of contract. As has been mentioned, in recent years, some acts that were traditionally the subject of contract law have become the subject of tort law. A tort is remedied by an action for damages. A plaintiff brings suit against the tortfeaser – the party who is alleged to have committed the tort. The tortfeaser is the defendant in the suit. The plaintiff seeks to be awarded damages, an amount of money, for the injury or damage caused by the defendant.

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

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

Negligence

Negligence is the failure to use due and reasonable care. The standards for determining what reasonable and due care are can vary based on the tort and the parties involved. For example,

professionals are generally held to a high standard of care by the courts. Many professionals are in a position of trust – they may be responsible for a customer's financial, health, housing, or family welfare. If those within a profession are generally expected to be expert, capable, thorough and competent, a court hearing a case against such a professional will judge that conduct that is less than expert, capable, thorough, or competent, as less than reasonable and due care. A non-professional involved in a negligence case may have less stringent standards applied when a court is determining whether negligence exists. In order to establish the presence of negligence, four elements must exist:

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

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

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

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

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

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

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

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

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

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

Assumption of Risk
Under the assumption of risk defense, the defendant must prove that the plaintiff understood the risks involved, including the possibility of the damage and injury in question, and yet allowed the act to occur. Under such a scenario, the plaintiff is said to have assumed the risk of the activity, and so cannot hold another liable for resulting harm.

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

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

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

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

Types of Damages Awarded in Liability Suits
If the defendant is found to be legally liable, the court will require the defendant to pay damages to the plaintiff. These damages can include compensatory or actual damages, general damages, nominal damages, and punitive damages.

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

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

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

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

Protection Provided
Liability insurance is available to provide protection against various types of liability. Besides payment to parties to which the insured is deemed legally liable, the insurer will also defend the insured and pay defense costs. The insurer may also settle claims outside of court on behalf of the insured.

Coverages and Exclusions in Liability Insurance

Negligence
All liability policies cover some forms of negligence in the course of rendering services. They do not cover criminal negligence, however, because criminal acts cannot be covered by insurance contracts.

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

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

Legal Obligation for Damages

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

Claims Expenses

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

Damages

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

In some cases, punitive damages may not be covered even if they are not specifically excluded in the contract. The reason for this is that the basis for punitive damages may be fraud, malice (which is by definition a willful act) or the commission of certain criminal acts. Insurance policies will not pay benefits for any act which is fraudulent, willful or criminal.

In certain states, punitive damages can be awarded without the plaintiff establishing fraudulent, willful or criminal conduct on the part of the defendant. If punitive damages are awarded in such a state and the damages are not based on fraud, nor on a willful or criminal act, the insurer may pay them (up to the limits of the insurance and as long as the policy does not specifically exclude coverage of punitive damages). However, in states that require that fraud, malice or the commission of a criminal act be present in order for punitive damages to be applied, punitive damages would not be paid by the insurer, even if the policy terms do not specifically exclude punitive damages.

In some cases, courts have excluded punitive damages from insurance coverage because punitive damages are not for the benefit of the third party. They are awarded to punish the defendant. Since liability insurance is purchased for the benefit of the third party victim, and premiums are paid in order to compensate that victim, having insurers pay for them is against the purpose of the insurance. And, some courts have determined, if insurers are required to pay for punitive damages, premiums will rise for all, in effect causing innocent insureds to take the punishment for the guilty defendant.

Punitive damages, then, may or may not be covered by a policy. If a client has questions regarding whether punitive damages are covered, the insurance company's legal department may be the best place to find an answer. However, there may not be a definitive answer until a claim is decided by a court of law.

Intentional Wrongs

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

Types of Liability Forms

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

Commercial General Liability Forms

Commercial General Liability forms cover bodily injury and property damage liability, personal and advertising injury liability and medical expenses incurred for bodily injury caused by an accident on or by the premises owned or rented by the insured, or that arise from the insured's operations. The form does not cover injury to employees of the firm. Such coverage is generally provided through Workers' Compensation.

The definitions of bodily injury, property damage, personal injury and advertising injury provide an explanation of the coverage provided:

Bodily Injury

Under the Insurance Services Office, Inc., Commercial General Liability form, © *Insurance Services Office, Inc., 1994*, bodily injury means bodily injury, sickness or disease sustained by a person. Bodily injury includes death resulting from any of these at any time.

Property Damage

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

Personal Injury

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

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

Advertising Injury

Advertising injury is defined in the Commercial General Liability form as injury arising out of one or more of the following offenses:

- Oral or written publication of material that slanders or libels a person or organization or disparages a person's or organization's goods, products or services;
- Oral or written publication of material that violates a person's right of privacy;
- Misappropriation of advertising ideas or style of doing business; or
- infringement of copyright, title or slogan.

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

Claims Made and Occurrence Based Forms

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

Occurrence-Based Policies

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

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

Claims-Made Policies

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

Claims-made policies can have provisions for expanding the coverage period. They can be written with a *retroactive date* and/or an *extended reporting period*, or *ERP.*

A retroactive date, typically a date no more than six months before the policy inception date, moves the policy coverage to that earlier date. Injury or damage that occurs before the retroactive date is not covered. Any injury or damage that occurs from the retroactive date until the policy coverage ends is covered, assuming the claim is made during the policy period. The retroactive date is sometimes referred to as a *nose.*

An ERP extends the amount of time under which a claim may be made. ERPs may include two coverages: a relatively short ***mini tail*** and a longer ***midi tail****.* The mini tail provides an extended period of time, for example sixty days, to report claims that arise out of covered injury or damage that had not been reported during the policy period. The midi tail, which may be for a period of up to five years, gives an additional period to make claims that arise out of an occurrence that was reported during the policy period or during the mini tail period. ERPs may also provide just one tail coverage – one period of time to report claims for injury or damage that occurred during the policy period.

A Supplemental ERP can be purchased for some insurance that provides an unlimited period of time to report claims for an occurrence reported during the policy period. This is known as *full tail coverage.* There are two ways to purchase full tail coverage. One way is known as a *pre-paid tail*. The charge for the tail is part of the annual premiums paid. The other way is to purchase the coverage purchases at the end of the policy period. Such coverage must normally be purchased while the policy is in force or within a limited time frame after the policy period ends. The price of full tail coverage varies. Generally, however, the cost of a tail is from 175% to 250% of the last premium. The cost is higher for a tail because the likelihood of a claim is greater as time goes on. A benefit of many claims made policies is free full tail coverage upon death, permanent disability or permanent retirement.

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

Exclusions from Commercial General Liability Coverage

Commercial General Liability Coverage forms include several exclusions. As with all liability insurance, expected or intended injury is not covered. As discussed earlier, intentional loss is never covered by insurance. Also excluded is liability assumed under a contract, unless the contract is an insured contract. An insured contract includes leases, sidetrack agreements, easement agreements, and agreements and contracts of the insured's business whereunder the insured assumes tort liability of another.

Also excluded form the Commercial General Liability Coverage form is Liquor Liability. Liquor liability is liability arising from an insured who is in the business of manufacturing, distributing, selling, serving or furnishing alcoholic beverages which arises from causing or contributing to the intoxication of any person, the furnishing of alcoholic beverages to a person under the legal drinking age or under the influence of alcohol, or based on any statute, ordinance or regulation relating to the sale, gift, distribution or use of alcoholic beverages.

Liquor Liability Coverage Forms

However, Liquor Liability Coverage forms are available. These forms are for businesses that manufacture, distribute, sell, serve or furnish alcoholic beverages. Liquor liability coverage is available under both an occurrence and claims-made basis. The Liquor Liability Coverage forms available through ISO can be included in a Commercial Package Policy that includes commercial general liability.

Under the Liquor Liability Coverage forms, insurance is provided for damages for injury if the liability results from the insured selling, serving or furnishing any alcoholic beverage. "Injury" as defined under the coverage includes bodily injury, property damage, and damages for care, loss of services or loss of support. If the coverage is occurrence-based, the injury must occur during the policy period. If the policy is claims-made based, the claim must be first made against the insured during the policy period, as long as the injury does not occur before the retroactive date or after the policy period ends.

The exclusions to the Liquor Liability Coverage Forms include:

- Expected or intended injury
- Obligations arising out of acting as an employer
- Injury arising out of selling, servicing or furnishing alcoholic beverage when a required license is suspended
- Injury arising out of the insured's product causing the poisoning of an individual (product liability)

Workers Compensation, Employers Liability and Pollution

Also excluded from the Commercial General Liability Form is any loss payable under any workers compensation, disability benefits, or unemployment compensation law. Employers Liability is also excluded from the Commercial General Liability Form, as is pollution. Both Employers Liability and Pollution Coverage forms are available

Employers Liability

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

Pollution Liability

One way that pollution coverage may be provided is through the *Pollution Liability Extension Endorsement*. This endorsement modifies the Commercial General Liability form by deleting the portion of the policy that states that "bodily injury" or "property damage" is excluded which arises out of the actual, alleged, or threatened discharge, dispersal, seepage, migration, release or escape of pollutants:

- at or from any location which at any time was owned or occupied or rented or loaned to any insured, unless the "bodily injury" or "property damage" arises out of heat, smoke or fumes from a hostile fire;
- at or from any location which at any time was used by or for any insured for the handling, storage, disposal, processing or treatment of waste;
- which at any time were handled, transported, stored, treated, disposed of, or processed as waste by or for any insured or those for whom the insured is legally responsible unless "bodily injury" or "property damage" arises out of the escape of fuels, lubricants or other operating fluids which are needed to perform the normal electrical, hydraulic or mechanical functions necessary for the operation of "mobile equipment. " However, if the fuels, lubricants, or other operating fluids are intentionally discharged, dispersed or released, or if such fuels, lubricants, or other operating fluids are brought to the location with the intent to be discharged, dispersed or released as part of the operations being performed by the insured, a contractor or subcontracts, any resultant damages are not covered unless the "bodily injury" or "property damage" arises out of heat, smoke or fumes from a hostile fire;
- at or from any location on which any insured or contractors or subcontractors working for the insured if the pollutants are brought on or to the premises, site or location by the insured or contractors or subcontractors working for the insured, or if the operations are to test for, monitor, clean up, remove, contain, treat, detoxify or neutralize, or to respond to, or assess the effects of pollution in any way.

By deleting these provisions from the Commercial General Liability form, the insured is provided coverage in these areas.

Besides the endorsement, forms such as the Pollution Liability Coverage Form, the Limited Pollution Liability Coverage Form and the Pollution Liability Coverage Form for Designated Sites may be used.

Other Exclusions

Besides these exclusions, the Commercial General Liability Form excludes:

- liability arising out of ownership, maintenance, use or entrustment to others of aircraft, motor vehicles and watercraft owned, operated by, or rented or loaned to any insured
- liability arising from mobile equipment, such as bulldozers, farm machinery, forklifts and other vehicles not used on public roads, while transported by an auto, or when being used in any racing, speed or demolition contest, or while practicing for such a contest
- liability arising from war if liability for war is assumed under a contract
- damage to property owned by, rented to, or, if personal property, in the care, custody or control of the insured
- damage to premises sold, given away or abandoned, unless the premises are the insured's "work"
- property damage to the particular part of real property on which the insured or subcontractor is working, and to property that must be restored, repaired or replaced because of work incorrectly performed on it
- property damage to the insured's product that arises from the product
- property damage to the insured's work arising out of it or any part of it and included in the "products-completed operations hazard" unless the damaged work or the work out of which the damage arises was performed on the insured's behalf by a subcontractor.
- property damage to "impaired property" or property that has not been physically injured, due to a defect, deficiency, inadequacy or dangerous condition in the insured's product or work, or due to a delay or failure by the insured or anyone acting on the insured's behalf to perform a contract or agreement in accordance with the contract's terms.
- damages claimed for any loss, cost or expense incurred by the insured or others for the loss of use, withdrawal, recall, inspection, repair, replacement, adjustment, removal or disposal of the insured's product, work or of impaired property if the product, work, or property is recalled because of a known or suspected defect, deficiency, inadequacy or dangerous condition.

Businessowners Liability Form

The Businessowners Liability form includes the same coverages as the Commercial General Liability form, and defines them very similarly. This form also does not recognize coverage for economic damages. Businessowners forms are issued only to certain types of businesses. Eligibility may vary by state, but generally includes:

- Office buildings that are no more than six stories high and no more than 100,000 square feet. These office buildings may include apartments and certain wholesale, service or processing occupancies that do not exceed 15,000 total square feet.
- Apartment buildings and residential condominium associations. These buildings may include offices and certain wholesale, mercantile, service or processing "incidental" occupancies.
- Other buildings that are no more than 15,000 square feet that are occupied primarily for certain wholesale, mercantile, service or processing uses.

Certain wholesale and retail services businesses also are eligible for coverage under the Businessowners policy. Eligible wholesale businesses include:

- auto parts and supplies distributors;
- baked goods wholesalers;
- barber or beauty shop supplies distributors;
- coin, stamp or rare book distributors;

- drug distributors;
- fabric distributors;
- fruit and vegetable distributors;
- grocery distributors;
- hardware and tool distributors;
- hearing aid distributors;
- janitorial supplies distributors;
- optical goods distributors;
- toy distributors; and
- other wholesalers and distributors.

Service businesses able to purchase businessowners policies include:

- bakeries;
- barber shops;
- beauty parlors;
- dental laboratories;
- funeral homes or chapels;
- laundries and dry-cleaners;
- photocopy shops;;
- printers;;
- tailors and dressmakers;
- television or radio repair shops;
- watch, clock and jewelry repair shops; and
- similar small service businesses.

Both the Commercial General Liability and Businessowners Liability forms can be endorsed to add other liability coverages. Businessowners Liability forms can be endorsed to extend pollution liability coverage, covered tenants liability and many other types of liability coverage, similarly to the endorsements that may be added to the Commercial General Liability Form.

Professional Liability and Errors and Omissions Forms

The third type of liability insurance is Errors and Omissions and Professional Liability. This is the only type of liability form that meets the special liability needs of professionals.

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

Consent of the Insured

The terms *Professional Liability* and *Errors and Omissions* (E&O) are often used interchangeably to discuss liability insurance for professionals. There is a slight difference between the technical definitions of Professional Liability and E&O insurance, however. Under the strict definition of E&O insurance, an E&O's contract's provisions must state that the insurer is not required to have the insured's consent in order to settle a claim. Under a strictly defined professional liability insurance contract the insurer would have to have the insured's consent in order to settle any claim. In every other way, the two types of insurance are virtually indistinguishable from one another. The distinction regarding the insured's consent is not generally recognized by insurers today; many, if not most, "professional liability" policies allow

the insurer to settle a claim without the insured's consent. (Because the two terms are commonly used interchangeably within the industry today, and because many policies, whether called *Professional Liability* or *Errors & Omissions*, allow the insurer to settle without the insured's consent, this course also uses either term to describe insurance that covers the liability risks of professionals.)

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

Damages

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

Other Injury

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

Occurrence

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

Premises Liability

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

Employee Liability

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

Employment Practices Liability

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

Contractual Liability

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

License Protection Coverage

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

Why Professionals Need Special Liability Insurance

Professionals have unique concerns and issues related to liability exposure. The services performed by professionals are considered very significant to their customers. The customer's finances, health, housing, or other items of critical importance can be seriously impacted by a professional's work. If a money manager fails to purchase a new investment on a timely basis, if an accountant overlooks an important tax due, if a real estate agent does not submit a timely bid, the customer can suffer financial loss. If a doctor does not prescribe the right medication, if an engineer miscalculates the amount of stress a structure can bear, or if an architect is ignorant of an important municipal code, the customer can suffer both monetary harm and general loss. A mistake made by a professional that causes damage or injury to a customer can, of course, lead to a lawsuit. Because of the vital nature of services provided by professionals and the potentially serious consequences of an error or omission, they need liability insurance protection.

State Regulation

Another reason professionals may need liability insurance is that they may be required by state regulations to carry such coverage. Those who practice medicine are normally required to carry liability insurance in order to carry a state medical license. In many states, directors and officers of charitable organizations must carry liability coverage. Government entities may require that professionals doing business with them carry liability insurance. For example, in Florida,

anyone providing legal, architectural, engineering or any other professional services must carry an amount of liability insurance determined by the state department for whom services are performed. Specific business owners may be required to carry liability insurance as well. Oregon recently established a rule that new Tavern Owners and those who offer liquor at public events must carry $300,000 of liquor liability insurance.

Customer Requirements

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

Professional Association Requirements

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

High Standard of Care

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

Fiduciary Responsibilities

If the professional is a fiduciary, such as a lawyer, accountant, trustee, real estate broker, retirement plan administrator, or money manager, special liability concerns apply. Fiduciaries are in positions of trust. They must act in the best interests of the client at all times. The law expects the fiduciary to fulfill six specific duties, regardless of the type of occupation the fiduciary is in. These are loyalty, obedience, disclosure, confidentiality, reasonable care and diligence, and accounting.

Liability Insurance for a Group

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

Severability

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

Conditions for Coverage

In some cases, legal group coverage applies only if all members of the group carry their own individual liability policies as well. For example, a policy covering a partnership of doctors may

require that each doctor carry malpractice insurance. If so, the policy issued to the group will normally apply as excess insurance over each doctor's own policy.

Premiums

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

Umbrella Liability Insurance and Excess Policies

Umbrella liability insurance is purchased to provide additional, high limit insurance that applies to liability for damages that arise from a suit or claim. These liability policies are called "umbrella liability policies" because they provide broad coverage that encompasses many forms of liability and provide additional insurance over other insurance policies the insured owns.

In order to purchase an umbrella liability policy, the insured must already have General Liability insurance. The insurer may also require other forms of liability insurance as well, such as automobile liability insurance. The requirements for underlying coverages depend upon the coverages the umbrella liability policy provides. This requirement is known as *required underlying limits.* The reason for this requirement is that umbrella insurance is structured to pay for damages as excess over underlying policies. Premiums are calculated and provisions written based on this assumption.

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

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

Two types of payment clauses are found in umbrella liability policies. One is an *indemnity* clause which states that the insurer will reimburse or indemnify the insured for amounts which the insured becomes legally liable to pay or which are assumed under contract. The other is a *pay on behalf* clause which states that the insurer will make direct payment on behalf of the insured for amounts which the insured becomes legally liable to pay or which are assumed under contract.

An umbrella policy or excess insurance policy can be an excellent complement to a professional liability policy if the professional is subject to high damage awards, or to a general liability policy if a business is subject to risks beyond that which will be covered by a general liability form. Purchasing an umbrella or excess policy can be less expensive than purchasing a general liability or professional liability policy with a high liability limit.

Insurability Under Liability Forms

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

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

Responses To the Risks of Liability Claims

Liability suits and claims seem an ever-present risk for the business or professional. However, some liability risks can be reduced, and perhaps even prevented. The best ways to reduce these risks include raising the awareness of business staff of the key liability risks of the business, providing education and training in these areas, establishing and following procedures aimed at reducing liability claims, incorporating an unincorporated business to protect the business owners from losing personally owned assets, using contracts to limit liability, and purchasing liability insurance to reduce the financial consequences of liability claims.

Raising The Awareness of Key Liability Issues

Each business has different key liability issues related to that business. If the people within the business are not aware of these issues, he or she may be able to get information about them from professional associations, from lawyers who specialize in liability issues, or from liability insurers. By being aware of the items the courts are focusing on, activities in the business can be identified that could put the business at risk for claims or suits in these areas.

Education and Training

Many businesses have employees who need education and training on what activities or actions can put the professional's business at risk. Each member of a firm or business should have sufficient training to be able to competently perform assigned duties. Time put into training can seem to a small businessperson to be a drag on productivity and an unnecessary expense. However, a well-trained staff can be well worth the investment not only because of the satisfied clientele it helps to develop, but also because of the liability exposures that are eliminated or reduced solely due to competence.

In some professions, certain positions should be filled by licensed personnel. Again, if a license is not a legal requirement, a business owner may feel equipping staff in this manner is expensive and unnecessary. However, the pre-licensing training and continuing education that come with many licenses can provide liability protection for the professional employer.

Establishing and Following Procedures

Some procedures are critical to a business. Certain disclosures may have to be signed prior to taking on a customer. In some businesses, it is illegal to describe certain services or products in certain ways. For example, in the insurance profession, only certain policies can be referred to as "Medigap" policies, one cannot discuss a state guaranty association except under very limited conditions, and anyone selling annuities has to disclose that the annuity is not FDIC insured. In the securities industry, risks associated with any product must be disclosed and a prospectus must be provided to each purchaser. Every professional outside of a lawyer or tax professional is forbidden to give tax advice. To reduce liability claims it is important that the businessperson and those working with him follow the required procedures of his or her job. One of the best ways to make this happen is to establish procedures, train all staff on them, document them in a procedural manual, and verify that they are followed. By doing so, liability related to omitting such procedures may be avoided or reduced.

Billing disputes are a common subject of claims or suits. Billing disputes can be significantly reduced if procedures are established and followed. Business owners sometimes like to leave the accounting side of an operation to someone else, preferring to concentrate on the services the business provides. But the business owner or key executive is the one responsible for the liability risk, not the secretary who mails the bills, so the owner or executive should take the time to ensure proper billing procedures are in place. All types of billing situations should be contemplated: Will the business allow payments over time? What amount of penalties should be charged for late payments? How often should reminder notices be sent? When will a payment be considered so delinquent that it must be turned over to a collections agency? What amounts will be written off as uncollectible? All these questions should be considered, procedures developed and consistently applied. Additionally, customers should be required to sign a statement indicating their understanding of their responsibility to pay for services and goods, and the signed statement should be kept on file. Should a dispute occurs, the court will want to see that all customers are subject to the same billing rules, and that consistent documentation is kept.

Keeping Good Records

Keeping complete records of all services rendered to customers is important in virtually all businesses. Manufacturers, wholesalers, insurance agents, securities brokers, lawyers, accountants, doctors, dentists, psychologists, bankers and hair stylists all need to keep some form of client records to ensure they are providing appropriate services.

There are many important considerations regarding record keeping. First of all, consistency in record keeping is important. Using standardized forms and following the same steps in dealing with customers in similar matters helps if a liability case must be defended. Following consistent, thorough procedures and documenting them in files can demonstrate to a court that a reasonable standard of care has been met.

Records must also be kept in a safe place. Confidentiality of customer information is also a requirement in most professions and a consideration in the location of customer files. Another issue to consider is access. If too many staff members have access to the records unnecessarily, important documents may be lost or misplaced. Records should also be stored in fire proof cabinets. If the records are kept on electronic media, a back-up procedure should be established and followed.

Whenever a change is made to a document, the date of the change should be noted. If the change is of any significance, the reason for the change should also be noted.

Some professions, such as insurance agents and securities brokers, are subject to regulations regarding the types of records which must be kept, the number of years they must be kept, and where the records must be located (e.g. at a branch location or at the home office). Any professional subject to such rules should ensure that he or she has a complete understanding of these rules and that they are consistently followed.

Incorporating the Business

Another method of reducing the financial effects of a liability claim or lawsuit is to consider incorporating a business that is not yet incorporated. A corporation is liable for its activities, and only the assets of the corporation can be the subject of a lawsuit based on those activities. The personal assets of the corporation founder or an employee of the corporation cannot generally be targeted in a lawsuit based on the activities of the corporation. On the other hand, if a business is not incorporated, the owner's assets and possibly those of his or her spouse, can be at risk should a lawsuit be filed. Incorporating can protect a business owner from the financial devastation a lawsuit can bring.

Using A Well-Worded Contract

Another method for reducing liability is through the use of a well-worded contract. As mentioned, the tort courts have expanded their activity regarding contracts in recent decades, but a well worded contract is still the best protection against costly disputes. The majority of court decisions still honor the provisions of a legal contract. By clearly stating the services to be provided, including the scope, duration and all fees involved, the business can protect itself from most disputes regarding these matters.

Contract provisions which should be included in order to avoid disputes include provisions which provide:

- clear payment terms,
- a dispute-resolution method,
- indemnification terms, and
- a detailed scope of services.

Using Contractual Liability Limits

Certain businesses can include clauses in their contracts to limit certain types of liability. For example, a financial planner can use a contract with her customers that states that liability will be determined only on the basis of gross negligence or bad faith. Such language makes it more difficult for claims to be made which are not based on serious errors or omissions on the part of the business.

Performing Due Diligence

Due diligence is particularly important when a business is operated by a professional, such as a doctor, lawyer or financial advisor. A professional should practice due diligence whenever a professional relationship is contemplated. For example, an insurance agent should investigate the financial condition of an insurer prior to placing business with the insurer. A financial planner or stockbroker should investigate investments thoroughly before recommending them to clients. An accountant, lawyer or doctor should investigate the backgrounds of other professionals who seek to join a practice. The status of licenses should be checked if the profession is one in which a license is required. Licensing boards can generally provide information regarding any disciplinary orders or complaints. References should be thoroughly checked on any employee who will join a professional's business.

Purchasing Liability Insurance

Even if a business takes the aforementioned steps to reduce exposure to liability claims, lawsuits can still occur. Negligence, errors or omissions happen because the people making up a business are human. They can make mistakes.

Even if a mistake is not made, an unhappy customer can decide to file a suit. Being found error free does not mean that a lawsuit will not bring financial loss. A business can be found to be not liable and yet still undergo great expenses in defending a suit.

Purchasing insurance protection as a response to the risk of liability claims means that the insurer will pay for the damage award for suits to which the insurance applies. The insurer will also pay the expenses involved in defending the insured against the claim, up to the limits of the insurance. The business owner or risk manager that buys liability coverage has the security that should a lawsuit occur, the business will be able to afford the costs the lawsuit inevitably brings.

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

Liability insurance provides coverage against the risk that a lawsuit will be brought against the insured. Generally, the coverage protects against liability for acts resulting from the insured's negligence, but types of liability that do not require the presence of negligence, such as strict and imputed liability, may be covered. The basic types of liability forms available for businesses and business owners are commercial general liability forms, businessowners liability forms and professional liability forms.

Commercial Auto Insurance

Commercial auto insurance protects a business against property damage risks and liability risks associated with automobiles. Commercial automobile insurance is generally provided on the Business Auto Coverage Form. This form includes Liability Coverage and Physical Damage Coverage for autos defined as covered under the policy. The policy includes several different categories of covered auto, and the policy declarations must state which category is used. These categories are numbered and are as follows:

- **Symbol 1**: Any "Auto."
- **Symbol 2**: Owned "Autos" Only.
- **Symbol 3**: Owned Private Passenger "Autos" Only.
- **Symbol 4**: Owned "Autos" Other Than Private Passenger "Autos" Only.
- **Symbol 5**: Owned "Autos" Subject to No-Fault.
- **Symbol 6**: Owned "Autos" Subject to a Compulsory Uninsured Motorists Law.
- **Symbol 7**: Specifically Described "Autos."
- **Symbol 8**: Hired "Autos" Only.
- **Symbol 9**: Non-owned "Autos" Only.

Liability Coverage

Under the Liability Coverage, the insurer will cover amounts an insured must pay as damages because of covered bodily injury or property damage caused by an accident and resulting from

the ownership, maintenance or use of a covered auto. The insurer also pays all sums an insured legally must pay as a covered pollution cost or expense that is caused by an accident and resulting from the ownership, maintenance or use of covered autos. The insured will only pay for the covered pollution cost or expense if there is covered bodily injury or property that is caused by the same accident.

Insureds

Under the Liability Coverage *insureds* are defined as: *The person named in the declarations for any covered auto. Anyone else while using with the insured's permission, a covered auto owned, hired or borrowed by the insured, except:*

- The owner or anyone else from whom the insured hires or borrows a covered auto, unless the covered auto is a trailer connected to a covered auto the insured owns.
- The employee if the covered auto is owned by that employee or a member of his or her household.
- Someone using a covered auto while he or she is working in a business selling, servicing, repairing, parking or storing autos, unless the business is the insured's business.
- Anyone other than the insured's employees, partners, members, or a lessee or borrower or any of their employees, while moving property to or from a covered auto.
- A partner or member for a covered auto owned that person or a member of his or her household.
- Anyone liable for the conduct of an insured as described above, but only to the extent of that liability.

Supplementary Payments

The Liability Coverage also includes payment in addition to the stated limit of insurance of the policy for the following items:

- All expenses incurred by the insurer.
- Up to $2000 for cost of bail bonds, including bonds for relating traffic law violations, that are required because of an accident.
- The cost of bonds, within the limits of insurance, to release attachments in any suit against the insured that the insurer defended.
- All reasonable expenses incurred by the insured at the insurer's request, including actual loss of earnings of up to $250 a day because of time off from work.
- All costs taxed in any suit against the insured that the insurer defends.
- All interest on the full amount of any judgment that accrues after entry of the judgment in any suit against the insured the insurer defends.

Out-of-State Coverage Extensions

When a covered auto is away from the state where it is licensed, the insurer will increase Liability Coverage limits in order to meet limits specified by any applicable compulsory or financial responsibility law in the jurisdiction where the auto is being used, other than laws regulating motor carriers of passenger or property.

The insurer will also provide the minimum amounts of no-fault coverage, required coverage or out-of-state vehicles coverage applicable in the jurisdiction where the covered auto is being used.

Liability Coverage Exclusions

The Liability Coverage has thirteen exclusions:

- Expected or intended Injury

- Contractual liability
- Workers' Compensation
- Employee Indemnification and Employer's Liability
- Bodily injury to a Fellow Employee
- Property damage to property owned or transported by the insured or in the insured's care, custody or control, unless liability is assumed under a sidetrack agreement
- Covered pollution cost or expense involving property owned or transported by the insured or in the insured's, care, custody or control, unless liability is assumed under a sidetrack agreement
- Bodily injury or property damage arising from the handling of property
- Bodily injury or property damage arising from the movement of property by a mechanical device
- Bodily injury or property damage arising out of the operation of mobile equipment
- Bodily injury or property damage arising out of the insured's work after the work has been completed or abandoned
- Bodily injury or property damage arising out of pollutants
- Bodily injury or property damage due to war
- Autos used in any professional or organized racing or demolition contest or stunting activity, or while practicing for such a contest or activity
- Physical Damage Coverage
- The Physical Damage Coverage may provide Comprehensive Coverage, Specified Causes of Loss Coverage and Collision Coverage.

Comprehensive Coverage

Under Comprehensive Coverage, the insurer pays for loss to a covered auto or its equipment under the Comprehensive Coverage from any cause except the covered auto's collision with another object or the covered auto's overturn.

Specified Causes of Loss Coverage

Under the Specified Causes of Loss Coverage, the insurer pays for loss to a covered auto or its equipment caused by:

- Fire, lightning or explosion;
- Theft;
- Windstorm, hail or earthquake;
- Flood;
- Mischief or vandalism; or
- The sinking, burning, collision or derailment of any conveyance transporting the covered auto.

Collision Coverage

Under the Collision Coverage, the insurer pays for loss to a covered auto or its equipment under the covered auto's collision with another object, or the covered auto's overturn.

Other Coverage

The Physical Damage coverage also includes towing and labor costs when a covered private passenger auto is disabled. If Comprehensive Coverage is purchased, the policy will also pay for glass breakage, loss caused by hitting a bird or animal , and loss caused by falling objects.

Under a coverage extension, the physical damage coverage pays for certain transportation expenses, such as temporary transportation expenses due to theft of a covered private passenger type, up to $15 per day to a $450 maximum

Exclusions

The Physical Damage Coverage excludes physical damage due to:

- Nuclear Hazard
- War or Military Action
- Racing or Demolition Use
- Wear and Tear

Conditions

Conditions under the Business Auto Policy include:

Appraisal--If the insured and insurer disagree on a loss amount, either party may demand an appraisal. Each party selects an appraiser and the appraisers select an umpire. Each appraiser ill appraise the loss, and if the appraisers disagree, their differences are submitted to the umpire. Once any of the three, the appraisers an umpire, agree, the loss, if the insurer accepts the claim itself, will be valued based upon their agreement.

Duties in the Event of Accident, Claim, Suit or Loss-- The insured has several duties in the event of an accident, claim, suit or loss. For example, the insured must provide the insurer with prompt notice of the accident or loss along with required details about the incident.

Legal Action Against Us-- The insurer may not have an action brought against it until there has been full compliance with the contract.

Loss Payment – Physical Damage Coverages-- The insurer has the option to pay for, repair or replace damaged or stolen property, return the property and pay for covered damages, or take all or any part of the damaged or stolen property and pay an agreed to or appraised value.

Transfer of Rights of Recovery Against Others to Us-- This is the subrogation condition and allows the insurer to recover damages from a responsible party for payments made on behalf of the insured.

Bankruptcy-- Bankruptcy or insolvency on the part of the insured does not relieve the insurer of its responsibilities under the policy. Bankruptcy generally relieves an insured of debts. Under bankruptcy rules, an insured would therefore not be responsible for damages awarded under a lawsuit. However, several years ago many state legislatures decided that a liability insurer should pay harmed third parties even if an insured declared bankruptcy. State legislatures felt the third party should be able to collect damages and believed that since the insurance was paid for, the insurer should pay regardless of the bankruptcy. As more and more states adopted such legislation, insurers began making this bankruptcy condition a part of their liability policies, and today this clause is standard.

Concealment, Misrepresentation or Fraud-- Any insurance policy is void if the insured commits fraud in relation to the coverage, or intentionally conceals or misrepresents material facts in relation to the coverage.

Liberalization-- If the policy form is revised to provide more coverage without requiring additional premium, the additional coverages will apply to the policy

No Benefit for Bailee – Physical Damage Coverages: The Physical Damage coverage does not apply to any assignment, or grant any coverage for, the benefit of any person or organization

holding, storing or transporting property for a fee regardless of any other provision of the Coverage Form.

Premium Audit-- the initial premium for the policy is assessed on an estimated basis. At the end of the policy period, the final premium is calculated based on the actual exposures of the insured's business as it relates to the coverage. If the insured owes more premium, the insured will be billed for it, and if the insured is due a refund based on the final premium calculation, the insured will be paid the refund.

Policy Period, Coverage Territory-- This condition states that the insurance applies to accidents and losses occurring during the policy period and within the coverage territory.

Other Automobile Coverage Forms

Besides the Business Auto Policy, other forms are available to protect against risks associated with automobiles and other motor vehicles. We will provide a brief overview of the Garage Coverage Form, the Garagekeepers Coverage Form, and the Truckers Coverage Form.

Garage Coverage Form

The Garage Coverage form is used for businesses such as car dealerships, gas stations and parking garages, that garage cars, and are excluded under the Business Auto Policy. Risks included in this form that are excluded by the Business Auto Policy are those excluding liability for and property damage to property in the insured's care, custody or control. The Garage Coverage Form provides liability and physical damage coverage.

The Garage Coverage Form includes four sections:

- Section I - Covered Autos
- Section II - Garage Liability
- Section III - Garagekeepers Coverage
- Section IV - Physical Damage Coverage

Covered Autos

Like the Business Auto Policy, covered autos are defined according to a number listed in the declarations page. Covered auto categories are as follows:

Symbol 21: Any Auto.
Symbol 22: Owned Autos Only.
Symbol 23: Owned Private Passenger Autos Only.
Symbol 24: Owned Autos Other Than Private Passenger Autos Only.
Symbol 25: Owned Autos Subject to No-Fault.
Symbol 26: Owned Autos Subject To A Compulsory Uninsured Motorists Law.
Symbol 27: Specifically Described Autos.
Symbol 28: Hired Autos Only.
Symbol 29: Non-owned Autos Only.
Symbol 30: Autos Left With The Insured.
Symbol 31: Dealers Autos and Autos Held For Sale.

Garage Liability

The Garage Liability coverage pays for liability arising out of garage operations. Garage operations are defined as the ownership, maintenance and use of covered autos and locations of the garage business, and include all operations necessary or incidental to a garage business and the use of that portion of roads or other accesses that adjoin the business locations.

Who Is An Insured
Under the Garage Liability insurance, an "insured" for the purposes of any of the covered auto coverage is the named insured and anyone who uses a covered auto with the permission of the insured. Excluded from the definition of insured is generally:

- an owner of the borrowed or hired auto;
- anyone who uses a covered auto while working in an automobile or garage business which is not the insured's business; and
- an employee who uses an auto owned by the employee or a family member of the employee.

Garage Liability Exclusions
Exclusions under the Garage Liability form include:

- damage to property in the insured's care, custody or control;
- bodily injury to any fellow employee
- workers' compensation, disability benefits or unemployment compensation law or any similar law
- bodily injury or property damage due to pollution; and
- covered autos used in any professional or organized racing or demolition contest or stunting activity, or while practicing for such a contest or activity
- loss of use to property not physically damaged if the loss of use is the result of a delay or failure of the insured or anyone acting on the insured's behalf to fulfill the terms of a contract or agreement, or as a result of a defect or deficiency in the insured's product or work performed.
- damages that are due to products or work withdrawn or recalled from the market.

Garagekeepers Coverage

The Garagekeepers Coverage provides liability coverage for property in the care, custody or control of the insured. Another form of Garagekeepers Coverage called *Direct Damage Garagekeepers Coverage* is available. Direct Damage Garagekeepers Coverage pays for physical damage to property of others in the insured's custody.

There are three forms of Garagekeepers Coverage available: Comprehensive, Specified Causes of Loss, and Collision. Under Comprehensive coverage, liability for loss other than collision is covered. Under Collision coverage liability for loss due to collision or another object or the covered vehicle's overturn is covered. Under the Specified Causes of Loss coverage liability for loss due to specified losses including fire, lightning, explosion, theft, mischief or vandalism is covered.

Garagekeepers Coverage Exclusions
Exclusions under the Garagekeepers Coverage include:

- Theft
- Faulty work or defective parts
- Tape decks and sound equipment

Physical Damage Coverage
The Physical Damage Coverage provides three types of coverages: Comprehensive Coverage, Specified Causes of Loss Coverage and Collision Coverage.

Optional coverage under the Physical Damage Coverage for towing pays for towing and labor expenses performed at the place of disablement, if a covered vehicle is disabled. Glass breakage may also be covered under the Physical Damage or under the Comprehensive Coverage. Loss that is caused by hitting a bird, by falling objects or missiles may be covered under Comprehensive Coverage.

Truckers Coverage Form

Truckers who hire themselves out to transport goods may be covered by the Truckers Coverage form. This form provides liability and physical damage coverage and may be used in conjunction with the Business Auto Policy Form, or as a stand alone policy. The policy includes the following Sections:

- Section I - Covered Autos
- Section II - Truckers Liability Coverage
- Section III - Trailer Interchange Coverage
- Section IV - Physical Damage Coverage

The covered autos under a Truckers Coverage Form are also defined and designated by numerical symbols, as other commercial automobile forms do. The categories for covered autos under this form are as follows:

Symbol 41: Any Auto
Symbol 42: Owned Autos Only.
Symbol 43: Owned Commercial Autos Only
Symbol 44: Owned Autos Subject to No-Fault.
Symbol 45: Owned Autos Subject To A Compulsory Uninsured Motorists Law.
Symbol 46: Specifically Described Autos
Symbol 47: Hired Autos Only.
Symbol 48: Trailers In The Insured's Possession.
Symbol 49: Trailers In the Possession of Anyone Else.
Symbol 50: Non-Owned Autos Only.

Truckers Liability Coverage

The Truckers Liability Coverage pays for damages due to bodily injury or property damage caused by an accident and arising from the ownership, maintenance or use of a covered auto for which the insured is legally responsible. It also pays for defense of any suit asking for such damages as long as they are covered by the policy.

Insured

Under the Truckers Liability Coverage, an insured is the named insured for any auto. Also included as an insured is anyone else who uses a covered auto owned by the insured with the insured's permission, except for owners of private passenger type autos. Excluded from the definition of an insured is:

- anyone liable for the conduct of an insured;
- anyone who uses a covered auto while he or she is working in a business of selling, servicing, repairing or parking autos except if such business is the business of the insured;
- anyone, other than the insured's employees, partners or lessee or borrower an employee of a partner, lessee or borrower, while moving property to or from a covered auto; and

- a partner of the insured for a private passenger auto that is owned by the partner or by a member of the partner's household.

Truckers Liability Coverage Exclusions

Exclusions from the liability coverage include the following:

- Expected or intended injury
- Contractual Liability
- Loss payable under Workers' Compensation or similar law
- Employer liability
- Bodily injury to a fellow employee
- Bodily injury or property damage arising from the handling of property
- Bodily injury or property damage arising out of the insured's completed work
- Bodily injury or property damage due to most pollutants
- Bodily injury or property damage due to war

Trailer Interchange Coverage

The Trailer Interchange Coverage provides insurance for the truck while in the possession of the trucker who borrowed or hired it. The three types of coverage available under this form are Comprehensive, Specified Causes of Loss and Collision. Under the Comprehensive Coverage, the policy pays for loss to a covered auto from any cause except collision with another object or the auto's overturn. Under the Specified Causes of Loss Coverage, the policy pays for loss to a covered auto or its equipment caused by:

- Fire, lightning or explosion;
- Theft;
- Windstorm, hail or earthquake;
- Flood;
- Mischief or vandalism; or
- The sinking, burning, collision or derailment of any conveyance transporting the covered auto.

Finally under the Collision Coverage, the insurer will pay for loss to an auto or its equipment due to the auto's collision with another object, or the auto's overturn.

Physical Damage Coverage

Under the Physical Damage Coverage of the Truckers Coverage Form, the insurer pays for loss due to physical damage. Optional coverage for towing and related labor expenses is available under this form. Temporary transportation expenses incurred by the insured because of the theft of an auto are covered under either Comprehensive or Specified Causes of Loss Coverage.

Physical Damage Coverage Exclusions

The physical damage coverage includes many of the exclusions found in other forms of automobile coverage, including:

- Nuclear Hazard
- War or Military Action
- Racing or Demolition Use

- Wear and Tear
- Electronic Devices

Another exclusion under this form is the loss of an auto placed in the possession of another person under a written trailer interchange agreement.

Summary

There are several types of insurance that may be used for risks found in the commercial, business and professional arena. Property forms may be used to cover most risks of damage, destruction or theft of property. Liability forms may be used to protect against risk of financial loss due to many kinds of legal liability. Automobile policies protect against both property and liability risks associated with autos and other motor vehicles. A clear understanding of commercial insurance forms is essential for the agent working in the risk management arena to support and assist business customers in determining the best insurance plans for their risk management needs.

SPECIAL BUSINESS COVERAGE ISSUES

Outbuildings

A lot of commercial / industrial owners have dotted their properties with small sheds and storage buildings. Some have even advised their agents to remove these buildings from their schedule in order to reduce premiums since the perceived value is less than the deductible.

Clients should be made aware the cumulative loss of many of these buildings, however, can be substantial. Also, even though these buildings may have little or modest insurable value, the business property stored in them can be significant. Remember, under ISO forms, business personal property is only covered while in a described building or in the open within 100 feet of the premises. Also, don't forget the uncovered cost of "debris removal" if the buildings are leveled or burned

Independent Contractors

Many businesses use independent contractors. While the business owner is not liable for the actions of the independent contractor, third parties can sue the owner or make claim on the basis that the work created a dangerous situation, defective tools or equipment were supplied or that the contractor was negligently hired or supervised. In essence, anyone can sue!

To protect themselves, owners can require a hold harmless from the contractor, depend on the limits to their policy, be named as additional insured under the contractors CGL or require the contractor to provide an Owners and Contractors Protective policy.

Autos and Business income

Many businesses depend on their auto fleets to such an extent that when one is damaged it can be a threat to business income. In general, most commercial property forms exclude damage to business autos but do they cover the loss of income?

Most business income coverage is triggered by direct damage to property:

We will pay for actual loss of business income you sustain due to the necessary suspension of your "operations" . . . The suspension must be caused by direct physical loss of or damage to property.

Therefore, it appears that any resulting business income loss resulting in a suspension of operations would be covered. Of course, damage would have to be a result of a covered peril.

Triple Net Leases

Your clients sign leases to ret space for their business everyday. Many are "triple net" (NNN) agreements that make them responsible for heating, air conditioning, plumbing, carpeting, glass, water heaters, sinks, toilets, etc., included with the space. In the event of a major loss, the typical NNN lease includes a Damage and Destruction clause that makes the Landlord only responsible to rebuild the facility to an unfinished floor. This leaves your Tenant client responsible for damage to the occupied space. The average Business Owners Policy, however, covers personal property and *"real property acquired or made at your expense"* . This leaves a considerable "claim gap". In addition, consideration should be given for business income and extra expense exposures such as boiler and machinery coverages.

Uncovered claims for these exposures can be significant when you consider total losses in a major high-rise or factory. Heating and air conditioning systems alone can amount to six figures.

It is important that agents identify the extent of these risks and suggest adding a ***building component*** for the leased space and its fixturing. Here, all risks are clearly identified and assessed.

Leased Property Claims

Clients who lease a large amount of equipment for their business, like a restaurant, are typically responsible to the lessor to bear the entire risk of equipment destruction and/or replacement. Further, lease agreements typically require that the leasee provide insurance in the amount not less than the full replacement value of the equipment.

The problem is that a lot of ISO Business Policy forms get down to covering leased equipment ("property of others") at actual cash value, versus personal property owned by the business at replacement cost. So, in loss situations, the adjuster is offering ACV for damaged lease equipment, but the insured argues that his equipment lease is actually a "conditional sale" because at the end of the lease he is entitled to purchase it for $1 and the IRS views it as a "capital lease" for tax purposes. He wants replacement cost applied.

The solution? Unfortunately, there is no endorsement in older ISO BOP forms. The newer CP2000, however, has added a "Replacement Cost on Personal Property of Others" option. Even here, there is some tricky language that can result in something less than full replacement cost. In essence, your client tenants need to be aware of this situation.

Boiler and Machinery

There are certain ambiguities in many policies that create claim disputes. A typical Boiler and Machinery policy, for example, excludes:

Sewer piping, underground vessels or piping, any piping forming a part of a sprinkler system or water piping other than: Boiler feed water piping; Boiler condensate return piping; or Water piping forming a part of refrigerating or air conditioning system; . . .

A recent claim involved the underground air conditioning water pipes that cracked. The adjuster declined the claim even though the wording above seems to want to cover "piping forming a part of air conditioning systems". Had the class of coverage words . . ."Sewer piping, underground vessels, any piping forming . . . " been properly punctuated, say with semi-colons, they would be clear to be distinct classes resulting in less policy ambiguity.

This is yet another special issue to uncover and disclaim to your clients. Your assurance that it would be "covered" could place "you" in the role as insurer.

Third Party Claims Exposure

CGL policies generally exclude claims arising out of employment-related injuries. These are best left to workers' comp and employers liability forms.

However, there are certain cases where a third-party, like an employee, can file a claim that is excluded or partially excluded by all forms, leaving your client exposed. Take for example a case where a machine in your client's warehouse injures an employee. If he is severely injured, he will likely receive workers' compensation which also precludes him from suing his employer (your client). However, the WC policy does not cover liability claims and the state he resides in allows third-party claims. So, the employee sues the equipment manufacturer for $1 million. The manufacturer now sues the employer (your client) citing an indemnity agreement and negligent supervision. Your client's EL coverage cites an exclusion for indemnity agreements and the CGL cites a contractual liability exclusion.

New "Long-Tail" Exposures

The CGL form is under revision to clarify previous policy period damage. In essence, injury or damage known about prior to the policy period will not be covered in the current policy period. The change is in direct response to recent court decisions that have expanded the definition of "occurrence". These decisions have created so-called "long-tail" liability exposures for incidents that happened months or years prior to the policy period. Of course, your clients need to be aware of these changes.

WORKERS' COMP CLAIMS

Workers' compensation has been established under state law to provide compensation to workers who suffer occupational injuries or death and to their families for medical costs, loss of support and rehabilitation expenses. Workers' compensation programs are for the most part administered by the states, although the Longshore and Harborworkers' Compensation Act and the Federal Employees' Compensation Act provide coverage for federal employees. Although workers' compensation laws vary by state and under the two federal statutes, there are some common features, including:

- ***Claims***—When an employee is injured or killed due to an occupational-related injury or disease, a claim must be filed with the administrative agency or commission that administers workers' compensation laws. The most frequent type of claim filed is an "accident" or "injury" claim for damages resulting from accidents, such as vehicle collisions, slip and falls, machinery malfunctions, or mishandling and lifting and dropping large or heavy objects. Another common type of claim is one for an occupational disease or illness, such as silicosis- or asbestos-related diseases. Most states differentiate between the two types of claims. In some states, there is a third type of claim for safety-code violations, which allows for additional awards if the injury or death was directly attributable to violation of a safety law or ordinance. Claims which are allowed in the event of a death of a worker result in payment of support, funeral expenses and medical costs to a spouse, dependent children or others who depended on the deceased for their support during his lifetime.
- ***Compensation***—The type of compensation awarded depends to a large extent on the manner in which a disabled worker is categorized. Classification includes temporary complete disability, partial temporary disability, scheduled losses, permanent partial disability and total permanent disability.
- ***Occupations included***—Coverage generally extends only to employees and not to consultants, leased employees or independent contractors. Federal employees are not covered by state workers' compensation laws and regulations. One state requires coverage for conditions of hazardous employment.
- ***Funding of coverage***—In a few states, employers are not permitted to fund coverage with private insurance, but rather must pay into a state-maintained fund. A number of other states allow employers to provide coverage through private insurance, and in some instances, only larger employers may do so. In some states, self-insurance is allowed.
- ***Rights of an employer***—An employer is granted immunity from a lawsuit by a worker or his or her family in the event of occupational injury, disease or death. In some states, immunity does not extend to those situations in which the conduct of the employer was intentional.
- ***Construction of laws, regulations and policies***—Because workers' compensation is designed to protect employees and their families from becoming subjects of public welfare, regulations governing implementation and administration of the system are construed liberally in favor of an employee and his family.

Workers' Comp & Disability Insurance

A "disability" is defined as a condition or a diminished mental or physical function that adversely impacts the ability of an individual to earn his or her livelihood. The determination of whether one is disabled must be made by medical examinations, testing and evaluation. Usually, an

agency that administers workers' compensation claims is bound by a medical finding that one is disabled. However, the extent of benefits which a disabled person will receive depends on a determination by such agency as to what degree the condition affects the disabled person's ability to engage in employment.

Many businesses offer a type of insurance to their employees which covers long- and short-term disabilities. Some plans may also cover intermediate disability. The features of such a plan differ somewhat from employer to employer, but every plan has as its goal protection to an employee and his or her family in the event of a prolonged disability caused by a physical or mental condition. Following are some of the more substantial provisions of an employee-sponsored disability plan:

- ***Eligibility***—Disability plans are usually available to regular, salaried or hourly nonbargaining employees located in the United States, who work a minimum of 20 hours a week and who contribute a nominal amount to the plan through payroll deductions. Excluded from coverage are temporary employees, members of labor unions whose bargaining agreements do not provide for participation in such a plan, and those who do not work more than six months in a given year. Also excluded from coverage are disabilities arising from self-inflicted injuries, losses that happen during the commission of a felony and injuries sustained during a war.
- ***Disability***—Many plans do not contain an exhaustive list of what conditions may cause a person to be considered disabled. Disability plans typically cover conditions that arise both on and off the job. The determination as to whether a qualifying disability exists is left in most cases to the results of a thorough medical examination. A company may accept the medical evaluation of a physician chosen by an employee, while reserving the right to require the employee to submit to a medical examination by a doctor chosen by the company. Some plans require an employee to be totally disabled and others may extend coverage in the event of a partial disability.

  An employee who is considered disabled for purposes of short-term coverage may not be sufficiently disabled to qualify for benefits under intermediate- or long-term provisions of a plan. For example, under a short-term disability plan, pregnancy may qualify as a disability. Further, for the first two years of coverage, disability may be defined as a condition that renders the employee unable to perform his or her normal occupation. After the expiration of a two-year period, an employee may be considered disabled only if unable to perform any job for which he or she is reasonably qualified by training, education or experience.

  Preexisting conditions may disqualify an employee if a physician was consulted or medical care was obtained within three months before coverage under the plan began. Sometimes, coverage will be allowed if the disability began after an employee worked full time for a year and was not absent due to the disabling illness or injury.

  Additionally, employees may be excluded from coverage if a disability was caused by intentional self-infliction of an illness or injury, act of war, insurrection, terrorism or riot, or during the commission of a felony. Thus, one who attempted suicide would not be eligible to receive any kind of benefits under an employees' disability plan.

- ***Types of coverage***—Eligible participants are usually covered automatically under short-term disability provisions and further enrollment is required for coverage under long-term disability provisions of the plan.
- ***Short-term disability***—This coverage usually applies to a disability that endures for a six-month period. A salaried employee who has completed a brief period of employment, usually two or three months, will receive all or part of his or her base salary in the event of a

short-term disability. The amount of benefits received depends on the length of service an employee has provided the company and the duration of the disability. For example, a disabled employee who has worked for a company for at least one year may receive 100 percent of his or her salary for one month, and thereafter, 60 percent of such salary for another five months.

- ***Long-term disability***—After an employee has been totally disabled for an extended period of time, typically six months, he or she becomes eligible for benefits under the long-term provisions of a plan if he or she qualifies as long-term disabled under the definition of the governing plan. Definitions may be liberal, such as "unable to perform the tasks of the occupation for which the person is trained" or a more conservative one, such as "unable to perform the tasks of any occupation for which the person might be trained." An employee and the employer share the costs of the premium for long-term coverage. Such cost is normally a small percentage of the employee's base earnings. Benefits under the long-term disability provisions of a plan are set at a modest amount to deter fraud and malingering, and customarily consist of payment of 60 percent of the employee's base salary for so long as the disabling condition exists. If a disabled person is receiving Social Security benefits at the same time, such payments are added into the maximum amount of disability benefits.
- ***Reduction of payments***—Under a typical disability plan, an eligible employee may be subject to a reduction in his or her benefits if he or she is also receiving other benefits, such as workers' compensation, primary, family or spousal old age Social Security disability and retirement benefits, disability benefits under state law or no-fault motor vehicle insurance, retirement benefits or periodic benefits in the nature of retirement benefits paid by any employer, maritime benefits under the Jones Act and payments received from a lawsuit involving subrogation of a third-party insurance carrier.
- ***Application for Social Security benefits***—Some plans require an employee who seeks benefits under a long-term disability plan to apply for SSDI at the same time. If an employee receives SSDI, the benefits under an employee plan will be reduced by the amount of SSDI payments.
- ***Continuation of other employee benefits***—A number of plans allow an employee to participate in other employee benefits. Normally, one collecting short- or long-term disability payments will also be permitted to take part in company-sponsored life, medical and dental plans, provided the employee makes all required contribution for the costs of those plans. Personal accident insurance coverage may be available for several years after the date of disability, if an employee pays the premiums.

Investigation of a Disability Claim

Once it is determined that a claim for workers' compensation coverage will be investigated, the examiner will obtain a statement about the circumstances, secure a medical authorization, verify the accident or injury with the employer and interrogate witnesses.

Work-Related Injuries

The most significant requirement is that a claim for workers' compensation must be based upon a "work-related" injury. An investigator must determine if an injury or death is related to, arose out of or is in connection with the claimant's work. To that end, if an employee was engaged in off-site errands or other activities not directly connected to employment, he or she must determine if the employer received an indirect benefit from such activities. If the claimant contends that he or she was entertaining customers or clients, the crucial issue to be determined by an examiner is whether the employee was engaged in work-related or personal activities. Likewise, if an employee was engaged in personal activities while on the job-site, the primary consideration in an examination of a claim is whether the activities were more personal in nature, rather than in furtherance of employment.

Preexisting Medical Conditions

As a general rule, an employee who suffers a work-related injury that results in exacerbation or aggravation of a preexisting condition may be entitled to workers' compensation benefits. Where this is the foundation of a workers' compensation claim, an investigator will have to determine the nature and extent of preexisting conditions by reviewing medical records for previous injuries or conditions. An examiner may also investigate to see if reimbursement from another carrier for expenses paid may be appropriate.

Occupational Diseases

Under the workers' compensation laws of some states, occupation-related diseases are covered. Some of the more common occupational diseases include hernias, histoplasmosis, allergies, hearing loss, dermatitis, infertility, black-lung disease, lead poisoning, asbestosis, carpal tunnel syndrome and a variety of mental disorders. One of the more difficult tasks of an investigator involved in a claim for an occupational disease can be to determine if the disease arose from the work environment or from other aspects of the claimant's environment that had nothing to do with work.

Activity Checks

Insurance carriers commonly employ independent investigators to monitor the activities of a claimant to make certain there is no inconsistency with the injuries or disabilities reported. Neighbors may be interrogated about a claimant's activities. Public records will also be searched for evidence of prior claims or litigation. It is not uncommon for the investigator to conduct surveillance. All such information is admissible at a hearing.

Medical Authorization

During the investigative stage, an adjuster will ask a claimant to sign a medical authorization which will allow for the release from the attending physician of medical records. Medical records allow the adjuster to document the facts underlying the accident or the occupational disease and should show if drugs or alcohol were involved.

Stress-Related Illnesses

In the last two decades, more and more courts have been allowing benefits under workers' compensation laws for stress claims in the workplace, if a connection can be made between a work-related incident and a specific disability. Massachusetts, California and Michigan have been the leaders in such a trend. Establishing causation becomes to a significant degree the job of the examiner who must take a daily history of the claimant, asking such questions as the nature of work the claimant was involved in, witnesses to the underlying situation, whether any voices were raised, the presence of any intimidating factors, undue influence carried out by the claimant's superiors and whether the type and amount of work or deadlines imposed were unreasonable. Additionally, an adjuster will have to probe into the non-work related environment of an employee to see if anything contributed significantly to his or her stress.

Evaluation of a Disability Claim

A person who is injured on a job due to the negligence of his or her employer or another employer may be entitled to pursue a liability claim in court. By pursuing third-party claims, it may be possible to recover for pain and suffering that cannot be realized under workers' compensation laws. When a set of facts such as these exist, an examiner or adjuster for a carrier must evaluate whether the carrier may be subrogated to the rights of the claimant with respect to the third party, or if a carrier can seek reimbursement from the third party.

Independent Medical Examinations

An independent medical examination may be required by a carrier for the purposes of confirming the claimant's injury, to determine the length and extent of treatment and establish a

time for the claimant to return to work. If the independent medical examiner's report differs from that of the claimant's personal physician, a hearing may be required. If both doctors determine that a claimant is able to return to work on a limited basis, the carrier may only be required to pay the difference between prior gross weekly earnings and what is now earned on a part-time basis.

A Claimant Who Resides in One State and Works in Another

In some cases involving a worker who resides in one state and works in another, the carrier may be saddled with higher benefits if the prescribed amounts vary from one state to another.

Evaluation of a Claim Under a Private Disability Plan

The evaluation of private disability claims may be confusing because of the variety of definitions of disability that arise under state laws. In one state, a person is considered to be totally disabled if he or she is unable to work with reasonable continuity in his or her ordinary and customary occupation or profession or in any alternate job which he or she may reasonably be expected to engage, considering such factors as past employment, job opportunities, education, physical status and mental capacity. Adding to the complexity is a practice by a number of carriers to use definitions of disability that are not the same as or are inconsistent with the definitions used under governing state law.

In assessing or evaluating a disability, the adjuster must satisfy him/herself that a claimant's physician fully understood certain facts about the claimant, including the job description, the nature and history of the claimant's employment, his or her educational level and whether, considering his or her physical condition, the claimant can be expected within reason to work. A carrier that uses its own doctor to evaluate a claimant may receive information that conflicts with that of the claimant's physician.

Disposition of a Disability Claim

Medical Bills

Upon approval of a workers' compensation claim, the insurance carrier will begin making payment of medical bills. Medical providers must be notified that an injury is work-related. Up-front payment may be required. All bills are paid by the carrier until the claimant is discharged officially by the treating physician.

Lost Wages

The number of weeks for which lost wages are to be paid is determined by state laws and may last as long as one year. When a carrier receives the average gross earnings for the required statutory period, he or she takes a percentage, and this figure becomes the compensation rate, which is also determined by state law. Under state laws, there is a maximum amount a carrier is required to pay. Thus, if an injured worker was making $500 a week in gross wages before the injury, the applicable percentage under state law would be 80 percent, with the carrier not being required to pay more than $375 per week and the claimant not to receive more than $375 per week in lost wages. Under the laws of some states, a carrier may be required to add payment for dependents of the claimant.

Claims That Are Denied

When a claim is denied, a carrier must notify the applicable state regulatory agency. In some states the department is known as the Department of Workers' Compensation, and in others as the Industrial Accident Board. The state agency must then notify the claimant of the denial, the reasons for the same and advise the claimant of his or her right to a hearing or an appeal. If a

claim is denied, the claimant can either accept the denial or request a hearing. Legal fees are typically assessed to the party who loses.

Settlement

When a workers' compensation case is settled, there is no signing of a release as there is in a liability case. Claims may remain on record for several years. However, if a claimant settles for permanent loss of function, the carrier will be released from further action in respect of that portion of the claim. Some states require the department that administers workers' compensation benefits to approve such a settlement before it is effective.

LIFE & HEALTH CLAIMS

HEALTH CARE INSURANCE

Health care insurance plans are the most common type of benefits provided by businesses to their employees. The primary types of health care insurance are individual and group coverage. Benefits are provided in group insurance to a specific mix of individuals whose eligibility is established because of their relationship to a particular group, such as an employee or trade association. Typically, group coverage ends when an individual ceases to be part of the group, unless continuation or conversion options are exercised.

Individual health care policies are usually sold to individuals or families. Sometimes referred to as personal insurance, the cost, coverage and availability vary from one carrier to another. Premiums are frequently quite higher because of the reduced opportunity to spread the risk among a larger pool.

During the 1980s and 1990s, health care costs continue to be among the most rapidly rising of all classes of expenses measured by the Consumer Price Index. The most pressing reasons for the inflationary spiral are escalating costs of physicians, nurses, medical equipment, buildings and other health care costs which rose at rates twice the increases in the Consumer Price Index. Other reasons include the exorbitant costs of research, development and production of technological improvements, staggering premiums for medical malpractice, the expenses attending the practice of defensive medicine, the rise in hospital labor costs, shifting of costs from the government to the private sector, the increase in the use of outpatient care, expenses arising from catastrophic cases such as AIDS, and an individual indifference based upon a perception that such high costs are solely the problem of the health care insurance industry.

Following are some of the more common health care plans:

- ***Comprehensive health care plan***—This type of health care plan is one that includes both major medical and basic protection coverage. Benefits which cover expenses for physician services and hospitalization make up basic coverage. Reimbursement of up to 80 percent of hospitalization expenses typically extends to such items as the room, medications, intravenous fluids and laboratory work. Some policies may also offer surgical benefits. Physician-cost benefits cover visitations by a doctor during hospitalization. Routine physicals are not covered. The purpose of major medical insurance is to cover those services not included in basic protection coverage and to insure against the catastrophic expenses of an extended illness. The deductible is rather significant, since such coverage is not intended to pay for ordinary and customary medical expenses.
- ***Cafeteria benefit plans***—In such a plan an employer offers an employee a variety of options or benefits in place of a comprehensive health care plan. For example, an employee might elect to take only catastrophic health care in exchange for more vacation or subsidized child care. Employees are allowed to mix a variety of benefits according to their own individualized wants and needs. In some cases, an employer may establish a spending account on behalf of an employee, against which expenses for health or dental care may be drawn.

- ***Catastrophic plans***—This is a plan which is intended to cover a situation in which there is a serious illness or injury necessitating extended hospitalization. Such a plan involves a substantially high annual deductible (typically $5,000 per person and $10,000 for a family). Catastrophic plans pay 80 percent of covered expenses until a large amount of individual or family expenses are paid (usually $25,000 for an individual and $50,000 per family, annually), and then coverage increases to 100 percent. The primary advantage of a catastrophic plan is that premiums are considerably lower than for a comprehensive health care plan.
- ***Health maintenance organization***—An HMO is an alternative to a traditional health care plan. Participants in an HMO pay a monthly fee in exchange for comprehensive medical services. The fee is the same regardless of the degree of use by a participant, although some HMOs charge a nominal amount for office visits. HMOs may be for-profit or nonprofit and some are owned by large insurance companies. Some HMOs allow their staff doctors to have an independent private practice. HMOs typically provide complete coverage for such items as physician's services, home health services, inpatient and outpatient hospital services, diagnostic and laboratory procedures, treatment for drug and alcohol abuse, emergency health services, preventive health care and limited mental-health care.
- ***Preferred provider organization***—A PPO is a plan in which a provider, such as a hospital, pharmaceutical company or a physician, enters into a contract with an insurer or an employer to provide health care at lower rates to groups of employees. Discount rates are offered to an insurer or an employer in exchange for a higher volume of patients. Employees who participate in a PPO are offered a greater variety of physicians and medical facilities to choose from than those who take part in an HMO. Employers penalize employees who go to a physician or facility of their choice by only paying half of their medical costs.
- ***Managed medical system***—This is a health care plan which blends the features of both an HMO and a PPO. Under an MMS, providers must offer good care at a reasonable cost. If a participant elects to seek treatment from a provider of his or her own choice, the penalty is a large deductible. Like a PPO, an MMS is a prepaid system.

Exclusions From Group Health Care Plans

There are a number of conditions that are excluded from group health care policies, including the following:

- ***Custodial care***—There is no coverage when an insured is in a facility such as a nursing home where the primary purpose of confinement is not improvement of the general health of a policyholder.
- ***Physical examinations***—Except for HMOs, group health care plans do not cover routine physical examinations.
- ***Cosmetic surgery***—Elective cosmetic surgery is not covered.
- ***Preexisting Conditions***—These medical conditions are ordinarily excluded or allowed only under restrictive conditions.

Investigation of a Claim Under a Health Care Policy

Review of Contract

One of the first steps usually taken by an insurance adjuster who is investigating a health care claim is to review the contract to see if a claimant has complied with all of the necessary terms and conditions that are a condition precedent to resolution of a claim. If a claimant intentionally or unintentionally failed to include material facts on the application for coverage, such as his or

her medical condition and history, age or any other facts upon which the carrier would have relied in deciding to extend coverage, the carrier may cancel the contract. A carrier may also be able to obtain medical information about a claimant from the Medical Information Bureau ("MIB"), which was established for the specific purpose of preventing consumers from perpetrating fraud upon insurance companies.

When an application is taken for health care, disability or life insurance, a provision may be included on the form requesting permission for a carrier to go to the MIB for a report on any medical information on file about an insured. Medical records that are used in connection with applying for insurance or pursuing a claim are kept by the MIB for a period of seven years. There is no guarantee that information traded among MIB subscribers is correct.

Preexisting Conditions

A preexisting condition is one that affected the policyholder before the effective date of the present health care plan. In order to be classified as such, a medical condition may have had to be obvious for a specified number of months before the present policy, and the policyholder either sought or should have sought medical treatment for the condition. Many policies contain provisions which limit or deny coverage for preexisting conditions. When a claim for health care coverage is filed, an examiner will routinely check to see if the condition for which coverage is sought is a preexisting condition.

Evaluation of a Health Care Claim

Usual and Customary Fees

During the evaluation of a health care claim, an insurance examiner must determine if the charges of a health care provider are "usual and customary fees," since most health care plans limit payment for covered items accordingly. The issue of what is usual and customary is determined on a theoretical basis according to the prevailing rates for the same or substantially similar services in a given geographical area. Usual and customary fees are ordinarily detailed in a health care policy for specific medical and surgical treatments, and in reality may only be a high percentage of what health care providers in the area in which the insured lives typically charge.

Reasonable and Necessary Treatment

Health care claims may be denied when a policy excludes coverage for medical procedures and treatment that are not "reasonable and necessary." One of the most perplexing questions facing consumers and the insurance industry is: Who is the proper party to determine if a medical treatment is reasonable and necessary? Naturally, a carrier claims that its physicians and other medical personnel have the right to make the decision, and the policyholder insists upon his or her own personal physician making the determination. Several state courts have ruled that coverage should be afforded to a claimant who relied upon treatment of his or her own physician, unless the carrier can prove that the attending doctor’s judgment was contrary to established medical practice or unless he or she was guilty of using bad judgment.

If a policy is ambiguous with respect to what medical treatments are reasonable and necessary, courts have been inclined to resolve the matter in favor of a claimant. Pretreatment screening should eliminate the question of whether a procedure is reasonable and necessary.

Disposition of a Health Care Claim

The settlement or disposition of a medical claim can be both a time-consuming and complicated process because of the usual involvement of more than one party. Once a policyholder obtains a claim form from his or her employer or group policyholder, it is necessary to provide a form to the doctor and to other health care providers who performed services or treatment. Attending physician's statements must be filled out by the doctor's office and returned to the carrier. Frequently, further clarification and supporting documents are required from the physician's office. If a second opinion was necessary, further delay will be occasioned. Calculations of deductibles may also be involved in determining the amount of coverage and the disposition of a claim.

Multiple Claims

When health care plans were not so expensive, it was uncommon for a consumer to be covered by more than one policy. When an injury, illness or disability occurred, both companies paid. One contract would reimburse the provider while the other would pay the insured. In an effort to reduce mounting health care insurance costs, carriers began inserting "coordination-of-benefits" clauses, which allowed a carrier to coordinate payments with other carriers that could be covering one individual through a homeowners policy, a personal vehicle insurance policy or some other group or nongroup policy.

As a result, the primary carrier now pays the full covered benefits and a supplemental carrier pays the unpaid balance. Industry guidelines determine which is the primary and which is the secondary carrier.

Experimental Procedures

Frequently, a question arises as to whether an experimental procedure qualifies as a regular and customary procedure. If it does not, there may be no coverage. In most cases, coverage does not apply to experimental procedures, giving rise to an inordinate amount of disputes between a policyholder and a carrier over the issue. When the nature of the treatment is in question, coverage will not apply unless the five criteria, measures of the medical necessity of a procedure, are satisfied. They include:

- The procedure must be appropriate and required for treatment and care of the injury or the illness.
- The treatment must be provided in accordance with accepted principles of medical practice in the United States at the time of the procedure.
- The expenses must be approved for reimbursement by the Health Care Financing Administration.
- Any appropriate technological assessment body established by any state or federal government shall not have deemed the procedure to be experimental, investigational or educational in nature.
- The procedure shall not have been provided in connection with medical or any other type of research.

Extension of Benefits After Termination of a Policy

If a claim is for medical expenses incurred after termination of a policy, coverage may not be available in some instances. In Edwadine Forbau v. Aetna Life Insurance Co., the Texas Supreme Court ruled on the limits of coverage a carrier is faced with when an accident or illness occurs during coverage and expenses relating to the same continue after termination of coverage. A child of the insured, a 14-year-old girl, sustained permanent disabling injuries during a car accident. Two years after the accident, the insured's employer terminated the group contract with the carrier. Benefit payments continued for approximately another year.

Stating the issues, the appeals court said: "in this case we are called upon to determine whether the...policy...created a vested right in unlimited benefits, or restricted benefits to the recovery of medical expenses incurred while the policy was in effect..." The Supreme Court held that Aetna was only obligated to cover the daughter's medical expenses as long as she was a covered family member. When the policy was terminated, coverage was discontinued.

LIFE INSURANCE

A policy of life insurance provides protection against the financial strains caused by the premature demise of a provider. There are some life insurance policies which also provide a source of funds for retirement income.

At first glance, the subject of life insurance might seem rather simple, but a more in-depth look reveals a number of complex issues surrounding the topic. Questions such as vested interest, issues surrounding the calculation of premiums and the cost of life insurance, the consideration of gender on the amounts of annuity payments and the part life insurance has as a savings vehicle make for some very challenging issues. Life insurance can be sold in one of three ways—by group insurance, by individual life insurance or by industrial or debit life insurance.

Group life insurance is provided to a specific array of people who are brought together or associated for some objective other than just purchasing life insurance. Examples of groups that might be covered are participants in the National Football League, members of a teacher's association or federal government workers.

Group life insurance provides a benefit for a specified period of time, ordinarily a year. When the term expires, the policy can be reissued.

When an insured dies, the designated beneficiary is paid the stated death benefit, typically a flat amount. Premiums are predicated upon the average age of the participants in the group. The average age, as is the underlying premium, is based upon the age and number of individuals entering and leaving the group.

Most policies allow an employee to convert to individual coverage in the event of termination of employment. However, conversion is limited to permanent life insurance. Credit life insurance is a specific kind of group life insurance which is bought by a lender for its debtors, typically made available by retail stores, credit unions, banks or other lending institutions who sell merchandise to their customers on an installment basis. Credit life insurance tends to be rather expensive. Group life insurance benefits are determined by a preset method such as the amount of compensation the insured receives in one year. The maximum amount of individual benefit may be set by state law.

Industrial life insurance, tailored to meet the needs of low-income workers, is basically burial insurance. Usually it is purchased in small amounts, rarely exceeding several thousand dollars. Premiums are collected on a weekly or monthly basis. The cost of industrial life insurance is so excessive due to administrative expenses that some critics of the industry have lobbied for its abolishment. Industrial life insurance in general has little consumer appeal, but does serve a purpose to those families whose option without it would be no life insurance.

Individual life insurance, sometimes referred to as ordinary life insurance, is written in large amounts. Premiums are ordinarily collected on a periodic basis—quarterly, semiannually or annually. There are two types of life insurance—cash value and term. In "term life" insurance, a policy is written for a period of one to five years, and can be renewed with an increase in the

premium as the insured becomes elderly. If an insured dies within that term, the beneficiaries are paid a cash settlement. A term policy has no cash value. Term insurance can be purchased with an option to convert to a cash-value policy. Many people buy term insurance and receive no payments from the carrier because they do not die before the end of the term.

There are several kinds of term life insurance. A "single-year term" will pay the insured if he or she dies within a year of having purchased the policy. Longer-term policies are available for 10, 15 and 20-year periods. "Terms to a specified age" policies pay if the insured dies before the age designated in the policy. "Multi-year-term" policies have benefits that increase, decrease or remain level each year the policy is in force. A "level-term" policy pays the same amount of benefits if the death happens while the policy is effective. "Renewable-term" policies permit an insured to continue coverage up to a specific age regardless of his or her health. Premiums increase each time a term is renewed since the insured will be older. "Convertible-term" policies provide an insured with an option to convert his or her policy to a whole-life policy. If an insured desires to continue the policy on a permanent basis, the option is advantageous.

Term-life insurance is most useful for taking care of a number of financial needs. A level-term policy can be used to meet educational needs in the event of the premature death of an insured. Debt retirement funds can be established by the use of a term policy where installment payments are used to satisfy the obligations of a mortgage payment. Income can be used to support dependent children. If a consumer’s life insurance dollars are limited, term-life insurance is optimal because premiums are considerably less than for a comparable amount of whole life insurance. Term-life insurance cannot provide a regular savings plan nor is it desirable when the necessity for life insurance is permanent.

Under a whole-life insurance policy, payments will be made to designated beneficiaries whenever the death of the insured occurs. Also, if the insured reaches 100 years old, the carrier will pay the benefits to the insured. Because claims are a definite event under whole-life policies, carriers must charge premiums that are sufficient in size to guarantee settlement. The consistent premiums that are paid for whole-life insurance are good for a savings value known as the "cash value." Insurers initially levy premiums that are in excess of what is needed to satisfy early mortality claims. After a period of time, additional premiums and the interest which is compounded on such premiums combines for a significant savings value.

The excess premiums are used to keep the policy effective in later years as the likelihood of death increases. Such savings give rise to a few contractual rights. Money can be taken from the policy at any time when protection is no longer needed. The savings can be used to purchase annuities for a predictable retirement income. Savings can also be used as the foundation for a loan to a policyholder.

Whole-life policies are categorized upon the basis of three methods of premium—single premium, continuous premium and limited premium.

During the late seventies, traditional protection plus savings insurance policies became less popular with consumers because of rapid inflation. Alternative investment vehicles with higher yields were made available. It was in this economic environment that universal life insurance became popular. Universal life insurance allows a policyholder to acquire term insurance and invest an additional amount with a carrier. A monthly mortality charge is subtracted from the accumulative premium fund and the balance, less a few charges, creates a cash value which earns a guaranteed interest rate and an excess interest rate. Death benefits under universal life insurance can be taken in one of two ways. In the first, the death benefit equals the initial quantity of insurance and accumulated cash value at the time of the death of the policyholder. The initial death benefit is guaranteed. Under the second method, the death benefit remains at a

given level until cash value is in excess of a definite amount. When cash value exceeds a prearranged amount, the increased amount is added to the death benefit.

Another type of life insurance which was introduced in the late seventies is variable life insurance. Compared to universal life insurance, variable life is more difficult to comprehend, involves more risk and is subject to federal regulation under the Investment Community Act of 1940 as well as under state law. Those who sell variable life insurance must be registered under federal securities laws as well as under state insurance laws. The premiums are flexible. The policyholder can select one or more underlying investment funds in which cash values can be invested. The investment funds can include money market accounts or stock and bond funds. Although there is no minimum guaranteed cash value, there is a minimum death benefit that is guaranteed.

Investigation of a Life Insurance Claim

Rather simple to process, investigation of a life insurance claim generally involves verification of compliance with the requirements of a beneficiary under a policy, such as notification of the death of the insured, filing of a "statement of claimant," which instructs the company how to dispose of the benefits, providing a death certificate to the carrier and, in some instances, surrender of the policy.

Employment Status

If a company takes out life insurance policies on its officers and employees, a requirement of coverage is that the insured is in fact a bona fide officer or employee. Such policies frequently require the insured to maintain a certain number of hours per week in furtherance of work duties. An insurance adjuster may look into the activities of an insured for a period of time preceding his or her death to make certain he or she was in fact putting in the required number of hours.

Medical History

An examiner will scrutinize the medical records to make certain that the deceased did not misrepresent his or her medical condition or history.

Birth Certificate

An examiner may ask for the deceased's birth certificate to verify the age of birth, since the amount of premiums are usually based upon the age of the insured. An adjustment may be made in the premium if the insured turns out to be older than he or she represented when completing the application for life insurance coverage.

Competing Beneficiaries

An adjuster may have to determine the whereabouts of competing beneficiaries, and his or her job is frequently made more difficult by a lack of cooperation from known beneficiaries. If the information is incomplete, the carrier may be forced to send the policy through a judicial process to resolve the status of the beneficiaries.

Incontestability Clause

Since all life insurance contracts are presumably made in good faith, there is a duty imposed upon an applicant to answer all questions truthfully and not to conceal any information. If a policyholder does otherwise, he or she (or his or her beneficiaries) may end up in court with the carrier who seeks to void the policy. An incontestable clause states that an insurer may not contest a policy for the purposes of voiding it after a policy has been effective for a specific period, usually one or two years. Thus, a carrier cannot investigate to uncover fraud after the

period of contestability has lapsed. However, fraudulent claims for accidental death benefits or income relating to a disability are generally not affected by a noncontestability clause.

Disposition of a Claim for Life Insurance Benefits

A number of state courts and legislatures have promulgated rules, regulations and statutes which address the inequity that can occur when a carrier attempts to withhold or deny benefits under a life insurance policy on the basis that the insured made misrepresentations to a carrier when he or she applied for such insurance. In some states, a carrier must show that an insured intentionally misrepresented information called for by an application. Others require that a misstatement of fact must have been material and that had the carrier known the fact, it would not have issued the policy. Some require the inclusion of an incontestability clause in the policy, which imposes a specific period of time during which a carrier can contest a policy coverage based upon misrepresentations. A few states require that the misrepresentation must relate to a serious ailment, disease or disability. If the questions on the application were vague or ambiguous, the carrier may not avoid payment of the benefits.

Disputes over the cause of death are frequent because of the number of states that allow a carrier to deny benefits for death by suicide if the suicide occurred within a one- or two-year period after the effective date of the policy. There is an arbitrary presumption that if death by suicide occurred after the prescribed period, the suicide was caused by mental illness. Since a policy covers death from other illnesses, a carrier must pay benefits in the event of death attributable to mental illness. Disagreements over suicide arise because of the difficulty of ascertaining the mental status of the insured at the time of his or her death. If an insured realized that death was a certain consequence of his or her actions, the suicide exclusion clause will apply. If he or she was so disturbed mentally that he or she could not have known death would follow his or her actions, the cause of death may be ruled as an accident.

An insured makes payment of the first premium when his or her application is taken. The application may contain a provision that the policy is not effective until acceptance by the home office. If the applicant dies before the application is accepted, the insurer may take advantage of an opportunity to deny coverage, notwithstanding that a policy may have been issued had the insured survived. Another timing situation occurs when the insured becomes sick or disabled, misses a payment and then dies before curing the default.

Many states have adopted laws to remedy these situations. In some states, the policy becomes effective upon payment of the first premium by the insured. In other states, if an insured ceases making payment of premiums, the cash value of the policy automatically converts to term insurance. Under most state laws, if a policyholder neglects to make payment of a premium, the policy is not automatically canceled, but rather a grace period kicks in under which the insured is given a certain period of time, usually 30 days, to make payment if the policy is to remain in effect. Under the laws of a number of states, if a policy has been permitted to terminate, a policyholder is provided with an opportunity to renew the lapsed policy under a reinstatement provision. For example, under the laws of New York there is a three-year period of reinstatement after the date of default if the policyholder has not taken out the amount of savings or withdrawn the cash surrender value. A number of states that have reinstatement laws may require the policyholder to demonstrate evidence of insurability through good health, including a demonstration that the insured does not engage in hazardous hobbies or pursuits, and the repayment of all premiums in default and any loans made to the policyholder which were secured by the policy.

Several settlement options, which are used to determine how the proceeds of a policy will be paid to a beneficiary after the death of the insured, are available under a life insurance policy, including the following:

- ***Single payment for face value***—A single payment affords a beneficiary the greatest flexibility since the entire amount can be spent at one time. Sometimes referred to as a "lump-sum" option, more than 95 percent of all settlements are taken in this manner. A beneficiary pays no federal income tax on the settled amount.
- ***Fixed-amount option***—This option affords an opportunity to the beneficiary to receive regular, fixed-income payments that continue until death proceeds and the interest on such proceeds has been exhausted. This option is beneficial in situations where income is necessary for a limited amount of time, such as to finance an education or to carry over a beneficiary until Social Security or private pension benefits are available.
- ***Fixed payments for a specific amount of time***—Payments are made over a restricted period of time, such as five or ten years, and the payments are greater than in the prior option.
- ***Specified payments lasting until investment income on cash value and death benefits run out***—Under this method, a larger payment results in fewer installments.
- ***Investment income on death benefits***—The entire amount of the benefits are left in the custody of the insurer. Generally, a carrier makes payments to one beneficiary in a series of regular payments. After the first beneficiary dies, the second and surviving beneficiary receives payment of the principal in a lump sum. The return earned in a given year determines the size of the payment. The principal amount of the death benefit remains unchanged.
- *Life-income option*—This option guarantees a series of regular payments to the beneficiary for so long as he or she shall live. The life-income option is best for a beneficiary who has no dependents to support after the death of the insured. The size of each payment is determined both by the gender and age of the beneficiary. Females may receive smaller installments than males because their life expectancy is longer.

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