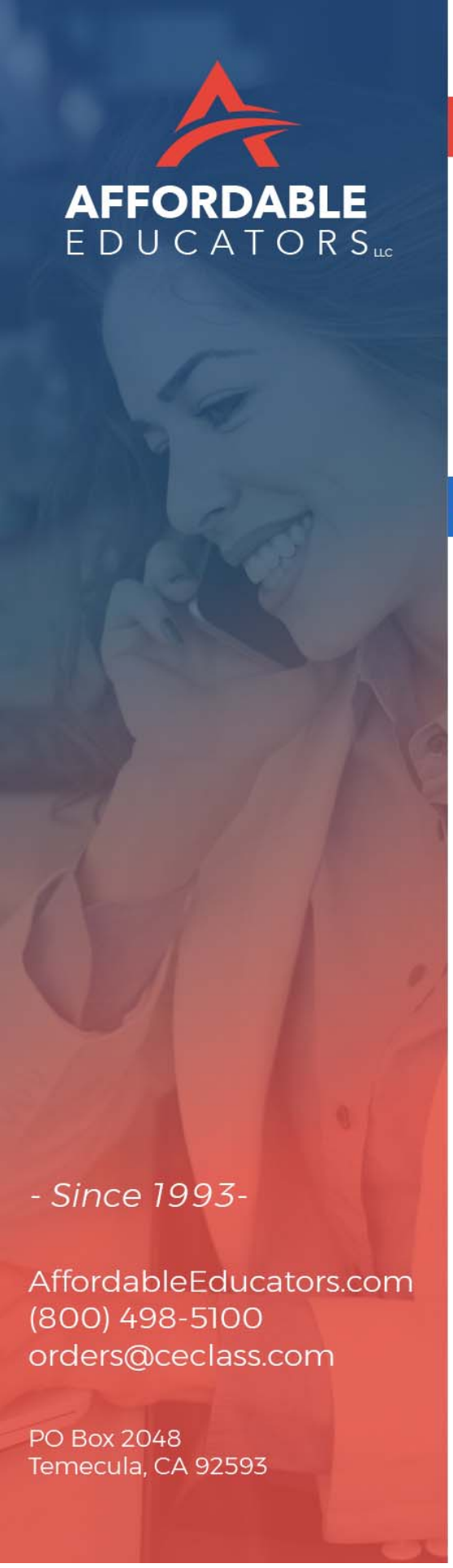

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171

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CHAPTER ONE
SALES PRACTICES

Less-than-honest selling is nothing new: ***Caveat Emptor*** *(buyer beware)* is said to have appeared on buildings in ancient Rome. But in the insurance business, it is the magnitude of damage that heightens the dishonesty. An unsuspecting client who buys the wrong retirement plan or building coverage is hurt a lot more than someone who buys a fake Rolex for $20 on the street corner. This is why agents need to practice sales conduct.

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

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

There are several components of sales conduct, including: Ethical Selling, Integrity, Choosing Product, Choosing Companies and Presentations of Quotes and Illustrations.

Ethical Selling

Do you think you're an honest agent? Could you prove it to a jury? What would your mother say about your sales practices? In the end, how will you judge your sales career? By how much money you made? By how many customers you helped? By what you accomplished for your family and your community? The answer lies within you. And, you are not alone if you are not 100% sure. There are many people and industries trying to grapple with the solution to "truth in selling".

In a way, the insurance industry is battling a decline of sales ethics; a ***moral combat*** if you will. One battlefield, where it is difficult to win, is the media where in recent times consumers read about state regulators warning 147 New York insurers on deceptive selling practices, or one company being penalized more than $700 million for deception, or an insurer's agreement to pay $25 million to cover the unscrupulous sales techniques of a single agent. ***Ethical selling***, as portrayed by the media, is just another oxymoron.

The troops leading the "offensive" for the industry are sales and motivational speakers and industry associations. Ethics, truth and responsibility are suddenly the core of seminars and newsletters with titles like ***Selling With Integrity, Principled Persuasion*** or ***Selling With***

Honor, The Ethical Challenge, Leading Quietly and more. Groups and associations are doing their share by promoting proprietary ***codes of ethics*** as the foundation to membership and/or the blueprint for all transactions.

Possessing a moral code is not all that is needed to set a professional apart from a salesperson. However, maintaining a Code of Ethics can inspire us to do better — especially if the breach of the code means we will lose our membership or be scrutinized by our peers.

Having ***high ethical standards***, or more simply being honest, can be more important than being right because honesty ***reflects character*** while being right reflects a ***level of ability***. Unfortunately, the insurance industry, for the most part, still rewards ability. There are, for example, plenty of "million dollar" marketing winners and "sales achievement awards"; but few, if any, "Ethics & Due Care" certificates.

For some, ethical selling, whether by a code of ethics or just plain honesty, is reward by itself. Consider, for example, the satisfaction you would realize when the interest of a client has been served by the proper placement of insurance in the following situations:

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

The list is endless, but the point is already made: The work of an insurance agent often impacts the entire financial well being and future of businesses and families. Ethics place the interest of these clients ***above*** an agent's commission and is, in fact, the very root of what constitutes a true professional.

Being ethical is indeed 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. It means more than being silent when something needs to be said, because saying nothing can be the same as a lie. Take the case of Bell v. O'Leary - 1984). An agent took an application for flood insurance but failed to notify the client that his mobile home was located in unincorporated areas that were ineligible for any coverage under the National Flood Insurance Plan. A loss occurred and the agent was sued. The courts determined that the agent had superior knowledge and failure to give the client a complete answer about the unavailability of coverage took precedence over the fact that coverage for the property was not available from anyone.

Someday, it may be real important for a court and jury to hear that you have a history of serving clients without consideration for how much commission you made or how busy you were, i.e., you are a person with good ethics. In Grace v. 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 considered the agent's lack of duty to notify his client a serious breach of ethics.

Perhaps this whole issue of ethics can be summed up in the very codes of conduct now in place for members of organizations like Registered Preferred AgentsJ, The American Society of CLU and ChFC, Chartered Property and Casualty Underwriters the International Association of Financial Planning and the Million Dollar Round Table. We summarized many of these in the box on the next page titled simply . . . ***An Agent's Code of Ethics***

Ethics From The Start

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 a forum like this course of study 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 greater sales and lessen the possibility of lawsuits.

Perhaps part of the blame for modern-day ethical indiscretions is the complexity of financial products and the intense competition among sellers and agents. Both make it harder for consumers to understand what they want or need and easier for an aggressive salesperson to mislead them. Consider Cunningham v. PFL Life - 1999. Agents, who promoted themselves as "experts" with superior knowledge, misrepresented the life insurance policies they were selling as investment vehicles. Consumers were easily convinced that the papers they held were investment contracts. The courts found the insurer liable for reckless and wanton failure to train and supervise its agents. The case did not disclose if any suits against individual agents were launched by the insurer.

Some believe that the ethics problem reflects our current culture that glorifies short-term success at all costs. This includes awards for the most sales in a given period of time as well as "golden boy" stories of the entrepreneur who goes from lonely computer geek to multi-millionaire from a single idea. Neither of these events is meant to say that these individuals accomplished their feats in an unethical manner. It simply ***raises the bar*** for those who follow them. If those who follow have inadequate skills and work habits, they could employ less than ethical means to reach the same goals.

Ethics For Life

The insurance industry can do a lot more to promote ethics-building habits. At the MONY Group, for instance, building a relationship in sales and marketing is emphasized with a program called ***Client for Life***. Its premise, "When you constantly exceed the needs and expectations of your clients, you're doing the right thing". Sales tools such as reports and newsletters are used to educate clients in a non-threatening and highly personalized manner. ***Long-term success*** is closely associated with building ***long-term relationships*** with clients rather than a quick sale. The results may vary from agent to agent, but a surprising benefit seems to be a ***loyalty factor*** where more than 70 percent of sales comes from existing policyholders or their referrals.

AN AGENT CODE OF ETHICS

In all my professional relationships, I pledge myself to the following rules of ethical conduct:

- I will make every conscious effort to help my clients in a manner in which I would want to be helped myself.
- I will maintain the highest standards of professional competence and integrity and give the best possible advice to clients.
- I will offer advice only in the areas I have competence and within the scope of my licensing.
- In a conflict of interest situation, the interest of the client shall be paramount. I will always place the interest of clients above my own.
- I will take responsibility for knowledge of the various laws and regulations affecting my services.
- When approaching prospective clients, I will immediately identify myself (verbally or in writing) as an insurance agent / company and disclose the product I am selling.
- I will avoid sensational, exaggerated and unwarranted statements. My proposals and quotes will be clear so clients may know exactly what is being offered and the extent of their commitment they are considering.
- I will make full and adequate disclosure of all facts necessary to enable clients to make informed decisions.
- I will constantly improve my professional knowledge, skills and competence.
- I will be truthful about client testimonials and endorsements.
- I will hold all business and personal information pertaining to my clients in the strictest confidence.
- I will maintain a professional level of conduct in association and when referring to peers and others in my industry. And I will be fair in any product or company comparisons.
- I will conduct my business in a way that my example might help raise the professional standards of insurance agents everywhere.
- I will cooperate with others whose services are constructively related to meeting the needs of my clients.

How can agents develop a sense for long-term ethics? The best way is to fully understand what ethics is and the many levels it plays in your career. Following are some special areas of interest you should know about ethics:

Ethics Defined

Just what is ethics? A simplified definition of ethics is a ***set of values*** that constantly guides our values. These values are typically ***aligned*** with what society considers correct and positive behavior within legal boundaries. Ethics is also the ***balancing*** of an individual's good with the good of the whole. Let's say you develop a seminar series on "asset protection". At the event, you have a person pass around a clipboard asking people if they would like to be informed of future seminars. The real purpose of this exercise, however, is to create a mailing list to market insurance products. Smart marketing? Or, breach of ethics? Are you really concerned with your clients education (the whole) or only what you will get out of their business (the one)?

Balancing the good of the one with the good of the whole is not as easy any more. The hole that we have to consider is everybody, not just a competing agent down the street or in the next town. Survival is important, but not at any cost. True survival requires long-term, successful relationships with customers and companies, as well a co-workers and competitors. When people do not understand their role in the "whole" and are completely self and survival oriented, it throws the ethical system we once knew out of whack.

How can you stay on track? Most important is that you know your personal core values and the values that your company or agency stands for and then live and work congruently and consistently with those values. The people will know you as a person of integrity. And, with integrity comes trust.

The authentically ethical person in our seminar example would have simply disclosed the purpose of the clipboard or simply buy a mailing list from someone else. Respect for privacy would be honored and remembered.

Shades of Grey

One of the problems with ethics today is that we have so many different mores or values that guide our society. The values that guide each individual and/or company can vary tremendously, therefore an individual or company may be ***ethical*** according to their values and not to yours or the definition above. Several major shifts in right or wrong standards means that we are faced with more and more gray areas in our personal and professional lives. The shifts are occurring at such a pace that they may even hinder our ability to cope and process the changes.

Take the example of two agents who met with numerous company officials at Universal Manufacturing Company ("Universal") for the purpose of securing permission to offer interested Universal employees a "unique," "local" product. The agents explained that purchasers of the product would receive allegedly ***better coverage*** than that provided by their current insurer which issued the policies then-held by many employees.

More specifically, the agents explained that what they were offering was not an ordinary life insurance policy; rather, it was a ***supplemental retirement program with a death benefit*** and an "immediate cash benefit plan" containing a $ 1,000 "check" which, in the event of an

insured's death, could be cashed immediately to pay for such burdensome expenses as funeral arrangements. Of critical significance, the agents assured that employees who decide to enroll in this "retirement program": (1) could allow their current policies to lapse, and (2) would be covered (insured) "immediately" and unconditionally upon completing an application and "upon signing . . . the[ir] payroll deduction card."

In essence, the agents guaranteed all-important ***risk aversion*** and ***peace of mind***. This was critical to those who were currently insured and were concerned about being without coverage once they allowed their policies to lapse. The so-called $ 1,000 "check" was not actually a check which can be taken to a bank and cashed. The only purpose it seems to serve is as a misleading gimmick to promote sales of the policies.

Clearly this is a ***shade of grey*** bordering legal issues like misrepresentation and fraud. The practice, unfortunately, is widespread.

Moral and Market Values

The American economy depends on ethical standards upheld by responsible business leaders. Unfortunately, this unwritten rule was violated in recent ethics scandals occurring in many corporate boardrooms. Respected companies lost credibility and innocent investors lost millions in the late 1990's and early 2000's. Cheating became rampant because it was the norm. It was no longer seen as wrong. In fact, at the peak of the problem, much of our economy resembled a giant pyramid scheme, taking in money from new suckers to pay those who invested earlier. A so-called ***bubble economy*** developed where businessmen willing to gamble with other people's money were rewarded handsomely. Stock prices were rising so fast that if you cut corners to meet projected numbers, you probably thought you were doing your shareholders a favor. And, there was always new money pouring in to make up the difference.

The insurance industry is not without its own horror stories. Take the case of Joseph and Annette Cooper. They purchased a "vanishing premium" life insurance policy insuring the lives of himself and his wife Annette Cooper.

Agents Steinhardt and Fish , whom Cooper had known for many years, and considered to be trustworthy friends, told Cooper that they were ***highly skilled insurance experts*** who understood complex insurance projects, and encouraged him ***to rely on their expertise and prior relationship of trust in choosing a policy***. Steinhardt and Fish recommended a $ 1 million Berkshire "disappearing premium" policy, and told Cooper he would have to pay the annual $ 9,000 premium for nine years. "Neither Steinhardt nor Fish showed him a 'Supplemental Footnote Page' or anything else that indicated the disappear-year was not guaranteed." To the contrary, they specifically told him that he would ***not have to pay any premiums beyond the illustrated disappear-year***.

Even though Cooper thought it was ***too good to be true***, he decided to buy two policies, one for the Trust, with a $1.5 million death benefit, and a second, with a $1 million death benefit for the Associated to endow a charitable fund.

About six years later, the Coopers learned for the first time that they would have to pay premiums for many years longer than the insurance agents originally represented. Fish disclosed this to Cooper during presentation of a "Life Insurance Policy Reprojection" as part of a meeting that he scheduled to sell them additional financial products.

The Coopers asserted that the ***assumptions*** underlying Berkshire's illustrations of the premiums that the Coopers would have to pay were inconsistent with Berkshire's own internal forecasts and estimates, and were based on abnormally high dividends that, to the defendants' knowledge, Berkshire could not sustain. If the illustration had been based on Berkshire's real investment earnings rate, the Coopers claim, it would have shown the "disappear year" to be ***later than*** the ten years represented to Cooper.

An "expert in the field of life insurance and actuarial science was brought in to testify to this conclusion. His opinion was that the ten year premium illustration was ***materially misleading*** at the time it was used to sell the policy to the Coopers because, contrary to Berkshire's claim, the illustration ***did not accurately reflect current company experience***. He also stated that the agents should have known that the ***disappear date*** portrayed in its sales illustrations were ***false*** and that the actual "disappear date" would be later. . . . Based Berkshire's Net Investment Yield during the five years before the Coopers purchased their policies (i.e., 1985-89). In fact, it was steadily declining. Thus, it was not realistically possible for Berkshire to continue paying dividends as represented in the illustrations while increasing their book of business. In short, Berkshire and the agents knew or should have known in 1990 that the Coopers would have to pay more premiums than illustrated.

The court agreed that a reasonable jury could find that the illustration constituted a materially misleading and inaccurate representation regarding the prospect of a ten year "disappear date" for the Coopers, and that the Coopers ***reasonably relied*** on that misleading illustration in deciding to purchase the Berkshire policy.

In insurance as well as the corporate world, people who rely on your word can be sucked in during times of market sensitivity. When interest rates are crashing down, for example, people will be intently interested in your interest rate programs. Some agents could take advantage of this enthusiasm. What about hard markets where a certain sectors of the industry refuse to insure. Insurers often play the game by offering higher commissions on the less attractive programs. The hope is that it does not get out of hand. During the bubble period, for instance, the economy resembled a giant pyramid scheme, taking in money from suckers to pay those who invested earlier.

Will tougher laws and longer prison sentences be a deterrent. It can't hurt. But, the fact is bubbles burst quicker than a business climate can change. If a crooked practice doesn't pay off, a lot fewer people will take the risk of using them. So, the real challenge is to create a new business culture that matches the market. Think about a system that rewards and reinforces the honest and careful agents and businessmen just like the bubble economies made heroes out of the gamblers.

Moral Compass

During times of fundamental change, values that were previously taken for granted may be strongly questioned. These are the times when the attention to business ethics is critical. Leaders, workers and agents must sensitize their actions -- they must maintain a strong moral compass.

John Kennedy Jr's last flight went wrong because he lost sight of land. In the growing dark around him, the horizon line became blurred and he became disoriented eventually flying his place right into the ocean.

When nothing is stable or dependable, you also can lose your own sense of moral direction. When it happens, you start accepting ambiguity as real. You begin making up your own rules. You cut corners. This is exactly how things started going bad at Enron. Accountants simply made-up their own accounting standards. They lied, cheated and waffled because it was to their economic advantage. Over time, they began justifying their unethical behavior as acceptable.

How can you keep this from happening to you? You can have a strong, unfailing sense of what is right and stay focused on it at all times. It's called ***integrity***. When you have it, it allows others to trust you, even when things go bad.

Kim Cameron, Professor of Organizational Behavior at the University of Michigan, says that it is not enough to simply encourage ethical behavior, honesty and integrity because these concepts in themselves imply an ***absence of harm***. A strong moral compass means that you strive for ***virtuousness*** where your actions rise to doing good, honoring others, taking a positive stance -- i.e., . . . "behaving in ways where ***self-interest is not the driving motivation***."

Too soft and fuzzy for you? Well take note, Kim's research proved that businesses with high scores on virtuousness significantly outperformed those with low scores. ***It pays to have a strong moral compass!***

Example: You investigate two proposal quotes for a client. Proposal A is the least expensive policy, but it meets the client's needs. Proposal B also meets the client's needs with a few bells and whistles added at a much higher premium. And, because it includes significant exit penalties, it also pays a much higher commissions. The client relies entirely on your recommendation and doesn't have a clue what a competitive premium might be for a comparable policy. What do you do? As an agent with a strong moral compass, you present Policy A, but explain the options available on Policy B and the fact that premiums and commissions are higher. If the client wants Policy B the honest response is that it is not the one you want him to buy as long as Policy A meets his protection needs.

This is a simplified example for sure, but you get the idea. You are legally able to sell either policy but what is the fairest deal for the client? Truly honest and ethical people live by the choice to do what is right, even when it is not pleasurable. This is how reputations are built. And, regarding reputations, ***Alan Greenspan*** summed it up quite nicely . . "Your reputation is your stock and trade. If you do something to undermine that, then you very well may not have a company any more."

Moral Distress

Have you ever thought about why people make bad decisions? One reason is dissatisfaction with your work or how about near impossible objections. When either one of these occurs, a person experiences growing pressure to engage in unethical behavior. You are left in a situation where every decision must weigh your own survival against the care and attention you give your client. The end results is that shortcuts will be taken or you become frustrated, resentful, angry or guilty about your bad decisions.

What can you do?

Stakeholders: Experts suggest that, among other things, you adopt a long-term stakeholder mentality, and, to be ethical under social justice theories you should be fair to all ***stakeholders***. What does this mean? A stakeholder is anybody that can be affected by your actions. Your client is a stakeholder in that he depends on you and your insurance products to protect is economic well-being. Your insurer is a stakeholder in you representing product fairly and within the scope of the law. The shareholders who have invested in the insurance company are also stakeholders and when it comes down to it, you are a stakeholder yourself. That's right! You owe it to yourself to survive in your chosen field. And, as we have already described, the best way to do this is long-term, with integrity and respect for others and all stakeholders.

Remember, customers ultimately pay your commissions and insurers enable you to make a living. That's something that should be important to you. So, how could you be a bystander and watch either of them be injured in any way by your actions?

Pace Yourself: Another way to reduce moral distress is to operate at a reasonable pace. We have already explained that when you cut corners it promotes unethical practices. For instance, if you fail to budget time to read a client's policy, they go out without being reviewed raising ethical questions and moral distress. What about when you forgot to get a client's initial on an application. It's awful tempting to sign it yourself when you know the client will approve it anyway rather than drive 30 miles back out to meet the client a second time. Again, moral distress raises its ugly head. Of course, the solution is to allow more time the first time out. But, this will mean less production which creates economic stress. At times like this, you have to assure yourself that you are in this for the long-term. Being genuine and ethical means that you live by the choice to do what is right, even when it is not pleasurable. You could also look at it in more positive terms. Why not make a ***client for life*** by taking that 30 mile drive and explaining why you did it!

A Tolerance For Problems: When you succeed at something, it's normally because you are doing something that other people do not want to do. In a sense, you have to "tune-up" your instincts to be ***satisfied*** at meeting objectives that others find hard to take or when people don't want you to succeed. What does this have to do with moral distress. A lot, because you can reduce your level of moral distress by increasing your tolerance for problems. Think about it. You can convince yourself that external forces are never-ending anyway, so there is no reasons to sweat it so much. The fact is, you're in the problem solving business and you're a pro! Just remember the immortal words of Saturday Night Live's Rosanna Rosanna Danna -- "It's always something!"

Loss Control

Being ethical does not mean you have to be the town's whipping boy. Use some of your own sales logic to understand this one. You've probably said this to a client or two . . . "People don't buy insurance and pay premiums so they can run in to every station wagon simply because they hate station wagons. In fact, if they own a small car, they are likely to ***avoid*** station wagons".

In a similar vein, you need to avoid problems that could cause major financial havoc to you and other stakeholders. When you do, your levels of moral distress will be lower. Of course, this is easier said than done, since there is NO foolproof method to avoid a conflict. There are, however, some steps that agents can use to help reduce the possibility of liability developing.

- Know your basic ***legal responsibilities*** as an agent and only exceed them when you are absolutely sure what you're doing. Then, pull out your agency agreement and ***read it . . . right now***!!! And, 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 you and your company from becoming a commissioner's target for suspension or revocation.

- 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. Countless lawsuits, for instance, surface due to something an agent wrote down in an application causing the policy to void or a claim denied. The insured typically denies they responded in that manner. If applications were made out in an insured's own handwriting, however, there is little they can say.

- Be aware of and avoid current industry conflicts that could develop into problems for your agency, e.g., mold prevention, viatical settlements, life insurance acting as retirement plans, etc. 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.

- 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.

- 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.

- 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.

- 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. And while we're on the subject, ***spend more time with client applications***. 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 a position and reasoning. For instance, assuming your state regulator and company approve, the applicant could be asked to write "I have read everything on this page. The answers are true".

- 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".

- Maintain and understand your errors and omission insurance. This policy is your "first line of defense", but know its limitations and gaps.

Ethics From Education

The customer can't understand what the salesperson can't explain. Further, a customer who understands a product is much less vulnerable to deceptive selling. Both statements stress the importance and need for more education. A recent study by the Insurance Institute found that four out of every five people don't understand their insurance policies. And, if the agent doesn't understand his product the company and client are at risk. Agents end up concentrating on a "comfort zone" product or service B even if it is not the most appropriate one because he is uncertain about newer, more complex products.

Constant training is the answer from the company's perspective, as well as making a long-term effort to ***demystify products***. One solution is the translating of legalese into easily understandable, everyday English. This includes brochures, advertising, applications and the policies themselves.

The process of educating ethics is also the responsibility of our schools. Currently, there is a glaring lack of attention to the selling disciplines. Besides learning the nuances of every product and the marketing behind them, young people could be taught the importance and responsibilities associated with being a salesperson. Like the athlete who trains long hours to prepare for the moment of action, salespeople can be groomed to do the right thing.

Misuse of Position

What are you doing that might ***influence*** people in an unfair or abusive manner. For example, do you represent yourself as an ***insurance expert*** when you are not? Do you claim to have special ***insurance knowledge*** when you don't? The point is, when you ***disguise*** your actual position you deceive clients with the intention of influencing their purchasing decisions. It is certainly unethical and may be illegal.

Here are examples of several insurance conflicts that developed because of influence.

Campbell v. Valley State Agency

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 exceeded 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.

Europeon Bakers v. Holman

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.

Seascape v. Associated Insurance

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.

Sobotor v. Prudential Property & Casualty

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.

Wright Bodyworks v. Columbus Agency

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.

These court cases offer some evidence that many agents might be better off to accept and position themselves as ***insurance agents***, not a "special consultant" or "expert". Customers can learn to accept that ***you are who you are*** without titles that could, influence, mislead or instill false promises.

This is the basic concept behind the ***Preferred Registered Agent™*** proficiency designation. The Preferred Registered Agent is an insurance agent who always practices due care, yet operates within the bounds of agency. They accurately describe policy options that are widely available but refer out if an inquiry is beyond their scope of duties B even if they know the answer. They do not profess to have expert status but know their products as good as they can. Their goal is simply to be the most responsible agent possible. ***Preferred Registered Agents***™ are bound to a strong code of ethics ***and*** a code of procedures.

Ethics Are Not Laws

Many agents believe that ethics and the law are the same. It is important to realize that ***ethics are not laws***, ***yet they can be guided by laws***. Proof of this exists in the fact that you can be unethical yet still operate within limits of the law. A perfect example of this is the insurance client who fears he has physical problem yet he is allowed to withhold disclosing it on an application. He has no duty to disclose his "fears" of a medical condition. It's legal, but not too ethical.

Laws in the United States are abundant, growing in numbers every day. The courts attempt to legislate protections from those without values or with values in opposition to what most of us would consider right and wrong. We have more laws than any one lawyer can ever know. And more and more lawyers seem to be necessary to handle the litigation that results from what seems to be a trend in "making others pay".

Privacy

Protecting a client's privacy is an ethical responsibility as well as an area of increasing liability for insurance agents. The concern by clients is that highly personal health and financial information you collect in the process of selling insurance will get in the hands of groups who might use this data to exploit them. As a result, new legislation has passed that requires certain disclosures be made to your clients whenever non-public (personal) data is being shared with other parties. Also, they must be given the opportunity to restrict its use.

The following case demonstrates how privacy issues can be violated and taken to the extreme. You won't believe how the sides get whipped into a frenzy with accusations like wiretapping and review board shams.

Richard Fraser joined Nationwide Insurance as an employee in 1986. Fraser later signed the standard Agent's Agreement to become an exclusive career agent with Nationwide.

Fraser also leased computer hardware and software from Nationwide for use in the automation of his office and insurance business. The lease agreement explicitly stated in the Preface that the Agency Office Automation ("AOA") system "will ***remain*** the property of [Nationwide]." Further, anytime someone logged on to the AOA system, a notice appeared on the screen that said:

Please note: for everyone's mutual protection, your AOA SYSTEM, including electronic e-mail, MAY BE MONITORED to protect against unauthorized use.

Problems developed when Fraser and other Nationwide agents met to form a Pennsylvania chapter of the Nationwide Insurance Independent Contractors Association ("NIICA"). NIICA had previously been in existence for some years in other states. Nationwide refused to

officially acknowledge NIICA. Fraser was elected to an office of the local chapter. He was also asked to create and write a chapter ***newsletter***, which became known as The Pennsylvania View.

Fraser raised some of the business practices believed to be illegal with Nationwide's Office of Ethics. Thereafter, Fraser initiated a complaint with respect to these practices with the Pennsylvania Insurance Department and the Pennsylvania Legislature. The agents' ongoing efforts to report these practices resulted in media publicity. Nationwide was aware that Fraser and other NIICA members were reporting business practices to state authorities. Nationwide was forced to enter into a series of consent orders with the Pennsylvania Insurance Department, by which Nationwide paid a fine and agreed to cease the business practices about which Fraser had complained. The Pennsylvania View publicized Nationwide's concessions under the consent order.

A short time later, Nationwide drafted a ***warning memo*** headed "Inappropriate Communication" to the entire agency force, including Fraser. The memo stated that Nationwide was aware of communications with the Pennsylvania Insurance Department and the State Attorney General. Citing examples of such communications, the memo asserted that many of these communications included "false statements or unsupported allegations that Nationwide has or intends to violate the law," and that they "have had a damaging effect on the business operations and reputation of Nationwide and its agents." The letter also stated that:

Nationwide recognizes and respects your right as a citizen to communicate with government agencies and the public. However, you do not have the right to make false statements or accuse Nationwide of wrongdoing, unless your allegations are reasonably supported by the facts and the law. Such actions will not be tolerated, and if they occur in the future, Nationwide intends to exercise its legal rights, which could include legal proceedings in addition to canceling your Agent's Agreement.

At or about the same time, Nationwide implemented a new business policy, to which Fraser and other agents were opposed. The policy changes were related to Nationwide's new publicized growth plan to establish "multiple distribution channels." Under the new plan, policyholders could buy insurance directly, rather than through an agent. The agents feared that the new policies would undermine their work and their independence.

Fraser, through the NIICA decided to make Nationwide's management aware of the agents' opposition to the plan. NIICA members asked Fraser to prepare a letter to competitors of Nationwide to solicit interest in acquiring the policyholders of the approximately two hundred NIICA members in Pennsylvania. In drafting the letter, the agents' did not intend to actually separate from Nationwide, but to send a warning that they would leave if Nationwide did not cease the objectionable policies. This letter was ultimately sent to at least one competitor.

A top-ranking officer of Nationwide learned of the letter and another "inappropriate communications" memo was soon sent out. Since they were not sure if the letter was actually sent to a competitor, they conducted a ***search of their electronic file server*** for e-mail communication used by all agents, including Fraser. Stored e-mails belonging to Fraser and other agents were opened, including an exchange of e-mails between Fraser and another agent of indicating that the letter had been sent to at least one competitor.

Subsequently, Nationwide ***cancelled*** Fraser's Agent's Agreement and retrieved its computer systems. Fraser immediately appealed the cancellation to an internal Review Board which determined that Nationwide had the right to terminate its relationship with Fraser for any reason or no reason at all, and that, nevertheless, Fraser's breach of loyalty to the company provided them with a good reason to terminate him.

Fraser filed a lawsuit contending his status as an independent contractor was undermined by Nationwide's policy changes as well as federal ***wiretap violations*** resulting from the unlawful interception of Fraser's e-mail communications.

However, the court determined that Nationwide's alleged conduct, although ethically "questionable," ***did not*** constitute an "interception" of an electronic communication under the Wiretap Act or unlawful "access" to an electronic communication under the Stored Communications Act. Why? Because Nationwide retrieved Fraser's e-mail ***from storage after*** the e-mail had already been sent and received by the recipient. Therefore, Nationwide acquired Fraser's e-mail from post transmission storage.

Fraser's second claim involved his right to ***free speech***. The court's decision, however, was that Nationwide is a private corporation and a private actor under the law. Therefore, Nationwide's decision to terminate Fraser's Agent's Agreement is not subject to constitutional requirements of free speech. Further, the court stated that even if it is true that Nationwide terminated Fraser for reporting to government authorities Nationwide's alleged unlawful practices, for drafting the letter to Nationwide's competitors, or for associating with NIICA, Nationwide is not liable under the constitution.

Opt-In / Opt-Out

It is your ethical and legal duty to honor a client's wishes concerning the handling of his personal and financial statistics. ***Opt-out*** is the process of having one's personal information removed from databases and lists that are often sold for marketing purposes. Personal information is collected on individuals in a variety of ways such as when they are applying for a credit card, telephone service, or entering contests. Credit bureaus also sell information for marketing purposes. If the consumer has active accounts with a brokerage house, credit card company, or insurance company, he will receive a privacy notice from these institutions. The term "financial institution" includes companies such as payday loan companies, collection agencies, and travel agents. For this reason, it is particularly important for the consumer to carefully review all preprinted notices that he receives in the mail or electronic mail messages.

Federal law now gives one some minimal rights to protect his personal financial information. The law gives him the right to prevent a company he does business with from sharing or selling certain sensitive information to non-affiliated third parties. The term "opt-out" means that *unless and until* the consumer informs his bank, credit card company, insurance company, or brokerage firm that he does not want them to share or sell his customer data to other companies, they are free to do so.

When this law was debated in Congress, consumer advocates argued unsuccessfully for an **opt-in** provision. This stronger standard would have prevented the sharing or sale of the customer data *unless* the consumer affirmatively consented. The opt-in standard did not prevail. Therefore the *burden is on the consumer* to protect his financial privacy.

Opt-in does not enhance consumer privacy. Since it is the consumer who makes the final and binding decision regarding the use, non-use, or misuse of his personal information under either "opt-in" or "opt-out", there is no privacy advantage to "opt-in". Neither approach provides the consumer with greater or lesser rights than the other. If this argument is valid, and both "opt-in" and "opt-out" fully reflect consumer preferences regarding the use of their personal information, then all the other arguments are invalid – sellers would receive the same amount of information under either approach. Thus, implementing "opt-in" would not impose any additional costs on either producers or consumers, as compared with implementing "opt-out". However, the choice of scheme – "opt-in" or "opt-out" – does distort consumer preferences by imposing transaction costs on one choice or the other. After acknowledging that transaction costs cause both "opt-in" and "opt-out" schemes to reflect imperfectly the "true" privacy preferences of the consumer, the policy debate can move forward and tackle the next question. Does "opt-in" or "opt-out" reflect the true preferences of the consumer better? Presumably, transaction costs under "opt-in" lead consumers to provide less information than their true privacy preferences would suggest; conversely, transaction costs under "opt-out" lead consumers to provide too much information. The structure of the seller-producer relationship suggests one reason why "opt-in" might represent the consumer's true privacy preference better. The seller can adjust the level of transaction costs involved in "opting" in or out, whereas the consumer cannot. Since the seller has an obvious interest in collecting information, it has an incentive to make it easy and simple to opt in, under an "opt-in" system, and an incentive to make it difficult and time-consuming to opt out, under an "opt-out" system. Whatever regulations exist to make opting out easier, the seller has an incentive to push the envelope, to make opting out as difficult as possible within the letter of the law. Thus, transaction costs under an "opt-out" scheme are likely to be higher than under an "opt-in" scheme, and the outcome under "opt-out" is likely to be concomitantly farther away from the correct outcome than under "opt-in".

Opt-in reduces consumer privacy by hampering efforts to fight fraud and identity-theft. Since an "opt-in" approach reduces the amount of information available to sellers regarding the consumer's preferences, spending habits and typical behavior patterns, it hampers sellers' efforts to detect unusual purchases and alert the consumer to possible fraud. This makes it easier for criminals to assume false identities and engage in other fraudulent behavior at the expense of law-abiding consumers. Not only is this an invasion of privacy in itself, but also the rectification of the situation often requires the consumer to provide personal information about himself. This is a valid point, which, under an "opt-in" scheme, producers might wish to present to consumers in order to convince them to permit use of their personal information. Under an "opt-out" scheme, this point could be presented to consumers to deter them from exercising their "opt-out" option.

Opt-in imposes significant costs on sellers, which are then passed on to consumers. Opt-in increases the costs to a seller of expanding its range of services, because of the necessary expenditure of resources to obtain consumer permission to use the additional personal information that enables the better service. *Opt-in also increases marketing costs* because, instead of sending promotional materials to a neatly identifiable population segment that is likely to find such materials useful, the seller must send the promotional materials blindly to broader population segments. Some believe that in the "distance shopping" market through catalogs and online sales, enforcing an "opt-in" scheme will result in increased costs, which will then be passed on to consumers. The data restrictions inherent in the "opt-in" scheme would affect catalog marketing more than online marketing. This is because the interactive nature of the Internet can counteract the lack of third-party information about prospective customers. To properly understand the aggregate impact of an "opt-in" scheme on sellers,

one would need to look at the reliance of other industries on catalogs, as opposed to more interactive means of marketing. One of the factors slowing the growth of e-commerce, though, is consumer hesitation over conducting business online. In a report to Congress on online privacy, the Federal Trade Commission presented surveys showing the extent to which privacy concerns hamper the growth of e-commerce. Recent survey data demonstrate that 92% of consumers are concerned and 67% are **very** concerned about the misuse of their personal information online. Concerns about privacy online reach even those not troubled by threats to privacy in the off-line world. Thus, 76% of consumers who are not generally concerned about the misuse of their personal information, fear privacy intrusions on the Internet. This apprehension likely translates into lost online sales due to lack of confidence in how personal data will be handled. Indeed, surveys show that those consumers most concerned about threats to their privacy online are the least likely to engage in online commerce, and many consumers who have never made an online purchase identify privacy concerns as a key reason for their inaction. There are benefits of adopting and enforcing an "opt-in" scheme, in which consumers are assured that no one will make use of their personal information without their prior and express consent. The resulting burgeoning in e-commerce would reduce sellers' costs, by enabling them to make more extensive use of the efficiency inherent in interactive marketing tools such as the Internet. This effect may offset, and perhaps even outweigh, the increase in costs attributable to the data restriction effect.

Opt-in reduces the amount of competition in the market. By raising costs of operation, "opt-in" will drive marginally profitable companies out of the market altogether. By requiring new entrants to go through a laborious process of obtaining personal data permits from each new consumer, "opt-in" creates a barrier to entry into the market. Market incumbents, on the other hand, will benefit from an established consumer base that has already given permits. Essentially, "opt-in" helps entrench market incumbents. Since consumers are more likely to "opt-in" to companies they know and trust, such a scheme will favor large firms with established brand names over smaller firms. Competition is most reduced in the industries that rely the most on expensive means of obtaining permission, such as telephone or paper-mail, rather than on website-notices and e-mail. As e-commerce continues to grow, and technology becomes more pervasive, there is likely to be a shift from the former to the latter, and a reduction in the height of the entry barrier. A new entrant, though forced to beseech consumers for information-permission, could do so inexpensively through mass e-mailing.

Opt-in costs to sellers will be passed on disproportionately to less wealthy consumers. A study of distance shopping in the apparel market (catalogs, online purchases) reveals that inner city and rural consumers are significantly more reliant on distance shopping than the average U.S. household. These populations will be hit hardest by increased prices or decreased discounts which will result from implementation of "opt-in", as companies seek to recoup the increased costs of providing the "distance shopping" option. These are also the consumers who can least afford such price hikes.

Confidentiality

Some confuse the confidentiality with privacy. Privacy demotes the right to be left alone and control information about oneself. Confidentiality concerns the communication of private information and personal information form on person to another. If you surreptitiously collect information for marketing purposes, you are ***intruding*** on an individual's privacy. If you pass on information without permission, you are ***violating confidentiality***.

The key ingredients of confidentiality are trust and loyalty. As an agent, you gather personal and confidential information from your clients. You must be willing to take responsibility for handling this sensitive information. For instance, do you take measures to secure client data? Do you unknowingly publicize a client's address, phone or e-mail address, exposing them to unwanted mail? Do you forward e-mail messages and attachments without reading them? Share passwords? Neglect to change your own password?

In a nutshell, it takes a combination of legal, technological and individual actions to preserve confidentiality.

Ethical Decision-Making

Before the Enron fiasco, Arthur Anderson had a steadfast reputation. When big organizations wanted him to falsify their accounting he said . . . "No, we'll find other ways to make our money". The point is, to maintain ethical standards, you have to be able to think around problems, cultures and differences. Here are some ways to accomplish this:

Get The Facts: The Makkula Center for Applied Ethics suggests you find the relevant facts about a situation. This means identifying the individuals or groups who have an important stake in the outcome. Some may have a greater stake because they have special needs or because you have a special obligation to them.

An example might be elderly clients. Due to their status or cognition, they may need to rely more on your advice than other clients. Your ethical standards may have to be raised in matters that concern them.

Sizing Up The Problem: Michigan University Business Ethics Professor Tim Fort suggest you ask the following questions when faced with an ethical decision:

What's the moral issue?
Who has been harmed? Or who could be harmed?
In what ways?
What are the alternatives that exist?
What facts need to be known to make a reasoned decision?
What are the personal impacts on the person making the decision?

Working within a format like this helps bring the issues away from your own self-interests over the interests of others.

Pursuasion: If an ethical dilemma arises between you and a peer or client, why not solve the problem with your powers of persuasion. Be convincing. Have convictions. The influence you exert may very well change their mind.

Taking Risks: The more you are paid, the more complex the decisions you must make. Things are rarely "black and white" and a lot of your decisions will challenge your integrity. But, these are the risks you must be prepared to assume in a sometimes difficult world. You must constantly weigh ***short-term results*** with ***long-term consequences***.

Evaluate Alternative Actions: Which option will produce the ***most good*** and do the ***least harm***? Which option respects the rights and dignity of all stakeholders? Will everyone be

treated fairly? Which option will promote the ***common good***. Which option will enable the deepening or development of the core values you share with your company? Your profession? Your personal commitment?

Solicit Client Feedback: Before you make the final decision ask the client if your solution meets with his approval. Always ask these important questions:

- Have I given you all the information you need to make a decision?
- Does this 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?

Reflect on Your Decision: Was you position defensible? Would you do it again? How did it turn out for all concerned? Was your decision successful for both you and your client?

Confronting Unethical Conduct

In a lot of ways, we have become a ***no-fault society***. Popular thinking dictates that as long as you don't own the problem you don't need to get involved. A crucial shift is needed to avoid this bystander mentality. People need to think of themselves as members of a community. And, their life in this community entails ***mutual obligations*** and ***interdependence***. In other words, be part of the solution, not part of the problem.

How can this be accomplished. Well, you can learn to help solve ethical dilemmas rather than walk away or simply ignore them. Here are a couple ways to do this:

State Your Position: Ask those who want you to perform an unethical task to ***state their position clearly***. This forces them to make an ethical choice. If your manager wants you to fudge an application, for example, pose the following question: Are you asking me to lie on this application? It is probably a safe bet that he will back away from his unethical request.

Present A Case: Many ethical dilemmas result because someone has taken a short cut. You can sometimes turn their thinking around by presenting things statistically or in an organized manner. Take the manager who wants you to submit an inaccurate application. If you use some of your CE materials, you could easily find a recent court case where an agent did a similar thing and faced a huge penalty and loss of license. When presented this way, it would be hard to ignore the correct path.

Don't Ratify Unethical Actions: One of the easiest ways to become entangled in the wrong deeds of someone else is to ratify their behavior. Not only is it unethical, but it can come back to haunt you in the form of rather large lawsuit. Take the case of Agent Roger McCall, a licensed life insurance agent and/or broker with Alexander Hamilton Life. McCall sold client Richard Barton a life insurance policy. Barton alleges that a number of representations regarding the policy were untrue and fraudulent, that the administration of the policy was fraudulent, and that Mr. McCall had falsified documentation, forged Mr. Barton's signature, and actually took out taken out an unauthorized loan on the policy.

A jury found that Mr. McCall made the intentional and negligent false representations, and the false promises, as an agent of defendant Hamilton. Further, it found that Hamilton had expressly authorized Mr. McCall to make the statements that were found to be

misrepresentations or false promises. The court awarded over $850,000 in compensatory damages!

Obviously, Roger McCall did not operate within ethical boundaries. The real question is did his company or anyone in it ***ratify*** or endorse his actions, and in the process, become part of his scheme. Absolutely not! As soon as Hamilton became aware of Mr. Barton's complaint, it terminated Mr. McCall's agent agreement and initiated an investigation. It hired an attorney to interview Mr. McCall and it reported Mr. McCall's conduct to the Department of Insurance and the local Police Department. It contacted policyholders, and it reimbursed them for their losses in the total sum of approximately $1.2 million. In other words, instead of ratifying or approving of Mr. McCall's conduct, it tried to ***solve the problem by restoring the stolen funds***. Hamilton also offered Mr. Barton the opportunity to rescind the policy and it offered to reimburse him for any money that he was out of pocket as a result of Mr. McCall's acts.

Such conduct, said the court, cannot be considered ratification of Mr. McCall's conduct. Instead, it falls within the established principle that, when the agent exceeds his authority, there is no ratification when the principal ***repudiates*** the agent's actions as soon as the principal learns of them. Despite Mr. Barton's contrary argument, the court did not view Hamilton's conduct as an improper attempt to ratify Mr. McCall's conduct. His misrepresentations were, in fact, not authorized or approved by Hamilton, and they did not provide a basis for an award of punitive damages.

Ratification of Misconduct

Ratification generally occurs where, under the particular circumstances, the employer demonstrates an intent to adopt or approve oppressive, fraudulent, or malicious behavior by an employee in the performance of his job duties. The issue commonly arises where the employer or its managing agent is charged with ***failing to intercede in a known pattern of workplace abuse***, or ***failing to investigate or discipline*** the errant employee once such misconduct became known. Corporate ratification in the punitive damages context requires actual knowledge of the conduct and its outrageous nature."

That's how ethics in insurance work!

A Moral Agency Climate

If you ***don't*** create an agency culture that reinforces values and ethics, other agents and employees will only do what is right so many times and then they will either leave or give in to outside pressures to cut corners, lie, fudge, etc.

In order to reinforce this theme, you can't punish people for taking actions they need to take. You have to ***support*** good, moral decisions, even at the ***cost of production***.

What happens if no one else cooperates? You must continue to forge forward, even if you are the only one doing the right thing. Why? It's a fundamental choice you are making to be an ethical leader. And, it will pay off in time.

Integrity

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

Qualifications

Insurance Commissioners have been known to suspend or revoke an insurance agent's license 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 v. 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 Laws

Agent licenses have been revoked or suspended for activities where the licensee (1) did not actively and in good faith carry on as a business the transactions that are permitted by law; (2) avoids or prevents the operation or enforcement of insurance laws; (3) knowingly misrepresents any terms or the effect of a policy or contract; or (4) fails to perform a duty or act expressly required of him or her by the insurance code. In Hohreiter v. 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 v. 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 v. 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". If this wasn't bad enough, 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 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 that agent responsibilities MUST NOT violate the “public interest”. This is obviously a catchall category that has been used where agents have perpetrated acts of mail fraud, securities violations, RICO (Criminal) violations, etc.

Choosing A Company

Agents choosing safe companies to insure their clients undertake many disciplines, including: disclosure, diversification among multiple carriers, product variation diversification, regulatory knowledge, multiple rating verification, key ratio comparisons, periodic monitoring and more. A Money Magazine survey is a painful reminder to the industry that the road to agent diligence may still be cluttered with potholes and a fair share of detours. Twenty insurance agents on their accuracy and clarity in explaining their insurance products and the role they played in a client's financial planning. Most of the agents ***failed*** simple standards of due care, including the ability to demonstrate simple financial assumptions concerning the solvency of a chosen insurer -- either at time of purchase or later. Agents must realize, that doing "too little" concerning how and where they place client business can be hazardous to their financial health and moral responsibility to the people they serve. This takes on special meaning to agents when they discover that lawyers want to prove that a pocket rating card and other company supplied financial condition brochures may not be enough to demonstrate that an agent did his best in selecting a carrier who, after purchase, declined to unsafe or liquidated status.

No doubt, it will be the same attorneys who expect an agent to quote code and verse about the company, a policy or illustration when something goes wrong. There is no question that young lawyers, and some very rich lawyers alike, are increasingly aware of the numerous legal theories available to hold the insurance producer liable for failing to meet some kind of professional standard. Could a jury be convinced, for example, that an insurance professional, especially one who has earned a designation such as CLU or CFP, neglected his professional duties in not explaining the full impact of estate taxation to a now deceased, but underinsured client? Is a casualty agent, possibly a CIC or CPCU, liable for placing a client with a B-rated carrier that liquidates at the very time a client files a claim or failing to recommend a specific policy option that later involves losses?

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

Company Choices

An agent's ***legal*** conduct in choosing a company centers on the *ability to direct a client to an insurer that is solvent at the time of purchase and able to meet its contractual obligations*. ***Sales conduct***, however, considers more: ***Diversification***, to spread risks among carriers

and to meet state guaranty fund protection, and ***on going monitoring*** by private rating services. Sales conduct is a noticeably higher level of service.

Policy owners must depend on agents for choosing insurers because they are generally unsophisticated in analyzing the financial complexities of solvency. Agents help businesses and individuals purchase property and liability insurance to minimize current financial losses. Life, health and annuity policies cover losses of future economic potential. In both cases, the purpose is to shift the financial consequences of loss. Sometimes, however, policy owners find that the "safety net" they purchased is not always as safe as it started out to be. In the late 1980's and early 1990's, the increase in frequency of insurance company failures and inability to pay claims is proof. It is further substantiated by the substantial increase in claims submitted to state guaranty funds during this period which are forced to step forward and make good on failed promises of defunct or faltering companies.

An agent is engaged by a client because of his knowledge. Clients should expect to be placed with financially reliable insurers. Too often, it is believed that state regulators are monitoring solvency closely and will advise agents and brokers by some mysterious "hot line" — it just doesn't happen that way — and we have recent examples to prove this is not the case. Regulators of insurance companies, like regulators of financial institutions such as banks and thrifts, do not make public announcements of pending problems. This could cause a "run on the bank" or a "run on the insurance company". Severe disintermediation, withdrawal of policyholder funds or policy cancellations could initiate a complete collapse similar to what happened with Mutual Benefit Life years ago. By stepping in without public warning or fanfare, regulators hope to avoid the severity of a takeover and minimize consumer panic. That is why an agent will not receive advance warning from regulators. Unless the agent is tracking solvency by demanding full disclosure from an insurer BEFORE AND AFTER involving a client, he may experience the unpleasant experience of dealing with a disgruntled client or his attorney who just read about an insurer's demise, complaints filed with the insurance commissioner, or worse, a surprise visit from the "60 Minutes" investigative team!

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

Using the Rating Services

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

precipitate a "run on the bank", as in the case of Mutual Benefit, and seriously exacerbate an insurer's financial problems.

There is little doubt that rating organizations play a significant role in the insurance marketplace. Some have expressed concerns about the potential adverse effect of ratings on particular insurers and consumer confidence in the insurance industry in general. Once the province of only one organization, A.M. Best, a number of new raters emerged during the 1980s. Questions have been raised about the motivations and methods of the raters in light of the recent sensitivity regarding insurers' financial conditions and what some perceive to be a rash of arbitrary downgrades. On the one hand, insurer ratings historically have been criticized for being inflated or overly positive. On the other side, there are concerns that raters, in an effort to regain credibility, lowered their ratings arbitrarily in reaction to declines in the junk bond and real estate markets and the resulting insurer failures and diminished consumer confidence.

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

For more information, consult the section called ***The Rating Services***.

On-Going Monitoring and Policy Replacement

In the past, there has been no legal premise to hold agents responsible for ***monitoring*** solvency of a company after the initial sale. However, in Higginbotham v. Greer, it is *suggested* that agents need to keep clients informed about ***significant changes*** in the financial condition of the company *on an on going basis.* ***Sales conduct*** goes much further by emphasizing on-going due diligence, and when replacement is considered, documentation of files and published and third party testimonials as justification, *especially for any recommendation to move a client's coverage from a company rated "A" or better to a lesser rated carrier*. Even if the intent was to provide superior coverage, the client's security position has technically downgraded.

Company Deals

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

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

Company Diversification, Business Lines & Parent Affiliation

In the quest to exercise proper sales conduct, a strategy of ***multiple company*** coverage may be the answer or at least a diversification of product among the same company's menu. For instance, if you can't provide a choice between companies, a client's life insurance needs might combine term, whole life, variable life or universal life to spread the risks among product lines. The variable life component could be diversified even more by using multiple asset purchases. On the casualty side, similar diversification might be employed between business and homeowners policies, workers' compensation, professional liability, primary and umbrella coverage, etc.

The insurance consumer should also be educated by agents about the different types of insurers, i.e., stock versus mutual company, although it might be considered an error to generalize about the safety of an insurer or the price of its coverage or the service it provides, based solely on the insurer's legal structure. This disclosure may be particularly appropriate where an insurer, due to its legal structure, may NOT be covered by state guaranty fund protection, e.g., non-profit Blue Cross and Blue Shield. Or, where the legal structure of the product offered may NOT be "insured" by state funds, e.g., variable annuities.

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

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

Senate investigations have revealed that the failure of many insurers can be directly tied to the "milking" of these companies by a "non insurance" parent. Conversely, not all abuses have been on the side of the parent. Insurance companies themselves have been known to tap huge sums of capital from their parents, commingle assets and devise elaborate schemes, including sale and leaseback arrangements and the securitization of future revenues.

Conflicts of Interest

Agents receive a commission for their expertise in selecting a suitable product and company. The fact that the agent receives this commission for selling a particular company's product is a huge conflict of interest from the get go -- But, this is the insurance business. An ethical

agent should disclose this fact in reference to the choice of the company selected. Where the commission is higher than normal, one might question the specific policy elements that will be affected, higher surrender or cancellation charges, etc or considerations about the financial qualifications of the insurer and include these facts in any disclosure. Years ago, for instance, a California insurer with a known history of paying higher than prevailing policy interest and higher than normal commissions was eventually placed in liquidation. Why didn't more agents question these practices? Does it make sense that one company could substantially outperform another year after year? Would this have been a reasons to, at the very least, diversify among other companies.

Reinsurance

Reinsurance is an effective tool for spreading risk and expanding capacity in the insurance marketplace. The strength of the guarantees backing the primary company, however, are ***only as strong*** as the financial strength of the reinsurer. Abuses have occurred where the levels of reinsurance have been too high, the quality poor and the controls nonexistent. Industry analysts suggest that the total amount of reinsurance should not exceed 0.5 to 1.3 times a company's surplus. Agents should also be concerned about foreign reinsurance since U.S. regulator control and jurisdiction is difficult. See how much of the foreign reinsurer's assets are held in the United States. Ask if the reinsurer has ***directly guaranteed*** the ceding company or used bank letters of credit for this purpose. These credit letters have not been effective guarantees in the past. Also, under terms of the ceding contracts, can the reinsurance be ***retroceded*** or assumed by another reinsurance company -- it is possible to have layers of reinsurance which could create difficult legal maneuvering during a liquidation? Does the ceding contract have a ***cut-through*** clause which allows the reinsurer to pay deficient policy owners or insureds directly, rather than to the liquidator? Is the insurer writing a significant amount of new business that may require costly amounts of first- year reinsurance?

Reinsurance surplus relief is another area of concern to investigate. The first year that an insurance policy goes on the "books", the insurance company suffers a loss. This is attributed to laws related to the accounting valuation of the policy and the high costs or expenses paid in the first year, such as commissions, etc. A loss to an insurer also reduces a company's ***surplus***. A strain on surplus can create all kinds of problems with regulators and lenders, so insurance companies go to great lengths to ***shore up*** their surplus from the losses of first year policies. This may be accomplished by raising additional capital or through some form of financing. More often than not, however, an insurance company will simply call up the local reinsurance company and obtain ***surplus*** relief reinsurance. Once in place, surplus reinsurance provides the ceding company, the insurer who uses the reinsurance funds, with assets or reserve credits which improve the insurers earnings and surplus position. The major difference between using reinsurance to cover first-year losses and a loan is how the transaction is reported. When an insurer obtains a loan, the accountant must record a liability. Reinsurance for surplus relief, however, is NOT ***considered an accounting liability*** under statutory laws because the repayment is tied to future profits of the policy or policies being reinsured. Collateral for the reinsurance, in essence, is future profits. Thus, reinsurers run substantial risks when the ceding company cannot pay. The fee or interest for providing the reinsurance is typically from 1 percent to 5 percent of the amount provided.

Regulators are well aware of reinsurance surplus relief practices. Over the years, they have introduced rules which attempted to minimize abuses. The 1992 Life and Health

Reinsurance Agreements Model Regulation was adopted by the National Association of Insurance Commissioners. The National Association of Insurance Commissioners also adopted a 1988 regulation which reads as follows: " . . . If the reinsurance agreement is entered into for the principal purpose of providing significant surplus aid for the ceding insurer, typically on a temporary basis, while not transferring all of the significant risks inherent in the business reinsured and, in substance or effect, the unexpected potential liability to the ceding insurer remains basically unchanged". The reinsurance market has taken some heavy blows in past years.

On the demand side, traditional buyers are looking for new approaches that bring together reinsurance and investment banking techniques to manage both capital and risk. Further, the industry has recorded heavy casualty losses from earthquake and hurricane catastrophes. Finally, there is the Unicover Pool fiasco. Primary insurers were ceding away significant amounts of their potential losses while only retaining a ***small exposure*** and managing agents were given too much writing authority without adequate controls. The Unicover Pool was packaging blocks of business for reinsurers to buy where the premiums received did not cover the risks assumed. Most of the losses were in the worker's comp arena, but the effects have shaken the entire industry.

As a result of these problems, reinsurance may be harder to come by and more expensive when you can. In essence, this is a huge wake-up call for the entire industry. Agents who were not fully aware of their company's reinsurance arrangements should be more alert in the future.

Size of Company & Loan Portfolio

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

Statistically, fewer failures have hit companies with assets ***greater than*** $50 million. It is thought that larger companies have more diverse product lines, bigger sales forces, better management talent — in essence, they are better equipped to ride out financial cycles. In recent wide scale downgrading of insurers, A.M. Best seems to have favored significantly larger companies in the over $600 million category. However, another advisor feels that a small, well-capitalized companies can deliver as much or more solvency protection as a large one suffering from capital anemia.

State Admission

Checking that an insurer is licensed or admitted to do business in the state at least assures that the company has met solvency and financial reporting standards. Most states offer toll free numbers for these inquiries. Some states will also divulge the rank of an insurer by the number of complaints per premium volume. Agents should realize, however, that to date no court has allowed an insured who has suffered a loss as a result of an insurer insolvency to recover from a state run department of insurance for failure to regulate the solvency of the insurer.

Risked Based Capital

Risked Based Capital guidelines could prove to be one of the most useful tools for quantitative analysis. In a nutshell, it is a ***capital sufficiency test*** that compares actual capital, surplus, to a required level of capital determined by the insurer's unique mix of investment and underwriting risks.

Guidelines for this new regulation took effect in 1994 for life and health companies and 1995 for property/casualty insurers. Risk Based Capital is the brainchild of the National Association of Insurance Commissioners. Since its inception, the National Association of Insurance Commissioners have strived to create a national regulatory system by the passage of ***model acts*** or policies designed to standardize accounting and solvency methods from state to state. Risk Based Capital is one of many "model acts" recently adopted by the National Association of Insurance Commissioners.

The ***Risk Based Capital Model Act*** defines acceptable levels of risk that insurance companies may incur with regards to their assets, insurance products, investments and other business operations. Insurers will be required, at the request of each state insurance department, to annually report and fill out Risk Based Capital forms created by the National Association of Insurance Commissioners. Formulas, under risk based capital, will test capitalization thresholds that insurers ***must maintain*** to avoid regulatory action; recalculate how reserves are used; reduce capitalization required for ownership of affiliated alien insurers and non-insurance assets; and allow single-state insurers to qualify for exemption from reinsurance capitalization if their reinsurance doesn't exceed 5 percent of total business written. The risked based capital system will set ***minimum surplus capital amounts*** that companies must meet to support underwriting and other business activities. Because the standards will be different for each company, the guidelines run counter to existing state-by-state regulations that require one minimum capitalization requirement for all insurers regardless of their individual styles of business or levels of risk.

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

It is clear that Risked Based Capital encourages certain classes of investment over others. For example, an ***asset-default test*** under Risked Based Capital, called C-1, establishes varying reserve accounts be established for various classes of investments based on their default risk. These amounts could be as much as 30 percent for stocks and low quality bonds and 15 percent for real estate owned as a result of foreclosed mortgages. Industry critics say that the ***C-1 surplus requirements*** alone could be far greater than all other categories of Risked Based Capital like mortality risk assumptions, interest rate risks and other unexpected business risks. Since the 1994 Risked Based Capital reports are based on 1993 financial conditions, many insurers have already started to restructure their portfolios to avoid as many C-1 assignments as possible. This has included the wide scale disposition of real estate and real estate mortgages, the repackaging of real estate products into securities and large reductions in "junk bond" holdings. Despite these efforts, C-1-rated classes of assets continue to represent a sizeable share of insurer portfolios. In many cases, companies have very few options to unload foreclosed real estate as long as the market

continues soft. A Saloman Brothers Inc study of almost 500 insurance companies clarifies the problem. Using 1992 financial reports for these insurers, the median level of surplus capital was found to be at 189 percent of their respective Risked Based Capital levels. Even though, a majority of companies exceeded the 150 percent threshold — thus, not requiring regulatory correction — the results indicate that hundreds of companies did not measure up. The concern by industry groups is that when Risked Based Capital is enacted, the results could generate significant "bad press" which could weaken demand for individual company and industry products. There is also speculation that companies will change investment portfolios to achieve higher Risked Based Capital ratios. This may critically hamper real estate investing for a some time to come.

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

Some in the industry also feel that the Risk Based Capital rules are simply too restrictive, subjecting many of the best known insurers to immediate regulatory action and "bad press". This, in turn leads to a "run on the bank" that could tip these insurers into worse condition. The concern of these parties is that the risk based capital system doesn't falsely identify adequate capitalized insurance companies and undercapitalized ones as being adequately capitalized. Too much is concerned with the type of investment, rather than its quality. Just how companies react to these guidelines remains to be seen. As mentioned, many life and health insurers have already changed their investment strategies to more favorably align with risked based capital guidelines by selling their large scale real estate investments and junk bonds.

Choosing Product

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

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

An agent seeks coverage as a means of transferring pure risk. A client views a policy in terms of obtaining reduced uncertainty, i.e., in most cases, your customers can only hope that the policy they purchase is appropriate. That is why agents are vital players in any insurance purchase. The greater agent due care exercised, the more valuable the service. Agent choices were at the heart of the issue in recent class-action suits involving pensions and life products. Allegations that agents marketed life policies and annuities to tax-qualified

pension plans have led to multi-million dollar settlements. Even though the insurance industry defends the choice of this product, the courts say that placing a tax-deferred product inside a tax-deferred retirement plan is redundant, unnecessary and costly to consumers. The critics say that mortality and expense costs associated with life products, like variable annuities, make them a poor choice compared to mutual funds. In addition, the tax-deferral feature is unnecessary. Oddly enough, the issue here does not focus on performance, where some variable annuities inside pensions have outperformed mutual funds. Rather, the focus is on disclosure and suitability.

Disclosure is also why, when viewed from an agent's liability, ALL options of the policy chosen should be disclosed. The textbook case here is Southwest v. Binsfield - 1995. A client requested coverage for his business and relied on the agent to make an appropriate policy choice. At no time was “employee dishonesty coverage” discussed and it was NOT included in the coverage even though it was a widely available option. A company employee embezzled over $150,000 and the insurer refused the claim. The agent was found liable because he was duty bound, but failed to advise his client that this type of coverage was an option. This case has broad application in all areas of coverage — life, disability and casualty — and agents would be wise to adhere to the simple principle of disclosing widely available policy options.

Policy Choices & Risk Management

The process by which agents help clients select the most suitable policy is known as ***risk management***. The two basic rules concerning risk management are: 1)The size of potential losses must have a reasonable relationship to the resources of the client, and 2) Benefits of risk reduction must be related to its cost

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

The agent must also consider a client's ***pure risk* vs. *speculative risk***. Both pure risk and speculative risk involve uncertainty, but in pure risk, the uncertainty relates only to the occurrence of the loss. In other words, there is no chance for a profit to be made. Speculative risk offers the opportunity for both gain and loss. An example of a speculative risk is when a dilapidated apartments burns and is replaced with new housing. Society can gain from speculative risk. However, the agent would do better to concern himself with the pure risk losses of the client. In the above case, for example, does the apartment policy provide pure risk provisions, such as a "lost rent clause" to provide the client and his family sufficient cash flow while the new apartment is being built?

The ***process of risk management*** requires setting and achieving goals in at least four areas: pure risk discovery, options to deal with the risk, implementation and on going risk monitoring.

Pure risk discovery: Requires knowledge about a clients assets, income and activities of his family or business. Several sources can be valuable, including: financial records (balance sheet and income statement), specific information on each asset (location, title replacement cost, perils, hazards they are exposed to). Questions about sources of income and expenses help determine the client's ability to self-insure all or a portion of any potential loss. Physical inspections of the client's home and business might also pinpoint additional

liability loss hazards. This can even include a study of all existing contracts such as leases, employment contracts, sales and loan agreements.

In the case Aetna v. Rodriguez - 1988 the agent chose a policy based on what he ***believed*** his client was saying. The courts determined that even though the client used words that could have been interpreted two ways the agent should have investigated the “real” need and not simply wrote the policy in a manner that was legally advantageous to the insurance company.

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

Options to deal with risk: These can be evaluated after specific risks have been identified. The risk manager's goal is to reduce the "post loss" resources needed by the client using the most efficient method. In essence, this is the age old battle of balancing costs and benefits. That is why risk management is maximized when using more than one insurance company to carry the burden. In this decision, however, there is temptation to resist paying for excess coverage of any type which can rob the client of cash flow that could otherwise be used to build assets more quickly and less expensively -- specifically, assets that are needed to provide for the present or to create a "living" for the future. As part of this consideration, it may just be that the client pays premiums for many years, is never disabled or does not die earlier that his life expectancy. Or, he may never sustain a loss of property. The responsible agent should advise the client that this too, is a possible outcome.

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

Implementation: Made after the agent has developed specifications for coverage, established criteria or standards for insurers; compared rates and terms for the most efficient contracts and arranged for all contractual requirements, like the application, rating history, specimen tests, inspections, etc. Probably the most important contribution the agent can make at this phase is in aiding client indecision. Clients and agents alike can be frequently confused by the continuing arguments favoring term versus whole life or the value of an inflation rider to protect future property values. The result of these conflicting considerations and advice can be that too much time is spent wallowing in indecision about levels and type of protection for what reasons. The fallout may be over insurance or under insurance or no insurance at all. The professional agent who practices due care will also provide counseling to bring these decisions to settlement.

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

While the process of risk management is conceptually similar across most product lines . . . life, health, disability, property, casualty . . . the analysis of exposure is quite different.

Too Good To Be True

Fundamental to choosing appropriate product for your clients is the understanding that all insurance is constructed of the same elements -- expenses; experience (claims risk or mortality); and return or profit. Therefore, a policy that appears to be significantly better than others in the marketplace should be suspect. Once a suitable product can be found, the decision to buy should be based on the assumptions in the policy and the financial stability of the company. Policy illustrations and quotes are one method to make this assessment. Unfortunately, agents and clients rely too much on these presentations to the extent that policies are rarely read. As a result, agents should be sure that any projection or estimate disclose the assumptions that went into the projection and the fact that variations in these assumptions can significantly change insurance results. Recent laws have even made it mandatory to include (in cases of certain product eliminate illustrations) and/or bold or highlight any "guaranteed" portions, as compared to simple projections. It is further suggested that illustrations be run again, using realistic input, to see if they still meet client expectations. And, always obtain a specimen policy, and if applicable an outline of coverage, to get to the bottom of glowing terms and/or "too good" features and benefits.

CHAPTER TWO
BUSINESS PRACTICES

Business conduct is the behavior you ***chose to uphold*** to be a better agent. This involves more than legal compliance and more than maintaining a code of ethics. Business conduct is the adherence to procedures that make you the most responsible agent you can be. As a positive side effect, following better procedures also helps mitigate the legal exposure you carry as an agent and should yield greater respect from your clients. Ultimately, the combination of these two aspects will lead to a higher level of success in your insurance practice.

There are many components of proper business conduct. Starting on the next page, we have boiled many of them down to a ***code of procedures*** that every agent should adopt. A closer look at some of the more important procedures are discussed below.

Solutions

Be solutions-based in your approach to helping clients. This means more than performing a task. It means providing solutions to their insurance dilemmas by knowing needs and financial objectives. It means ***listening*** to clients, ***discussing*** exactly what the product will do for them and be sure they ***understand*** the information you are presenting.

Some of the most frequent complaints that insurers and regulators receive stem from purchases where clients did not know exactly what they were buying; thought they were ***fully covered***; thought the coverage was for more than the limits allowed; did not know there were surrenders, penalty charges or taxes associated with the product; and / or the product simply was not appropriate for their needs.

Solutions create ***satisfied customers*** which minimizes conflicts and prevents problems like these from ever starting. Further, if a problem does develop, you will be better prepared to respond.

Of course, before you can offer solutions, you must engage in a fact-finding process to gather information on the client's current insurance / financial needs and goals. Each client's needs are unique; based on individual circumstances and goals. You will need to consider age, health, education, employment, dependents, income, assets, debt, standard of living, new worth, tax status, financial experience, current financial status, retirement plans and risk tolerance to mention a few.

Finally, and just as important, you need to understand your products; which one is appropriate for the client and explain to them exactly how they work. For your own protection, it is also important that you document all analyses and conversations so that if questions arise later they can be effectively answered. To accomplish this, you should keep all records pertaining to information about your client, information on their needs and the matching of appropriate product as well as your explanation on how the product works to meet their needs.

AN AGENT CODE OF CONDUCT

In all my professional relationships, I pledge myself to the following code of procedures

I will focus on customer service and customer satisfaction ***first***.

I will disclose all facts needed to enable my clients to make informed decisions.

I will sell to my client needs, not my own. My approach will be ***solutions-based***; helping my clients solve their insurance dilemmas by knowing their needs and financial objectives

I will ask the ***3 closing questions*** to determine that my clients understand the product I am recommending:

- Have I given you all the information you need to make a decision?
- Does this 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?

I will pay close attention to my client's need for ***liquidity***. Products that fail to match a client's time frame should be avoided and those that fall short of a specific need supplemented.

I will spend ***extra time with client applications*** – a serious matter where mistakes can void a policy. I will make sure that my clients understand the importance of accurate information and the ramifications of mistakes – especially intentional misinformation.

I will never promise complete coverage if it is not possible to achieve. Rather, I will strive to provide my client the most ***correct coverage available at the time of sale***.

I will do my absolute best to spot and disclose ***gaps in coverage***, even if it means my clients must purchase additional coverage elsewhere. My silence about inadequate provisions or coverage gaps is the same as a lie.

I will offer immediate or conditional coverage to clients if it is within my authority to do so.

I will always explain widely available options available on policies I sell.

I will know the difference between policies I am selling and carry ***specimen policies*** to answer specific questions on coverage or terms.

AN AGENT CODE OF CONDUCT - 2

I will always use *reasonable care* and follow through in obtaining coverage. And, I will always act within *standards* of other agents in the same field.

I will never make promises that exceed the limits of the policy I am selling.

In all my advertising I will follow strict consumer protection rules including the prior approval by my insurer, identification of my insurers, accuracy and truthfulness, realistic illustrations and quotes, fair comparisons and competitive references, real testimonials or endorsements and the fair treatment of all individuals I approach and serve. Also, my advertising shall not employ words, letters, initials, symbols or other devices which are similar to those used by a governmental agency, charitable institution, etc to mislead clients into thinking I am endorsed by or authorized by these entities.

To reduce client disputes, I will develop and *utilize client disclosure agreements* acknowledging any limitations in my services, policy options that were refused as well as client refusals to seek outside tax or legal advice. Posting a Public Policy (on a website and in my office) with regard to disclosures and referring to it in my ads and stationary will help if I forget to present a written disclosure form.

I will follow strict procedures when using illustrations that involve showing all pages of the printout and explain to clients that it is a projection not a guarantee of future policy performance. Also, I will be careful not to highlight or change the illustration. In any casualty quotes or proposals, I will be very specific to match the quote to the specific coverage and avoid any language that implies the client is covered.

I will always obtain a *specimen policy* for products I sell or intend to sell. I will study these policies and *know what they say and say what they mean* because ambiguity, whether in a policy or my presentation, will not be decided in my favor in any dispute.

I will strive to learn as much as I can about the *underwriting of products* I sell in order to better place my client's coverage in an expedient and efficient manner because in any insurance transaction *time is working against my client*.

If I profess to have *special knowledge or expertise* in a field or product, I realize that I have assumed a *higher standard of care* that my clients depend on. In any dispute, I will have to prove my special skills were used properly in accordance with rules of fairness and fiduciary responsibility.

I will be certain that the insurers I represent are *financially solvent* at the time insurance coverage is placed for my client. Monitoring solvency after the sale may not be a legal responsibility, but it is a good measure of "preferred business conduct".

I will develop my own Privacy Policy to explain to my clients how and why I will protect the personal and financial information they have entrusted to me.

AN AGENT CODE OF CONDUCT - 3

I will never advertise or represent that an insurer or product as *safe* because of the existence of state guaranty funds.

I will never make an untrue statement or derogatory comment about another insurer or competing agent.

I will witness clients signing papers and try never to simply leave them or mail them for later signatures where I am not present to witness.

I will strive to personally deliver issued policies promptly because it is "preferred business conduct".

I will develop ***standard operating procedures and an operations manual*** to help me be consistent in how I treat all clients, handle premium payments, document client conversations, review client policies, process applications and cancellations, respond to client inquiries and complaints.

I will maintain good customer contact and always respond to letters, calls, voice mails and e-mails. And, since I am aware that virtually ***all communications with a client is considered advertising***, my words will be clear, complete and balanced concerning benefits, costs, limitations and terms.

I will take all client complaints and concerns seriously and be sure that they are resolved fairly and quickly. Where a dispute develops, I will not try to settle the case or ignore the duty I have to my errors and omission carrier.

I will respect my clients right to privacy and safeguard any information I collect on them. I will ***never*** make a derogatory remark in my client's file or reveal personal information.

I will always make a note to my client's file regarding any actions taken or proposed and I will create a paper trail of all conversations and reminders.

I will review my client's coverage annually. Where I have a special or long-term relationship with my client I realize that I may have a legal and ethical duty to monitor the appropriateness of these policies ***after the sale***.

I will make sure that any replacement policies are beneficial and understood by my clients. And, I will ***document why*** a replacement policy serves my client's needs and objectives better than keeping the old policy.

I will abide by all laws and regulations in my area.

AN AGENT CODE OF CONDUCT - 4

I will not influence clients or prospects in thinking they will lose a right, privilege or benefit under any federal, state or local law if they fail to respond to my letter in order to make a sale.

I will not use an address so as to deceive as to my true identity, location or licensing status or that of my insurer.

I will not use the term *seminar, class, informational meeting* or substantially equivalent term to characterize the purpose of a public gathering if the real intent is to sell insurance without adding the words *and insurance presentation* immediately following those terms in the same type size and font.

If I am doing business with *senior citizens* I will be particularly careful to avoid any actions that might scare or intimidate like alluding to their loss of benefits in any way from Medicare or Medicaid. I will voluntarily withdraw any offer if I become aware that a prospective senior client may lack the short-term memory or judgment to knowingly purchase an insurance product.

I will not restrict or limit a client or prospective client from having other persons present at a meeting, including family members, financial advisors, attorneys, etc.

If I am meeting in a client's home, I will properly notify him that I am coming, either by phone or in writing.

At any meeting, my client has and I will honor his right to end the meeting at any time. And / or , I will end any discussions and leave the client's home immediately after being asked to leave.

I will read and know the terms of my ***agency agreement(s)*** including all duties and responsibilities they bear.

If I refer a client to another professional, I will refer only to those I believe to be trustworthy and I will let the referred professional do his own fact-finding concerning my client's needs and objectives.

I will remember that I am also a ***fiduciary*** of my insurer and must always exercise reasonable care, skill and diligence on their behalf.

I will be come a student of consumer protection issues and "agent blunders" because I can learn a lot about serving my clients correctly from the mistakes made by others before me.

A case where agent's ***failed to back-up*** is State Farm v. Gros - 1991. The client alleged that the agent advised him that the policy covered landslides; the agent remembers advising him it did not. Three years after purchasing the policy the client filed a landslide claim which was NOT covered by the insurer. Because the agent file lacked notes regarding client conversation, the courts held that the policy was misrepresented and the insurer was bound by the agent's actions.

In another case, a policyholder claimed that she ***informed*** the agent that she would need money in three to five years for her children's college education. The agent sold her a fixed annuity with a nine-year surrender charge period. Of course, when it came time to fund college expenses there were taxes and penalties which led to a claim of misrepresentation. Unfortunately, the agent could only provide a brief narrative account with no meeting notes or written documentation. Surrender charges were eventually waived and the producer was charged-back the commissions.

How could these situations been handled better? Let's look at another case where a client alleged that a product did not meet her needs. The agent maintains a ***standard operating procedure*** of providing all applicable disclosure documents, many with the client's signature. The agent routinely sits down after each sale and makes a record of the conversation, including topics discussed, special comments regarding the clients needs, liquidity and anticipated future events. The agent's file included an objective and needs questionnaire filled in by the client which memorialized her statements regarding specific needs like liquidity. The bottom line? The agent was able to demonstrate that he knew the client and her needs by keeping notes and records of all contacts and documents. The file showed that the agent was solution-oriented and had made a good sale. All charges were dropped.

Applications

Applications are serious business where a mistake can void or decline a policy or claim and get you sued. Spend at least 50% more time than you do now to make your applications accurate and complete.

Applications are the lifeblood of the your business yet most agents regard them as a hassle. You have a ***legal duty*** to be sure that each application is completed ***fully without deceit*** of any nature. The information on all forms must be accurate to the best of your knowledge. Following are a few instances where this did not happen: In Bitz v. Knox (1998), an agent was sued for inadvertently submitting erroneous financial information on a disability application. In Johnson v. Illinie Mutual (1958) an agent was requested to insure a specific home at a specific address. On the application, the agent "misdescribed" the house number. The insurer refused the claim and the agent was liable for failing to follow instructions. In BSF v. Cason (1985) the client's claim was refused and the agent was taken to task for failing to record a client's past claim and cancellation experience. In Lewis v. Equity National (1994) the client alleged that the agent filled out the application and failed to list the clients many heart-related treatments. The courts awarded punitive damages. In Life Investors v. Young (1999) a life insurer sued its own agent for $26,000 when he failed to indicate a known pre-existing heart condition on a credit life application. Information must be current, especially medical and health information and all dates must be correct. Predating and postdating of applications is strictly forbidden by every insurer. In American v Hollins (1999) even though the insured lied about her preexisting condition the fact the agent was ***in charge*** of the application meant the policy could not be voided. This caused problems for

the insurer and the agent. And, in Malonev Basey (2002), the agent bound the insured but the 3rd page of the application failed to transmit over the fax. Sure enough, an accident occurred and the company denied coverage due to an incomplete application. The agent was in the middle of his client and his carrier.

Minimizing Application Conflicts

Agents should ensure that the applicant understands the questions in the application and ask the prospective insured to read it to confirm that everything is answered correctly and completely. Only then should it be signed. Under no circumstances should applicants sign blank forms. In Smith v. Dodgeville (1997) the agent was sued for failing to answer a standard question on the application regarding "previous cancellations". The client indicated he would have answered the question truthfully if asked. In Ward v. Durham Life (1989) the agent assured the applicant that missing health history information on the application did not need to be disclosed. Coverage was denied.

It is important that applicants understand the need to complete ***accurate applications*** since errors or intentional misinformation can void a policy and lose you a commission and future business. This is especially true for your own policies or those you write for families and friends. In Southland Lloyd's v. Tomborlain (1996) an agent misrepresented age, purchase price and condition of property on an application for property he personally owned. The court held that an agent's fiduciary duty is highest when he writes his OWN contracts. Of course, there are thousands of cases involving clients who misrepresent information on an application. As you will learn later, these misrepresentations are considered ***material*** if it is relied upon by the insurer in issuing the policy.

Concerning knowledge about a potential claim or concern at the time of application, your clients have a duty to disclose information on an application ***only to facts and not mere fears or concerns***. There is no requirement that applicants disclose their fears or concerns or facts that an insurance company may already know or has already waivered. For example, someone who has occasional headaches does not need to disclose his fear that he has a brain tumor.

As a ***witness to the application***, you must be sure that only the applicant himself, sign or initial and you should never leave an application, surrender form or affidavit to be signed if you are not present at the signing. In Crobons v. St Paul Fire (1981) an agent thought he was "helping" a family when he "witnessed" someone other than the client (who was in a coma at the time) sign a change of beneficiary application. The agent was responsible for his damages for his fraud. In Great American v. York (1978) an agent was responsible for the client's damages because he failed to follow insurance company instructions to submit a completed application – he accepted an application from the client's wife without the client's knowledge and signature.

Just as important as the procedures above, you have no authority to ***change answers*** on an application without the knowledge, consent and written approval of the applicant or insured. Likewise, your insurer restricts you from altering or waiving any term or condition of an application without prior consent. In Saunders v. Cariss (1990) a client sued his agent for signing his name without his authorization. The agent purportedly filled in a box on the application which reduced uninsured coverage. In Commissioner v. Grossman (1986) an agent actually back-dated an application with his postage meter to give the appearance that

an application was submitted two days prior to a fire. A conviction for fraud against the agent was won.

Additionally, you have a duty to notify applicants when their applications have not been accepted. This is exactly what happened in Boothe v. American Assurance (1976) and the agent was found liable for his negligence.

Agency Agreements

The relationship and liability you owe to both your client and insurer should be clearly spelled out in your agency agreement. Unless you wish to assume liability beyond your license responsibilities, it is imperative that you take out your agency agreement and read it at least three times. Some agents ***never*** read their contracts. How about you?

Your agency agreement, if you follow its provisions, can protect your ***agent status*** in a lawsuit between your client and the insurer. Most insurers will attempt to focus or narrow the authority of agents to limit their exposure to agent wrongdoing. In practice, however, the law ***generally*** considers the agent and the insurer as one and the same so the insurer is the ultimate "deep pocket" for problems – in essence an ***agency relationship*** is established. While this may help to insulate, agents are regularly and routinely named in suits against an insurer. Agents are also sued by their own insurers looking for reimbursement for violations of agency agreements.

If you don't read your agency agreements, how would you know if you routinely promise things to clients ***outside*** the limits of this agreement for which you could be personally liable. How would you know you violated certain fiduciary duties to your insurer that are defined in your agreement? Or, acting outside agency agreement limitations, you could be establishing yourself as an ***expert*** or ***dual agent*** with almost unlimited liability for whatever goes wrong with your clients' policies. In essence, if you choose to ***push*** the limits of your agency agreement in accepting unapproved business ***you act as the insurance company until coverage is accepted***. Take Stuart v. Indemnity National (1982), for example. An agent offered to ***bind coverage*** for a client when the agent, in fact, did not have binding authority. A loss occurred before the application was approved and the courts made the agent responsible for the applicant's losses as those he was the insurer.

In another case, Sobotor v. Prudential (1984), the agent held himself out to have ***special knowledge*** in a certain area of insurance – again, outside the purview of the agency agreement. The client, knowing little about the technical aspects of insurance in this area, asked the agent for the "best available" coverage. A claim was denied by the insurer for "optional coverage" that was not recommended for the client and the agent, not the insurer, became liable to cover the losses. Had the agent simply promoted himself as a responsible agent of the company and promoted correct product, it is likely he would have been afforded the protection of his agency agreement and the insurer would have paid.

Simply because you have an agency agreement, do not be lulled into thinking that there is nothing that can touch you. There are clauses in your agreement that may seem to protect you, yet leave you in the lurch. For example, in the Goebel v. Suburban (1997) matter, an insured launched a meritless case against the agent for negligence in procuring coverage. The claim was quickly dismissed but the agent wanted reimbursement for court costs from his insurer because a clause in his agency agreement outlined indemnification for liability

caused by the insurer's acts of omission. Even though the agent was "in the right" and his contract called for indemnification, the common law of his state did NOT require insurer's to indemnify agents against frivolous claims. The agent was out.

Routine reviews of agency agreements have found other, unpalatable clauses, such as:

- Unreasonably limited indemnification of the agent for insurer wrongdoing
- Loss of insurer indemnification if there was ***any*** wrongdoing by the agent
- Termination of agent with as little as 30 days notice or without prior notice
- Minimum net premium volume requirements
- Forfeit of all agent profit-sharing and override payments earned if terminated
- Change in commission rates without notice
- Agent indemnification of the company even if the insurer was the significant contributor to the liability
- No protection for agent ownership of expirations

Any agent would consider these terms unacceptable yet agreements with these vary clauses are signed every day. Shouldn't you take out your agency agreement and find out if they have similar weaknesses?

Communications

Be a student of consumer protection laws and unfair selling practices because practically all insurance communications you have with clients is regulated by insurance code or as consumer advertising. That's right! ***Nearly ALL client contact is considered advertising*** that is subject to strict state and federal laws (*and penalties*) with titles such as *The Uniform Sales Practices Act; Deceptive Trade Practices and Unfair Insurance Practices*.

In practicing better business conduct, it is important that ***any communication*** with your client (written, verbal or electronic) be ***clear, complete and balanced*** in providing benefits, costs, limitations, and contract terms of products you present or service. Remember, even though people today are generally more sophisticated and have access to more information, most clients still have trouble understanding the terminology of insurance, determining appropriate product and the amount of coverage to buy. They look to you NOT to make those decisions for them, but to guide them through the process so they can make informed decisions based on their own best interests.

Issues where conflicts abound include prior approval of advertising by insurers, identification of insurer and product sold, accuracy and truthfulness in advertising, unrealistic illustrations or quotes, unfair comparisons and competitive references, unapproved testimonials or endorsements, discrimination among individuals of the same class, unlawful rebates, deceptive name or symbol usage and at least another two dozen violations.

Agent licenses have been revoked or suspended for activities where the licensee did not actively, and in good faith, conduct proper business conduct communications. In Steadman v. McConnell (1957) a licensee was found guilty of making false and fraudulent representations of a policies expected cash values for the purpose of inducing clients to buy them. In Horeiter v. Garrison (1947) an agent's license was revoked for misrepresenting policy benefits. And in McConnell v. Ehrlich (1963) an agent's misleading letters and

advertising inferred he could place coverage lower than others because of his ***volume plan***. His license was revoked.

Minimizing Communication Conflicts

Be ***current and responsive*** to your clients. Promptly answering client / insurer mail, e-mails and phone messages can eliminate conflict and build confidence. There are many insurance professionals who ***block off*** a certain time of day just to open mail or respond to e-mail – without fail and without interruption – it's that important. There are countless documented and undocumented cases where a simple failure to respond mushroomed from a little problem to a huge liability. Take the Gulf Insurance v. Kolob Corporation (1968) case. For various reasons, an insurer decided to cancel all of an agent's business policies – it happens--and, because the agent had a large volume of clients to find replacement coverage, it took more than six weeks to notify a some clients. Naturally, a claim occurred and the insurer refused coverage for the agent's ***unreasonable*** delay in cancellation notification. Ultimately, the insurer was forced to pay but the agent was pursued for indemnification. In a similar action, Boothe v. American Assurance (1976), an agent was sued for failing to mail an application and advance premium payment to an insurer. The agent was forced to cover the client's losses when a flood damaged the applicant's property.

Replacements & Exchanges

In any known replacement or exchange of policies a producer should:

- Provide and ***carefully review with the client*** information to help the client understand the advantages and disadvantages of replacing an existing policy; and
- ***Document why*** the purchase of a new policy serves the client's needs and objectives better than does the maintenance of existing coverage

A replacement may NOT be in the client's best interest because of:

- Suicide or contestability limitations in a new policy
- Higher premiums for new coverage at current attained age;
- Diminished value of the existing policy where unpaid loans will be deducted
- New acquisition expense charges may result in lower future cash values (assuming the same face amount)
- New possible surrender charges
- Loss of privileges and options under the old policy which may not be available in the new one

Replacement regulations and requirements apply if a new insurance or annuity policy is to be purchased, and it is known or should be known to the producer that, by reason of the transaction, an existing policy has or will be:

- Lapsed, forfeited, surrendered or otherwise terminated
- Converted to reduced paid-up insurance, continued as extended term insurance, or otherwise reduced in value by the use of nonforfeiture benefits or other policy values
- Amended so as to effect either a reduction in benefits or in the term for which coverage would otherwise remain in effect.

- Reissued with any reduction in cash value; or
- Pledged as collateral or subjected to borrowing for amounts exceeding 25% of the loan value of the policy.

Know when a replacement form or exchange form is required because there is considerable regulatory and civil litigation surrounding these procedures. Utmost in the minds of the legal powers is high standards of honesty, fairness and whether or not you clearly identified that a replacement was in your client's best interest.

What can be especially troublesome is situations where ***you may not even recognize that a replacement has occurred!*** Sound impossible? Well, let's talk about a case where the money for a new annuity or life policy comes directly from your client and not another insurance company, i.e., you collect a personal check from a client yet the money that he is giving you actually came from the surrender proceeds of another policy with a different company. ***Just because the money went into the client's account before it made its way to you as a "cash application" doesn't mean it is exempt from replacement regulations.*** The above is also true if the client receives a check from the surrender of an existing policy and endorses it directly over to a company for the purchase of a new policy.

Know Your Own Product

You must know your own product. Know the options available and be able to explain the differences between policies you sell. If you don't, it can land you in court. In R-Anell Homes v. Alexander (1983) the agent indicated a phone system would be covered under the building's blanket policy. It wasn't and the agent paid the price. In Benton v. Paul Revere Life (1994) an agent ***upgraded*** a client's disability coverage where coverage was extended for ***life*** for an additional premium. The new policy, however, required a higher level of disability. The courts were clear to point out that ***any agent*** who does not understand the difference between two policies he is selling is subject to liability for fraud.

Disclosures

It is imperative that there is disclosure of all facts be so clients can make ***informed decisions***. Formal disclosures (in writing or in front of witnesses) also help establish proper business conduct if a dispute surfaces. Become disclosure-oriented in your practice and always ask ***3 Valuable Closing Questions***:

- Have I given you all the information you need to make a decision?
- Does this 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?

Where possible, use ***client disclosure agreements*** (signed by clients) acknowledging any limitations on the services you provide, e.g., premiums are subject to change, continued solvency of an insurer, the responsibility of an accurate application, etc. Additional disclosures could include options the client chose to refuse life seeking outside tax or legal advice, riders, waiver of premium, higher deductibles, etc.

Some agents use ***mini-disclosures*** throughout the application. 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. One of the better ***disclaimers*** around has application in many areas. Short but prominent notes of this nature do much to bring unsettled issues to the surface and protect both agents and clients:

This is not (legal, investment, etc) advice unless you and I agreed in writing beforehand that it is. These are complicated issues, and you need to discuss your particular fact situation with your (attorney, advisor, etc) before relying on any other advice.

Illustrations and Quotes

Agents should follow strict procedures when using illustrations, including:

- Show the client a complete illustration – no pages should be omitted
- Carefully explain that the illustration is a ***projection***, based on non-guaranteed factors, and it is not a guarantee of future policy performance
- ***Do not highlight*** portions of the illustration or make notations on the illustration. Such actions may be considered misleading.
- Always keep a copy of the illustration or the Certificate in Lieu of Illustration form.

The handling of illustrations has become very complex in recent years. Some policies now require them; some prohibit them; some require annual reporting updates and actuarial certification. These guidelines are established by your insurer and generally require the following of an agent:

- You and the applicant must sign the numeric summary page of the illustration
- You must provide the client a sign copy of the illustration
- You must submit an illustration with each policy (where required) during the sale
- Where an illustration is not used, you must submit with each policy application a completed Certificate in Lieu of Illustration signed by the applicant

You may also be interested to know that insurers are generally required to answer specific questions in their ***annual statement filings*** pertaining to the "basis" of dividend and interest rate projections in their illustrations; including their opinion of their ability to continue supporting current rates and their assumption factors if projected rates exceed their current experience level.

One of the biggest traps concerning illustrations is when a policy is issued ***other than as applied for***. In these cases, a new illustration must accompany the policy as a delivery requirement (assuming an illustration is required for the particular product).

Problem areas can and should be solved before you ever arrive in the field by requesting a copy or running various illustrations for policies you wish to handle. Clear up questions as soon as possible. If company management doesn't know the answer or they avoid questions, it may a clue that they will handle client policies in a similar way.

You should also know that mistakes in illustrations, even though made by the insurer, can cause problems. In Metropolitan Life v. Haney (1999) an agent used software provided his insurer. When policies were issued, however, differences between the original illustration and the policy caused several of his insureds to rescind. The agent sued the insurer for loss earnings and stress. The courts did not completely agree, saying that the illustrations were a

benefit to the agent and only incidental to sales. While he kept his commissions, the agent paid legal fees for his lost case.

Casualty quotes or RFQ's (requests for quotes) also impose specific agent responsibilities. The Eddy v. Sharp (1988) case is a prime example of what can go wrong. The agent prepared a standard proposal for a client wanting coverage for multiple rental buildings. The agent described coverage as ***All Risk*** subject to a list of eight exclusions. He even provided a disclaimer reading . . .

"*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*".

The client relied on the proposal letter, bought the policy but ***did not read it*** when it arrived. Client losses resulted from the back-up of water through his drains which was NOT covered in the policy. Of course, it was also NOT one of the eight exclusions mentioned in the agent's proposal. The courts held the agent responsible because his proposed coverage was "all risk" and client accepted same.

In any quote or proposal, be specific. If you are going to mention exclusions, you'll have to list them all. Also be sure that the quote matches the requested coverage; disclose principals and avoid any wording that might remotely imply the client is bound unless you intend him to be.

Correct Coverage

At a minimum, your clients should expect you to provide policies that are fair and appropriate coverage at the time of the sale. Your duty to inform a client of possible ***gaps in coverage*** is considered preferred business conduct. Discovering gaps in coverage is to be distinguished from providing "complete coverage" – something that is difficult to promise or expect. Rather, you are more geared to providing your clients ***correct coverage at the time of sale***.

The Bayley v. Pete Satire (1987) case is a prime example of what can go wrong. A client owned a bar-lounge and was assured by the agent that his business was "covered" . In fact the policy purchased contained an ***exclusion*** for alcohol-related lawsuits. An accident caused by a patron of the bar caused a lawsuit to end up on the agent's doorstep. The court concluded that the agent was indeed negligent. In an extreme lesson, the judge also ruled that the agent was held liable for all ***future*** alcohol related lawsuits until proper coverage could be secured. In another case, Free v. Republic (1992), an agent was asked by a client if his homeowner policy limits were sufficient to rebuild his home. The agent assured the client they were. A subsequent fire and quote to rebuild proved otherwise. The client brought suit against the agent and his insurer for failing to inform him of the inadequate limits of coverage. Even though the courts held that the agent had no legal duty to advise the client about sufficiency of coverage, once he elected to respond to the client's inquiries he acquired a special duty to use reasonable care.

Correct coverage is also obtained after you have assessed client needs, the appropriateness of a specific product and discussed any available options the policy offers that are widely available and cost effective. Client needs may also involve the investigation of ***split limits*** and / or the exploration of ***difference in conditions insurance*** where coverage gaps that

are excluded in underlying contracts may be available under a separate policy. In Lazzara v. Esser (1986) the client requested $100,000 of auto coverage. The agent purchased two policies, a primary with $300,000 maximum and an umbrella covering claims from $250,000 to $1 million. A few years later, the primary coverage was issued "split limits" of $100,000 per person and $300,000 per occurrence. The client was not notified about the gap in coverage, sued and prevailed against the agent when a loss occurred.

Determining the appropriateness of a product sold ***after the sale*** is a matter of the relationship you wish to develop with your client. There is no legal responsibility to continue advising a client about the adequacy of his policy after the sale. However, if you decide to commit yourself to doing so, be sure you are actually monitoring the situation and not along for the ride. For instance, in the Grace v. Interstate (1996) case, the agent continued to collect premiums for a health insurance policy. Eventually, the potential benefits of the policy were substantially supplanted by Medicare when the client turned 65. The length of time the agent did business with the client (ten years) was a factor in the courts determining that the agent had a special relationship leading to a higher standard of care to notify the client about double or incorrect coverage. In essence, if you are doing business with a client over an extended length of time, you may be responsible for ***continuous*** and correct coverage whether you choose to assume this duty or not.

Standard Procedures

If you don't already have standard operating procedures, develop them ***now***! Every client deserves to be treated equally and given the same level of service. It is also the best way to establish evidence and protect you in a liability suit. The best standard procedures involve the establishment of ***office protocol and operations manuals*** that:

- Create consistent and comprehensive steps for every sale. The offer of a special endorsement or rider, for example, should be offered to everyone and their acceptance or denial noted.
- Reduce oral agreements, scattered notes and conversations to a formal writing as soon as possible.
- Use automated equipment with database capabilities for up-to-date documentation and "date stamping" features.
- Note and file client needs and requests.
- Create a "follow-up" or "hot list" system for notifying clients about important dates, renewals and endorsements.
- Lay out set procedures for handling and logging phone messages, faces, copies, e-mails, photographs, microfilm, proof of mailing receipts, records storage, etc.
- Review policies received to be sure they are meeting client needs.
- Complies with application and cancellation procedures with the ability to track notices sent.
- Provide quick, easy access to claim processing and claim procedures.

Mishandling Money

Virtually all agents know that the proper handling of premiums is an everyday fiduciary duty to the insurer. There can be, however, situations "beyond your control" where premiums and coverage is lost and you are still held responsible. In Evanston v. Ticker (1989) the agent collected premiums and sent them to an intermediary broker who failed to obtain proper

coverage and refused to return the money. The good agent was sued. What most agents may find hard to believe is ***lost premiums are not covered by E&O insurance.*** The agent was personally responsible for $75,000 in lost premiums. This is the risk in dealing with an unfamiliar intermediary.

Underwriting & More

The most important aspect of underwriting is that ***time is working against the client***. If you are selling a life product, the client could develop complications or fall ill almost overnight. For casualty business, it could be an overnight fire or next day flood that destroys your client's home or business. Your underwriting responsibility is to process applications in a timely manner and collect and assess accurate facts for the application. An agent practicing preferred business conduct would also be sure that the transition to a new policy ***does not leave the client unprotected.***

Assessing the facts may involve reading documents or physical inspections. Take Hardt v. Brink (1961), for example. The client was a tenant in a commercial building. The client's lease (which was NOT read by the agent) had language that specifically excluded the tenant from coverage if the building was damaged. Unfortunately, the policy that the agent wrote specifically exempted the insurer from liability for damage to leased property. An investigation fell short, the client was not covered and the agent was sued. In Odendorf v. American Family Insurance (1982), even though the agent had personally visited the client's farm he did not inspect the operation in a sufficient manner to advise client that liability coverage for farm employees was needed. An on-the-job injury cased uninsured damages and a liability suit against the agent.

In a health insurance matter, Born v. Medico Life (1988), a client purchased a new health policy with a typical six-month waiting period for pre-existing conditions. The client assumed he was covered by the new policy and cancelled the old one. A health problem developed that was waivered by the six-month waiting period. The client was denied coverage and sued the agent. In this case, however, the agent proved that he advised his client about the six-month waiting period. He was found innocent. Could you see this case going another direction if the agent failed to mention the waiting period?

In another example, Jarvis v. Modern Woodmen (1991), an agent encouraged the client to drop an incontestable policy and purchase a new policy even after being advised about certain mental and financial problems. When these facts were found missing from the application the new policy was cancelled leaving the client bare. The courts awarded $500,000 in punitive damages.

These are all cases where ***agent knowledge*** of underwriting and facts of the case would have retained coverage for the client. There are also occasions where you need to assess underwriting facts and suggest a different tact. Let's look at a fictional case for an insured we will call "Mark". His application for life insurance included several notes to recent tests run by his doctor. The include three routine enzyme tests: GGT, AST and ALT. Mark's GGT test, which is the most sensitive to alcohol and accounts for 99% of most declines, was high. He claimed that he simply had too much to drink the night before. The AST and ALT tests, however, were also high indicating the likelihood of liver impairment. Again, Mark had some excuse. Further, Mark had refused his doctor's request to take additional tests including a scope and liver biopsy. When clients refuse these tests it always results in an automatic

decline, which is exactly what happened with Mark. The point is, if you know more about reading test results, you can better counsel your client on how to save further delays in processing (during which time he could deteriorate further). In this case, you could advise Mark that he is likely to be declined no matter how many times and how many places you submit his application. The problem with continuing is that something could happen in the meantime, leaving him no coverage at all. From here, your skill in placing him can depend on your knowledge of the impairment or suggest an alternative path like a different rating class or in Mark's case converting existing term coverage to permanent coverage without medical underwriting, etc. Look for the "tell-tale" signs and discuss them with clients instead of incurring repeated underwriting rejections.

Conditional Coverage / Binding Authority

Time is of the essence in every insurance transaction but mismanagement of coverage is one of the highest breaches of proper business conduct. Don't leave clients stranded without protection, even temporary, if it is within your power to provide it.

What can go wrong?

In Brill v. Guardian Life (1995) an agent took a client's life application but failed to advise the client his option to pay a small fee for a conditional receipt that would have provided immediate, although temporary life insurance. Upon the client's sudden death the widow sued the agent for negligence and the court agreed.

In Stuart v. National Indemnity (1982), an agent represented to a client that he had "full coverage" when the agent had no actual binding authority. A loss occurred and the claim denied. The agent was held completely responsible as though he was the insurer himself.

In National Inspection v. Valley Forge Life (2002) and agent accepted a check with an application where the applicant answered "yes" to a medical issue. Had the company not (by mistake) cashed this check, the agent would have been liable for the death claim that ensued.

Controlling Exposure

Pay attention to your carrier ***requirements***. Requirements may include: a signed application, payment, and minimum health requirements, reference to the terms of the full policy, etc. Each company's conditional receipt or binding authority varies.

In attempt to ***limit or control*** the exposure of conditional coverage, insurers craft them to be ***subject to*** later acceptance of the formal policy. In other words, an insurer is not going to be liable for a policy he would not approve in the first place. Theoretically then, the insurer retains the power under a binder or conditional receipt to reject the contract, thereby rendering conditional coverage ineffective if a claim arose before the formal policy was issued.

However, numerous court decisions have made this difficult in practice. Strict interpretations of language and the resolution of ambiguities ***in favor of the insured*** are more than norm. This being the case, insurers often take to suing their own agents for indemnification of conditional coverage gone bad.

Referrals

Since you cannot control how good a job someone else will do for your client, refer only to extremely trustworthy professionals and let them do the fact-finding. In one case, Rieger v. Jacque (1998), a client suffered financial injuries from a defective trust put together by an agent-recommended attorney. Fortunately for the agent, it was determined that the attorney did not rely on any statements made by the agent to prepare the trust, i.e., the attorney did his own fact-finding. Be careful out there!

Insurer Solvency

Always verify the ***current financial condition*** of insurers at the time of coverage. There are clear and certain legal penalties for placing coverage with an insolvent insurer or for having knowledge of pending insurer problems at the time coverage is placed. More importantly, there are severe financial consequences for your client. In the Moss v. Appell (1998) case, the agent sold annuities to a client and placed them with a company that ultimately became insolvent. The client contended that the agent ***knew*** of pending problems with the insurer when he received a letter from them indicating they needed to find capital to bolster reserves. The courts determined that a ***breach of fiduciary duty*** had occurred. The agent's liability hinged on the outcome of the insurer insolvency.

Liquidity

Determining and abiding by the client's need for liquidity is a basic agent function. You need to practice ***reasonable care*** in the products you choose to be sure your client's liquidity is protected. This means that you are steering a client away from a deferred annuity with surrender charges ***through year nine*** because the client needs to have money available for her son's college expenses ***in three years***. In one case, Campbell v. Valley State (1987), the agent was a manger of an agency owned by a bank. The director of the bank was known by the agent to be a millionaire. Agent obtained auto coverage for the client in the amount of $100,000 per person and $300,000 occurrence. A major accident occurred which exceeded the limits of the policy. The client sued for these additional damages. The original jury found that the agent had a duty to advise the client about his liability needs since a special relationship existed. The agent knew the client needs to protect his liquidity but chose a product that fell short.

Privacy

Protecting a client's privacy is an ethical responsibility and an area of increasing liability for insurance agents. The concern by clients is that highly personal health and financial information you collect in the process of selling insurance will get in the hands of groups who might use this data to exploit them. As a result, new legislation (HIPAA, the Gramm-Leach-Bliley Act, the Federal Medical Privacy Rule, and possibly the new Patriot Act) requires certain disclosures be made to your clients whenever non-public (personal) data is being shared with other parties. Also, they must be given the opportunity to restrict its use.

It may seem obvious and oversimplified, but the information in the agent's file is extremely confidential and all efforts to make it secure should be practiced. Remember, ***agent files are accessible by an insurance company and / or a plaintiff's attorney***. Then again,

always check with your errors and omissions carrier before turning over any documents with client information.

Your attention to privacy issues is particularly important where electronic files are concerned. The problem is two-fold: You can unintentionally send records (e-mails, files, etc) to the wrong party -- E-mail users often hit the "enter" key which could send a message to a wrong party. Just as likely, you could "delete" something you do not want someone to know about your client and a plaintiff's attorney, with help from a programmer, could recover it from your computer.

Ways To Minimize Privacy Conflicts

The best approach to client information is to ***establish guidelines*** for handling files and communications (including e-mail). It also goes without saying that since others have access to your files, it would be wise to NEVER make a written derogatory comment or reveal some personal information about a client. Either could be damaging to you and your client. Extremely sensitive information on your computer may need to be encrypted to protect it from being accidentally transmitted. Software that uses passwords is always recommended. And, it is probably a law in your state, or soon to be, that your entire system be protected by a ***firewall*** to prevent unauthorized access.

What is A Firewall

A firewall is basically the first line of defense for your network. The basic purpose of a firewall is to keep uninvited guests from browsing your network. A firewall can be a hardware device or a software application and generally is placed at the perimeter of the network to act as the gatekeeper for all incoming and outgoing traffic.

A firewall allows you to establish certain rules to determine what traffic should be allowed in or out of your private network. Depending on the type of firewall implemented you could restrict access to only certain IP addresses or domain names, or you can block certain types of traffic by blocking the TCP/IP ports they use.

Effective systems can be installed for as little as $500.

Policy Delivery

After all the work you put into a sale, it only makes sense for you to close the sale by ***promptly*** delivering the policy. The time between the application and delivery can cause the new policyholder to forget the reasons for and benefits of the purchase, and how the policy works. Prompt delivery of the policy or contract provides an opportunity to build upon your relationship with the client. It allows you to review the reasons for buying the policy, how it meets a real need and how it works, and to explain any changes in the policy if it is other than what was applied for.

Prompt delivery is also important because you may be subject to a "free look" period. During this period, a policyholder may change his mind and return the policy for a full refund of premium – no questions asked. The free-look period does not expire until specified number of days AFTER you deliver the policy. Commissions may be charged back for any policy returned during the free-look period.

If a policy cannot be delivered personally and has to be mailed, you should use “certified mail, return receipt requested” to document delivery. Some carriers require a producer to obtain a policy delivery receipt.

Occasionally, a client may ask you to hold his policy. If you do agree to keep the policy at the client’s request, you should document your policy file with the client’s dated, written consent to your holding the policy.

Complaints and Claims

Quality customer service and customer satisfaction should be important to you. You must ***take all customer concerns very seriously.***

Insurance regulations define a ***complaint*** as a written communication expressing a grievance and require companies to record all complaints. Since it is essential that all complaints be properly recorded and resolved in a fair and expeditious manner upon receipt of a complaint, an agent should immediately forward a copy of any complaint to his insurer and E&O carrier.

All complaints, either received directly from customers or from departments of insurance on behalf of clients, must be recorded and responded to. An effective response requires a thorough investigation, a sound decision, and timely communication of the decision.

Many complaints from clients involve agent misconduct. If this occurs, it is important for you to ***respond promptly*** (with the blessing of your E&O carrier) with information and documentation to support your position. In this regard, it is very beneficial to maintain thorough client records, including the how and why you made the decision to recommend a specific product or company.

If the matter escalates into a suit, the most helpful advice is: ***Don’t try to settle a case yourself***. 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. And, if your E&O carrier or insurer want to settle the matter it is usually best to agree. If you don’t, you could be liable for court judgements that exceed the settlement already proposed.

Satisfying Needs of Clients

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***. It's all about service and customer satisfaction. Neither is a sales tool, rather both are simple but critical extensions of good business conduct. 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.

Preferred agents understand the importance of customer service and customer retention.

Customer Service

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 and improve agency operations:

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.

The Agent Call Center

One of the most important elements of serving customers is ***communication*** and 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.

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 a ***client's 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, your 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.

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 Retention

The end result of meeting customer needs and good customer service should be a certain degree of customer ***loyalty***. The theory is that when you identify what customers expect and then meet or exceed their expectations, they will be far less likely to seek services elsewhere.

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. Also, do you have the time to completely rebuild your customer base?

To keep more of your customers sticking around longer, 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 even when their satisfaction drops. Just keep what you are doing with these folds!
- High risk customers are both unhappy and more likely than others to move on. 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.

Understanding Clients

Drawing out what a client needs can often be difficult, but it is a major part of proper business conduct. Fact-finding interviews and spending more time on product applications are great places to start, but they too can miss important client needs and wants. A direct approach is simply to ***ask***. How could you know, for instance, that *low prices* were not the only determinant in a client's decision to purchase unless you ask? Then again, direct response may not always work if the client is not in the mood to answer or he simply does not know how to respond. At the very last, you should push for his input.

Another method is to ***put yourself in your client's situation***. Try to understand his needs from the standpoint of a fictional client with similar age and economic status. When you do, it can help you formulate important questions; the answers to which are key to determining his true needs.

Following are topics that arise in the minds of most clients. They reflect how they perceive agents and services. Try to envision your own clients and their specific needs. Put yourself in their position and by all means seek their input.

Always the Lowest: *I know that as customers, we always seem to want the lowest price. But, if price is the only thing we want, why don't we always buy from the lowest-priced companies? Because, we also want service; and, if your grade of service is good or excellent, a fair portion of us will stay with you even if your price is not the lowest (as long as it is competitive).*

Sharing Secrets: *When it comes time for renewal of my policy, my agent will involve me in the process by actually discussing the various companies he has shopped and what he found for rates. At times, he has even admitted that he doesn't handle a particular company that seemed to have the lowest rates. Since I know that my agent can't ALWAYS be the lowest bidder, and I appreciate his honesty, I stay with my agent . . . even at a higher, but competitive price.*

I'll Never Use It!: *I used to think poorly about insurance protection. Insurance to me was something I prefer to think of as "out of sight, out of mind". Why pay for something that I may never need? Fortunately, my agent overcame this thinking by discussing a few important statistics and demonstrating (after a few questions) that friends and even family members were beneficiaries of insurance proceeds and glad they had it! With some forms of insurance, I was told that a return of premium rider was available that returned my payments to me at a certain point. As long as the amount of the rider made sense, this is another way to help me meet my insurance needs without worrying too much about the cost.*

Dig Deep: *Whenever I complain to my agent that I couldn't possibly pay the cost of an insurance policy he is wise to ask me where I would get the money to pay for the cost of an accident, injury, sickness, death, etc if something happened* ***without coverage in place****. Do you have an emergency fund?, he asks. How about a savings account, money market, CD, etc? Since I always have funds for these purposes, I can also use them for buying adequate and reasonable insurance protection. Actually, I am simply repositioning some assets in order to protect all my assets.*

There Has To Be More Than This? *I've had a lot of insurance agents try to sell me coverage. Many think that the processing of quoting a price or delivering an illustration is meeting my needs. Nothing can be further from the truth. The elements of a sale consider time, knowledge (information) and power. As a customer who doesn't like being pushed around, I will always try to exert my POWER by requiring the agent work within my TIME restraints and LIMIT the information I give him. The professional sales agent, however, will always keep trying to get as much information as he needs to prudently choose product and company, sufficient time to get the job done and a balance of power so that everyone comes out a winner. He never lets negotiations boil down to just one issue (like price). He makes sure that our talks involve other issues in order for me to more easily accept an alternative proposal that may, in the long run, be better coverage. He makes a supreme effort to understand my desires, gather information to respond to my needs and solve my problems. He asks open-ended questions and actually listens to my answers.*

Give The Customer What He Wants: *Surveys prove that aside from price, honesty and efficiency, customers like me want reliability in an agent. Reliability means an agent that can make decisions and is "there for me" when I need him. My agent, Jack, really works hard at*

making himself available to customers when they need him. Even though his carrier has a full, 24-hour service center to handle claims, Jack hires an answering service to take his calls after hours. Jack has instructed the answering service to ask questions about the customer call in order to determine if it is an emergency for him to handle or not. If it is, the answering service has Jack's home number and pager to call.

You've Got Mail: *I really value the ability of my agent to respond to BOTH my request for business and any problems that arise. I hope he is personally involved in the review of any letters of complaint I may send . . . since customer complaints are a serious matter that can "mushroom" from little to big issues if not addressed. It would be good to know that if my agent could not be involved in every complaint letter that he closely supervises his staff to be sure that are responding. An annual customer survey would help him know if these matters are being taken care of or not.*

How Am I Doing? *My agent can show me how much he values my business by asking me if his service is meeting my needs. He could send me a simple customer checklist identifying various services, response time, accuracy, etc. Or I would be equally impressed with a Customer Bill of Rights outlining the services I can expect of him. I rarely see feedback forms like these so I am easily impressed with the skills of my agent over a competitor.*

The Personal Touch: *I like the idea that my agent keeps in touch with me from time to time. I know this is a form of prospecting for new business and referrals, but he doesn't make a pest of himself. His approach is moderate, but continuous. I also like the fact that he makes his own telephone calls. Sure, a lot of agents hire telemarketers, which might work for a first-time customer, but I am an existing client. I want to know that he appreciates my past business.*

A Real Legend: *I need my agent to survive a really long time by keeping me and other customers as long as possible. What is the most important element of the "legendary agent"? Information on the activities of customers to learn where gaps in service occur. To help in these areas, I know that my agent conducts Customer Retention Reports, Premium Reports and Lost Business Reports. Besides these procedures, my agent will survive long term because of his ability to get referrals, both solicited and unsolicited, from existing customers. He is also not afraid to look-up customers who have left him and find out why they made the move so he can learn from his mistakes. Best of all, he is a "legendary thinker". He doesn't regard clients as problems or interruptions to his day. And, he doesn't blame someone else, like a carrier, for constantly trying to undermine his business. He also hires the best employees and treats them as equals understanding that owners who do this get the most reliable staff and better customer relations. Finally, my agent has a list of "10 Commandments of Customer Service" he learned from a consultant named Al Diamond:*

1. *Do things right -- every time.*
2. *Customer problems are our opportunities to provide the highest grade of service possible and to create "Customers for Life".*
3. *Create service legends.*
4. *No one ever complained about being treated too nicely.*
5. *Continuous improvement is more a function of the questions we ask than the answers we provide.*
6. *The customer's perception IS reality. If he thinks we blew it, we blew it!*
7. *Guarantee your service - UNCONDITIONALLY*
8. *Work should be fun*

9. Be proud of your agency -- but never satisfied
10. To your customers -- YOU are the agency and the agency IS the company.

Tips / Backwards form future: *If I have a choice (and I do!), I want to talk direct to my agent, only my agent. However, I also realize that he is a businessman who needs to delegate jobs to other people in order to be efficient. What is important to me is that he delegates the authority, but he remains responsible and he monitors the results. Further, I am impressed with the fact that he delegates to the best people, gives them proper instructions and a time frame to handle my transaction. Finally, I know he makes the delegation of authority work because he has many status meetings with his staff to determine the success, issues or problems of transactions by individual other than himself. He never assumes that all is progressing as "expected".*

Tips / Catch 22: *I need to know that my agent trusts his employees enough to delegate some authority. After all, there are times when he will go on vacation or be out of the office and I really need to have an answer. When I call and a staff member can handle my request, I know that he must be a trusted member of my agent's staff. My agent must be very involved in managing his employees and trusting them enough to share vital information to help me when I need it most. I'm sure he also takes the time to share his plan to grow his agency and how all of them can be involved. Agents before him were less in control of their time and priorities, therefore uncomfortable about delegating to others. If I called and they could not help me, I sensed the frustration in their voice or the stress from being "out of the loop".*

Tips / Bit I can't Afford to Advertise: *I used to do business with another agent before I met Jack. He was ok, but when times got tough I never heard from him. I need to know that my agent is there for me. Jack seems to be quite different. Instead of waiting for his company to grow, he "funds growth" through a consistent ad campaign. I get pens, magnets, calendars, newsletters, e-mails from Jack that remind me that he is still around. More important, when I call about some new business or refer him to a friend, someone at his office is always careful to ask "What made you think of us today?" So, I know he is monitoring his advertising to find out what works.*

Being Creative: *I want creative thinking from my agent; he or she must be a problem solver. I know this is not easy and it is sometimes the product of collective minds rather than just one agent. I have heard, for instance, that the creative juices for a lot of agencies comes from within the agency through the power of group meetings. This certainly wouldn't work in a company where departments were constantly competing for attention or business at any price or where the owner is King. Rather, an environment where personnel can make suggestions to the agent without being "blown away" will probably help customers by keeping a flow of ideas. Employees will only be creative as they are allowed to be.*

Satisfaction Guaranteed: *I encourage my agent to conduct Customer Satisfaction Surveys so he knows where to look for improvement. A lot of agents fear or avoid the results of surveys, perhaps because they haven't conducted them regularly or the results they get are inconclusive. But, these surveys are the best way to determine my needs and wants in areas like 1) delivery of services, 2) dependability and accuracy, 3) perception of services, 4) employee knowledge, 5) promptness, 6) employee empathy or 7) perception of the agency's physical appearance. The most successful surveys my agent has conducted include a letter explaining the purpose and procedure of the survey along with a postage paid envelope to send the results back. The most important part, however, is tabulating the results to show*

where we (the customers) feel you are strong and weak. Confident agents will actually share these results with customers and ask their input on how to make improvements. So, the survey becomes both a public relations tool and self-analysis tool for the agency.

The Wall: *Why do some agents reach a certain level of success and then stop? I need my agent to watch out for this "wall of inertia". I need him to be progressive and make changes to better serve my needs. How do agents get trapped at "the wall"? They get too comfortable. Sometimes, just doing the minimum to keep from getting sued. They may also have an ego that doesn't lend itself to making changes. After all, if he has to change, he must have been doing something "wrong", right? Maybe he should just leave everything alone because a change would reflect badly on his management and insurance skills. Also, employees of the agency also fall into their own "comfort zones". Some are open to changes, others are not. My agent found ways to defeat the "wall" by making a commitment to change in step with the changing times. In some agencies, this commitment is actually put in writing and explained to employees before they are hired. Anyone who does not agree to change with the agency is given the opportunity to find another agency that maintains its old ways!*

Now I Remember: *When I'm searching for an agent I want to remember why I should do business with him and not a competitor. His agency brochure was extremely helpful in presenting the information I needed to make my decision. Most agencies have a brochure, others simply haven't recognized the need for one. Still others have a brochure but it is simply designed to satisfy their image. The brochure I saw worked for me because it gave me the facts I needed to "differentiate" my agent from the rest of the crowd in several areas: 1) service, 2) company identity, 3) personnel and 4) price competitiveness. A mistake made by other agent brochures was the lack of concentration on my needs.*

Team Building: *My agent's office is extremely organized -- it has to be to get my business! Specifically, I like how he has organized duties between himself and staff. In other offices, there is a lot of the typical "in-fighting" that seems to occur quite often. The customer service employees blame the agents for not doing what they are supposed to be doing and can't serve the customers properly. The agents, on the other hand, feel that these employees are there to help them so they can go out and sell some more. My agent has devised a system that lets everyone in the office know who will be performing tasks. He calls it a "work assignment" system. The basis of the system is a code system something like this. "P" stands for a producer's task, "C" stands for customer service rep, "E" means either may do task, "B" means both will work together on the task and "S" assigns the task to support staff. Next, he made a list of all the tasks in the office surrounding the establishment of new accounts as well as renewals. Next to each task is a code. So, when it comes time to prepare a proposal or a quote, everyone knows who is supposed to do it. I know it that these are the "behind the scenes" operations of his business that I am not supposed to notice, but it makes his office run so efficiently that I just had to say something.*

Service Is In Your Head: *I have done business with a lot of agents over the years. Most all of them "think" that they offer excellent service because their egos will not permit otherwise. The fact is, excellent service is a state of mind that is constantly open to improvement. My agent's attitude toward his employees is a good example. While other agents may take every opportunity to criticize employees, my agent is always there with praise, especially in front of customers. And, his praise is genuine, not patronizing. A lot of agents might worry that too much praise leads to employees asking for more money. In fact, it leads to a higher level of satisfaction, even if they are NOT the highest paid staff on the block. Other agents*

also worry that the more service you give customers, the more they expect of you. And, to some extent this is true, but isn't continuous improvement one of the habits the agents should pursue? And, who am I going to refer my friends for their business -- someone with lower levels of service? A lot of agents measure the level of their service based on the number of complaints they receive. This is a rather negative approach because as service drops to lower and lower levels, customers simply give up and stop complaining -- it doesn't seem to do any good. Lower levels of complaints might make that agent feel he is giving good service. Instead of counting complaints, my agent asks me about his service issues. His questions are very specific not just "How am I doing?". In a way, he is proving that he provides excellent service to me and to himself. The verification does wonders for his state of mind and it makes me a believer!

Focus on Real Needs: *My agent is one of the most successful around because he focuses on the needs, priorities and perceptions of his customers and not his perceptions of my needs. The difference is something that few agents realize. They think they are concentrating on the needs of their clients, however, they have tried to define these needs themselves without input from the customer himself. When business starts declining, agents try to blame it on the fact that someone else offered a better deal. If this were true, however, agents would* ***lose*** *every price conscious customer when his price is a little higher and* ***get*** *every customer when he had a better deal. The fact is, customers like me worry that a lower price might mean lower service and it is not worth the effort to move to another agent as long as I feel I am getting good service for a competitive rate. But what is a good level of service? My agent takes regular surveys to find out. Better yet, he shares his surveys with his customers and lays out an action plan where he* ***commits*** *to make changes to improve service. Finally, he follows up at a later date to be sure that the changes actually made a difference.*

Ready, Aim, Focus: *A lot of agents want my business but they miss the point when they send me a slick-printed brochure and an introduction letter. This isn't a marketing program that can inspire me to move. What does make me sit up and take notice is an agent who implements a "campaign" to educate me about his business. Better yet, a specific insurance coverage that I need. His goal should be to make himself more familiar to me than my regular agent. This is not very hard in a lot of cases since most agents don't see their customers more than once or twice a year. I have heard that marketing plans that follow a three-year cycle are the most effective with contact messages at least five times per year. The smarter agents also realize that they need to appeal to several different target markets at the same time, e.g., motorcycle insurance, earthquake insurance, umbrella coverage, etc. And, even though my new agent is marketing a specific product line, he makes sure to inform me that he can also cover me for my home, life, auto, etc.*

Can You Manage? *In using several agents over the years I have noticed that some reach a certain level of growth, then stop. I'm not saying that big is better and I don't want to get lost as a customer in a huge office, but I also want the agent I use to be able to grow with me and a base of customers. If he goes away for lunch or vacation, I don't want to get an answering machine and a return call two weeks later. Like any other business, I'm sure that the reason agents fail to grow beyond their owner's ability to personally produce is that they refuse to invest in people and learn the arts of delegation and management. The longer they have been in business (20 years or more) the more they fight these changes or additions. But, the sooner that agent owners hire managers to accomplish administrative tasks the sooner they will move to new levels of sales and efficiency. However, delegating functions does not mean delegating control. An agent needs to maintain control over the day-to-day operations*

through a reporting system that informs him what comes in, what goes out and how much and how old are the items remaining undone. Knowledge about any business is EVERYTHING!

Where Do I Start? *My agent found himself in a rut a few years back and decided to fix some problems that a lot of agencies have. First, he felt that prospecting for new customers was a bit degrading, after all, he was 15 years in the business. However, when he first approached me I told him that was the last thing I thought of. It was a downgrade in his mind not mine. Soon after he simply started acting as though he was the world's most professional agent -- the old positive thinking routine. It worked! Next, he complained that his producers in the office were falling into the habit of selling on price alone. The answer was to brainstorm every single benefit about his product and the differences from his competitor's product. He sent his agents to a professional training school where they learned that you don't need to sell as much on price if you are able to establish a relationship of trust between themselves and clients. His customer service reps were another problem. When they were first hired they were self-starters, tackling problems head-on and with enthusiasm. After a few years, they were more like drones. Everything was a crisis and he was left to solve all the problems. I guess they felt that he would correct them so much when they took action and they were tired of the criticism. The solution was simple. When a problem arose, he would ask them how they would handle it. In most cases he would agree with their decision. In a short while, his employees began to realize that they could do it on their own. Of course, this will only work if the employees make common sense decisions.*

A Waste of Time: *I get a lot of calls from solicitors and agents alike. What I don't understand is why someone would want to continue wasting time on me if I have given them a clear indication that I don't want to buy. When I mentioned this to my agent he told me that it is true that a lot of agents refuse to give up even though they should recognize that the prospect is not going to buy. He said there are several clear signals or characteristics to look for. First of all, he is quick to point out that a lot of agents fail to ask the most important question: "If we can provide you excellent coverage at a fair price would you buy from us?" If the answer is a flat "no", why waste your time. Another good signal is when the prospect starts pumping the agent for more information than he needs to know. For instance, he starts talking about a situation that happened to him a year ago and how it was handled. There is also the prospect who throws out a ridiculous price demand, perhaps with the promise of more business in the future or friends he will send over. Liar. How about the "last minute Johnny". He calls for a quote at the llth hour. Most of the time, he is simply trying to get information to negotiate a better deal with his existing agent. Then there is the guy who knows everything. He considers all agents to be the "same". He contradicts everything you say. If he does buy anything, he'll probably only be with you a short while. He's never happy. Let's also not forget about the people who just can't make a decision. They get your proposal and re-read it 50 times. Perhaps you would be wise to ask him who makes the insurance decisions at his home or office. More than likely, it will not be him. The guy who just likes to talk can also rob you of time. It sounds like you are building a great relationship, but he never commits to a purchase. Finally, there is the "Private Peter" who never, ever discloses to you his current coverage and premiums for fear that once you know, you will never quote him a lower price. The truth here is that if you know what he has, you have a chance to make it better, instead of taking a lot of time to do a complete interview and quote.*

No One Does IT Better: *I have friends who try to get me to switch to the "direct selling" insurance companies but I just can't imagine that they can do a better job than my agent. Sure, they are persistent and good marketers, but I want "old fashioned advice", the kind I*

can get from my local agent. I like the fact that I have a relationship with him and I sense differentiation between him and direct writers on three levels. 1) He knows and addresses my basic needs to want to the lowest possible insurance cost, efficient processing and quick handling of claims. 2) He responds to my second level of desire which is to feel important. I want to be "known" and recognized, not just a number. Direct writers use random servicing which means I get a different person almost every time I call. 3) The level of expectation is when I, as the client, am "thrilled" by my agent providing services I did not expect to get at all. Things like getting a call back from my agent on the weekend or instant account information or certificates of insurance are examples of unexpected services.

Earning Business: *I have seen a lot of things that agents do to earn my business. What I want is an agent who gets to know me. Didn't I hear somewhere that familiarity breeds sales? Well it works so long as I know an agent was really working to build a relationship and not just saying anything to get a sale. How would I know the difference? An agent who is interested in my long-term business* ***never loses track or stays out of touch*** *too long. Even if I haven't bought anything recently. He never pushes too much, so he earns my trust. He also sells what he knows. Rather than moving from one "hot product" to another, he waits till he has sufficient knowledge to suggest something or he refers me to someone else. Finally, a good agent would not be afraid to ask for referrals. His knowledge and reputation have earned him my referral and when he asks, I will provide him some names of friends who, like me, appreciate that a good agent is more than someone who has the lowest price.*

Read M Lips: Q-u-a-l-i-t-y : *What should I expect from my insurance agent? Well, you don't need to completely retool your business. There are, however, a few key issues I want you to address for a higher quality agency: 1) Employees are not expendable. If treated properly and made part of the quality management philosophy they will last longer and serve me better; 2) Quit guiding the agency by the almighty "price tag". I'm just as interested in quality control issues and efficient delivery of good product; 3) Education. It is not a discretionary expense or simply the meeting of minimum state requirements. Commit to a practical continuing education program and/or a professional designation. It has to help me in the long run; 4) Customer service should be more than lip service. Do what you say you are going to do in clear, visible terms; 5) Don't blame the companies. Your success is due to your own actions and inactions. You need to plan for them properly. 6) Keep your ego out of the mix. You should be the guide for your employees. Give them decision-making powers so they can do the best job possible for me. Be a participative manager by including your employees in the planning and management of your practice. 7) Keep it all going. You were the guy who started the business. You are responsible for keeping it alive with the same kind of spark you gave it years ago!*

Service Is Your Middle Name: *The agent where I buy insurance has a good handle on customer service. He knows that it is impossible to treat every customer the same. For example, an emergency, for any size client, should be handled right away. It is also logical that a big customer should receive more attention than a small one. Yes, that's right! If I have multiple accounts and spend five times more than the average policyholder, I want some more attention. Also, while each employee in his office has special duties, he constantly reminds all of them that if a customer needs something, each and every employee is a customer service representative. What about phone management? The average agent can get dozens and dozens of calls. Are the employees informed that every call is important to answer and to keep personal calls to a minimum? When times are rough, my agent is careful not to respond by eliminating key employees. If some positions have to be cut, he may ask the remaining staff to work a little harder so that my needs can still be met. In*

conclusion, my agent knows that good customer service is just as important as sales and marketing. He needs BOTH new clients and continued revenues from me and my referrals.

Merging : *I don't want to encourage any sale or merge of my account with my agent, but if he gets too old to run his business or so set in his ways, I hope that he does the right thing by selling his book of business to a younger person who is better able to flex with the times and new products. As an insurance customer, I worry about this "urge to merge" thing. All kinds of independent companies are being bought up and merged into huge entities. I really don't want to be lost in the shuffle if his company is sold to a large agency, or gosh forbid an automated agency. Ideally, my agent has some children or friends, who think like him, to take over the business.*

Be The Best You Can Be: *If more agents had the attitude that my agent has, they would all be rich. 1) He makes it easy to do business! That means he makes himself or a staff person available to solve my problems. 2) He makes the purchase of insurance easy. I don't have to wait long to get a competitive quote or proposal. If he is higher than someone else, he explains why in terms that I can understand. 3) He works hard to determine and accomplish my objectives. He listens and asks leading questions to determine my needs before presenting a product. 4) He educates me. Instead of just dropping a quote or proposal at my home or office, he presents me with additional points to ponder -- reasons to do business with him and real benefits of the product he is suggesting. 5) He doesn't try to be all things to all people. I like that he is a source to buy several lines of insurance, but he is able to refer me out for more specialized needs in order to better serve my existing business.*

Getting to Know Me: *There is a lot of talk about building relationships with clients like me. Does that mean that my agent needs to come out to my office or home to discuss my insurance needs? This may not be possible every time. So, my agent uses a combination of phone, e-mail and consistent, strong customer service. I hear from him even when it is not time to buy or renew a policy. In a nutshell, he stays in touch to make me feel like a "client" not a "customer". I guess even small agents can learn from the big boys by using customer contact methods like contact management systems that quickly find a customer and remind when to call again. It works!*

Keep It Fresh: *There are a lot of different ways to approach me when asking for my insurance business. What I like about my agent is that he does not rely on the same old thing to continue to work for him -- unless it does! In other words, he is constantly evaluating his advertising and testing new ways to get me motivated as well as his employees. That's right, a successful marketing campaign should be designed to produce results and get people (including his employees) excited about new business. Depending on the product, he may use a "shotgun" approach by promoting his company "image". Other times he may target a specific mailing, just to the product I want to know about. In either case, his program has a goal and a way to measure results.*

Relationship Building: *My relationship with my agent is destined to be long-term because he has learned to: 1) Give more than he takes. He volunteers information and doesn't try to constantly change my mind. 2) Discuss important things rather than burying his head in the sand. 3) Overlook times when I am less than cordial and too demanding. 4) Appreciate my business and he let's me know it. 5) Listen. He listens to more than just the words. He's looking for the meaning and objectives behind them. 6) Communicate. He stays in touch and he makes sure when we do talk that we are communicating. He'll always ask things like*

. . . "What I think you're saying is . . . or Does that make sense to you?". 7) Responsible. When he is wrong he admits it. 8) Never stop learning or caring about my needs and ways to meet them. He reads books related to insurance and other training materials to help manage his business better.

Fine Tuning: *Very few insurance agents really know how to fine tune their business like Jack. What I like about him is that he as a strategic plan in place. More important, he involves his employees in the plan and calls me periodically to see if it helps to meet my needs. How does it work? First he makes a written plan with a Mission Statement and a Vision Statement. The Mission Statement describes his business goals while the Vision Statement is more how he wants to be viewed by prospects, clients and companies he works with. A lot of companies have Mission Statements or Vision Statements but few have BOTH. When you think of it though, a company really needs both because it takes more than defining goals (Mission Statement). You need to also define how you expect to be perceived by your clients.*

He's MY Agent: *What makes an agent MY agent? If I haven't bought any new policies from him in the past 5 years is he still MY agent? Perhaps it is the e-mail letter I get from him every month that reminds me that he is still around and the one I will see when I need my next insurance coverage. Or, maybe it's the post card letting me know that he has placed insurance for another satisfied customer in the city. Perhaps it's his business card ad I see every week in the local newspaper or the article he writes. I'm not sure which of these mediums is the most important, but one thing I know . . . HE'S MY AGENT!*

What Makes Me Want To Do Business With My Agent: *He's confident, not arrogant. He's genuine. He only sells to friends, not strangers. He finds common ground to make sure we get to know each other before we do business. He does not "judge" me by my appearance. He doesn't sell price alone. He educates and doesn't simply quote. He presents things skillfully in an interesting and informative way. He asks open-ended questions to learn my needs and objectives. He makes sure he understands my needs before the sale. He lets me know how he has helped other clients (he just doesn't talk about himself). He listens more than he talks. He is prepared to honestly answer my objections with positive statements that put me back on the road to making a purchase. He never bad mouths or criticizes a competitor; instead, he sells the benefits of doing business with him. He doesn't promise more than he can deliver. He always follows-up on his proposals by asking me when I will be prepared to make a decision. He doesn't expect me to call him when I'm ready to purchase -- he asks when he should call me. He is organized and respectful of his and my time. He networks by asking me for referrals. He never blames someone else for problems. He celebrates his success but doesn't brag.*

Customer Service To The Rescue: *Why do some agents do so much better at customer service? Well, my agent is a perfect example of doing things right. Here's a few things I've noticed about his customer service style: 1) He does things right -- every time. Sure, he makes mistakes, but he has zero tolerance for errors. When they occur, he remedies them ASAP! 2) He views customer service problems as "opportunities" to provide a higher level of service and create a "customer for life". 3) He thrills people with his service; on-site visits, personal delivery of papers to sign, etc. And, he rewards his employees who also "thrill" customers. 4) He treats me nice, even when I'm stressed or abrupt. 5) He is never satisfied with his service. He's always looking for ways to improve it, shape it, fine tune it, etc. 6) He accepts my perception as real. In other words, if I feel he blew it, then he accepts the fact that he blew it. 7) His service is guaranteed . . . UNCONDITIONALLY. If it's not right, he will*

apologize, fix it and prevent it from happening again. 8) He has fun at his job because he and his employees BOTH like talking to customers and solving their problems. 9) He is proud of his agency but never completely satisfied. That's why he keeps trying harder to constantly improve service. 10) He never blames the company or employees because my perception is that HE is the company, not someone in underwriting or claims.

Go Ahead, Ask Me: *I want you to ask me about additional insurance you think I might need. Some refer to this as "cross selling". Its just like the fast food places that always ask if I want a coke with my meal. Sometimes I'm irritated with them asking, then again, there are times when I'm glad they did. The same is true with insurance. You're the expert, and if you feel there are additional needs that are not being met, I want you to suggest that I consider additional coverage. I may say no. Or, I may buy it. The important thing is that you, or your employee, has suggested something that may patch a critical gap in coverage that I have not identified.*

Plan To Succeed: *If you're going to be around to help me over the long haul, you need to implement your plans. I know that as an insurance agent you are basically an independent entrepreneur. Most entrepreneurs have a desire to succeed. If they fail, however, it is typically because they failed to implement their plans. For some, it is the difference between "contributing" to their business (money and time) and "committing" to their business (whatever it takes). Some are simply unable to change when they discover their previous plan is not working. The success survivors create new paths and bridges to cross. They never retreat to comfortable ground. They keep trying new directions until they have found a path to success.*

Hang In There: *Is customer loyalty a lost phenomenon? Back in the 1950's, customers like me were very loyal about 66% of the time. By 1995, experts feel this ratio was slashed to only 12%. Why have we become less loyal? Trust. Years ago, insurance companies were among the most trusted of industries. If an agent told me I needed to buy a certain coverage I believed him and I bought it. After all, he was a "professional". The consumer movements of the 1960's changed a lot my perception. I was told NOT to trust anybody, especially insurance agents. Insurance agents were the brunt of comedian jokes and sub-plots for decadent movie villains. Also, insurance products were sold more and more on price alone which led me to think of it as a commodity rather than a service. And the insurance agent as a salesman, not a solver of problems. Then too, I came to be more educated about the ways of insurance and found that former agents "sold me" something I didn't need or charged me twice what I could get it for elsewhere. Is it any wonder I am not as loyal as you want me to be? How can you get me back? Keep me satisfied. Live up to your promises. Do more business with me (the more policies I have with you, the less likely I will look elsewhere). Don't forget about me (contact me about 4 times a year, send letters, e-mails, etc). Instill brand loyalty in your product and agency. (Perhaps you can sponsor local soccer teams or charity events. Maybe your company invites a speaker to talk about a special product at a seminar, etc.) Sell your services and yourself as someone who is friendly and familiar. Over time we will get to know you and perhaps trust your opinion. As we are more convinced to stay with you, you should publicize our loyalty which should make you more trustworthy to other clients.*

Quality Is The Game: *As we move into the new millennium, what are the issues that will make me want to do business with you? How can you keep me from moving to other agencies? 1) Build relationships. With me; With carriers. Be part of a team to solve my problems. 2) Be more trustworthy and reliable. This means maintaining higher ethical*

standards. Be consistent in fulfilling promises and provide full disclosure. 3) Communicate better by actively listening. Meet with me to review my needs and coverage and keep me informed. 4) Help me identify my needs and give me solutions for them. Evaluate my exposures and respond to my needs. Give me options and innovative solutions that match my risk management needs.

Can You Afford To Lose Me? *The cost of acquiring new clients is astounding -- about $1,500 to $2,000. So, if I'm so expensive, why would you ever want to let me go! Customer retention is the term for keeping clients. However, the process is far from simple. I can be demanding, but if you are a smart agent, you know that there is tremendous long term value in a client who stays with you ten years or more. I know it sounds like a long time, but remember, you have invested time, effort and resources in communicating with me at least four times a year as well as the initial cost to find me.*

I Want You To Succeed: *As a long-term customer, I want you to succeed because I don't want to shop around for a new insurance agent. I read a lot about what it takes to succeed . . . hard work, work smarter, time management, delegation, etc. All of these are important, but the agents that really survive are ones who "do the right thing". They have principles. Sometimes it's easy, sometimes it's not. Sometimes the right thing is expensive and you realize after that you could have cut corners and saved. But, the important thing is that you know you did the right thing.*

Another reason agents succeed is that they do what is important most of the time. Important things needs to be handled and handled quickly before they grow to "crisis" proportions. Why don't we always take care of important things? Because we are busy "putting out fires" of all kinds. A lot of times, you let demanding customers rule your day, when in fact, you need to be the one who prioritizes what is urgent form what is important. The goal is to get away from "crisis management". You can use contact management software to place reminders and do scheduling for smoother operations.

A final reason that some agents succeed is that they learn to depend on others and work independently. It takes a lot to trust an employee to do the job you once did. The fact is, however, many of them can do that same job better than you. The key is transition yourself from an individual producer to a successful manager. How is this done By giving your employees responsibility to accomplish tasks, authority to get the job done and trust to support them.

Service Limits: *A lot of businesses in our neighborhood start out like a shot. They grow fast and prosperous as word spreads about their prices, service and friendly staff. Then it hits. Like a tidal wave, there is more business than the business can service. In essence, the owner has reached his service limit. It happened to a former insurance agent I used about five years ago. First the phones started ringing busy, the fax machine was impossible to reach and the agent was ALWAYS on the other line. Like me, I'm sure other customers complained but few things changed. The agent was uncomfortable about turning control of customer service issues over to a competent staff person and becoming a true manager. He tried letting loose of the reins here and there but he was never satisfied with the result. Perhaps he was lulled into believing that "anyone" could handle the job. I think he quickly learned that when you hire staff, you do not always get what you pay for. A lot of employees simply lack the customer service skills needed to run an insurance business.*

How do you know when you have reached your "service limit"? Probably when long-term customers start leaving you for the simple attraction of a lower price somewhere else or "to be closer" to the new agent's office. What can you do to prevent service limits? My former agent would have kept my business if he made an attitude adjustment from the top, down. He needed to re-commit to an improved service philosophy. He needed to develop a written service plan, explain it to his staff in detail and manage it once in place. The plan should specify goals and objectives that are both reasonable and achievable. Finally, he needed to measure his results against his objectives to see if the service plan is working. This could include productivity reports, complaint activity levels, transaction time and customer interviews to be sure that his new service efforts are well received and functioning.

Manage Your Time: *Consultant Al Diamond has a lot of great tips that can help my agent manage his time better: Identity your functions (meetings, customer service, etc). Then place a percentage of allowable time you can devote to them. Maintain a log to make sure you are on track and to find who is "robbing you" of time. Make a "to do" list every morning. Assign priorities where needed. Do something that makes you happy every day. Make it a priority. Know your limitations. Delegate things that others can do better. Avoid urgencies. End your fire fighting days. These things are probably not as urgent as your customers think. Recognize that being busy is not the same as being productive. Make deadlines for yourself and others. Make them realistic. Use meetings wisely. Agendize, set start and stop times, hold to the schedule. Avoid memos. A call is quicker. Use calculated neglect. Some things have to slide for the moment. Practice selective trashing. If you don't need it or can't figure out what you need it for, throw it out.*

Get Answers: *The last agent I did business with could care less that I'm gone. How do I know? He never called or wrote to ask what went wrong! How will he ever know that there were serious problems with his customer service if he doesn't ask his lost customers. I understand that the most prosperous agents are just as concerned with their failures as their successes. If a client leaves, they conduct an exit interview by phone to determine the reason. A lot of the time, customers will simply say that it was price. However, if the agent asks "Is this the only reason?", he may learn more. Perhaps the customer didn't feel appreciated or believed he was out of contact with the agent. Results of surveys like these should always be shared with the staff so that an attitude of continuous improvement can be pursued. The goal is to keep customers as long as possible because new clients are extremely costly to obtain. Most agents realize that doing more business with the same client and showing your appreciation for his continued patronage are two of the best methods to make this happen.*

Customers Speak: *There are a lot of surveys that can give agents clues about my views and needs when it comes to insurance. Are you listening? For instance, a recent survey by the Quality Insurance Congress, called "Voice of the Customer", helped identify the gaps between my expectations (about 1600 insurance clients) and current industry performance. Its not unexpected that I want:*

- *Improved accuracy, timeliness and communication.*
- *More standards of quality.*
- *Innovative products and services.*
- *Specialized services.*
- *Insurance cost containment.*
- *Smooth product and service delivery.*

It is also not surprising that customers and the industry do not share the same priorities and viewpoints. Consider the following results of the survey:

- *Customers view the insurance industry as a poor performer. Worse than other financial services.*
- *Customers view insurance as a whole while the industry views many completely separate parts, i.e., casualty, life, health, long term care, surety, non-standard, etc.*
- *Customers want innovation yet the industry believes it is mature.*

Concerning agents, customers felt highly impacted by issues concerning responsiveness, problem solving and the performance of transactions. Other characteristics had less impact: representing a broad range of carriers, insurance knowledge and personal contact. Perhaps these latter items are issues that customers believe to be automatic or assumed as "part of the job".

Tell Me What You Do: *If you have different products to offer, tell me before I buy them from someone else. I would much rather do business with one person instead of five. And, the more business I do with you the more likely I will refer to other people and stay with you longer. Perhaps you can send me a newsletter, e-mail or refer me to a special website that details your product lines. Some agencies I have called put this information on their phone systems so I can hear it while on hold.*

Why Are Customers Afraid? *As a customer, I get the same uneasy feeling when I talk to any kind of salesperson . . . insurance, auto, clothing, cell phone, etc. What's the problem? I feel like I am NOT in control. I'm worried that the salesperson will somehow influence me into buying spending more than I should and/or buying more product than I intended to buy and/or buy something that does not meet my needs but helps him meet a quota.*

I would prefer that your approach be toned down. Back off enough and seem interested in what I want to buy rather than what you want to sell me. Also want to know the negative features as well as the strengths of your products compared to others I'm not stupid). Rather than attack me with demands to see my existing policies or complicated surveys to determine my needs, why don't you just start by asking me . . . "How Can I Help You?"

Let's also get by the price issue. I'm concerned about price and you should tell me if there are lower priced products out there. However, I wouldn't mind if you pointed out to me that I could always find a better deal if "I shopped til I dropped" but finding a competitive price for what I really wanted is the best way to go. Perhaps your best approach would be to answer all my questions, make yourself available for any further information I might need and leave the impression that you are more interested in me being a satisfied customer than making another sale.

When you're done educating me, I would expect you to "soft close" me by asking questions like . . ."Have I given you all the information you need to make a decision? Or . . . "Does this information or policy make sense? Or . . . Is there something else I can answer for you to assure you that this is the right solution based on your needs and objectives?"

I realize that these approaches will not always work for you. There will be some prospects who will take advantage of your "laid-back" approach to get information and then buy somewhere else. Or they may simply be pressured to buy by the next salesperson they

encounter. Please don't be discouraged. The word that you are a caring professional will spread and eventually work to your favor.

Business Tips: *I realize that some insurance agents have reputations similar to used car sales people. But, I find the approach of my agent refreshing and honest. His agency discovered that not everyone has sales skills: overcoming objections, managing rejection or closing. In part, this is because the industry and the higher education system in general does not "train" sales people anymore because it has become something less than a "profession" to pursue. What makes my agent different is his adoption of something called "Best Practices". He continues to grow and prosper regardless of industry problems because he is able to "flex" to any current situation and sell the products I need at the time I need them. Also, he doesn't just hire a sales person and let him start selling. On a visit to my home, for instance, he accompanied the new salesman to guide him through the process. And, he "manages" his salespeople through constant supervision and additional training: seminars, newsletters, etc.*

Tips / Changing Minds: *During the past couple of years, I have noticed that my agent channels more service-oriented transactions to a centralized "service center" for claims, forms, etc. I suppose this is more efficient and it has resulted in him being more sales oriented and more interested in fulfilling my needs than running his office. This can be good, especially when he does not coerce, intimidate or trick me into buying something from him. He doesn't concentrate on price as the primary benefit and he asks questions, listens to my priorities and objectives. Yes, I realize that we still need technically-oriented people in the insurance industry, but I kind of like the attention that a skilled salesman gives to my needs. I hope it is not a lost art that may be overtaken by the huge direct selling insurers.*

What About Me? *I know that my agent is really a dual agent . . . serving both me and his insurer. But, I want him to always be sure that "I (the client) come first" in his attitude. I want him to challenge underwriters about their decisions if they are not in my favor, etc. What I like about my agent is that he developed a marketing plan that balances my needs and those of his carrier. He found a way to make good submissions to his carrier which improved his relationship with them and make clients happy as well. What was his plan? He found out what carriers did well by researching their lines of business. The most successful lines of business had the most chance of being successfully approved. Next, he found his own niche for writing certain types of business. Examples include personal lines, commercial lines, ethnic orientations, industry orientations, product orientations, etc. Then he really dug into the demographics of his marketplace. He knew the numbers and types of businesses and residents within 15 minutes of his office. Finally, he combined all his knowledge about carriers, their products and potential clients to develop a marketing plan targeting various market groups. Some agents might target Heat and Air Contractors, or Senior Markets, or Teachers, etc. His mailings were appropriate. His sales calls were low key, but continuous. And, he measured, monitored and constantly revised his plan for the best results!*

Do You Do What You Say? *It is important that I understand the mission statement of my agent and that my agent does what his mission statement says. I 'm grateful that he publishes his mission in his brochure and at his office so it is clear what kind of agent he intends to be during the next five years. It also makes it easier for his employees to understand what is expected of them. I'm pleased that the underlying theme of his statement is to meet my needs as a customer and his willingness to respond to changes in technology and markets by revising his mission statement periodically. Finally, it is very impressive that*

at regular intervals my agent conducts Customer Satisfaction Surveys where he repeats his mission statement and asks me if his goals are still meeting my needs.

Speaking Up: *I met my agent at a seminar he gave several years ago. Other seminars I have been to were strictly a gimmick to get sales. But the seminar my agent gave was different. He did no selling at the seminar. It seemed his primary purpose was to introduce himself and the solutions he had developed for someone in my situation. It was nice that he was the speaker and not some guest expert. After, I want to do business with the guy that is speaking. I want to get to know him, not some professional talk-show guy who makes the rounds on a speaking circuit. Best of all, my agent was relaxed, open and honest. He kept the seminar short (under 1.5 hours) and he made it interesting by presenting his concepts using stories about various clients.*

If You Believe It, Put It In Writing: *Many agents want to simply sell me something and move on. If you are after my long-term business, however, you should let me know your intentions by presenting me with a written Mission Statement. A Mission Statement might say that by the year 2005, you intend to be serving 500 customers in the city with a full range of insurance and financial products by hiring professional, courteous employees and the latest office automation. You may go on to say that the innovative strategies and controlled growth you anticipate will help cement strong client and company relationships.*

In addition to these business goals, you may also put forth a Vision Statement that tells me how you want me to perceive you five years. An example of a Vision Statement might be that you plan to provide a full range of insurance and financial products with integrity, honesty and trust to all clients at a fair price with uncompromising attention to service. In essence, you have told me that you intend to go beyond just business goals. Your focus is in meeting my needs and doing your absolute best. And, since you used terms like honesty, integrity and trust you need to define what they mean. For instance, if you realize that you could do better about returning problem calls, your statement might read . . . "I will return all calls within 24 hours, but I will return problem calls within 2 hours of receipt". Or, how about . . . "I will only market the best policy to serve my client's needs regardless of the commission structure."

My agent also has an Action Plan that he visits quarterly to monitor the progress of his Mission and Vision Statements. His written Action Plan, for example, may determine that he is not on target to serve 500 customers by 2005. So, he decides what needs to change to make it happen through planned activities that either he or an employee must do to achieve the stated goal. In another example, he may find that by the end of the second year he is only returning 85% of all problem calls within 2 hours. Again, activities will be decided to change this to meet the Vision Statement strategy.

Mission Statements: *A lot of agents want me to believe that they have some special interest in my well-being. Let's be honest! I need insurance protection and your goal is to make money. The more you satisfy my needs and service my account the more you will make. I will be happy to hear that you are doing well because that means you will be around to serve me for a long time and you will be able to hire better employees to help me in your absence. How can you let me know you are doing better. Well, it isn't my business to know what you make, but it would help to know that you are profitable, not just busy. Perhaps your newsletter or marketing could convey that your Revenue per employee is up over last year by 10%, etc.*

Agent Reputations: *The thing I really like about my agent is that he guards his reputation wisely. Nothing is more valuable to him in business because a person's reputation defines his character. You'll never hear my agent making excuses for making bad decisions. Even honest mistakes are not always so innocent. He makes sure that he aligns himself with trustworthy people and he has his own personal code of ethics. He knows his purpose and practices self-discipline rather than a lot of indulgence. He appreciates his lot in life and doesn't feel he deserves any entitlements.*

The fictional client comments you just read have been adapted from articles and ideas inspired by the following three industry experts. We strongly encourage you to contact these individuals and learn about their valuable services:

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CHAPTER THREE
E-PRACTICES

The recent passing of federal and state ***e-signature laws*** grant electronic signatures the same legal status as a handwritten signature for any legal document or transaction – including insurance. Combine this event with the electronic commerce explosion, and you will see why agents and insurers need to develop a digital strategy. One of the most significant elements of this strategy is a responsible approach to selling and servicing clients on the Internet – we call it ***e-conduct*** -- the responsibility you ***chose to uphold*** to make online insurance information or transactions better, more secure and usable for your clients.

At present, the insurance industry is not really ***leading*** the charge in the development and innovations in electronic commerce, in fact, some would say they are ***lagging behind***. However, there are two important reasons why the industry could prevail:

- As a product, insurance services can be sold on the Web as well as some (retail goods, stocks, etc) and better than others (real estate, legal services, etc).
- As a highly regulated and organized sector of the economy, insurers and agents will eventually come to have a large presence on the web.

When it happens, the consumer will be the ultimate beneficiary with greater convenience, access and control. The Web will increase their knowledge, choices and product offerings. Positive side effects might be lower prices and improved service.

If we are indeed destined to be a significant Internet force, it is even more important to develop an ***e-conduct approach***.

The E-Sign Act

This federal legislation provides the essential foundation for transacting insurance business electronically by endorsing the validity of electronic signatures and records.

Industry analysts like the NAIC, have said that this legislation will NOT view insurance information posted to a website as ***transacting insurance*** provided it does not solicit, sell or negotiate terms. Consequently, a website owner would not need to be licensed or registered as a producer.

Further, this same legislation proposes that states should not assert jurisdiction over a website where ***reasonable access to information*** is provided to the consumer indicating that advertised products are not available in a particular state where the appropriate licenses have NOT been obtained.

E-Code

As of yet, there are no Internet police so it is up to you to abide by standards of ethics and reason when using the Internet for insurance-related transactions or communication. An ***E-Code*** is a foundation of e-commerce procedures you may wish to adopt. The suggestions

that appear on the following page are organized under three categories: ***Netiquette***. ***Compliance*** and the ***10 Commandments of Computer Ethics*** Keep in mind, new technologies and changing consumer views will require constant E-Code revisions.

Changes to your E-Code will also occur from the regulatory arena where new laws and the eventual codification of Internet insurance transactions will require new and different approaches to e-commerce compliance. For example, California passed a law requiring agents to include their license number on all ***printed materials***, including business cards, advertisements, premium quotes, etc. In coming years, look for the law to be modified to include all Internet advertising and websites. Or, look for so-called ***clean-up*** regulations like those passed in Arkansas where a new statute allows the Insurance Commissioner to interpret the words “print” or “printed” to include electronic printing. Additional legislation, like various state and federal ***electronic signature acts***, pave the way for legalizing online purchases, including insurance, that formerly required hand-written signatures. Any of these events change your E-Code.

COMPLIANCE & BUSINESS ISSUES

There are at present many challenges to the sale of insurance on the Internet. Some of a business nature; some of a legal nature. Following is a discussion to help you understand the issues at hand.

Legality of Internet Transactions. Still unanswered is the question of whether insurance commerce conducted on the Internet is an insurance transaction regulated under the McCarran-Ferguson Act, or an interstate electronic transmission to be federally regulated under the Commerce Clause.

Lack of Commonality. Insurance industry participants in e-commerce will, for the moment, experience difficulty in sharing data and systems due to an absence of common technology or languages. Many data transfers within the industry, for example, are still done by mail or fax. In addition, electronic data interaction is still limited by the fact that only a few players have sufficient technology and transfer mechanisms. An example is the simple fact that many insurance agents are still not linked to insurance carriers. Likewise, other parts of the chain, such as insurer to reinsurer, have virtually no systematic links.

Consumer interpretations. A California agent's web site is just as likely to be read by a consumer in Florida. Insurance law between these two states is clearly different. Without a significant disclosure of same, consumers can all too easily request quotes or fill-in an application for coverage you cannot provide.

License Jurisdiction. In certain states, you may merely "trigger" an activity that requires licensing. For example, providing quotes or referring business may be considered actions requiring a producer license in some states. Agents wanting multi-state access to clients will need to review and ensure compliance with producer licensing in all states in which he intends to "farm" web interest.

Situs Problems. Since the Internet knows NO geographic boundaries, it is unclear as to the physical location where a sale or solicitation occurred. Did the transaction occur in the state where the agent is physically locate, or the state where the client visited the web site?

NETIQUETTE

(The following is courtesy of Arlene H. Rinaldi, The Net: User Guidelines and Netiquette, 1998)

- I will never assume that e-mail can be read by no one except me; others may be able to read or access my e-mail or the electronic messages sent by my clients.

- I will never send or keep any e-mail that I wouldn't mind seeing on the evening news.

- It is my responsibility when downloading programs, to check for copyright or licensing agreements. If the program is beneficial to my use, I will pay any authors registration fee. If there is any doubt, I won't copy it.

- I understand that under United States law, it is unlawful "to use any telephone facsimile machine, computer, or other device to send an unsolicited advertisement" to any "equipment which has the capacity (A) to transcribe text or images (or both) from an electronic signal received over a regular telephone line onto paper." The law allows individuals to sue the sender of such illegal "junk mail" for $500 per copy. Most states will permit such actions to be filed in Small Claims Court. This activity is termed "spamming" on the Internet and I refuse to do it

- I will never give my userID or password to another person except authorized system administrators that need to access your account for maintenance or to correct problems.

- I will keep paragraphs and messages short and to the point to help avoid confusion and inconvenience to the recipient of my e-mails.

- I will focus on one subject per message and always include a pertinent subject title for the message, that way the user can locate the message quickly.

- I will include my electronic signature (name, position, company, e-mail address and phone) at the bottom of Email messages when communicating with people who may not know me personally or when broadcasting to a dynamic group of subscribers.

- I will capitalize words only to highlight an important point or to distinguish a title or heading. Capitalizing whole words that are not titles is generally termed as SHOUTING! *Asterisks* surrounding a word can be used to make a stronger point. Use the underscore symbol before and after the title of a book, i.e. *The Wizard of Oz_.*

NETIQUETTE (Continued)

- I will limit line length to approximately 65-70 characters and avoid control characters.
- I will never ever send chain letters through the Internet. Sending them can cause the loss of my Internet Access.
- Because of the International nature of the Internet and the fact that most of the world uses the following format for listing dates, i.e. MM DD YY, I will be considerate and avoid misinterpretation of dates by listing dates including the spelled out month: Example: 24 JUN 96 or JUN 24 96
- I will follow chain of command procedures for corresponding with superiors. For example, I won't send a complaint via Email directly to the "top" just because I can.
- I will be professional and careful what I say about others: Email is easily forwarded.
- I will cite all quotes, references and sources and respect copyright and license agreements.
- I will not forward personal email to mailing lists without the original author's permission.
- Attaching return receipts to a message may be considered an invasion of privacy if the party I'm sending to is not expecting the message.
- I will be careful when using sarcasm and humor. Without face to face communications a joke may be viewed as criticism. When being humorous, use emoticons to express humor. (tilt your head to the left to see the emoticon smile) :-) = happy face for humor
- Acronyms can be used to abbreviate when possible, however messages that are filled with acronyms can be confusing and annoying to the reader.

  Examples: IMHO= in my humble/honest opinion
  FYI = for your information
  BTW = by the way
  Flame = antagonistic criticism

NETIQUETTE (Continued)

- I will not include very large graphic images in your html documents. It is preferable to have postage sized images that the user can click on to "enlarge" a picture. Some users with access to the Web are viewing documents using slow speed modems and downloading these images can take a great deal of time.

- While it is not usually a requirement to ask permission to link to another's site, out of respect for the individual and their efforts, I will send a simple email message stating that I have made a link to their site would be appropriate.

- When I include video or voice files, I will include next to the description a file size, i.e (10KB or 2MB), so the user has the option of knowing how long it will take to download the file.

- If I create a website it shall always include my email address and a date of last revision - so users linking to the site can know how up to date the information has been maintained.

- Infringement of copyright laws, obscene, harassing or threatening materials my website can be in violation of local, state, national or international laws and can be subject to litigation by the appropriate law enforcement agency.

COMPLIANCE & BUSINESS E-CODE

- To be the best agent possible, in my Internet communications and transactions I will comply with the same high standards of ethics and market conduct I practice in my everyday business.
- I understand that it is the ***burden of insurers and agents*** to meet all policy requirements, as mandated by the State, for any transaction, regardless of whether it is electronic or on paper.
- I realize that all forms of communication with my client, including the Internet, is considered ***advertising***, which is subject to intense and thorough state and federal regulations that may not distinguish the fact that communication is Internet-based versus other, more traditional mediums.
- I will comply with any and all state guidelines concerning ***signatures***, ***authenticity of signatures, delivery of policies, replacements, exchanges, etc.*** If my state does not except ***digital signatures*** it may mean that I must provide my client a combination of electronic forms and / or hard copies.
- I will follow any and all state guidelines regarding illustrations and RFO's (Request for Quote) that are sent over the Internet; including the transmission of ALL pages, and where indicated, client / agent signatures and initials on hard copy.
- I will develop ***standard operating procedures*** to follow when handling inquiries, applications and other insurance-related transactions on the Internet to be sure my clients have been treated equally, fairly and with full disclosure.
- I will comply with any and all business and insurance laws regulating the collection of premiums from my clients through ***electronic funds transfer*** or other electronic medium, including verification of payment to meet ***proof of payment*** requirements under existing statutes.
- I will implement or contract with a ***secured transaction system*** to assure that my client's funding of premiums through the Internet are protected from theft and further tampering.
- I will satisfy ***records retention requirements*** by being able to produce information or data which accurately represents a record of electronic client communications or electronic transactions.
- I will be certain that any ***proof of coverage*** form or notification that is processed through the Internet will be in an acceptable format to satisfy requirements.

COMPLIANCE & BUSINESS E-CODE (Cont)

- I will do whatever possible to protect my clients ***privacy*** by safeguarding outside access to any personal and financial information I have collected through the Internet by using a ***firewall*** or other acceptable device. Where security needs are at their highest, I will consider a system of ***encryption*** where only a specific sender and receiver of information is permitted access.

- I must also realize that computer crimes, such as embezzlement or planting of logic bombs, are normally committed by trusted personnel who have permission to use my computer system. Computer security, therefore, must also be concerned with the actions of trusted computer users.

- I will address consumer complaints through the Internet in the same efficient manner I would offline. Also, where it might be required, I will establish any ***hotlinks*** to allow a client direct access to the Department of Insurance consumer protection division for registering unresolved complaints or settlements.

- Since the Internet know no boundaries between states, I will make every effort to alert users of my website that my services and products are not available in states outside my licensing.

- Where products require special underwriting I will make everyattempt to present these additional requirements on my website so that consumers coming to my site are not mislead into believing there are no special requirements.

- I will respect the intellectual property of others by not posting unauthorized, copyrighted information on my website. To do so would infringe the owner's rights of public display.

- I will investigate the wishes of my carrier to learn rules and regulations regarding their company name, logos, trademarks, forms and other proprietary information used on my web site or transmitted via electronic means.

- I will provide consumers of my e-commerce system complete knowledge about the products I offer. Doing so puts them in charge of the flow of information, the widest possible choice, convenience, accuracy and speed in order to make better-informed buying decisions.

- To the extent possible, I will NOT restrict my consumer's ability to compare by limiting my e-commerce products. To this end, I will try to present a range of premium choices, a variety of carrier options and/or referrals in areas I cannot help.

Signature Problems. Until electronic signatures become workable on a widespread basis, most state insurance laws require a "wet" signature accompany insurance transaction documents, including applications, added endorsements, release forms, changes in beneficiary or policy limits, product disclosures, etc. This is currently difficult to accomplish with "paperless" Internet transactions.

Countersignature Rules. Policies sold out of an agent's resident license state may require the countersignature of a resident producer.

Privacy Regulations. New requirements concerning Internet transactions now demand compliance with some stiff penalties for avoidance. Since insurance applications and underwriting involve personal financial and medical records, privacy rules and regulations will apply. More on this later.

Delivery Problems. There are many state-specific forms and disclosures involved in insurance transactions which are tightly regulated by states. Existing laws may not be satisfied through electronic delivery or electronic storage via the Internet -- another obstacle to insurance e-commerce.

Taxation. There are currently no taxes levied on Internet services. Even products are exempt in many out-of-state transactions. However, there is a movement under foot to tax Internet commerce. Such a tax on insurance transactions could negatively impact the selling of insurance on the Internet.

Fraud. Internet fraud is described as any illegal scheme in which the Internet plays a significant role in offering nonexistent goods and services, communicating false or misleading representations, or transmitting victims' funds to a perpetrator. Overall, Internet fraud is said to cost innocent consumers over $2 billion annually in the United States. Examples in the insurance arena might include an illegal web site designed to collect premiums for non-existent policies. Of course, the site would terminate before deliver and clients were motivated to file a complaint. Other potential abuses include the altering of beneficiaries, deductibles and coverage, stolen identities and low-ball quotes. Violations such as 'weblining" -- similar to redlining -- could completely exclude the sale of policies in certain geographic areas or to certain consumer demographics. Also, a scam where the web site resides in one state, the scammer in another, the consumer in a third and the payment to a fourth will considerably cloud the ability to pursue violators. What state law would have jurisdiction over the scam "maze"? Is it insurance fraud, computer fraud, wire fraud, racketeering or theft? Current laws on such matters are scarce. And, it is significant that the Coalition Against Insurance Fraud has identified the on-line of insurance as an area to be closely examined. Many of these issues are being reviewed by both state and federal legislatures, including prominent organizations like the National Association of Insurance Commissioners. Some states (California and Pennsylvania) have already enacted versions of the Uniform Electronic Transactions Act (UETA) which mandate that electronic contracts (including insurance) are as binding and enforceable as those entered into in writing.

E-Conduct Code of Procedures

How do the issues above effect your e-conduct? Well, until your state adopts specific guidelines, the preferred practices you have just read below are highly recommended.

THE 10 COMMANDMENTS OF COMPUTER ETHICS

By the Computer Ethics Institute

1) **Thou shalt not use a computer to harm other people:** If it is unethical to harm people by making a bomb, for example, it is equally bad to write a program that handles the timing of the bomb. Or, to put it more simply, if it is bad to steal and destroy other people's books and notebooks, it is equally bad to access and destroy their files.

2) **Thou shalt not interfere with other people's computer work:** Computer **viruses** are small programs that disrupt other people's computer work by destroying their files, taking huge amounts of computer time or memory, or by simply displaying annoying messages. Generating and consciously spreading computer viruses is unethical.

3) **Thou shalt not snoop around in other people's files:** Reading other people's e-mail messages is as bad as opening and reading their letters: This is invading their privacy. Obtaining other people's non-public files should be judged the same way as breaking into their rooms and stealing their documents. Text documents on the Internet may be protected by **encryption**.

4) **Thou shalt not use a computer to steal:** Using a computer to break into the accounts of a company or a bank and transferring money should be judged the same way as robbery. It is illegal and there are strict laws against it.

5) **Thou shalt not use a computer to bear false witness:** The Internet can spread untruth as fast as it can spread truth. Putting out false "information" to the world is bad. For instance, spreading false rumors about a person or false propaganda about historical events is wrong.

6) **Thou shalt not use or copy software for which you have not paid:** Software is an intellectual product. In that way, it is like a book: Obtaining illegal copies of copyrighted software is as bad as photocopying a copyrighted book. There are laws against both. Information about the copyright owner can be embedded by a process called **watermarking** into pictures in the digital format.

7) **Thou shalt not use other people's computer resources without authorization:** Multiuser systems use **user id's** and **passwords** to enforce their memory and time allocations, and to safeguard information. You should not try to bypass this authorization system. **Hacking** a system to break and bypass the authorization is unethical.

THE 10 COMMANDMENTS OF COMPUTER ETHICS (Cont)

8) **Thou shalt not appropriate other people's intellectual output:** For example, the programs you write for the projects assigned in this course are your own intellectual output. Copying somebody else's program without proper authorization is **software piracy** and is unethical. **Intellectual property** is a form of ownership, and may be protected by copyright laws.

9) **Thou shalt think about the social consequences of the program you write:** You have to think about computer issues in a more general social framework: Can the program you write be used in a way that is harmful to society? For example, if you are working for an animation house, and are producing animated films for children, you are responsible for their contents. Do the animations include scenes that can be harmful to children? In the United States, the **Communications Decency Act** was an attempt by lawmakers to ban certain types of content from Internet websites to protect young children from harmful material. That law was struck down because it violated the free speech principles in that country's constitution. The discussion, of course, is going on.

10) **Thou shalt use a computer in ways that show consideration and respect:** Just like public buses or banks, people using computer communications systems may find themselves in situations where there is some form of queuing and you have to wait for your turn and generally be nice to other people in the environment. The fact that you cannot see the people you are interacting with does not mean that you can be rude to them.

A Word On Unsolicited Online Advertising

Unsolicited advertising by e-mail, commonly referred to as ***spamming,*** is one of the web's most annoying problems. It is estimate that almost one-third of all in-box e-mails today is filled with spam. And it will approach 50% in a short time.

Despite today's sophisticated spam-killer programs, we are doomed to receive this unwanted e-mail. A recent North American survey of 1,000 consumers by Insight Express said 65 per cent of respondents spend more than 10 minutes a day dealing with spam. And 37 per cent of respondents get more than 100 spam e-mails a week.

Today, sophisticated spamming gets to many e-mail recipients by massive hit-and-miss deliveries, hitting popular online e-mail services first. Many Internet providers offer filtering services from their servers, but they can also block legitimate e-mail.

In the next chapter, we will be discussing privacy protection from spamming, including many new laws that prohibit its use.

Electronic Commerce and Insurance Sales Background

In all areas of sales, customers are getting used to going "online" to learn more about products and services. According to the *GIGA Information Group* internet purchases are expected to rise to $233 billion in 2004. The growth of ***e-tailing*** is so rapid that consumer expectations in this area are changing about every 12 months: a cycle that is much quicker than the insurance industry is accustomed to. Right now, e-commerce is dominated by so-called ***dotcom retailers*** (companies that exist only on the Internet) selling goods and services like computers, travel, brokerage, auctions, books and music.

In the insurance arena, the supply-side players are diverse. There are ***aggregators*** -- companies who provide quotes and insurer information enabling consumers to comparison shop -- provide a quick quote in seconds and complete a brief online application. Prominent names here include INSweb, Quotesmith and SelectQuote. Then, there are aggressive ***virtual insurance*** companies such as Esurance and eCoverage that are writing complete consumer lines of insurance; including online applications, underwriting information, postmarked binding of coverage and even the ability to file a claim and track its progress.

Add to this a host of existing ***click and mortar*** insurers and agencies marketing their own special brand of e-commerce. Some of these web developers are having tremendous success as various levels while others are merely placating their client consumers who want some part of their insurance distribution channels online. The idea here is that some consumers may be comfortable about buying insurance online; some may not, but you still have to have a physical presence to deliver policies and inspect homes.

Some feel that ***direct-selling*** is the absolute wave of the future. Some worry that it will replace agents altogether. Others are fighting the change, electing to stay on a paper-based system in hopes that their clients still value the "personal relationship" enough to bypass use of the Internet completely.

On the demand-side, surveys continue to validate the acceptance of purchasing by e-commerce. For now, younger and more affluent segments have greater comfort with buying

products like insurance on the Web. Long-term penetration will be positively influenced by greater utilization by agents and brand name insurers. In addition, the continual movement in consumer buying patterns from traditional methods to the Internet should be a plus.

Bottom line? There will be successes and failures in selling insurance on the Internet like any other industry. The agents and carriers most likely to survive are those concerned with providing efficient, secure consumer solutions in compliance applicable insurance laws and state requirements.

Will Consumers Buy Insurance Online?

Insurance is a ***complicated financial product***. Some feel that a majority of the market is not ready to buy it online. However, the fact is that new market groups are entering the system. People who are in their 20's – the "Nintendo generation" -- are becoming agents as well as day-to-day consumers. To them, computers and the Internet are just another tool. These people will be thinking about creative and expanding ways to use the Internet for faster, effective consumption of goods and services. As their numbers, and the generations behind them, become major players as consumers and competitors, it will be harder to ignore an Internet presence.

A recent *Booz-Allen & Hamilton* survey of 144 insurance companies found that most had websites, but only a few had a strategic plan for the use of the Internet. Sixty-six percent used it only for name recognition, whereas only eight percent used it for lead generation and one percent for direct sales. Obviously, selling insurance on the Internet has a long way to go, ***but e-cycles are changing rapidly***. The time when online insurance sales represent a meaningful portion of all sales could be sooner than you think.

The biggest fear of agents is the prospect that the selling of insurance online could increasingly cut out the ***middleman*** (agents). Most experts do NOT believe this will happen since most insurance is purchased when an agent uncovers a need and encourages the consumer to take action. This prediction, however, has not stopped certain companies from trying. Direct sellers are surfacing on the Internet and competing with agents at reduced rates or simply by appealing to the consumer's growing demand for 24-hour services. Agents and brokers are fighting back by finding ways to ***add value*** to the equation. For example, one major broker is developing a "global brokering system" so its agents and offices around the world can trade placements electronically with carriers. Another is building its technological services and capabilities simply to expand its level of customer service.

Electronic Records

As a general rule, electronic records are ***recognized and admissible*** in a court of law. Most states have laws in force that require insurance agencies to produce records on a ***best available*** basis.

Written documents are preferred, however, scanned or electronic records that are date stamped, unchangeable and attached to customer files in such a way they cannot be deleted, are just as good as the original.

However, agents must be careful to comply with state laws. Some states, for example, may only recognize ***wet signature*** applications and other forms

Why Should Agents Develop Internet Skills?

Even if the internet does not soon become a vehicle for widespread direct purchasing of insurance policies there are more than a dozen reasons and ways that the industry and agents can benefit:

- Clients and agents can check the status of policies or cash values
- Clients and agents can check the status of pending applications
- Premiums can be paid by credit card or electronic transfer
- Quotes and illustrations can be instantly retrieved
- Clients can stay in touch directly with their agent using E-mail
- Agents can be connected to carrier news on new products or learn of commission problems
- Insurance loss claims can be reported
- Clients can use an agent website to review benefits of their policy
- Agents can provide clients with a 24-hour information source using an electronic newsletter
- Clients will be able to buy insurance using electronic signature technology
- Agents can inexpensively market their services with their own website or as a member of an "insurance mall".
- Agents can download forms and order underwriting requirements
- Agents can learn of new regulations and licensing requirements or complete their continuing education
- Discussion groups (chat rooms) can provide valuable interaction with other professionals about policy benefits and insurance news.
- Independent and employee agents alike can have access to powerful prospecting databases, professional tax and planning reference materials and rating services
- Agents in the field could log on for sales presentation / quote information
- Regulators can post "consumer-beware" bulletins and comb the web for violations and less than ethical insurance dealings.
- Insurers and agents alike can use the Internet as an inexpensive recruiting tool

Experts predict that no major insurer will be without Internet presence in the next couple of years. Given their vast resources and ability to tap into new technology it is likely that the insurance industry will soon maintain a high profile that will not go unnoticed by the many information search services such as Yahoo, Excite, Alta Vista, AOL and Infoseek. As a result, it won't be long before consumers will be offered a stockpile of user-friendly insurance sites and links from related sites in banking, financial planning, tax and retirement planning.

Still others are using the Internet to find a special niche in the market, e.g., the sale of term life insurance using instant quotes from multiple carriers. The non-standard automobile market is another area where drivers with multiple accidents can go online to research their options. Some companies already boast the ability to upload information, get a policy number and billing information, bind coverage and let the customer know they're protected, all within minutes!

All of above are reasons that agents should develop a ***digital strategy***. Begin investigating the potential use and application of the Internet. To aid in this research you will need to know

some background on the Internet and some of the legal and regulatory obstacles to selling insurance online. Much of the information that follows was presented in a NAIC (National Association of Insurance Commissioners) “white paper” titled *The Marketing of Insurance Over the Internet, 1998*.

What is Electronic Commerce

Electronic commerce is a broad category of activities that ***allows goods and services*** to be selected, purchased, received or serviced using, in all or in part, electronic based technologies.

Electronic based technology means the transmitting, receiving, and storing of data in an electronic format including, but not limited to, the following:

- The electronic transmission of data including transmission via telephones, electronic mail (e-mail), facsimile, File Transfer Protocol (FTP) or any other transmission of data over communication lines;
- Use of the Internet, Electronic Data Interchange (EDI), or other public or private networks;
- Imaging;
- Electronic funds transfer (EFT) or other established means of electronically transferring funds between two parties;
- Television, radio or other broadcast media;
- Interactive voice response (IVR) mechanisms;
- Wireless transmissions; or any other means of conducting business by transmitting, receiving and storing data in an electronic format.

A Quick Internet History

The Internet began in 1968 when the Advance Research Projects Agency (ARPA) at the United States Department of Defense began developing ARPAnet, the first large_scale computer network. ARPANet was designed to give computer scientists at universities and other research institutions access to distant computers, permitting them to use computing facilities which were not available at nearby locations.

Before ARPANet, most networks depended on a central server which, if it went down for any reason, jeopardized the entire system. ARPANet used multiple servers and communications lines and protocols so that if any server had a problem, information could be re-routed through remaining servers.

In the 1980's, the National Science Foundation (NSF) created five supercomputer centers and made them available for general research purposes. Until this time, access to these supercomputing facilities was limited primarily to scientists, universities and researchers. With the advent of the NSFnet, opportunities for access by others began to open up. Regional networks were developed and interconnected within the NSFnet and these, along with the MILNet, Bitnet, DECnets, and hundreds of Local Area Networks (LANs) made up what has become known as the Internet.

A computer network is two or more computers which are connected to each other and can communicate information from computer to computer. Today, the Internet is comprised of

thousands of computer networks which are located throughout the world. Common tools used to gain access to this world wide network of computers are e-mail and the World Wide Web. Because this access is available 24 hours a day and is available world wide, the Internet is revolutionizing the ability of individuals to communicate and to obtain information on almost any subject at any time.

Accessing The Internet

Access Through Commercial and Public Internet Service

E-Mail, the World Wide Web, Internet Service Providers and computer online services are all means by which one can obtain access to the Internet.

Electronic mail, similar to conventional mail, allows individuals to send messages to other people. The major advantage of electronic mail over conventional mail is that electronic mail is delivered immediately, at any time and is paperless. In addition, recipients can retrieve the message at any time and print out the message if the need arises.

Another way to gain access to the Internet is through commercial online services. These services have electronic magazines, chat rooms, and software libraries that are available to subscribers of the service. They also usually have Internet access via e-mail, newsgroups, and the World Wide Web.

A person can also obtain access to the Internet through ***Internet Service Providers*** (ISP's). ISP's are organizations that have servers connected to the Internet. ISP's charge a fee to individuals for access to the Internet through their server.

Access to the Internet is typically through a fee-based Internet Service Providers or commercial online services. For corporate or government entities these may be high-speed, dedicated lines, and for individual consumers they are typically ordinary telephone lines using modems. There is an increasing use of satellite and cable connections, though these are still in a distinct minority.

Many people assume that only sophisticated individuals will be using the Internet. However, with the development of low cost, simplified hardware for use exclusively on the Internet or in concert with cable television connections, electronic capabilities will be present in many, if not most, American homes. This means the purchasing of a home computer will not be necessary to access the Internet. Thus, the Internet could offer the promise of improved distribution of products and dissemination of information to households almost everywhere, especially those underserved by current distribution methods. In addition, people may also access the Internet at public libraries and schools.

However, unless the cost drops significantly, low-cost home access to the Internet may not soon become a reality for many people. Current prices for equipment necessary to access the Internet via a TV are still beyond the means of many people, and they still must pay monthly Internet access fees. It remains to be seen if these prices will drop sufficiently in the next couple of years. The limited access to the Internet of certain classes of potential insurance consumers could raise some issues for regulators concerning insurance companies, producer marketing and distribution methods.

The Internet is relatively new yet its popularity, has grown dramatically in recent years. In fact, reports of the Internet's dramatic growth have seemed common for some time. Still, the essential question for the insurance industry is not how quickly the Internet has grown, but how large and accessible it currently is and how quickly it may grow in the future.

The World Wide Web

The Internet is actually a variety of technologies including File Transfer Protocol (FTP), Gopher Servers, electronic mail (e-mail), and the World Wide Web. The World Wide Web is the interface familiar to most consumers, and uses Universal Resource Locators (URLs) also known popularly as domain names to identify web sites. This, combined with a user-friendly interface known as hypertext (HTTP) allows users to navigate by clicking with a mouse or other pointing device on select words or phrases, icons, or other graphic images. This is the methodology most people associate with the Internet.

The World Wide Web is also where many companies have set up established home pages. A home page can be compared to a company brochure in an electronic format. Like a brochure, a home page will provide basic information about an organization, such as the location of the organization, main area of business and available products. Depending upon the amount of information, an organization wishing to make a home page available may be limited to one page or may expand to include numerous pages of information. In addition, a home page often includes hypertext links to other pages; thus forming a web of information on thousands of subjects.

Potential Users of the Internet

Consumers

The Internet provides a convenient way to learn more about products, sources and pricing. And, since people make most purchasing decisions based on information they receive through manufacturer marketing materials, companies looking for more efficient ways to target their market will find that the Internet will allow consumers to purchase a product, rather than being sold a product.

E-mail capabilities allow consumers to communicate with agents and/or companies about changes to their insurance policies and to report and process handle claims. Not only can the Internet cut down or reduce "phone tag," it can help provide instantaneous confirmations that consumers' instructions have been complied with, furnish another option for carrying out correct notification procedures, and provide "hard copy" (print out capability) of agents'/companies' instructions (e.g., directions to repair facilities, inspections procedures, etc.) without the need to write down or remember the information.

Regulators

Regulators in their consumer protection and consumer education roles could benefit from near ***universal consumer access*** to the Internet. For example, Insurance Departments can post consumer information that would appear more or less automatically in consumers' insurance related searches. Thus, this information could be disseminated much more cost effectively and consistently than it currently can be supplied. Many departments already provide this type of information in hard copy format including general insurance information

and premium comparisons, but its dissemination is limited and sometimes expensive because of its hard copy format.

The marketing of insurance over the Internet also offers regulators an additional opportunity to actively monitor market conduct. Regulators, like consumers, can "surf" the Web, looking for suspicious solicitation activity. Ordinarily, regulators must wait to be made aware of market conduct problems through consumer complaints (outside normal market conduct audits). The Internet is a more pro-active approach to such audit efforts.

The ease and speed of Internet communications mean that regulators could more frequently monitor insurer compliance with regulatory procedures and time frames. Once appropriate record keeping requirements are in place, "spot checking," "surprise audits," and other tools could be as simple to implement as an exchange of E-mail. This could instill greater compliance efforts in insurers with chronic service problems.

Industry

Producers and insurers recognize the vast capabilities of the Internet and the ability to provide information to prospective clients, in a format that more closely fit their clients' needs. The Internet allows their information to be ***easily and continuously available***, to post a "presence" that accurately portrays the variety of products and services; and to provide a convenient way for consumers to contact them for follow-up.

The relatively ***low cost*** of electronic communication, compared to that of hard copy mailings, telephone solicitations, etc., should provide potential cost savings for agents and companies that use the Internet effectively.

Insurance companies are already taking advantage of the electronic commerce available through the Internet by establishing home pages on the Internet. With these home pages, insurance companies are opening new distribution channels which could eventually incorporate all facets of the insurance transaction, from initial contact with the consumer to collection of premium, issuance of the policy, and the payment of benefits. The Internet is recognized by agents and companies as potentially more efficient than many traditional marketing methods.

The Internet allows companies to service existing markets and expand into previously untapped markets. Huge marketing possibilities are more easily possible on the Internet, allowing agents or insurers to post their information in such a way that it will be found by people pursuing related interests, such as crop insurance information by farmers, and fine arts coverage by art collectors, etc.

In addition to sales, insurance companies are finding the Internet a means by which to better educate consumers on the different type of insurance available and the benefits of such insurance. Insurance companies can also utilize the Internet to service current policyholders by offering online claim assistance, complaint handling and answering general inquiries. Finally, the Internet offers companies the opportunity to expand its communication with its agents. The Internet offers insurance companies the opportunity to offer these services with greater speed and efficiency and at a lower cost.

Selling Insurance Over The Internet

Electronic commerce, for now, favors the sale of goods as opposed to services, such as insurance. This disparity can be tied to a variety of issues, including technology acceptance by consumers, security and regulatory concerns surrounding insurance sales on the Internet. Unlike the sale of a book or article of clothing, the sale of an insurance policy involves complicated contractual language, the transmission of sometimes confidential information and a relationship of good faith on behalf of the buyer and the seller.

Current methods by which insurance sales can occur over the Internet are either single source or via insurance malls.

Single Source Sale Sites

Single source sale sites are comprised of a single insurance company or agency marketing its products over the Internet through the establishment of a home page. When developing a home page for a single source sale site, insurance companies can use their home pages as a promotional tool, to direct consumers to their existing agents or as another distribution channel. A survey conducted by the LIMRA International, Inc. revealed that two thirds of the companies use their home pages for name recognition. Eight percent of the companies indicated they use their home pages for lead generation for their agents while only one company indicated direct sales was the main purpose of its home page.

A ***single source sale site*** is a method of marketing insurance over the Internet which enables the consumer to select and purchase his/her insurance ***directly*** from an insurance company. This type of insurance marketing over the Internet will presumably provide the consumer with all the steps necessary to purchase insurance; from filling out an application online to payment of the premium and receipt of the policy online.

Insurers' and producers' home pages can offer marketing and/or educational information about a company and its products. For instance, a home page may explain the benefits of life insurance or explain different auto coverages.

In addition to simply providing information, some sites will go a step further and offer online ***requests for quotation*** (RFQ) forms. RFQ's typically involve a questionnaire which the consumer must answer in order to obtain a quotation. Once this information is obtained the consumer can obtain an instant quote for insurance. RFQ's allow the consumer to obtain information directly and relatively quickly. If a consumer wishes to obtain more information on a particular product or make a purchase, insurers could provide a list of agents that may be contacted to complete the transaction. In addition to providing a quote to the consumer, RFQ forms provide the company with valuable statistics on the profiles of the individuals visiting the site and the type of insurance being requested.

Insurance companies may also develop home pages that work in conjunction with their agents. These sites offer general information on products and help educate consumers about their insurance needs. Similar to sites which provide RFQ's, these sites direct consumers to existing agents in order to obtain quotes, more information about a particular product and to make a purchase. Insurance companies using this arrangement may be selling a more complex insurance product, such as whole life insurance. When referring a

consumer to an agent, the typical referral is to the agent's phone number and address. However, some sites may refer a potential consumer to an agent.

Just as insurance companies are establishing home pages for single source site sales, insurance agents are likewise establishing home pages for direct sales over the Internet. Currently, these home pages provide general insurance information to the consumer In the future, many of these home pages, along with the single source sites of insurance companies, will presumably offer all of the features necessary to complete the sale and delivery of an insurance policy.

Insurance Malls

Insurance malls are sale sites that offer the products of more than one seller. ***Vertical insurance malls*** offer the products of multiple sellers from the same industry, while horizontal malls offer the products of multiple sellers from multiple industries. Because of the diversity of products offered at both types of malls, these malls attract a wide diversity of consumers and have the potential to become true electronic markets.

One of the key features of insurance malls is their ability to provide consumers with access to a wide variety of products and comparisons of these products. These Insurance malls are designed to provide consumers with one or more purchase alternatives by matching consumer profiles against company underwriting criteria and present a list of alternative companies from which the consumer may selects. The consumer can then review policy information, pricing, and other aspects of various offerings from companies participating in the mall.

Apart from being wholly geared to focusing on cost comparison and sales, many sites are educational. Insurance malls also present information about the different types of insurance available, insurance companies, and ratings of these companies. Such malls may also provide a brief description of insurance terms and information on state insurance laws.

A third category are malls which combine sales-oriented information with consumer-oriented information. These sites provide the consumer with the same information available in a site geared to consumer education; however, they also provide the consumer with the ability to fill out complete RFQ forms. In addition these insurance malls may also offer a list of agents as well as hyperlinks to the home pages of these agents or to other insurance Internet resources on the Internet.

Quote Services

In still another Internet twist, agents wanting to add online quotes to their websites can sign-up with an independent ***quote service***. Adding a quote service to an agent's website allows consumers to obtain an instant insurance quote by choosing type and amount of coverage desired. In most cases, the consumer is actually "hyperlinked" from the agent's website to the quote service site where sophisticated software produces the online quote. When completed, the customer is returned to the agent's site. Quote choices can be limited to specific companies and products offered by the agent. Services are usually sold to agents on a subscription basis or in some cases piece-meal.

Service of Insurance Over the Internet

The more transactions a consumer has with a company via a certain medium, the more bound the consumer becomes to the company and the medium of communication. Unlike consumers in other industries, consumers who use the Internet may have increased interaction with their insurance companies -- with noted benefits. A typical insurance consumer, without Internet service, only interacts with his/her insurance carrier on four occasions: 1) when he/she purchases the insurance policy, 2) when he/she pays the insurance premium, 3) when he/she makes a claim on the policy, and 4) when he/she changes coverage or other contract provisions such as a beneficiary. Consumers may, therefore, be more likely to use this medium to make their initial purchase of insurance if all facets of the insurance transaction are available over the Internet.

Many websites are already increasing the interaction insurance companies have with consumers by offering educational information. It has been stated that these types of interactions not only increase the general public's understanding of insurance but also create a familiarity and level of comfort in terms of a company's online services.

Another method of increasing consumer familiarity and confidence in a company's online services might be its provision of complaint and claim services over the Internet. Because the processing of claims, complaints and policyholder services is probably the most important aspect of the insurance transaction for consumers, providing them online might be an added benefit.

The increased use and demand for services over the Internet should be a constant reminder to insurance companies and regulators that an increasing number of consumers have a strong desire to access more information that is relevant to their individual interests and needs, insurance services being among them. Once all facets of the insurance transaction are available over the Internet, consumers may begin to use this medium to make their initial purchase of insurance. And as capabilities increase, so should insurance commerce on the Internet.

Company/Agent Communications

The Internet also is a tool which could enhance company and agent communication. With the use of the Internet, agents can have a continuous line of communication to their insurance companies. This could enhance the educational level of agents and thus enhance the information agents pass on to consumers during the sales process. In addition, the Internet has the potential to permit the electronic transmission of policy forms; thus cutting down on the cost of the application and policy issuance process.

Legal Aspects of Selling Insurance Over The Internet

The Internet is full of risk for the insurer and consumer alike. The growth rate of this media has people and regulators worried that it could go unchecked. This has led to much rumor and speculation about Web laws and restrictions. The *NAIC (National Association of Insurance Commissioners)* and other insurance-oriented associations have been actively discussing and weighing the regulatory issues. The fact is, ***there is regulation*** and ***it is being regulated***.

What is being regulated? The same sales, legal and business conduct issues that are regulated offline:

- Advertising, sales and marketing
- Licensing requirements
- Forms and rates
- Disclosures and restrictions
- Complaint handling
- Consumer privacy rights
- Replacement activities
- Settlement rules
- Records retention
- Security

Unfortunately, many agents and insurers alike are lulled into believing that "no one is watching" . There are details and infractions on some websites that would never have gone to a consumer in hard copy. However, the process of uncovering these sites is the same as in the hard copy world – "it's just a matter of time".

Let's look at some of the areas where electronic insurance sales demand current and future regulatory presence. Information that follows was presented by the NAIC in a white paper titled *The Marketing of Insurance Over the Internet, 1998.*

Countersignature Requirements and Other Non-resident Solicitation Restrictions

The countersignature of a resident agent is required in some states in order for a non-resident agent to transact business within the given state. The resident agent signature is referred to as a countersignature.

Countersignatures impede the sale of insurance through traditional and electronic means. Countersignature requirements were originally intended to protect consumers under the assumption that the resident agent would be more knowledgeable about the state laws and would provide a valuable service to policyholders by reviewing the policy for compliance with state law. They were developed in a time when state jurisdiction was a concern. It is generally agreed that this requirement has served its usefulness and now only serves as a protectionist of resident agents' commissions.

Some states also have laws, regulations or other requirements that specify that a non-resident producer must be accompanied by a resident producer to solicit insurance. While originally implemented to protect consumers, the utility of this type of requirement has passed.

Most E-commerce experts believe countersignature requirements should be eliminated, as should any requirement for a resident agent to physically accompany a nonresident agent when visiting a potential policyholder.

Signature Requirements

The traditional "wet" signature is used to signify several actions. It is used as a formal symbol of intent to denote an individual's agreement to terms and conditions set forth in a document

– "by my signature set forth below I hereby agree…", or to acknowledge receipt of the item(s) in question. It is also used to convey that the signer is indeed who he/she purports to be (authentication). This latter use may be equated to a "notarized signature."

The terms electronic and digital signatures tend to be used interchangeably but there are significant differences. An "electronic signature" may be any symbol or mark originated electronically with an intent to authenticate an action. A "digital signature" is a methodology of signing an electronic document to ensure its integrity during transmission utilizing "public key cryptography." The individual sending a document signs and encrypts it with a private key that only he/she possesses. Once so encrypted, the resulting document is termed a "digital signature." A recipient of the document uses a public key (which may be in the possession of multiple parties) to decrypt the document. Verification of the authenticity of the digital signature is facilitated when the signature includes a "digital certificate" issued by a "certification authority" or CA. The digital certificate is issued only after the identity of the signer seeking the certificate is verified by the CA, and, in this way, is analogous to the function performed by a notary public. The digital certificate carries the name of the subscriber and the subscriber's private key.

Public key cryptography provides the foundation for network security through encryption and digital signatures. Together these provide the following capabilities fundamental to conducting secure electronic commerce transactions: confidentiality (data is obscured and protected from view or access by unauthorized parties); access control (data can only be accessed and decrypted by those specifically identified when the data is encrypted); authentication (users can securely identify themselves to other users and servers on a network without sending secret information about themselves); data integrity (the verifier of a digital signature can easily determine if the digitally signed data has been altered since it was signed); and non-repudiation (users who digitally sign data cannot successfully deny signing that data).[1]

Requirements that documents be "signed" are found in all lines of insurance. Following is a partial list of the types of "in-writing" requirements that provides some examples of the types of signature requirements that now exist:

- With respect to life and health lines, insurers are generally prohibited from asserting that an applicant materially misrepresented facts unless the facts are contained in an application signed by the applicant and attached to the policy. This effectively requires all underwritten policies to be accompanied by a signed application.

- Some health insurance policies, including Medicare supplement insurance, may not be issued unless the applicant has signed the application. The purpose of the signature requirement is to protect consumers by evidencing they have read the materials accompanying the solicitation.

- Property and casualty forms evidencing coverage offers must be made in writing by the insurer and often accepted or rejected by the insured in writing. Such coverage includes, but is not limited to: uninsured/underinsured motorist; personal injury protection; medical payments; deductibles; tort thresholds; extended reporting periods on claims made coverages and fraud disclosure statements. The rejection in writing has been interpreted

[1] Entrust Overview. Chris Voice. Entrust Technologies, Octover 22, 1998. Page 1.

to require the applicant or insured's signature.

Before electronic signatures can work, we must determining what constitutes a valid signature. A review of each requirement for signature should be undertaken to determine if the requirement is necessary for consumer protection. "Electronic authentication" such as that provided by digital signatures utilizing the public key cryptography approach described above, allows commercially acceptable and reasonable security measures to take the place of " wet" signature requirements for the purpose of accommodating electronic commerce. Authorities like the National Association of Insurance Commissioners (NAIC) recommend that electronic authentication be an acceptable form of signature. However, limiting acceptable signatures to digital or digitized electronic signatures may exclude other reasonable means of authenticating one's identity. Therefore, electronic authentication strives to allow any reasonable type of technology to fulfill the basic purpose of a "wet" signature requirement (i.e., the authentication of the signer).

A working group assembled by NAIC recommends that, where possible, the legal definition of "signature" be redefined to include all verifiable electronic signatures as follows:

1. Signatures

In cases where a written signature, or other means of authentication, is required, the use of electronic means, which may include an electronic signature, to authenticate the identity of the party(ies) involved shall be acceptable as long as:

- The means of electronic authentication is uniformly applied to the consumer; and
- The electronic authentication is unique to the signer, is verifiable, and neither the signature nor the document to which it is affixed can be altered once signed.

2. Electronic Authentication

Electronic authentication should be permitted wherever "signatures" are required, including processes such as application and claim submittal. A review of authentication requirements in all insurance transactions should be conducted to identify and remove inhibitors to electronic commerce. For example, when a consumer shops for private passenger automobile insurance, he/she may be required by state law to submit a separate form to verify that he/she was offered such benefits as uninsured or underinsured motorist coverage, certain levels of deductibles, or a warning that insurance fraud is illegal. With electronic commerce, separate forms, each signed or authenticated by the consumer, may not be necessary or even feasible. If the consumer is shopping on a web site he/she should be permitted to view a page that discusses and offers uninsured/underinsured motorist coverage and warns that insurance fraud is illegal. To continue with the online application, the consumer would have to select a link at the bottom of the page and be asked to verify that he/she had read and understood the previous page or pages. This process, with some means of authentication that it was the consumer who indeed "clicked" the "OK" button, could take the place of separate forms, being authenticated by the consumer in a way very much like signing separate forms.

The following list of documents are typically required to be accompanied by a "signature":

- Policy application

- Warranties
- Release of confidential medical information
- License applications
- Beneficiary changes
- Uninsured motorists coverage
- Earthquake offers
- Fraud prevention
- Life illustrations
- Claims forms
- Proof-of-loss
- Financial filings (Form A, B, D, etc.)
- Disclosures for consumer protection
- Change in coverage
- Life insurance insurable interest concerns

3. Delivery of Documents

The delivery of complete documents refers to transmissions between insurers and regulators as well as the receipt of insurance policies, notices and any other documents relating to the sale of insurance, by the insured, owner and other third parties that may have a pecuniary interest.

The major concerns with electronic commerce and document delivery are the ability of regulators to verify that the policy or other insurance documents involved in a sale of insurance from an insurer were actually delivered to the consumer in the sale transaction, are maintained by the insurer in either electronic or paper format and are available to the consumer within a reasonable time upon either electronic or written request by the consumer. Records retention systems will allow regulators to verify the content of a policy or other insurance document through inspection of the policy or document, and such systems must also reasonably accommodate requests from insureds for copies of their policies or insurance documents.

In the arena of electronic commerce, many consumers will want policies and other insurance documents delivered electronically. Moreover, there are clearly advantages to electronic delivery for the consumer, mainly in the speed with which the delivery can occur. While the insurer must let the consumer know prior to the purchase of the policy how it will be delivered, laws and regulations need to allow for electronic delivery.

There is a special area where notice requirements deserve special attention. For various lines of insurance, the delivery and receipt of a notice of cancellation is important not only to the insurer and the policyholder, but various other parties that may have a pecuniary interest in the insurance contract. For example, cancellation of an auto insurance policy may not only affect the policyholder, but third party victims of the policyholder's negligence. Further, mortgage holders have an interest in property polices. The issue is whether the notice has been delivered by the insurer and whether the notice has been received by the policyholder or other party with a pecuniary interest in the policy that is entitle to receive such notice. Free look periods for life insurance are also an issue.

Following is a list of some current document delivery requirements:

- Many states require insurers to deliver hard copy (paper) versions of documents, including policies, positional letters from claims, billing notices, cancellation/non-renewal notices, certificates of insurance.

- Some proof of mailing requirements specify registered or certified mail from United States Postal Service or a verifiable courier service.
  (1)
- Some states have proof of coverage laws that may be unique to different coverages.

Document delivery through electronic means should be permitted if agreed upon by the insurer and the applicant, policyholder, certificate holder, or other parties involved in the transaction, but the burden is on the insurer to meet all existing requirements for policy delivery regardless of the method in which the policy or other insurance documents are actually delivered to the insured. In addition, any policy or other insurance document delivered to an insured during the insurance transaction must be maintained by the insurer in either electronic or paper format and the insurer must be able, in a reasonable time period, to provide an electronic or paper copy of the policy or other insurance document to the insured upon written or electronic request by the insured.

The NAIC working group recommends that states review and, if necessary, amend existing laws, regulations and processes to recognize electronic notification as a valid way to notify a policyholder, given that both parties agree to the method, and receipt of the notice by the insured is verified to the extent required by law, and acceptable records are maintained. For purposes of delivery, and other communications required or permitted by a state and its attendant regulations, delivery and communication by electronic or other verifiable means shall not be precluded where agreed to by the parties

Once again, it is preferable to specify the parameters for document delivery rather than trying to predict all of the ways in which policies may be delivered electronically in the future, developing requirements for each method of delivery.

4. Format of Documents

Format of documents refers to stylistic presentation requirements including font size, margins, paper color and paper size.

Insurers are burdened by requirements that relate to font size, paper color, or other requirements that are related to presentation on printed documents that may not be able to be met electronically. For example, some states have required workers compensation notices to be on non-standard sized paper and printed in red.

Because of the wide variety of operations that users can perform upon displayed and printed text in the modern PC environment, it is impractical to hold originators responsible to insure that textual content is displayed or printed with a specific font or size, or on a specific page size or color. On the other hand, protection of the consumer is the paramount concern.
Therefore, to promote electronic commerce, it is recommended that existing law specifying font type and size for printed documents be interpreted for electronically transmitted or displayed documents as using a font with characters which are clearly discernable and understandable to a person conversant in the written language presented, with as nearly as

possible, in the given font, the same relative character sizes for different parts of the document as are specified by current law. Any web site containing documents covered by such laws should offer a readily-selectable large print display option for the benefit of persons whose eyesight is diminished due to aging or for other reasons.

5. Electronic Payments

Electronic payment includes, but is not limited to any electronic means of securing payment that is acceptable to all parties involved; such as, wire transfers, smart cards, phone cards, electronic fund transfers, electronic checks, credit cards or debit cards.

The following text details various impediments to electronic payments that appear in state laws, regulations or processes:

(1) Premiums

Currently, the principal statutory impediment to the use of electronic forms of premium payment involves payment by credit card. Requirements for insurers may vary with the line of insurance. Some state laws, regulations or processes totally prohibit the use of a credit card for payment of life or property/casualty insurance premiums or allow those payments only if the card is issued by a bank that is domiciled in the state.

In some states, an insurer which offers a credit card payment option must offer additional payment options, such as advance payment by check or the “bill me” option. In addition, certain states require that, if payment by credit card is made available to some insureds, it must be made available to all insureds on a nondiscriminatory basis.

(2) Claim Payments

Certain state statutes, which formerly required claims to be paid by check or draft, have expanded permitting forms of payment to include electronic funds transfer. Such statutes arguably prohibit newer forms of electronic payment, such as electronic checks.

(3) Settlement Refunds

Refunds directed by insurance commissioners almost always require insurers to issue a check to the insured rather than a credit to his/her premium account or bank account. The most recent example is a Michigan Insurance Department directive to insurers, which stated that crediting an insured’s premium account rather than issuing a check was in violation of the spirit and intent of the mandated refund in the state.

(4) Payment of Taxes and Fees

Some states authorize the ***System for Electronic Rate Form Filings*** (SERFF) and permit the commissioner to accept filings in electronic form. Some states accept SERFF filings but nevertheless require that a check in payment of filing or retaliatory fees be mailed to the department of insurance.

With the implementation of the ***Producer Information Network (PIN)***, the processing of agent appointments and licenses may be done electronically. A barrier to the implementation

of PIN, however, is the requirement in some states that a check in the amount of the fee be paid before the transaction may be completed.

A few states affirmatively authorize the insurance commissioner (or more commonly, the commissioner of revenue) to require or accept payments of fees or taxes by ***electronic funds transfer*** (EFT). This would suggest that the removal of statutory or regulatory barriers prohibiting payments by EFT are insufficient to allow such form of payment; specific authorization is apparently necessary. Additionally, as discussed earlier with respect to claims payments, newer forms of electronic payment, such as electronic checks, may not be permitted even under these EFT enabling statutes.

For electronic commerce to be as effective as possible within the insurance industry, the use of various electronic means, such as credit cards, debit cards, electronic funds transfer (EFT) or other means of electronic payment that is acceptable to both the insurer and the insured and is verifiable in order to meet the "Proof of Payment" requirements under the statutes must be allowed. Insurance consumers will demand that electronic payments be facilitated when using electronic systems to purchase and receive insurance products. To this end, regulators should eliminate prohibitions or restrictions against electronic payments to the fullest extent possible. This issue should be dealt with on a nondiscriminatory basis.

The NAIC working group received comment that some insurers may be reluctant to accept premium payment by credit card because there are limitations on how merchants pass fees paid to the credit card company back to the credit card users. The working group did not confirm this, but if true, it is a barrier to credit cards as a form of electronic commerce in premium payments. Any restrictions on pass through of credit card fees are most likely governed by banking laws and regulations. Insurance regulators may wish to review the interaction of banking and insurance regulation in their states as they review various forms of electronic commerce for premium payment. Therefore, the working group notes that pass-through issues resulting from the use of electronic payment options should also be considered.

Note:

A Connecticut statute applying to the Commissioner of Revenue Services might serve as a model for payment of fees by insurers to insurance departments. The statute gives the Commissioner the authority to require "the filing, by computer transmission or by employing new technology as it is developed, of any return, statement or other document that is required by law or regulation to be filed with said commissioner ...and permits any person "to pay any tax, to which such return, statement or other document pertains, by electronic funds transfer...and further permits the Commissioner to "prescribe alternative methods for the signing, subscribing or verifying of such return" and "permit the payment of any tax...by use of any new technology as it is developed."

6. Records Retention

Records retention encompasses the requirements for length of retention and method for storing company records. Records retention laws, requiring insurers to maintain hard copy (paper) documents for a period of years, are found in many states.

Rather than attempting to specify technical requirements for electronic records retention systems, which will continue to evolve rapidly, the NAIC working group recommends that

regulators clearly enunciate the basis for records retention requirements and place the burden solely on the insurer to meet those purposes with whatever system is chosen. Following is sample language taken from the NAIC Market Conduct Record Retention Model Regulation:

"Records required to be retained …may be maintained in paper, photograph, microprocess, magnetic, mechanical or electronic media, or by any process which accurately reproduces or forms a durable medium for the reproduction of a record. A company shall be in compliance with this section if it can produce the data which was contained on the original document. In cases where there is no paper document, a company shall be in compliance if it can produce information or data which accurately represents a record of communications between the insured and the company or accurately reflects a transaction or event."

7. Disclosure of License Status

License status disclosure ensures that consumers have a means of readily identifying whether an insurer or producer is authorized to transact insurance in the consumer's location and for the insurance products being considered.

Some states currently have disclosure standards that contain stylistic requirements such as font size or other characteristics like the use of strong, bold or emphasis tags, or the use of specific heading levels.

Existing standards that apply to this type of consumer notification should apply to electronic transactions, however, additional standards should not be imposed on electronic or Internet-based transactions that do not exist for other means of delivery.

Disclosure standards should, at a minimum, continue to require disclosures to be prominently displayed and easily readable. Disclosure standards should not contain stylistic requirements that could cause impediments to electronic commerce.

To ensure that consumers are provided the data needed to make informed decisions on purchasing insurance, the NAIC working group recommends that an insurer's web site should provide a disclaimer containing the following information: a listing of states and product lines it is authorized to conduct insurance business in; the specific name of the insurer, if it is an affiliate of a large group of insurers and the name, phone number and address for the state insurance department consumer representative that can be contacted for licensure confirmation. The working group also recommends that a producer's web site provide a list of product lines and insurers that it is soliciting for, the complete producer name (as registered with the state insurance department), the corporate name if applicable, the trade name if applicable, the certificate of qualification number and the complete business mailing address and telephone numbers.

8. Advertising

To advertise is to make a public announcement, regardless of the media used, to proclaim the qualities or advantages of an insurance product or service for the purpose of increasing sales.

The regulation of advertising can be a problem for insurers and producers regardless of advertising medium. The Internet complicates this issue because an individual can access an

insurer or producer web site from any location. This feature makes requirements for filing and prior approval of advertising material difficult or impossible for insurers to meet. Further, the fact that an insurer or producer maintains a web site, or other electronic presence, does not, in and of itself, necessarily mean that the insurer is "advertising" insurance products or transacting the business of insurance within a state. Similar concerns exist with national media advertisements.

The NAIC working group recommends that filing and prior approval of advertising be eliminated as an inefficient use of scarce regulatory resources. The working group believes that retrospective review of advertising through market conduct examination or other state regulatory review processes will adequately and efficiently protect consumer's interests. Further, Unfair Trade Practices Acts provide sufficient relief for consumers regardless of the medium used.

9. Compensation

For purposes of this discussion, compensation is something of value provided to an individual or business as payment for a service rendered.

A problem has been identified that hinders insurer development of electronic commerce solutions. If an insurer or producer enters into an arrangement with a third party service provider where the third party service provider is compensated based on a percentage of premium, there is a technical violation of state insurance law. The third party vendor is considered to be a "producer" under many state laws and must be licensed to sell insurance. This gets in the way of insurers and producers entering into this type of service arrangement or causes the parties to engage in creative financing to get around the law that was intended to prevent commission sharing arrangements with non-licensed insurance entities.

10. Code and Regulation Clean-up

Many existing statutes and regulations unnecessarily hinder the growth of electronic commerce. These statutes and regulations have evolved over periods of many years, and are presumed to hinder the growth of electronic commerce out of a lack of anticipation of its needs, rather than out of any intention to hold back its development.

Examples of this problem are statutes and regulations worded in such a way as to require traditional mailing of notifications, and thus precluding some form of electronic mailing which would include verifiable receipt. Another example is statutes and regulations worded in such a way as to require hand-written signatures, and thus precluding some otherwise acceptable form of electronic signature.

Rehabilitating these statutes and regulations one at a time might take as long as the original enactments, and would be extremely costly in time and resources. The recommended approach by many is to enact legislation which globally allows the interpretation of existing statutes and regulations in such a way as to embrace electronic commerce technology. For example, legislation can be enacted to allow all statutory and regulatory requirements for a handwritten signature on a paper document to be optionally satisfied by a verifiable electronic signature on an electronically transmitted document.

The State of Arkansas recently enacted legislation that may be useful to other states looking for a quick way to clean-up existing statutes and regulations to make them more compatible

with industry and regulatory uses of electronic commerce. In short, the new statute allows the Commissioner to interpret the words “print,” “printed,” and “printing,” among others, to include an electronic printing or form.

11. Proof of Coverage

The ability to verify that specified coverage is in force for a given insured or risk.

In many instances, particularly with automobile, homeowners’ and health insurance, individuals are called upon to prove that they have a specific type of coverage in effect. Often, states specify the format of a proof-of-coverage form. This form can then, as an example, be used to verify automobile coverage to register the car or when stopped by a peace officer.

If proof-of-coverage is required by other codes and is maintained electronically, experts agree that the proof-of-coverage must be producible in an acceptable format to satisfy the other requirements.

12: Privacy Issues

Following are some areas that may be considered in an analysis of privacy:

- Underwriting issues related to medical information — The NAIC Health Information Privacy Model Act deals with these issues.
- Access to personal information collected including personal information, financial information, claim information and health information
- Regulator access to insurer information — There is much controversy today concerning insurers turning internal documents requested by regulators for monitoring purposes only to have it procured by a plaintiffs attorney in a class action filing against the insurer.
- The NAIC domestic violence model acts deal with issues related to the issuance of insurance policies and discrimination for victims of domestic violence.
- Compliance of electronic commerce with current federal and state laws dealing with privacy issues.
- Access to information contained in documents supporting rate and policy form filings.
- Access to statistical information that advisory or statistical organizations compile for insurance regulators to assist with providing industry statistical data.

Miscellaneous Legal Impediments

There are several areas not identified in the sections above that affect an insurer’s ability to employ electronic commerce. The following list discusses various miscellaneous impediments to electronic commerce that appear in state laws, regulations and processes:

- Approval of Electronic Policy Forms - The issue here is how can insurance regulators address “electronic” policy forms. These are forms that are stored in component parts and only become a complete contract when assembled for an individual policyholder. Recommendation: SERFF should, in a future iteration, be able to access insurer web sites to review electronic form features and notices.

- Underwriting Issues - The issue here is access to underwriting information addressed by

the Health Privacy Models. The tendency is to require consumers to give their approval before an insurer can gain access to confidential health information. See consent authorization.

- Binding authority issues. Similar to proof-of-coverage.
- Overcoming lack of consumer trust in institutions and/or producers.
- Consumer complaints. Is it possible to link insurer electronic sites with state sites so the consumer can hot-link to the DOI.
- Mortgages – original certificates of insurance. Add to proof-of-coverage area.

Advantages and Disadvantages of Insurance Sales and Service Over the Internet

Consumer Advantages

Consumers already have the ability to search the Internet for life and auto insurance quotes on the Internet via numerous home pages and other Worldwide Web Sites provided by or on behalf of insurers and agents. Some Internet sites are interactive and permit the consumer to provide certain information and allow the agent or insurer to determine eligibility for coverages.

In addition to obtaining quotes, consumers currently have the ability, from at least one auto insurer, to complete the entire transaction online. Another auto insurer provides consumers the opportunity to complete the application online and then forwards the application to an agent located near the consumer to complete the transaction.

Consumers may also browse the Internet to locate agents and insurers in their area. This provides consumers the ability to narrow their search for a particular agent, insurance company or specific type of insurance coverage. In many cases, agents advertise the names of insurers they represent and the types of coverage they most commonly provide.

A particular advantage to consumers appears to be accessibility. Often times, consumers may not have the time nor the opportunity to shop for insurance during normal work hours. The Internet increases the opportunities for these consumers to shop after hours and in most cases, a quote can be received within minutes or the next day. The quote arrives electronically, which eliminates the need to personally interact with an agent, which some consumers prefer.

Consumers using the Internet for the purchase of insurance have the ability to contact their agent or insurer 24 hours a day. Depending on the Internet site's capabilities and response time, this is likely to substantially enhance consumer service by eliminating the delays in obtaining policy information and service. While some insurers already provide 24-hour service via telephone, the Internet has the potential to increase this practice.

Consumers already have the ability from at least one company to review their account status to determine when and how much they need to pay for their existing policy. After checking

how much is due, they can make a payment to the company online. This service eliminates the two step process of calling the company to find out how much is owed and then mailing a payment. Online payment could potentially prevent cancellations as this can be done at any hour of the day without the delay of the postal service.

Many major insurers have indicated they will be able to deliver insurance products and services via the Internet in a more cost effective environment. This may result in lower a overall lower cost of premiums to all consumers if a substantial number who are willing to purchase coverage and interact with an agent or insurer electronically.

Consumer Disadvantages

The most significant disadvantage to some consumers may be the lack of personal interaction with an agent. Agents are generally trained to assist consumers in determining the type and amount of coverage that should be purchased to adequately insure their needs. Some consumers may focus on how much coverage they want to purchase, rather than how much coverage they actually need. ***Since many consumers may not be well versed in the purchase of insurance, they may end up "ordering" insurance, rather than purchasing insurance that fits***. Unfortunately, "ordering" insurance is not a practice that would be unique to Internet sales.

Many consumers are not acquainted with insurance laws and regulations. This includes, but may not be limited to familiarity with the requirements for insurer and producer/agent licensing, producer appointment, policy form filing and approval for products sold in the admitted market, and qualifications for sales in the surplus lines and reinsurance markets. Because the location and actual identity of the producer and/or agent is not always obvious, consumers may not in all Internet transactions be able to determine whether they are doing business with regulated producers and insurers, or are purchasing insurance products that have been approved by state regulators. Or worse, could learn they purchased a fictitious policy. This could result in a variety of consumer issues where the desired level of regulatory protection may not be available to consumers.

Some consumers lack the financial ability to purchase computer hardware or software, and access the Internet. Even in today's environment where accessing the Internet is becoming increasingly more affordable, the lowest cost access can be unaffordable for some consumers. If insurers offer lower premiums to Internet access users, certain consumers will not benefit from those savings unless they have Internet access from another source such as a Public Library. Inadequacies in the telecommunications infrastructure also limits some consumers access to the Internet, especially in the rural areas of the country.

Even though Internet marketing of insurance products and services is growing at a rapid rate, there are only a limited number of insurers presently offering electronic quotes. At least for now, this may limit the number of comparisons or quotations a consumer may obtain electronically.

Regulator Advantages

Industry and consumers will have electronic accessibility to those regulators who have a presence on the Internet. This will permit regulators to respond to inquiries or consumer complaints in a quicker fashion and more efficient manner. Regulators can provide the insurance industry with electronic access to compliance information; guidelines; license

applications and fees, information bulletin boards; e-mail; and, of course, faster response time to industry requests for information.

Those state regulators with Internet access will have the ability to directly monitor Internet sales and solicitation activity. There are approximately 35 state insurance regulatory agencies currently online, along with the National Association of Insurance Commissioners (NAIC). The NAIC has an extensive Web site at http://www.naic.org that serves as a communication link between insurance regulators, consumers and the industry. The site also provides links to all 35 of the state insurance regulatory agencies that have active Web sites, providing users with direct access to insurance regulators in each jurisdiction.

Many agent and insurer home pages currently contain a hyperlink to the NAIC and State Insurance Departments. This provides consumers with electronic access to those regulators and in turn, will provide those regulators with a better ability to respond to industry and consumer needs in a more timely and manageable manner.

The insurance industry has recently gained Internet access to the NAIC Producer Data Base (PDB) through the Insurance Regulatory Information Network (IRIN). For those states participating in PDB, industry will have electronic access to agent licensing information. This will substantially reduce the number of phone calls and written requests state insurance departments currently receive from industry for verification of good standing and/or licensing status and prior administrative actions. Time previously spent by regulators responding to these requests may instead be spent issuing licenses in a more timely manner.

In addition, the Internet has the potential to permit the electronic transmission of policy forms; thus cutting down on the cost of the application and policy issuance process.

Regulator Disadvantages

Some state regulators do not currently have adequate Internet access making it very difficult to monitor electronic commerce or investigate consumer complaints related to Internet insurance sales and service or monitor unlicensed activity. This impairs the ability of state regulators to provide adequate consumer protections.

It may become very difficult for regulators to monitor potentially increasing unlicensed activity. This severely impairs the ability of state regulators to provide adequate consumer protections.

Someone intending to commit insurance fraud could create an Internet presence, and complete a number of sales (collecting premium) and subsequently terminate the illicit Internet presence. In these cases, regulators may have difficulty obtaining sufficient evidence that a violation of state law has occurred in order to take and/or prosecute for fraud. Unless there is a specific tie to an insurer and/or licensed agent, it may become very difficult to restore policy benefits.

Industry Advantages

The most significant advantage of the Internet to industry is the ability to communicate and transact business electronically which could substantially reduce administrative costs, and increase profits and bring more innovative and less expensive services to a wider audience.

Insurers will also have the ability to communicate and deliver marketing materials to their producers electronically, including rate manuals, underwriting guidelines, applications, company procedures and advertising guidelines. to name a few.

Consumers who commonly use the Internet or similar electronic providers for the purchase of other products and services could search for competitive insurance quotes and seek out an agent or insurer that best fits their personal needs. Consequently, the Internet could substantially enhance marketing potential for those agents and insurers willing to be on the cutting edge of this new marketing opportunity.

Automation vendors are currently designing web sites that are integrated with agency management systems. This will permit policyholders to access their agent or insurer electronically to examine their premium billing status, determine the type and amount of coverage, make changes on their policy, request quotes and obtain information about other coverages. The insurance industry views this as an opportunity to operate a "virtual" insurance agency that is accessible to policyholders and consumers 24 hours a day.

The industry will also be able to electronically access most state insurance regulators to obtain compliance information such as license applications and guidelines, applicable fees, interpretation of certain state laws, communicate by e-mail with insurance department staff and respond to consumer complaints in a more timely manner. There are those in the insurance industry who believe the Internet will enhance their ability to improve regulatory compliance and reduce exposure to potential market conduct violations.

Agent and insurer access to the NAIC Producer Data Base will allow on-line verification of the license status of agents on a state-by-state basis, as well as access to producer demographics, lines of authority, prior administrative actions taken by insurance and NASD regulators and NASD exam results. In the near future, industry will also have access to agent appointment information and will have the ability through the Producer Information Network (PIN) to electronically appoint and terminate agents or producers. This should enhance the ability of the industry to comply more efficiently with various state agent licensing and appointment requirements.

The National Council on Compensation Insurance, Inc. (NCCI) currently provides, via its Web site, carriers, agents, employers and regulators alike with worker's compensation related safety and educational materials as well as information on its products and services.

NCCI's Web site will be expanded to facilitate access to key NCCI products and services. NCCI's Web site will also provide the door through which applications and deposit premiums can be submitted to the worker's compensation residual market in NCCI plan administered jurisdictions.

In the current paper environment, agents and insurers have expressed frustration and concern regarding the binder or effective date of coverage. Those agents who choose to transmit residual market applications electronically will receive immediate notification and verification that coverage is bound per the requested effective date. The NCCI system will also facilitate electronic payment of premiums.

Industry Disadvantages

An issue for the insurance industry is remaining in compliance with insurance regulations while engaging in Internet-based sales and services. The Internet is global, and therefore insurance offerings can appear anywhere, including states or countries where the insurance company or agent may not be authorized to do business. Thus the insurance industry needs to be cognizant of state regulatory requirements in regards to licensing of agents and insurers, approval or filing of insurance products.

In most states, insurers may only issue a policy through a licensed agent. Insurers, are expressing concerns that their producers may be offering policies in states where they are not approved, Insurers, therefore, need to make particularly sure that their web sites clearly disclose where their products are intended to be offered, to insure they are only soliciting business or making representations where they have authority to transact business.
Based on recent surveys conducted by the NAIC, most states consider electronic solicitation of insurance no different from solicitation through any other media. Therefore, in most states, agents and insurers must first be authorized or licensed to transact business before soliciting insurance to consumers in that state.

In using the Internet, there may be some question as to where an insurance transaction may have occurred. When an agent or insurer solicits insurance electronically, does the transaction occur in the state in which the agent is located, or in the state in which the consumer is located? The majority of states have indicated in recent NAIC surveys that they believe the transaction occurred in the state in which the consumer resides.

Some in the insurance industry have also expressed a concern that without an agent present in a face-to-face contact with the consumer, it may become more difficult to qualify the applicant for insurance. Inadequate medical records and other sources of information about the consumer may impair an underwriter's ability to determine eligibility without actual contact and verification by the agent.

The rapid growth in development of Internet web sites for agents leaves some insurers with concerns regarding specific state advertising laws and regulations. Agents may be advertising specific insurance products and services without authority from the insurer and in violation of these laws and regulations. Furthermore, in a recent NAIC survey of state insurance departments, Internet advertising is considered subject to regulatory approval in many states.

Because agents must be licensed and in most cases appointed by insurers in those states in which the agent transacts business, licensing costs will increase for some insurers who permit their agents through the Internet to solicit business in all states.

Security and Privacy Issues

Security and privacy concerns are nothing new in the insurance industry. However, the possiblity of widescale Internet sales and servicing “raises the bar” considerably. Why is this more of a problem online? Simply because data on the Internet has, up to now, proved to be vulnerable to eavesdropping and outright piracy.

The Internet is a perfect target for someone with skills and the technology for these individuals is progressing at a rapid pace. Ads for “investigative programs” now allow access to almosy any personal computer, any file, every keystroke, at anytme – without needing physical access!

Secure websites have added protection, but even these are susceptible to attack. Let’s look at what the Internet industry is doing to mitigate these issues:

Security

Consumers and insurers may be hesitant to engage in insurance transactions over the Internet due to concerns about security. While numerous security safeguards are currently available for use on the Internet, they have not been widely assimilated and used. One reason is their perceived limited reliability and a general lack of insurance industry and consumer confidence in the overall security and reliability of Internet transactions, particularly with regard to using credit cards (and other payment systems) over the Internet. Current security safeguards also have a limited scope of use due to a lack of industry standards. Many of these safeguards are not currently supported by the various popular applications, servers, web browsers, and e-mail systems. However, as will be discussed below, the computer industry is quickly moving to alleviate the security problems with Internet transactions.

Because of the rapidly advancing nature of Internet security safeguards, it may be too early to think about regulation of Internet transactions with regard to security concerns in any substantive way. It is an emerging technology, and how it will develop cannot be totally predicted. Thus, it can be argued that regulation should not be unduly burdensome lest it impede the innovation and growth that has been seen thus far achieved. At the same time, however, it is important for regulators to weigh consumer protections while not impeding innovation as they consider what regulatory role needs to be played regarding security over the Internet.

There are three primary points in Internet insurance transactions in which security is an issue.

1. The privacy and confidentiality of personal information transmitted between an applicant and an insurer.

2. The alteration of information provided by the consumer/applicant by a third party such as the agent or another party with access to the file.

3. The tampering by unauthorized individuals with insurers' home pages which may affect the accuracy of information consumers receive regarding insurance sales over the Internet.

Security concerns are multi-faceted. One aspect refers to the concern that information transferred from the applicant to the company or agent could be read and misappropriated by a third party. This concern includes misappropriation of personal information and credit card (or other payment system) information. Another dimension of security is authentication, ensuring the identity of the sender and the recipient. A third aspect is data integrity, ensuring that information transmitted is not altered in the transmission process by third parties or accidentally altered by some anomaly in the transmission process.

Security concerns will likely be resolved by technical solutions from developed by the computer industry. The various players in the computer industry are cooperating to develop industry standards and protocols. Most producers of Internet products, such as servers and web browsers, are upgrading their products to be compatible with the various security standards and protocols being developed.

Security measures currently in use by the Internet community include firewalls, encryption technologies, and good management practices (passwords, digital certificates, tokens, etc.). A discussion of these topics is outside the scope of this paper, though its importance cannot be overstated. Anyone seriously considering availing themselves of the opportunities provided by electronic commerce would be well advised to learn as much as possible about these issues, and to deploy the best techniques and technologies available.

Encryption is probably the most efficient and potentially universal method of Internet security. Its purpose is to ensure privacy by keeping data from being read if it is intercepted by an unintended third party. Any message that is encrypted must be decrypted (i.e. transformed back into its original intelligible form) before it can be read. Encryption and decryption require the use of secret information shared between the parties to the message, usually referred to as a key. Most people are familiar with the method of encryption referred to as secret key or symmetric encryption. Secret key encryption involves both the sender and the receiver using the same secret key to encrypt and decrypt a message.

Public key encryption is a slightly more complex method. Both the sender and the receiver get a pair of keys, one referred to as a public key and the other referred to as a private key. Each party's public key is published while the private key is kept secret and not published. This is significant because the need for the sender and receiver to share or transmit secret information is eliminated since only the public key is ever transmitted or shared. For example, if a consumer wishes to send information to an insurer, the consumer looks up the insurer's public key and uses it to encrypt his or her private information before transmitting it to the insurer. The insurer then uses its private key to decrypt the consumer's information. Even if the consumers encrypted information is intercepted or copied, only the insurer can decrypt it. At this time, there does not appear to be an established industry_wide standard for public key encryption.

The security concerns regarding compromise of the transmittal process between the applicant and the insurer or agent can be broken down into two elements: (1) authentication, defined as the verification of the identity of the sender and receiver and (2) data integrity or the alteration of information during the transmission process. Data integrity addresses both concerns of intentional alteration by the insurer, agent, or a third party and accidental alteration that might have an impact on the insurance application process. It should be noted that the transmission process will likely consist of information being sent and received by both parties. Thus, we are also concerned with company information sent to the consumer being altered. For example, a quote of $200 per month could be received as $20 per month, either intentionally or accidentally.

The computer industry is also developing technical solutions to address authentication and data integrity concerns. These technical solutions are referred to as "digital signatures" and "digital certificates." Used in tandem, they allow the person receiving a message to be confident of both the identity of the sender and the integrity of the message.

A ***digital signature*** is used to "sign" a transmitted message to be transmitted. To create a digital signature for a message to be transmitted on the Internet, the sender creates a message digest using a hash function. The message digest serves as a "digital fingerprint" of the message. The message digest is then encrypted using the sender's private key to become a digital signature. The digital signature is transmitted attached to the encrypted message data. The receiver can decrypt the message digest using the sender's public key and apply the same hash function to verify the message's integrity after transmission. Thus, the receiver knows that the message has not been altered in transmission and data integrity is ensured. The receiver also knows that the message was sent by someone with access to the private key that purports to be that of the sender.

To verify that the digital signature is in fact sent by the sender, and not some third party who has obtained a public-private key pair through some form of fraud or other means, the digital signature can include a digital certificate. A ***digital certificate irrevocably binds*** a person's or entity's identity to a public key or group of public keys. In effect, it becomes an electronic equivalent to a driver's license, passport, or other evidence of identification.

A digital certificate is issued by a "certificate authority." A certificate authority is a trusted third party that provides secure mathematical computations that result in unique individual digital certificates that cannot be duplicated. A certificate authority has the burden of verifying the identity of a person or entity requesting a digital certificate. Once a person's identity is verified, the certificate authority can issue a digital certificate. The typical digital certificate is issued by the certification authority and signed with its private key. The certificate will verify the owner's name, public key, expiration date of the public key, name of the issuing certification authority, serial number or register number, and the digital signature of the issuing certification authority. In any given consumer insurance transaction, the consumer would have a digital certificate, along with the insurer, the server, and a financial intermediary (if any). Thus, the identity of each of the parties that would have access to the message can be verified and authentication of the identity of the parties is ensured.

Other security concerns involve agent and industry tampering with an insurer's home pages, affecting the consumers perception of the reliability of the information presented, and subjecting the insurer to possible legal exposure should the changes be made to policy language and the like.

A separate security concern for Internet sales is that unauthorized individuals will tamper with insurers' home pages. For example, an unaffiliated third party could add a hypertext link to an insurer's homepage. When a consumer clicks on that link, he or she will leave the insurer's domain and any text or information presented will be provided solely by the unaffiliated third party. If security measures, such as those discussed above, are in place, the possibility of entering into bogus transactions with an unaffiliated third party engaging in this practice becomes unlikely. Clearly, if the practice of tampering with home pages becomes common, it will affect consumers' perception of the reliability of insurance information provided over the Internet. After discussing this problem with a number of individuals from the industry, the solution seems to rest with developing technical security measures and continuous homepage monitoring by the person or entity maintaining the homepage.

Private Information

The first step in analyzing privacy concerns regarding personal information transmitted from an applicant to an insurer is to define the scope of the personal information that might be

transmitted. Generally, the following information is requested from an applicant: (1) name; (2) address; (3) sex; (4) date of birth; (5) type of product to be purchased; and (6) payment information (i.e. credit card number or other payment source). Depending on the type of insurance being solicited, other information could include: (1) detailed health information; (2) detailed financial information; (3) type of automobile(s) applicant owns, applicant's automobile financing arrangements, and the applicant's driving record; (4) family information; and/or (5) specific information regarding property owned by the potential insured (i.e. home, boat, recreational vehicles, jewelry and other valuables).

The privacy concerns deal with how information is used once it has been received by the recipient, presumably an insurer or agent. These concerns are present with all types of insurance transactions; however, privacy concerns are heightened with Internet sales due to the aggregate dissemination of data that is facilitated by the efficient and interactive nature of the Internet.

Online Communications

Online communications are communications over ***telephone or cable networks*** using computers. Examples of online communications include connecting to the Internet through an Internet Service Provider (ISP), connecting to a commercial online service such as America Online, CompuServe, or Prodigy, dialing into a computer bulletin board service (BBS). Increasingly, the differences between ISPs, the commercial services, and BBSs are blurring. The larger commercial services and many BBSs now provide Internet access. The Internet raises some unique privacy concerns. Information sent over this vast network may pass through dozens of different computer systems on the way to its destination. A different system operator known as a sysop may manage each of these systems, and each system may be capable of capturing and storing online communications. Furthermore, the online activities of Internet users can potentially be monitored, both by their own service provider and by the sysops of any sites on the Internet that they visit. ISPs, commercial services, and BBSs are managed by sysops who may have different attitudes toward online privacy. Additionally, there are a tremendous variety of activities provided by all types of online services, each of which may raise specific privacy concerns. The vast information flow created by the Internet has been driving much of the public attention to privacy. The Internet-privacy principles will have a significant impact on the insurance industry. The insurance business is moving to the Internet and the primary principles of privacy on the Internet are becoming a common denominator for businesses in any sector, on-line or off-line, and will probably serve as guidelines for litigation challenges in the future.

Level of Privacy

Often the level of privacy one can expect from an online activity will be clear from the nature of that activity. Sometimes, however, an activity that appears to be private may not be. *There are virtually no online activities or services that guarantee an absolute right of privacy.*

Public Activities

Many online activities are open to public inspection. Engaging in these types of activities does not normally create an expectation of privacy. In fact, according to federal law, it is not illegal for anyone to view or disclose an electronic communication if the communication is "readily accessible" to the public. A message that is posted to a public newsgroup or forum is available for anyone to view, copy, and store. One's name, e-mail address, and information

about his service provider are usually available for inspection as part of the message itself. Most public postings made on the Internet are archived in searchable databases.

Other public activities may allow one's message to be sent to multiple recipients. Online newsletters, for example, are usually sent to a mailing list of subscribers. If one wishes to privately reply to a message posted in an online newsletter, he should be sure that he addresses it specifically to that person's address, not to the newsletter address. Otherwise, he might find that his message has been sent to everyone on the newsletter mailing list. The consumer should not expect that his service account information would be kept private. Most services provide online "member directories" which publicly list all subscribers to the service. Some of these directories may list additional personal information. Even individuals with direct Internet accounts may be identified with commands such as "finger," which let anyone with Internet access find out who else is online. Most service providers will allow users to have their information removed from these directories upon request. Some service providers may sell their membership lists to direct marketers.

Semi-Private Activities

Often the presence of security or access safeguards on certain forums or services can lead users to believe that communications made within these services are private. For example, some bulletin board services maintain forums that are restricted to users who have a password. While communications made in these forums may initially be read only by the members with access, there is nothing preventing those members from recording the communications and later transmitting them elsewhere. One example of this kind of activity is the real-time "chat" conference, in which participants type live messages directly to the computer screens of other participants. Often the service provider describes these activities as private. However, chat line users may capture, store, and transmit these communications to others outside the chat service. Additionally, these activities are subject to the same monitoring exceptions, which apply to "private" e-mail.

Private Services

Virtually all-online services offer some sort of "private" activity, which allows subscribers to send personal e-mail messages to others. The federal Electronic Communications Privacy Act (ECPA) makes it unlawful for anyone to read or disclose the contents of an electronic communication. This law applies to e-mail messages. However, there are **three** important ***exceptions*** to the ECPA.

- The online service may view private e-mail if it suspects the sender is attempting to damage the system or harm another user. Random monitoring of e-mail is prohibited.
- The service may legally view and disclose private e-mail if either the sender or the recipient of the message consents to the inspection or disclosure. Many commercial services require a consent agreement from new members when signing up for the service.
- If an employer owns the e-mail system, the employer may inspect the contents of employee e-mail on the system. Therefore, any e-mail sent from a business location is probably not private. Several court cases have determined that employers have a right to monitor e-mail messages of their employees.

Once a sysop has intercepted e-mail for any of these lawful reasons, the sysop generally may not disclose the contents to anyone other than the addressee. Certain exceptions to this disclosure prohibition exist. These exceptions include

- When any party to the message consents to disclosure
- When disclosure is ordered by a court
- When the message appears to involve the commission of a crime (in which case disclosure is limited to the appropriate law enforcement officials)

A sysop does not violate the ECPA if the message is accidentally sent to the wrong person. The sysop may be responsible for damages caused by negligence in operating the service. Law enforcement officials may access or disclose electronic communications only after receiving a court-ordered search warrant. Only certain officials may apply for this order, and a detailed procedure is set forth in the ECPA for granting the order. These provisions are relaxed for messages that have been stored in a system for over 180 days.

The consumer's e-mail message may be handled by several different online services during delivery. The sysop of each of these systems may view e-mail under the above exceptions to the ECPA. Additionally, the message may be intercepted if either the sender or recipient consents. So even if one does not consent himself, the person he sent the e-mail to may have consented to the disclosure of the message.

Tracking and Recording Activity

Many types of online activities do not involve sending e-mail messages between parties. Internet users may retrieve information or documents from sites on the World Wide Web. Or users may simply browse these services without any other interaction. Many users expect that such activities are anonymous. *They are not*. It is possible to record many online activities including which newsgroups or files a subscriber has accessed and which web sites a subscriber has visited. This information can be collected both by a subscriber's own service provider and by the sysops of remote sites which a subscriber visits.

When one is surfing the web, many web sites deposit data about his visit, called cookies, on his hard drive When he returns to that site, the cookies data will reveal that he has been there before. The web site might offer him products or ads tailored to his interests, based on the contents of the cookies data. Records of subscriber browsing patterns, also known as ***transaction-generated information***, are a potentially valuable source of revenue for online services. This information is useful to direct marketers as a basis for developing highly targeted lists of online users with similar likes and behaviors. It may also create the potential for junk e-mail and other marketing uses. Additionally, this information may be embarrassing for users who have accessed sensitive or controversial materials online.

The practice of collecting browsing patterns is increasing. Online users should be aware that this practice poses a significant threat to online privacy. Additionally, online users should educate themselves about what information is transmitted to remote computers by the software that they use to browse remote sites. Most World Wide Web browsers invisibly provide web site operators with information about a user's service provider, and with information about the location of other web sites a user has visited. Some web browsers are programmed to transmit a user's e-mail address to each web site a user visits. Users who access the Internet from work should know that employers are increasingly monitoring the Internet sites that an employee visits. In order for law enforcement officials to gain access to

subscriber transactional records, they must obtain a court order demonstrating that the records are relevant to an ongoing criminal investigation.

Many of the commercial online services will automatically download graphics and program upgrades to the user's home computer. News reports have documented the fact that certain online services have admitted to both accidental and intentional "prying" into the memory of home computers signing on to the service. In some cases, personal files have been copied and collected by the online services. It is difficult to detect these types of intrusions. The online user should be aware of this potential privacy abuse, and investigate new services thoroughly before signing on.

Protecting Internet Privacy

The consumer should be aware that at any step along the way, his online messages could be intercepted, and his activities monitored, in the world of cyberspace. One should create ***passwords*** with nonsensical combinations of upper and lower case letters, numbers and symbols. He should change his password frequently, and never write it down or give it to someone else. He should not let others watch him log in. One should never leave his computer logged in unattended. One should contact the sysop of any online service he intends to use and ask for its ***privacy policy***. Most of the commercial services have written privacy policies that are provided to new subscribers. One should carefully read all messages, which appear on initial login. Many sysops notify online users in login messages that e-mail is subject to inspection. Many services require new subscribers to allow e-mail to be monitored as part of the sign-up process. All sysops should have a well defined, written policy concerning privacy. Those that do not should be avoided. When one is "surfing the web," he should look for the privacy policies posted on the web sites he visits. If he is not satisfied with the policy, or if there is no policy posted, he should not spend time on that site.

One should investigate new services before using them. He can post a question about a new service in a dependable forum or newsgroup. Bad reputations get around quickly in cyberspace, so if others have had negative experiences with a service, he should get the message. One should assume that his online communications are not private unless he uses powerful encryption. He should not send sensitive personal information (phone number, password, address, credit card number, vacation dates) by chat lines, forum postings, e-mail or in his online biography. Consumers must be cautious of "start-up" software that makes an initial connection to the service for him. Often these programs require one to provide credit card numbers, checking account numbers, Social Security numbers, or other personal information, and then upload this information automatically to the service. Also, these programs may be able to access records in one’s computer without his knowledge.

Public postings made on the Internet are often archived and saved for posterity. It is possible to search and discover the postings an individual has made to Usenet newsgroups. This information can be used to create profiles of individuals for a variety of purposes, such as employment background checks and direct marketing. Online activities leave electronic footprints for others to see both at his own service provider and at any remote sites he visits. His own service provider can determine what commands he has executed and track, which sites he visits. Web site operators can often track the activities one engages in on their site, particularly at sites, which ask him to "register" or otherwise provide personal information. Some web browsing software transmits less information to remote sites than other software. One can avoid leaving tracks when he sends e-mail messages by using anonymous remailers. If one’s online service allows him to compile a list of favorite newsgroups, or lets

him range newsgroups by priority, he should be aware that his sysop can monitor that list. He should not place controversial or sensitive newsgroups in this list if he wants to avoid being connected to particular issues. The consumer should know that if he publishes information on a personal web page, direct marketers and others may collect his address, phone number, e-mail address and other information that he provides. One should take advantage of privacy protection tools. There are several technologies, which help online users protect their privacy. Some of these are encryption, anonymous remailers and memory protection software.

CHAPTER FOUR

PRIVACY PRACTICES

As we previously mentioned, protecting a client's privacy is an ethical responsibility and an area of increasing liability for insurance agents. The concern by clients is that highly personal health and financial information you collect in the process of selling insurance will get in the hands of groups who might use this data to exploit them. As a result, new legislation has passed that requires certain disclosures be made to your clients whenever non-public (personal) data is being shared with other parties. Also, they must be given the opportunity to restrict its use.

Privacy is an additional concern in the area of online services. In the previous chapter we discussed many issues surrounding your ***e-conduct***, including the use of firewalls and passwords to protect client data. Protecting privacy from unauthorized electronic advertising . . . ***spamming*** . . . is a related topic we will explore.

New legislation and agents requirements have also surfaced in the telemarketing arena where unsolicited faxes and phone calls to your clients or prospects are meeting with stiff ***invasion of privacy*** resistance by consumers, supported by substantial federal and state violation penalties.

Why Is Client Privacy An Issue Today?

There are many reasons. First and foremost is the fact that the sharing of information has become complicated. The United States is in the midst of a revolution in information technology. Gone are days of a customer's financial and health records being locked in a file room at the rear of the office. New electronic distribution channels of providing and servicing insurance products have created exposure of personal financial information and health histories. And, the way we get our health care is changing from one-on-one, patient/doctor relationships, to large, integrated health networks where many levels of employees have access to records. In a sense, a new by-product of trying to control health-care and insurance costs using technology and centralization has resulted in a profound potential for abuse of privacy.

In a nutshell, today, entire networks distribute and / or disclose the data you collect on your clients with a variety of affiliates and third parties; all the while, putting you and other agents in the path of tighter and more responsible privacy rules.

Telemarketing abuses and e-mail/fax spamming speak for themselves. Who of us actually enjoys evening phone calls, dozens of nuisance e-mails or unwanted faxes eating up our paper and toner?

Information Sharing Problems

Some have a problem understanding why the sharing of client information is a problem. After all, wouldn't it be to the client's benefit for a central database to itemize a history of

medications and comprehensive medical records? For example, what if you were involved in a car accident far from home and unconscious by the time you arrived at the local hospital? The emergency room doctor might conceivably access a special computer link; plug-in your social security number and instantly learn about your specific allergies, medical conditions and medications. Life-saving therapies might be administered faster and costly re-testing for certain information might be avoided. Sounds great, right?

Unfortunately, not everyone will use this kind of information as it was intended. For example, what if the same medical records were retrieved by a prospective employer. Could he use the health and financial information in making a decision not to hire you? Insurers themselves have been accused of privacy invasion when they use personal financial information, like FICO scores (a system to determine a consumer's credit worthiness), to raise insurance premiums or rank insurability based on the types of credit cards, catalogs or cars a prospect owns and uses.

Also, consider cases where records have fallen into the wrong hands. Are the consequences of exploiting personal information sufficient to deter someone from the temptation? Think it doesn't happen? Think again. In Nevada, for example, a woman purchased a used computer and discovered that it still contained the prescription records of the customers of the pharmacy that had previously owned the computer. The pharmacy database included names, addresses, social security numbers, and a list of all the medicines the customers had purchased. What happens to the data on your old computers? In another case, a 30-year FBI veteran was put on administrative leave when, without his permission, his pharmacy released information about his treatment for depression. Or, how about a 1999 incident in which the health insurance claims forms of thousands of patients blew out of a truck on its way to a recycling center in East Hartford, Connecticut.

In all these instances, client privacy could be breached. In response, legislation has passed to address the better handling of client privacy; especially by making the "caretakers" of this information more responsible. As you might guess, insurers, financial institutions and health care corporations have been at the head of the responsibility list since they wield incredible influence over detailed records related to age, health, finances and lifestyle.

Agent Responsibility

Agents are also involved in the current privacy debate because under the definition of this privacy legislation, you are referred to as a "financial institution" or "covered entity". As such, you must comply with sweeping and complex rules and standards including HIPAA, the Gramm-Leach-Bliley Act, the Federal Medical Privacy Rule, the Patriot Act and the Terrorism Risk Insurance Act. In addition, there are new Federal Trade Commission "Do Not Call" rules and more anti-spamming legislation that affect every agent.

To complicate matters more, your individual state may pass privacy legislation that exceeds or conflicts with these requirements. So, you may fall under ***double standards***. For example, the privacy rules under HIPAA state that items such as a person's name, address, social security number and payment history are protected "health information" subject to an ***opt-in standard***. Therefore, HIPAA would prohibit any sharing of this information with a third party unless an express release is signed by your client. Many states, however, would consider these same items as "financial information" subject to ***opt-out standards*** where the sharing of client information is allowed until he "opts-out".

Can you see where disputes might surface? And, the penalties for a mistake or not complying can be stiff, ranging from $100 to $25,000 per incident; and, even prison terms of up to one year. Violation of FTC "Do Not Call Rules" can be as high as $11,000 per call! Failure to provide a required notice is also a violation of agency rules subject to enforcement by your State Department of Insurance, and enforcement action under federal and state unfair trade practices rules. In addition, an individual whose information has been shared in violation of the rules or called/faxed without permission may bring their own, private civil action against you.

For these reasons and more, this chapter will attempt to provide as much information as possible to help you understand the many client privacy requirements. First we will give you a thorough understanding of ***Privacy and Telemarketing Issues*** and the reason they are important in today's business world. Next we will explore the two major areas where these matters effect your business most: ***Protecting Financial Information Privacy*** and ***Protecting Health Information Privacy.*** Finally, we have devoted sections to answer specific questions on how insurance agents might comply with new privacy and telemarketing rules.

Social Security Numbers

Social Security numbers are the key to much of the insurance, financial, medical and other personal information that most people would like to keep confidential. Yet, the numbers are so widely used, by business and government, that they have acquired a special status as a security risk.

With a SSN, an identity thief can access bank accounts and establish new ones.

New privacy laws are requiring businesses to cease the use of SSNs for referencing customers if they are requested to do so in writing. The same laws prohibit the public display of SSNs on ID cards, mailed documents or as passwords to a website.

Keep in mind when reading this information, that even though you see a lot of legislative activity today, privacy laws in the United States are truly in their infancy. Experts say we are years behind most European countries. More rules can be expected.

Always consult proper counsel such as an attorney or your carrier before using any information from this course in personal or client matters.

Understanding Privacy Issues

The Importance of Privacy

The reasoning behind the enacting of state and national ***privacy rules*** includes the assertion that privacy is a ***fundamental right*** of the citizenry. It is considered as essential to individual and collective freedom. All fifty states recognize a common law or statutory right to privacy. A few states include the right to privacy in their respective constitutions.

From the founding of the United States, privacy has played a fundamental role in the structure and content of America's laws. As stated in the Federal Register: December 28, 2000, Volume 65, Number 250:

"Throughout our nation's history, we have placed the rights of the individual at the forefront of our democracy. In the Declaration of Independence, we asserted the "unalienable right" to "life, liberty and the pursuit of happiness."

Many of the most basic protections in the Constitution of the United States are imbued with an attempt to protect individual privacy while balancing it against the larger social purposes of the nation.

To take but one example, the Fourth Amendment to the United States Constitution guarantees that

"the right of the people to be secure in their persons, houses, papers and effects, against unreasonable searches and seizures, shall not be violated."

By referring to the need for security of "persons" as well as "papers and effects" the Fourth Amendment suggests enduring values in American law that relate to privacy. The need for ***security of persons*** is consistent with obtaining patient consent before performing invasive medical procedures. The need for security in ***papers and effects*** underscores the importance of protecting information about the person, contained in sources such as personal diaries, medical records, or elsewhere. As is generally true for the right of privacy in information, the right is not absolute. The test instead is what constitutes an "unreasonable" search of the papers and effects.

The United States Supreme Court recognized two different kinds of interests within a constitutionally protected "zone of privacy" in a New York case, Whalen v. Roe, 429 U.S. 589 (1977). In this case, a New York statute that created a database of persons who obtained drugs that were available both lawfully and unlawfully. One of the interests said to be protected in the zone of privacy is "the individual interest in avoiding disclosure of personal matters."

However, an individual's right to privacy in information about himself is ***not considered an absolute right*** under United States law. For example, the right to privacy does not prevent the reporting of communicable diseases to public health agencies, or stop law enforcement from obtaining information as long as due process is observed.

It is largely held that each individual has some rights to control personal and sensitive information about himself. In particular, medical and health information may be among the most sensitive type of information. People do not want their medical and health information to be publicly available, where anyone from neighbors, relatives, employers and the government could review it.

Mental health information may be the most sensitive type of medical or health information. Mental health treatment may include records of reflections of a patient's most intimate thoughts, words and emotions. The Supreme Court held in Jaffee v. Redmond, 116 S. Ct. 1923 (1996), that statements made to a therapist during a counseling sessions were protected against civil discovery under the Federal Rules of Evidence. Within its opinion, the Court noted that some form of psychotherapist-patient privilege has been adopted by all fifty states. The Supreme Court stated that it "serves the public interest by facilitating the appropriate treatment for individuals suffering the effects of a mental or emotional problem.

The mental health of our citizenry, no less than its physical health, is a public good of transcendent importance."

The Right of Privacy

Privacy has become a prominent issue in every part of the American and international economy in the last few years. Legislators have been introducing many privacy bills. Laws already in place are being reinforced with new regulations and deadlines. The process of underwriting and gathering client information go hand in hand. The Internet, consolidation in financial services, and the electronic transfer of medical and financial client data have sparked new privacy concerns. Privacy is a fundamental human right recognized in the UN Declaration of Human Rights, the International Covenant on Civil and Political Rights and in many other international and regional treaties. Privacy underpins human dignity and other key values such as freedom of association and freedom of speech. It has become one of the most important human rights issues of the modern age.

Nearly every country in the world recognizes a right of privacy explicitly in their Constitution. At a minimum, these provisions include rights of inviolability of the home and secrecy of communications. Most recently written Constitutions such as South Africa and Hungary's include specific rights to access and control one's personal information. In many of the countries where privacy is not explicitly recognized in the Constitution, such as the United States, Ireland and India, the courts have found that right in other provisions. In many countries, international agreements that recognize privacy rights such as the International Covenant on Civil and Political Rights or the European Convention on Human Rights have been adopted into law.

Of all the human rights in the international catalogue, privacy is perhaps the most difficult to define and circumscribe. Privacy has roots deep in history. The Bible has numerous references to privacy. There was also substantive protection of privacy in early Hebrew culture, Classical Greece and ancient China. These protections mostly focused on the right to solitude. Definitions of privacy vary widely according to context and environment. In many countries, the concept has been fused with Data Protection, which interprets privacy in terms of management of personal information. Outside this rather strict context, privacy protection is frequently seen as a way of drawing the line at how far society can intrude into a person's affairs. It can be divided into the following areas:

- **Information Privacy**, which involves the establishment of rules governing the collection and handling of personal data such as credit information and medical records
- **Bodily privacy**, which concerns the protection of people's physical selves against invasive procedures such as drug testing and cavity searches
- **Privacy of communications,** which covers the security and privacy of mail, telephones, email and other forms of communication
- **Territorial privacy**, which concerns the setting of limits on intrusion into the domestic and other environments such as the workplace or public space

Insurance Risk Appraisal

No one is more affected by the consumer's privacy concerns than the insurers. Insurance is based on the concept of a group of people sharing the risks and the costs of unexpected events. ***Risk appraisal*** helps the company determine the appropriate cost to cover one's risk

profile—or his ***fair share***. It prevents him from having to pay the same as someone with a less favorable risk profile. Risk appraisal is necessary to allow the company to offer coverage at an affordable price, and in some cases, to offer coverage at all. However, nothing can be accomplished in the risk appraisal arena without the use of personal financial and health information supplied by consumers. It is to the advantage of BOTH that this information be collected with as little restriction as possible and protected with best efforts.

Think about it. A world without risk appraisal would mean everyone would pay the same price. Even if a consumer would be considered a "good risk," he would end up paying more than the appropriate amount for his risk level. That is because he and every other policy owner would have to absorb the extra risk and costs associated with those who have less favorable risk profiles. These extra costs would drive up the cost of insurance for everyone. Risk appraisal is especially important to the policy owner because it protects the value of his insurance. It ensures that the underwriter will only issue appropriate amounts of insurance, at the appropriate price, to people who fall within established guidelines. It also ensures that the underwriter's risk appraisal guidelines and goals remain consistent over time. Risk appraisal safeguards against compromising the value of customers' insurance and the financial stability of the company. A thorough risk appraisal process helps the consumer in several ways.

- **Lower Cost** – He is often able to purchase a policy as a member of the most favorable risk group, which means the best price—he pays only his fair share.
- **Locked-in Risk Classification** - Once the risk classification has been determined for one's policy, it cannot be changed due to deterioration in his health.
- **Quality Coverage** - A thorough risk appraisal process is a hallmark of a strong company. One can be confident he is receiving the finest-quality coverage for his money.
- **Non-Cancelable Coverage** - Once a policy is issued, the company cannot cancel it due to a deterioration of your health. By participating in the risk appraisal process, and supplying accurate information, he can secure insurance coverage that can be with him for the rest of his life.
- **Early Warning** - The risk appraisal process might alert one to potential or existing health problems that he otherwise may not have known about.

The risk appraisal process allows the underwriter to determine the state of the client's health, his financial situation and, if necessary, whether his job and hobbies impact his application. It is critical for insurers to ask for and collect information from the client about himself. The underwriter treats all of this information as personal and sensitive. And, just as the client has a responsibility to provide the underwriter with this information, the underwriter also has a responsibility to ensure that it is handled carefully and with confidentiality. The professional underwriter has established procedures in every step of the application and risk appraisal processes to help maintain the consumer's privacy. He is committed to maintaining the confidentiality of all of the information that he receives from his clients.

Understanding Consumer Concerns

The most important compliance issue for the insurance industry over the next ten years will most likely be privacy. The quest for greater privacy is a natural reaction to the information age. Privacy is a ***basic human right*** that is being reasserted. Consumers are demanding a choice in how information is used. The National Association of Insurance Commissioners

believes that consumers are concerned about all types of marketing activities. They are concerned about activities related to their financial or health information.

The Internet holds tremendous potential for reducing healthcare costs and opening the door for patients to take a more active role in the administration of their healthcare. The same systems, which streamline the processing of healthcare information and afford easy, timely access to personal health information, also open new doors to the ***misuse*** of sensitive information. It is not hard to see how personal health information given to a physician or other healthcare provider, would be sought by insurers, employers or even advertisers. It is the doctor and patient's fears of this potential misuse that is the Achilles Heel of online healthcare services. Unfortunately, countless abuses of personal information by e-commerce companies have created an environment of open distrust of online services.

Privacy advocates' numbers have exploded in the past two years in response to corporate abuses. The fact that corporate America openly spends hundreds of millions to lobby against new privacy legislation adds to consumer distrust. But, privacy concerns in the world of e-commerce pale in comparison to a patient's perception that his or her personal health information could be revealed to someone without consent. The damage that could occur from misuse could be devastating to an individual, causing great personal harm. No wonder indeed, that doctor and patient acceptance of Internet technologies will depend on the perception that information that is entrusted to the healthcare system will be protected by stringent standards.

A report by the American Medical Association says the majority of today's health information web sites ***do not comply*** with their own stated privacy standards, and fail to protect personal health information of their visitors. As e-health moves beyond information sites to more direct healthcare functions, privacy will become even more important. Building confidence in the online experience is critical to the future success of e-health. Privacy failures will stifle physician and patient enthusiasm for the online health industry.

Personal Health Information

Even though the consumer is concerned about activities related to both his health and financial information, he desires a greater level of protection for his personal health information. Health records are among the most sensitive data that are acquired, used, and disclosed by the government and the private sector. Health information reveals a great deal of personal facts about individuals which may lead to stigma and discrimination when possessed and misused by government officials, employers, insurers, and by friends and family. The increasing potential for disclosure of this information within a rapidly developing national health information infrastructure, facilitated by massive computerization of records and other technological developments, presents significant risks to individual privacy.

Despite the highly sensitive nature of individual health information, protecting the privacy and security of these records has been historically de-emphasized when compared with statutory protections allotted to other types of personal information such as banking and investment records, consumer spending information, tax information, and video rental records. There are many reasons for the de-emphasis of health information privacy, including economic and political theories. However, modern legal developments are likely to improve privacy and security protection. As we develop a national health information infrastructure, the importance of privacy and security become crucial.

Health information privacy, of course, is a ***two-edged sword***. While it is important in respecting the autonomy and dignity of individuals, excessive amounts of privacy can impede many of the goals of the health care system. Health information creates unprecedented opportunities to benefit individuals and communities. Health care professionals can use computerized data to improve clinical care for patients. Health service researchers can better assess the quality of services. Government and health service managers can gain administrative efficiencies. Health insurers, including Medicare and Medicaid, can prevent fraud and abuse. Public health authorities can improve surveillance and epidemiological investigations within the community.

In each of these areas, overly restrictive health information privacy and security protections may thwart legitimate and important uses of identifiable health data that benefit society. Though privacy is certainly necessary, legal protection should strike a reasonable balance between individual rights and the collective goods of health information. Today, society is witnessing tremendous changes in both the collection and use of health information and in the environment in which it resides. The transition from fee-for-service health care to managed care has led to a demand for an unprecedented depth and breadth of personal information by a growing number of players. At the same time, the environment for information is moving rapidly from paper forms and files to electronic media, giving organizations a greater ability to tie formerly distinct information together and send it easily through different sources.

Personal health information can be used to hurt consumers in various ways. Consumers realize that their health information can be used against them when they are trying to qualify for a loan or mortgage. It can also be used against one when he is applying for a job, or cause termination of employment. An individual with a medical condition requires treatment with a very high-priced prescription drug. After his insurance company receives the claim for reimbursement, his doctor receives numerous calls from pharmaceutical companies trying to convince him to change the medication to a drug that their company produces. Other patients have received marketing calls for products related to their illness, even though they had not disclosed this information to anyone other than their insurance company.

Because of these consumer concerns, the National Association of Insurance Commissioners (NAIC) has decided to treat health information differently from financial information. This will be done by using an “opt-in” standard for individually identifiable health information, and by enforcing marketing restrictions. It is critical for underwriters to be thinking about the future, and making privacy compliance a significant factor in planning for the future. It is also important for them to begin developing a privacy compliance program.

Studies have shown that health web sites understand the consumer’s concern about the privacy of their personal health information. These web sites have tried to establish privacy policies, but there is inconsistency between the privacy policies, and they fall short of truly safeguarding consumers. Visitors to health web sites are seeking to manage their health better. The risks of doing this, however, are that they are not anonymous, even if they think they are, and their personal health information is probably not adequately protected. To make matters worse, health web sites disclaim liability for the actions of third parties, which negates the privacy policies.

Personal Financial Information

Banks, insurance companies, and brokerage firms operating as one are known as ***financial institutions***. They offer benefits such as consolidated account statements and lower fees. At the same time, the ability of these companies to merge customer data from several sources and even sell it to third parties represents a real risk to one's privacy. Consumer information kept in the files of financial institutions is some of the most sensitive, personal information imaginable. In the past, there were few restrictions on a financial institution's ability to share or even sell one's personal information. Title V of GLBA (Gramm-Leach-Bliley Act) gives the consumer some minimal rights to protect his financial privacy.

The GBLA requires that a financial institution give the ***consumer notice*** of three things:

- **Privacy Policy:** The financial institution must tell one the kinds of information it collects about him and how it uses that information.
- **Right to Opt-Out:** The financial institution must explain one's ability to prevent the sale of his customer data to third parties.
- **Safeguards**: Financial institutions are required to develop policies to prevent fraudulent access to confidential financial information. These policies must be disclosed to the consumer.

The deadline for financial institutions to comply with new privacy regulations under Title V of the Gramm-Leach-Bliley Act was July 1, 2001. In preparation for these new requirements, financial services professionals spent hours attending seminars, pouring over the legislation and reading clarifications from the office of the Comptroller of the Currency. The law contained extensive federal requirements governing the disclosure of consumer information by banks and other private entities. Differing requirements created some confusion because satisfying one set of requirements does not necessarily amount to compliance with another.

Consumers continue to express concern over the availability and distribution of their personal financial information. Relieving their concerns may not be as simple as complying with the letter of the law. While consumers may have been only vaguely aware of debate in Washington leading up to the new legislation, they find it impossible to ignore one of its by-products. A typical consumer's home mailbox has been stuffed with privacy notices from banks, credit card companies, brokerage and investment firms, and other finance companies. While financial institutions have notified consumers, it's ongoing communication and education that are the key to long-term consumer confidence. Effective communication requires a certain amount of empathy, and the ability to see a situation from another point of view. Financial service companies must continue to develop their privacy policies keeping their customers at the forefront. Financial service companies should ask themselves how their customers might react to the following issue:

- The quantity of a customer's personal financial information the business collects
- How the business uses the information
- Whether that information is transferred to affiliates or other parties
- Which other entities receive that information
- What happens to the information once it is handed over to another party

Financial service companies that deal with a customer's nonpublic financial information should make ***every effort*** to explain their privacy policy in ***plain language***. Failing to understand the volatility of sentiment surrounding privacy may endanger the public trust that financial institutions have worked diligently to earn and maintain. Eroding consumer trust could constrict the flow of vital credit information, and this in turn would have a negative impact, not only on financial institutions, but also on consumers. When lending institutions have an accurate and complete picture of creditworthiness, they reduce their risk in lending, which ultimately reduces the cost of credit. Consumers can shop for the best rates among many lenders who can quickly access the applicant's financial information. This increases competition among lenders and also helps to drive rates down for consumers. The ability to monitor information also helps financial institutions spot fraudulent activity, and identify unusual transactions or unacceptable risks. When fraud does occur, immediate access to information helps investigators limit loss and apprehend criminals.

Availability of consistent and accurate information has enabled investors to buy loans of similar credit quality that are packaged and sold as asset-backed securities. Access to this information allows investors to judge with more confidence the risks and potential return of their investment. The secondary mortgage market is one example of successful secondary markets that provide liquidity, spread the risk among a large pool of investors, and lower the price of loans. According to at least one estimate, the secondary loan market has lowered the price of mortgages in the U.S. by a full two percentage points in comparison to other countries.

Secondary markets for automobile loans and credit card receivables are producing similar results. Investors in pools of security backed assets hold more than 50% of all revolving credit and over 30% of all non-mortgage consumer credit, currently totaling approximately $436 billion. The advent of online financial transactions heightened consumer demands that financial service companies handle and exchange nonpublic financial information responsibly. Technology has opened the door for new, more specialized financial products and services, but in order to successfully take advantage of those opportunities, banks must reassure consumers that the bank-customer relationship -- and the expectation of privacy that is an essential part of that relationship -- will be honored as much on the Internet as it is in the branch office.

Customers enjoy the benefits and convenience that an information-based marketplace makes possible, such as fast credit approval or financial products tailored to their specific needs. In the past, consumers may have enjoyed these benefits without understanding what is required to handle nonpublic financial information responsibly. The new privacy regulations may prompt consumers to make more informed choices about how their personal financial information is used. At the same time, the rules are moving financial institutions to demonstrate they take privacy protection seriously. Education and privacy protection are both vital because consumers and financial service companies have too much to gain from a marketplace where information can be exchanged quickly, accurately and securely.

Privacy Regulations

We will discussing these regulations in detail in later sections. For now, it is important to familiarize yourself with their names and purpose since we refer to them often:

HIPPA – Administrative Simplification

The final rule for the Standards for Privacy of Individually Identifiable Health Information, known as the ***Privacy Rule***, implements the privacy requirements of the "Administrative Simplification" provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996. The Privacy Rule applies to health plans, health care clearinghouses and certain health care providers. It also includes standards regarding the rights of individuals regarding their health information, the procedures for exercising these rights and the authorized and required uses of the information.

The type of health information that is protected by the Privacy Rule is information that

- Relates to a person's physical or mental health, the provision of health care, or the payment of health care;
- Identifies or could be used to identify, the person who is the subject of the information;
- May be created or received by a covered entity; and
- Is transmitted or maintained in any medium.

The reasoning behind the enacting of national health privacy rules includes the assertion that privacy is a ***fundamental right*** of the citizenry. It is considered as essential to individual and collective freedom.

There is clear indication that this information could impact agents. This we will discuss later.

The Gramm-Leach-Bliley Act

The Gramm-Leach-Bliley Act (GLBA) is a comprehensive law regulating the use of customer information by financial institutions. GLBA's privacy regulations went into effect on November 13, 2000. The deadline for full compliance was July 1, 2001. These provisions apply to insurance agents, brokers and companies. HIPAA and Gramm-Leach-Bliley Act are both statutes dealing with the financial privacy statue. The legislation applies to all financial institutions. These include all that are involved in:

- Traditional banking activities such as lending
- Investment-oriented activities such as providing investment advice or underwriting securities offerings,
- Insuring, guaranteeing, or indemnifying against loss, harm, damage, illness, disability or death
- Providing and issuing annuities
- Acting as principal, agent, or broker for these activities

The Gramm-Leach-Bliley Act (GLBA) has issued privacy regulations for all insurers. The Federal Trade Commission has given examples of businesses that could be covered with these privacy regulations. These include retailers who issue their own credit cards, real estate and personal property appraisers, tax preparers, automobile dealerships who lease automobiles, developers of financial software, career counselors providing advice for employees in the financial services industry and business that print and sell checks for consumers. Most ***insurers will be included*** within these provisions. These regulations and provisions not only apply to health insurance, but any other line of insurance. For non-health

lines of business, the GLBA may contain the only federal privacy restrictions on medical information.

The rules of the GLBA apply to any person or entity that is authorized to conduct business under state insurance codes. The GLBA establishes a federal standard of privacy of protection. Individual states may provide greater consumer privacy protection. An insurance producer that is licensed by a State's department of insurance does not have to comply with GLBA privacy notice requirements if

- He is an employee, agent or other representative of another licensed agent
- If his affiliates provide the required notices
- He does not disclose any non-public information to any person other than his employer or those affiliated with him

This agent exception relieves any agency from compliance with GLBA notification burdens if the agency ***limits its information sharing*** to insurance companies for which they are acting as agent. If the agent shares the information with anyone other than an insurance company, the agent must provide separate notices and opt out opportunities as required by the rules. If an agent, for a fee, provides any other services to any institution such as financial, investment or economic advisory services relating to an insurance product, that individual becomes the agent's customer and must be provided with all required notices about the agent's privacy policy.

The rule provides that an independent agent sharing information with multiple insurance companies in order to obtain the best price quote for a client ***does not need*** to provide notices to the client. It is the responsibility of each insurance company to comply with the notice requirements as to that client. The client will be considered a consumer of each company to whom the client's information is provided, and if the client purchases coverage from one of the companies, the client becomes the customer of that company.

However, if the agent discloses or plans to disclose that information to anyone other than the companies, the agent must send that client all ***required notices*** and provide the client with the opportunity to ***opt out***. Each agency's operations are different, and because the law is designed to reflect all of the different types of information-sharing in the marketplace, there is no one single privacy notice agencies can use to comply with the federal law. Each agency will need to develop its own internal privacy policy and consumer privacy notice.

The agent exception benefits agencies that have ***exclusive agency*** relationships with an insurer, such as life insurance agents. It may be better for the agencies to be covered by that company's GLBA privacy policy. The agent exception also benefits agents that are involved in the ***more traditional*** types of agency activities. This would include those who do not share protected information with third parties after a sale is complete. If an agent submits an individual's application to a number of different insurance companies, that individual is not a customer until an application is accepted and the individual becomes a policyholder of the insurance company.

Any agent wanting to take advantage of this exception should be sure that its appointment contracts require the insurer to be in compliance with its GLBA obligations.

Again, the impacts of this legislation are far-reaching for agents and we will discuss it in greater length in a later chapter.

The Federal Medical Privacy Rule

In April 2001, President Bush approved The Federal Medical Privacy Rule. This rule imposed a major shift in health care ethics applicable to ***patient consent***. For the first time in our nation's history, the federal government is going to decide for each and every citizen who can access his or her personal health information, including genetic information. The concept of informed consent has been defined as a person's agreement to allow personal data to be provided for research and statistical purposes. The individual's agreement to share information has been based on full exposure to the facts the person needs to make the decision intelligently. Informed consent has described a condition appropriate only when patients have a clear choice, and have not been subject to penalties for failure to provide the data sought. The federal medical privacy rule does not meet this definition of consent.

The Patriot Act and The Terrorism Risk Insurance Act

On April 24, 2002, the Patriot Act became law. The Act, put in place after September 11, addresses terrorism and money-laundering activities. The intent is for businesses to ***know their customer*** better than ever before by verifying their identities. Industry experts agree that the Patriot Act is clearly directed at financial institutions such as banks and security brokers.

The Terrorism Risk Insurance Act was signed into law on 11/26/02. It's primary intent was to act as a ***federal backstop*** for certain acts of terrorism. In other words, the federal government is willing to share the risk of loss from foreign terrorist attacks with the insurance industry. The Act is triggered when the Secretary of State and the Attorney General certify that an event is indeed an ***act of terrorism***.

Like all forms of government backing, there are exclusions which insurers and possibly agents must disclose. These will be discussed in the chapter titled ***Loss Control Conduct.***

Other than these exclusions, neither of these acts impose specific duties or responsibilities on independent insurance agents. However, this does not mean agents do not have a moral obligation to be aware of claim activity that could be providing a source of revenue for terrorists or help their company comply. As the ***primary point of contact*** for policyholders, agents are clearly in the path of knowing much sooner than others.

Federal Communication Commission "Do Not Call" (DNC) Rules

The Telephone Consumer Protection Act of 1991 has been amended by the FCC's published ***Do Not Call (DNC)*** rules issued on 7/25/03. These new rules could have a significant impact on insurance agents in the areas of telemarketing and fax solicitations.

Starting 10/1/03, people using the telephone to solicit business will have to purchase the national do-not-call (DNC) list and use it to ***scrub*** or filter out their calling lists ***within 90 days*** of making telemarketing calls. Other rules of the original act; like maintaining your own DNC list, attention to calling hours and identifying your company, remain intact.

The new DNC rules apply to ***all calls*** -- intrastate and interstate -- and all ***telephone solicitations*** which are defined as any

"*Telephone call or message for the purpose of encouraging the purchase or rental of, investment in, property, goods, or services, which is transmitted to any person . . . "*

The rules do not cover calls that are made to conduct surveys or provide information. However, ***mixed purpose calls***, such as surveys or informational calls that ***also*** solicit the purchase of goods or services, are covered by the rules.

Established Business Relationship: The rules do exempt calls to those whom an agent has an ***established business relationship (EBR)***. Such a relationship is considered while an agent is doing business, e.g., during the life of an insurance policy, and for ***18 months*** after the last payment or the last goods and services provided.

If someone calls an agent to inquire about potential business an established business relationship is automatically created for a period of ***three months***. Someone merely calling for directions to your office or asking about your business hours does not establish a business relationship. In other words, you would need to know if they are on a DNC list before telemarketing to them.

Sample Do Not Call Policy

(In addition to a DNC Policy such as this, there are compliance and legal issues you should review with a competent professional).

ABC Insurance wishes to comply with the Federal Trade Commission (FTC) and Federal Communications Commission (FCC) regulations regarding consumer requests not to receive future telephone solicitations from our Company or who have placed their names on the National Do Not Call (DNC) List.

Our Company has trained its employees engaged in telephone marketing on these policies and procedures and we require these employees to follow them at all times. Our Company has a policy and disciplining and will discipline employees who fail to abide by these procedures.

Our Company utilizes two different do not call procedures: 1) It maintains a Company-specific list, and removes all numbers requested to be removed; and 2) It acceses the national DNC List and removes all numbers appearing on it from the Company's call list.

(If your state has its own DNCLIst you would add that you access the State DNC list and use it to remove numbers from your Company List as well).

Of course, if any person, even if they are listed on the national DNC list, gives you written authorization to call them its ok to do so. This consent is good until revoked, so it usurps the EBR time limits. Retaining these consent forms is important if any complaints arise.

Complying With DNC Rules: Merely knowing the rules and or not calling someone is ***not complete compliance***. The DNC rules require that the following steps be taken before making telemarketing calls:

- If you plan to telemarket, you must establish and implement a written DNC policy and make it available on request.

- Train personnel and possible subcontractors who call for you on your written DNC policy.
- Maintain a company-specific DNC list for five years. People who request their name be added should be added within 30 days or less.
- Identify yourself and company when calling, including address or telephone number.

In addition to these rules, all businesses making telemarketing calls will have to generate caller identification (caller-id). The number displayed must be a number that is answered during normal business hours and that can receive a DNC request. The number may be answered by an automated system as long as a DNC request can be made.

Accessing The DNC List: The national DNC list will be downloadable online at www.telemarketing.donotcall.gov. Only phone numbers are provided. The cost is $25 per area code per year with the first five area codes free of charge. Fee-splitting between users is prohibited. And, each separate corporation that uses the list must purchase it separately. Every business making telemarketing calls must register on the national registry website. If and outside telemarketing vendor is used, your name and information ***must*** still be registered on the website. In others, a vendor who is calling for 15 different agents must show that all 15 have registered and paid DNC fees; the telemarketeer cannot just register once and use the list for all 15 clients. Also, if you are buying a ***scrubbed list*** from a list company, you must register your name and pay fees DNC fees or the list company may do this on your behalf.

State DNC Lists and Requirements: Many states have enacted their own DNC list procedure. Some are completely independent from the federal system, others are ***uploading*** their list data to the federal DNC. The FTC and FCC are working toward a single source system, however, this might take several years. Until that time, it would be wise to comply with ***both*** state and federal procedures by buying both lists. And, while some states are uploading their list to the federal list, they may also have a ***separate*** DNC fee and registration that must be met. ***Special, more restrictive rules*** may also apply surrounding state requirements for EBR (Existing Business Relationship) that may not be exempted by federal rules.

Safe Harbor Provision: Liability may be limited or avoided if you have called someone in violation of DNC rules if you have followed the compliance rules above, including the establishment and training of your own, written DNC policy. Monitoring and enforcement of these rules is critical, and it is assumed that frequent or outrageous abuses will be pursued.

Violation penalties: Federal and civil remedies for DNC violation are significant:

- ***Each call*** in violation of your company-specific policy or the national DNC list is subject to a penalty of ***$11,000***.

- Federal courts, through State Attorney Generals, may commence actions for violation of the Telephone Consumer Protection Act of 1991 for ***$500 per violation***, ***plus*** unspecified damages. Also, state courts may get involved for varying amounts.

- Private lawsuits in the amount of ***$500*** are permitted and ***punitive damages*** are possible for willful violation of DNC rules.

Fax Spamming

As of the writing of this course, amendments to the Telephone Consumer Protection Act of 1991 were in place to ***severely limit unsolicited faxes*** without written consent from recipients. The measure was published in the Federal Register on July 25, giving affected parties just 30 days to comply with the new rules.

However, the Washington, D.C.-based American Society of Association Executives immediately filed a request for a stay with the FCC to prevent the legislation from going into effect, along with a call for an "emergency clarification" of the rules. The FCC evidently got the message. The stay, which lasts until Jan. 1, 2005, is meant to allow associations more time to obtain written permission from those to whom they wish to send faxes. It also gives the agency time to consider petitions for reconsideration and other filings received from ASAE and other concerned parties.

For now and through 2004, organizations can continue to send faxes as usual under a longstanding qualification that allows such communications to be sent to recipients who have an ***established business relationship*** with the sender.

If the new rule is implemented in its current form, faxed notices could result in fines as high as $11,000 per fax.

E-mail Spamming

E-mail spam costs U.S. companies and government more than $10 billion in lost productivity and additional equipment, manpower and software. A majority of states and the federal government are reacting with new anti-spam legislation.

In California, for instance, the state attorney general and spam recipients can now sue advertisers and spam senders who use misleading information in an e-mail subject line, invalid reply addresses or disguised paths of transmission. The limit for civil judgments against spammers is $1,000 per message or $1 million per incident.

Companies can send bulk messages only if recipients have given their permission, or if there's an existing business relationship. In that case, the law requires that consumers must be able to opt out of future messages.

But even though individuals could sue, experts say it would be a mistake for spam victims to count on a windfall solution. The problem is that the Internet crosses state and national boundaries. Extradition from another state is unlikely in a civil case.

Even with national laws, if the spammer is offshore, how can that be enforced? Probably the best solution is for consumers to refuse to buy from spamming companies.

Additional Legislation

Other legislation that could affect your clients right to privacy include The Privacy Act (1974), The Freedom of Information Act, Federal Substance Abuse Confidentiality Requirements, Employee Retirement Income Security Act of 1974, The Family Educational Rights and Privacy Act, Federally Funded Health programs (Medicaid, Medicare, etc), Food, Drug and

Cosmetic Act, Clinical Laboratory Improvement Amendments, Federal Disability Nondiscrimination Laws, Fair Credit Reporting Act and more!

As you can see, there is much you need to know about collecting and transmitting information from a prospect. This will be further discussed in later sections.

Advantages of Privacy Compliance

Simplification: The magnitude of changes mandated through privacy regulations has had a significant impact on health care organizations and insurers alike. Accomplishing this change successfully has required a process that facilitates advanced planning so that an organization can become completely accountable for the management of a patient's health care information. The smart organizations have used the task of moving towards compliance as an opportunity to improve their effectiveness. This has resulted in the benefits of administrative simplification.

Increased Security: The growing concern over increasingly malevolent hacker attacks and viruses, as well as the need to meet government privacy regulations, has many companies searching for solace in outsourced security services. Viruses such as Code Red, the Love Bug, and Nimda have caused billions of dollars in damage to companies' systems. Researchers estimate that the Love Bug, which hit in 2000, cost businesses $8.75 billion in lost productivity and cleanup efforts. Any company that deals with proprietary customer data has to be concerned with these and other security threats. The Health Insurance Portability and Accountability Act of 1996 is pushing health-care companies to tighten the security of their patient information. The act's primary objectives are to provide better access to health insurance, limit fraud and abuse, and reduce administrative costs for health-care and insurance providers. Companies that rely heavily on the Internet need to be acutely aware of security issues. As an added protection, some corporations have hired senior security personnel to conduct an internal risk assessment. While the financial-services and health-care industries are at the forefront of heightened Internet security, others will likely follow. The price of performing a risk assessment and adding managed security services is small when compared with the cost of losing customer confidence

Disadvantages of Privacy Compliance

Even with all the emphasis on privacy issues, the American people still do not have true medical privacy. In reality, they weaken one's ability to restrict access to his medical records, and increase the federal government's power to access one's personal health information without his consent. Every doctor and other health care practitioner are required to share patients' records with the federal government without patient consent. Medical records can be disclosed for many reasons. Some of these are:

- Public health surveillance and activities
- Law enforcement activities
- Research
- FDA monitoring
- Judicial and administrative proceedings
- Oversight of the health care system
- Licensing
- U.S. public health officials working with foreign governments

After one's medical records are disclosed to a third party other than a business associate, the final rule no longer protects the information. There is ***nothing*** that prohibits the federal government, state governments, or private parties from using the patient information listed above without patient consent. This can be compiled into large databases of information. The privacy rule does not apply to information that was collected or stored in databases without consent prior to February 26, 2003.

Patients are not guaranteed the right to restrict access to their records. Health care providers may refuse to treat a patient if he will not give consent to share his medical records. Any doctor can use those records to treat other patients without one's consent. Patients will be given limited information about when and to whom their medical records were disclosed for most health care activities. There is no penalty for disclosing information in one's medical record. Consequently, patients have no rights for any kind of action even if they believe that their medical privacy has been violated. Identifiable health information such as banking of blood, sperm or body tissue is not protected by the privacy rule, because it is not considered to be health care under this rule. These items include genetic information, and lack of privacy protection in these areas could have far-reaching effects.

With the Internet, it is easy to transfer electronic medical records. The medical privacy rule promotes the development of a national health information network through standardized codes for all health care services throughout the United States. The privacy spotlight will glare on the health-care industry as providers and insurers scramble to comply with new regulations governing the confidentiality of patient data. While some fight to delay or dilute those regulations, there are some who champion even broader efforts to protect patient confidentiality. Medical experts contend that to maintain trust in the doctor-patient relationship, lawmakers must pass more-comprehensive legislation to ensure the privacy of health records. They know that an essential to that caring relationship must be a trust that health-care professionals will protect the confidentiality of patient information. Health-care providers, insurers, and transaction processors must comply with new patient-data privacy regulations included in the Health Insurance Portability and Accountability Act by June 2003.

Opt-Out, Opt-In and Client Privacy

Definition of "Opt-Out"

"Opt-out**"** is the process of having one's personal information ***removed*** from databases and lists that are often sold for marketing purposes. Personal information is collected on individuals in a variety of ways such as when they are applying for a credit card, telephone service, or entering contests. Credit bureaus also sell information for marketing purposes. If the consumer has active accounts with a brokerage house, credit card company, or insurance company, he will receive a privacy notice from these institutions. The term "financial institution" includes companies such as payday loan companies, collection agencies, and travel agents. For this reason, it is particularly important for the consumer to carefully review all preprinted notices that he receives in the mail or electronic mail messages.

Federal law now gives one some minimal rights to protect his personal financial information. The law gives him the right to prevent a company he does business with from sharing or selling certain sensitive information to non-affiliated third parties. The term "opt-out" means

that ***unless and until*** the consumer informs his bank, credit card company, insurance company, or brokerage firm that he does not want them to share or sell his customer data to other companies, they are free to do so.

Controversies Concerning Opt-In

When this law was debated in Congress, consumer advocates argued unsuccessfully for an **opt-in** provision. This stronger standard would have prevented the sharing or sale of the customer data ***unless*** the consumer affirmatively consented. The opt-in standard did not prevail. Therefore the ***burden is on the consumer*** to protect his financial privacy.

Opt-in does not enhance consumer privacy. Since it is the consumer who makes the final and binding decision regarding the use, non-use, or misuse of his personal information under either "opt-in" or "opt-out", there is no privacy advantage to "opt-in". Neither approach provides the consumer with greater or lesser rights than the other. If this argument is valid, and both "opt-in" and "opt-out" fully reflect consumer preferences regarding the use of their personal information, then all the other arguments are invalid – sellers would receive the same amount of information under either approach. Thus, implementing "opt-in" would not impose any additional costs on either producers or consumers, as compared with implementing "opt-out". However, the choice of scheme – "opt-in" or "opt-out" – does distort consumer preferences by imposing transaction costs on one choice or the other. After acknowledging that transaction costs cause both "opt-in" and "opt-out" schemes to reflect imperfectly the "true" privacy preferences of the consumer, the policy debate can move forward and tackle the next question. Does "opt-in" or "opt-out" reflect the true preferences of the consumer better? Presumably, transaction costs under "opt-in" lead consumers to provide less information than their true privacy preferences would suggest; conversely, transaction costs under "opt-out" lead consumers to provide too much information. The structure of the seller-producer relationship suggests one reason why "opt-in" might represent the consumer's true privacy preference better. The seller can adjust the level of transaction costs involved in "opting" in or out, whereas the consumer cannot. Since the seller has an obvious interest in collecting information, it has an incentive to make it easy and simple to opt in, under an "opt-in" system, and an incentive to make it difficult and time-consuming to opt out, under an "opt-out" system. Whatever regulations exist to make opting out easier, the seller has an incentive to push the envelope, to make opting out as difficult as possible within the letter of the law. Thus, transaction costs under an "opt-out" scheme are likely to be higher than under an "opt-in" scheme, and the outcome under "opt-out" is likely to be concomitantly farther away from the correct outcome than under "opt-in".

Opt-in reduces consumer privacy by hampering efforts to fight fraud and identity-theft. Since an "opt-in" approach reduces the amount of information available to sellers regarding the consumer's preferences, spending habits and typical behavior patterns, it hampers sellers' efforts to detect unusual purchases and alert the consumer to possible fraud. This makes it easier for criminals to assume false identities and engage in other fraudulent behavior at the expense of law-abiding consumers. Not only is this an invasion of privacy in itself, but also the rectification of the situation often requires the consumer to provide personal information about himself. This is a valid point, which, under an "opt-in" scheme, producers might wish to present to consumers in order to convince them to permit use of their personal information. Under an "opt-out" scheme, this point could be presented to consumers to deter them from exercising their "opt-out" option.

Opt-in imposes significant costs on sellers, which are then passed on to consumers. Opt-in increases the costs to a seller of expanding its range of services, because of the necessary expenditure of resources to obtain consumer permission to use the additional personal information that enables the better service. *Opt-in also increases marketing costs* because, instead of sending promotional materials to a neatly identifiable population segment that is likely to find such materials useful, the seller must send the promotional materials blindly to broader population segments. Some believe that in the "distance shopping" market through catalogs and online sales, enforcing an "opt-in" scheme will result in increased costs, which will then be passed on to consumers. The data restrictions inherent in the "opt-in" scheme would affect catalog marketing more than online marketing. This is because the interactive nature of the Internet can counteract the lack of third-party information about prospective customers. To properly understand the aggregate impact of an "opt-in" scheme on sellers, one would need to look at the reliance of other industries on catalogs, as opposed to more interactive means of marketing. One of the factors slowing the growth of e-commerce, though, is consumer hesitation over conducting business online. In a report to Congress on online privacy, the Federal Trade Commission presented surveys showing the extent to which privacy concerns hamper the growth of e-commerce. Recent survey data demonstrate that 92% of consumers are concerned and 67% are **very** concerned about the misuse of their personal information online. Concerns about privacy online reach even those not troubled by threats to privacy in the off-line world. Thus, 76% of consumers who are not generally concerned about the misuse of their personal information, fear privacy intrusions on the Internet. This apprehension likely translates into lost online sales due to lack of confidence in how personal data will be handled. Indeed, surveys show that those consumers most concerned about threats to their privacy online are the least likely to engage in online commerce, and many consumers who have never made an online purchase identify privacy concerns as a key reason for their inaction. There are benefits of adopting and enforcing an "opt-in" scheme, in which consumers are assured that no one will make use of their personal information without their prior and express consent. The resulting burgeoning in e-commerce would reduce sellers' costs, by enabling them to make more extensive use of the efficiency inherent in interactive marketing tools such as the Internet. This effect may offset, and perhaps even outweigh, the increase in costs attributable to the data restriction effect.

Opt-in reduces the amount of competition in the market. By raising costs of operation, "opt-in" will drive marginally profitable companies out of the market altogether. By requiring new entrants to go through a laborious process of obtaining personal data permits from each new consumer, "opt-in" creates a barrier to entry into the market. Market incumbents, on the other hand, will benefit from an established consumer base that has already given permits. Essentially, "opt-in" helps entrench market incumbents. Since consumers are more likely to "opt-in" to companies they know and trust, such a scheme will favor large firms with established brand names over smaller firms. Competition is most reduced in the industries that rely the most on expensive means of obtaining permission, such as telephone or paper-mail, rather than on website-notices and e-mail. As e-commerce continues to grow, and technology becomes more pervasive, there is likely to be a shift from the former to the latter, and a reduction in the height of the entry barrier. A new entrant, though forced to beseech consumers for information-permission, could do so inexpensively through mass e-mailing.

Opt-in costs to sellers will be passed on disproportionately to less wealthy consumers. A study of distance shopping in the apparel market (catalogs, online purchases) reveals that inner city and rural consumers are significantly more reliant on distance shopping than the average U.S. household. These populations will be hit hardest by

increased prices or decreased discounts which will result from implementation of “opt-in”, as companies seek to recoup the increased costs of providing the “distance shopping” option. These are also the consumers who can least afford such price hikes.

Control of Personal Information

Now, we face the question of consumers’ rights to financial privacy, an issue that was brought to the forefront by recent federal legislation, the Financial Services Modernization Act, also known as the Gramm-Leach-Bliley Act. At the core of this, as well as most other privacy debates, is the issue of ***control of personal information***. Who ultimately determines how personal information flows, and how it is used? Is it the individual who is the subject of the data or the company that compiles that data?

The Gramm-Leach-Bliley Act (GLB) enables financial institutions such as banks to affiliate with insurance companies and brokerage firms under one corporate roof. A major ***incentive*** for these industries to affiliate with one another is the ability to share and intermingle their customer data. Industry representatives sell their services as merged industries providing one-stop shopping for their customers, and offering benefits like consolidated statements and total relationship pricing. But there are also profound privacy implications of the federal legislation. One’s financial information can now be shared with the affiliated insurance company for use in making decisions about coverage and rates. Sensitive health information held by insurance companies might be shared with affiliated banking and brokerage firms. Moreover, comprehensive data profiles can be compiled by combining the customer data of the affiliated banks, insurance companies and investment firms, creating dossiers of unprecedented depth and specificity.

The federal law does provide some small degree of control to consumers. Financial institutions are required to provide customers an "opt-out" opportunity before selling customer data to unaffiliated ***third parties***. But until and unless the customer says "no" to third party sharing of their data, the bank is free to sell it. However, the law says nothing about obtaining consent for ***affiliate sharing***, leaving consumers no opportunity to prevent the compilation of detailed profiles of their sensitive financial, health-related and investment data. Many consumers feel strongly that information they must supply to a financial institution to open a bank account, get a car loan, a mortgage, an insurance policy or a mutual fund should be used for that one purpose alone. The information consumers must give to financial institutions is the sort that most people would never think to share, even with close family members, let alone strangers. This includes Social Security number, income, account balances, net worth, debt level, payment history, alimony or child support payments, and bankruptcies. Also included in a consumer’s file may be incidental personal information such as health status, buying patterns, political affiliations, and charitable donations.

Even if “opt-in” never becomes the law in individual states; some consumers will try to protect their privacy by following the opt-out procedures. Writing letters and filling out forms would be no easy task for a busy consumer who has, two major credit cards, several checking and savings accounts, a mortgage, a car loan, a couple of insurance policies and a brokerage account. Some experts believe that it is likely that financial institutions will obtain ***implied consent*** because most individuals will simply not respond to the opt-out notices. Perhaps they are too sick, too tired, too confused, or just uninformed to respond to the opt-out notices.

The issue of control does not end there. Even a well-intentioned, consumer-conscious financial institution loses control over how the information is used once it shares or sells its

customer data. Industry can offer little to no assurance that information will not end up, for instance, in the hands of unscrupulous telemarketers selling fraudulent investments. The elder population is a prime target of deceptive marketing, because they are unlikely to respond to all opt-out notices. Nor do consumers have any assurance that the opt-out procedure will not increase the already rising tide of identity theft crimes, where minimal consumer information such as a name and Social Security number are sufficient to allow crooks to impersonate the innocent consumer. Opt-in is the better choice for businesses as long as the company merely wants to sell its products and services and has no interest in making money off the sale of confidential customer data.

Some companies may use the notice as a marketing opportunity. Instead of referring to the consumer's rights under the law, there may be statements at the beginning of the notice such as these: "Because we respect your privacy…" or "In order to provide you with the best services..." However, the rights described in the notices are the consumer's under federal law and companies are required by law to give the notice. The notices are a combination of one's opt-out rights under ***two*** federal laws -- the Financial Services Modernization Act (also known as Gramm-Leach-Bliley, or GLB, after the Congressmen who introduced it) and the Fair Credit Reporting Act (FCRA). The notice may not identify either of these laws by name, so the consumer should be able to identify the words and phrases associated with each law. An important difference is that GLB allows the consumer to opt-out of information sharing only with ***non-affiliated third parties*** and ***not*** with a company's *affiliates.* The FCRA allows him to opt-out or prevent a company from sharing "creditworthiness" information with its ***affiliates***.

The Internet and Client Privacy

With the wealth of personal data stored on the web, privacy violations associated with e-commerce activities have created a minefield of fraud, ethics, and legal issues for agents, insureds and insurers alike.

The real danger for many companies is that information processes and data that are used by Web sites often originate in marketing departments, are implemented by information technicians and change frequently. Often, they do not receive the scrutiny of the company's policy, legal and business operations staffs, where compliance with privacy laws may be viewed more cautiously.

Online Communications

Online communications are communications over telephone, satellite or cable networks using computers. Examples of online communications include connecting to the Internet through an Internet Service Provider (ISP), connecting to a commercial online service such as America Online, CompuServe, or Prodigy, dialing into a computer bulletin board service (BBS). Increasingly, the differences between ISPs, the commercial services, and BBSs are blurring. The larger commercial services and many BBSs now provide Internet access.

The Internet raises some unique privacy concerns. Information sent over this vast network may pass through dozens of different computer systems on the way to its destination. A different system operator known as a sysop may manage each of these systems, and each system may be capable of capturing and storing online communications. Furthermore, the online activities of Internet users can potentially be monitored, both by their own service

provider and by the sysops of any sites on the Internet that they visit. ISPs, commercial services, and BBSs are managed by sysops who may have different attitudes toward online privacy. Additionally, there are a tremendous variety of activities provided by all types of online services, each of which may raise specific privacy concerns. The vast information flow created by the Internet has been driving much of the public attention to privacy. The Internet-privacy principles will have a significant impact on the insurance industry. The insurance business is moving to the Internet and the primary principles of privacy on the Internet are becoming a common denominator for businesses in any sector, on-line or off-line, and will probably serve as guidelines for litigation challenges in the future.

Online Privacy

Often the level of privacy one can expect from an online activity will be clear from the nature of that activity. Sometimes, however, an activity that appears to be private may not be. *There are virtually **no** online activities or services that guarantee an absolute right of privacy.*

Many online activities are open to public inspection. Engaging in these types of activities does not normally create an expectation of privacy. In fact, according to federal law, it is not illegal for anyone to view or disclose an electronic communication if the communication is ***readily accessible*** to the public. A message that is posted to a public newsgroup or forum is available for anyone to view, copy, and store. One's name, e-mail address, and information about his service provider are usually available for inspection as part of the message itself. Most public postings made on the Internet are archived in searchable databases.

Other public activities may allow one's message to be sent to multiple recipients. Online newsletters, for example, are usually sent to a mailing list of subscribers. If one wishes to privately reply to a message posted in an online newsletter, he should be sure that he addresses it specifically to that person's address, not to the newsletter address. Otherwise, he might find that his message has been sent to everyone on the newsletter mailing list. The consumer should not expect that his service account information would be kept private. Most services provide online ***member directories*** which publicly list all subscribers to the service. Some of these directories may list additional personal information. Even individuals with direct Internet accounts may be identified with commands such as a ***finger***, which let anyone with Internet access find out who else is online. Most service providers will allow users to have their information removed from these directories upon request. Some service providers may sell their membership lists to direct marketers.

Often the presence of security or access safeguards on certain forums or services can ***lead users to believe*** that communications made within these services are private. For example, some bulletin board services maintain forums that are restricted to users who have a password. While communications made in these forums may initially be read only by the members with access, there is nothing preventing those members from recording the communications and later transmitting them elsewhere. One example of this kind of activity is the real-time ***chat*** conference, in which participants type live messages directly to the computer screens of other participants. Often the service provider describes these activities as private. However, chat line users may capture, store, and transmit these communications to others outside the chat service. Additionally, these activities are subject to the same monitoring exceptions, which apply to ***private*** e-mail.

Private Activity: Virtually all-online services offer some sort of ***private activity***, which allows subscribers to send personal e-mail messages to others. The federal Electronic

Communications Privacy Act (ECPA) makes it unlawful for anyone to read or disclose the contents of an electronic communication. This law applies to e-mail messages. However, there are ***three*** important exceptions to the ECPA.

- The online service may view private e-mail if it suspects the sender is attempting to damage the system or harm another user. Random monitoring of e-mail is prohibited.
- The service may legally view and disclose private e-mail if either the sender or the recipient of the message consents to the inspection or disclosure. Many commercial services require a consent agreement from new members when signing up for the service.
- If an employer owns the e-mail system, the employer may inspect the contents of employee e-mail on the system. Therefore, any e-mail sent from a business location is probably not private. Several court cases have determined that employers have a right to monitor e-mail messages of their employees.

Once a sysop has intercepted e-mail for any of these lawful reasons, the sysop generally may not disclose the contents to anyone other than the addressee. Certain exceptions to this disclosure prohibition exist. These exceptions include

- When any party to the message consents to disclosure
- When disclosure is ordered by a court
- When the message appears to involve the commission of a crime (in which case disclosure is limited to the appropriate law enforcement officials)

A sysop does not violate the ECPA if the message is accidentally sent to the wrong person. The sysop may be responsible for damages caused by negligence in operating the service. Law enforcement officials may access or disclose electronic communications only after receiving a court-ordered search warrant. Only certain officials may apply for this order, and a detailed procedure is set forth in the ECPA for granting the order. These provisions are relaxed for messages that have been stored in a system for over 180 days.

The consumer's e-mail message may be handled by several different online services during delivery. The sysop of each of these systems may view e-mail under the above exceptions to the ECPA. Additionally, the message may be intercepted if either the sender or recipient consents. So even if one does not consent himself, the person he sent the e-mail to may have consented to the disclosure of the message.

Activity Tracking: Many types of online activities do not involve sending e-mail messages between parties. Internet users may retrieve information or documents from sites on the World Wide Web. Or users may simply browse these services without any other interaction. Many users expect that such activities are anonymous. They are not. It is possible to record many online activities including which newsgroups or files a subscriber has accessed and which web sites a subscriber has visited. This information can be collected both by a subscriber's own service provider and by the sysops of remote sites which a subscriber visits.

When one is surfing the web, many web sites deposit data about his visit, called cookies, on his hard drive When he returns to that site, the cookies data will reveal that he has been there before. The web site might offer him products or ads tailored to his interests, based on the contents of the cookies data. Records of subscriber browsing patterns, also known as

transaction-generated information, are a potentially valuable source of revenue for online services. This information is useful to direct marketers as a basis for developing highly targeted lists of online users with similar likes and behaviors. It may also create the potential for junk e-mail and other marketing uses. Additionally, this information may be embarrassing for users who have accessed sensitive or controversial materials online.

The practice of collecting browsing patterns is increasing. Online users should be aware that this practice poses a significant threat to online privacy. Additionally, online users should educate themselves about what information is transmitted to remote computers by the software that they use to browse remote sites. Most World Wide Web browsers invisibly provide web site operators with information about a user's service provider, and with information about the location of other web sites a user has visited. Some web browsers are programmed to transmit a user's e-mail address to each web site a user visits. Users who access the Internet from work should know that employers are increasingly monitoring the Internet sites that an employee visits. In order for law enforcement officials to gain access to subscriber transactional records, they must obtain a court order demonstrating that the records are relevant to an ongoing criminal investigation.

Many of the commercial online services will automatically download graphics and program upgrades to the user's home computer. News reports have documented the fact that certain online services have admitted to both accidental and intentional "prying" into the memory of home computers signing on to the service. In some cases, personal files have been copied and collected by the online services. It is difficult to detect these types of intrusions. The online user should be aware of this potential privacy abuse, and investigate new services thoroughly before signing on.

Online Privacy Protection

Consumers and agents alike should be aware that at any step along the way, his online messages could be intercepted, and his activities monitored, in the world of cyberspace. One should create passwords with ***nonsensical combinations*** of upper and lower case letters, numbers and symbols. He should change his password ***frequently***, and never write it down or give it to someone else. He should not let others watch him log in. One should never leave his computer logged in unattended. One should contact the sysop of any online service he intends to use and ask for its ***privacy policy***. Most of the commercial services have written privacy policies that are provided to new subscribers. One should carefully read all messages, which appear on initial login. Many sysops notify online users in login messages that e-mail is subject to inspection. Many services require new subscribers to allow e-mail to be monitored as part of the sign-up process. All sysops should have a well defined, written policy concerning privacy. Those that do not should be avoided. When one is ***surfing the web***, he should look for the privacy policies posted on the web sites he visits. If he is not satisfied with the policy, or if there is no policy posted, he should not spend time on that site.

One should investigate new services before using them. He can post a question about a new service in a dependable forum or newsgroup. Bad reputations get around quickly in cyberspace, so if others have had negative experiences with a service, he should get the message. One should assume that his online communications are not private unless he uses powerful encryption. He should not send sensitive personal information (phone number, password, address, credit card number, vacation dates) by chat lines, forum postings, e-mail or in his online biography. Consumers must be cautious of "start-up" software that makes an initial connection to the service for him. Often these programs require one to provide credit

card numbers, checking account numbers, Social Security numbers, or other personal information, and then upload this information automatically to the service. Also, these programs may be able to access records in one's computer without his knowledge.

Public postings made on the Internet are often archived and saved for posterity. It is possible to search and discover the postings an individual has made to Usenet newsgroups. This information can be used to create profiles of individuals for a variety of purposes, such as employment background checks and direct marketing. Online activities leave electronic footprints for others to see both at his own service provider and at any remote sites he visits. His own service provider can determine what commands he has executed and track, which sites he visits. Web site operators can often track the activities one engages in on their site, particularly at sites, which ask him to "register" or otherwise provide personal information. Some web browsing software transmits less information to remote sites than other software. One can avoid leaving tracks when he sends e-mail messages by using anonymous remailers. If one's online service allows him to compile a list of favorite newsgroups, or lets him range newsgroups by priority, he should be aware that his sysop can monitor that list. He should not place controversial or sensitive newsgroups in this list if he wants to avoid being connected to particular issues. The consumer should know that if he publishes information on a personal web page, direct marketers and others may collect his address, phone number, e-mail address and other information that he provides. One should take advantage of privacy protection tools. There are several technologies, which help online users protect their privacy. Some of these are encryption, anonymous remailers and memory protection software.

Encryption: This is a method of scrambling an e-mail message or file so that it is gibberish to anyone who does not know how to unscramble it. The privacy advantage of encryption is that anything encrypted is virtually inaccessible to anyone other than the designated recipient. Thus, private information may be encrypted, and then transmitted, stored or distributed without fear that outsiders will scrutinize it. An encrypted e-mail message cannot be read by the online service sysop, or anyone else who has obtained the message legally or illegally. Therefore, any message containing private or sensitive information should be encrypted prior to communicating it online. Various strong encryption programs, such as PGP (Pretty Good Privacy) are available online. Because encryption prevents unauthorized access, law enforcement agencies have expressed concerns over the use of this technology, and Congress has considered legislation to create a back door to allow law enforcement officials to decipher encrypted messages. Users should be aware that the legal status of this technology is still unsettled. Moreover, federal law limits exporting certain types of encryption code or descriptive information to other countries. However, its use within the United States is not currently restricted.

Remailers: Because it is relatively easy to determine the name and e-mail address of anyone who posts messages or sends e-mail, the practice of using anonymous remailing programs has become more common. These programs receive e-mail, strip off all identifying information, and then forward the mail to the appropriate address. There are several anonymous servers available on the Internet.

Software: Software security programs are now available which help ***prevent unauthorized access*** to files on the home computer. For example, one program encrypts every directory with a different password so that to access any directory one must log in first. Then, if an online service provider tries to read any private files, it would be denied access. These programs may include an audit trail that records all activity on the computer's drives.

The health care industry is currently moving toward linking institutions through a proposed information infrastructure and communications networks. Linkages would allow transfer of patient data from one care facility to another to coordinate services, and would allow collation of clinical records of each patient over time among providers and at various health sites to provide a longitudinal record, one that forms a cradle-to-grave view of a patient's health care history. Electronically connecting the health care industry by an integrated system of electronic communication networks would allow any entity within the health care system to exchange information and process transactions with any other entity in the industry. As a result of the linkage of computers, patient information will no longer be maintained, accessed, or even necessarily originate with a single institution, but will instead travel among a myriad of facilities. Smart cards have also been proposed as a means to computerize and maintain health care information. Smart cards can function to store information, which can be accessed when a patient presents the card to a health care practitioner, and/or as an access control device, carrying out security functions to maintain a more secure and efficient access control system for health care information computer systems.

A major focus of security and confidentiality measures for these systems is preventing privacy invasion by ***trusted insiders***. For online computer systems, security is generally provided by use of user identification names and passwords, and by menus to control access to computer system functions. Some systems also use audit trails to record significant events on a system. However, technology alone cannot completely secure a system. Organizational education, policies, and disciplinary actions supplement technical protection for confidentiality. Smart cards can serve as an access control device, providing the security functions that are normally carried out by the user.

All health care information systems, whether paper or computer, present confidentiality and privacy problems. Computerization can reduce some concerns about privacy in patient data and worsen others, but it also raises new problems. Computerization increases the quantity and availability of data and enhances the ability to link the data, raising concerns about new demands for information beyond those for which it was originally collected. The potential for abuse of privacy by trusted insiders to a system is of particular concern. In addition, special policy problems are raised by computerization. Proposed use of a unique patient identifier assigned at birth and retained throughout a patient's lifetime raises concerns among privacy advocates, who claim that if the Social Security number is used for this purpose, linkage of a wide variety of information resulting in dossier type files on individuals would be possible. Policies governing requirements for informed consent could be challenged as well, since currently patients have limited access to their health care record and may have little choice in consenting to its disclosure for certain purposes.

The Online Revolution

The United States is in the midst of a revolution in information technology and health-care delivery. Some are concerned that as clinical information systems and health-care management resources are established in cyberspace, the Hippocratic foundations of patient privacy, trust and confidentiality may be sacrificed to efficient processing of medical records and insurance profiles. Though information technology may allow us to control health-care costs and understand the true implications of managing disease, that same technology may represent a very real threat to our civil liberties if it is not managed appropriately. There may even be greater concern over the ability of insurance companies and employers to gain access to comprehensive medical histories, and even to track people's information-seeking habits as they browse insurance company homepages and coverage information on the World Wide Web.

The spread of managed care from coast-to-coast is generating enormous economic pressures to simplify health-care delivery through streamlined networks and to simplify the filing of health insurance claims. Information technology will play a key role in these advances. At the same time there is great concern as to how patient privacy might be compromised as physicians, insurers and HMOs exchange information over vast Internet-based computer networks. Computerized records are now the norm, and access granted to insurance providers has meant a significant loss of physician control over detailed patient information. As brokers of health care, insurers and managed-care organizations wield incredible influence over the dissemination of patient information, HMO providers, for example, need to know how sick their clients are in the aggregate, which requires detailed data on each client. With medical information resources so interconnected, comprehensive medical records could compromise patient privacy.

An accurate profile of a patient's mental health may be gleaned merely from a record of medications they need -- even if they pay cash to avoid informing an insurer. Pharmacy databases are often vast, and many chain pharmacies boast refill capabilities coast-to-coast. Anything that is on a database somewhere can be found. If a patient were taking medication specific for schizophrenia, for example, any pharmacist in the country who has access to these databases would know. The same is true for drugs specific to the treatment of HIV infection, or any other drug.

Databases

Just as pharmacy databases are useful for itemizing a patient's history of medications, comprehensive medical records in centralized databases now store ***complete medical histories*** that could have a major impact on the efficient and cost-effective delivery of health care. If a person is involved in a car accident in a rural area far from home, and brought unconscious to a nearby hospital, the emergency room doctors obtain his complete medical record through a special computer link. With the push of a button, they learn about any allergies, medical conditions and medications the person may have. Life-saving therapies might be administered faster, and costly retesting for certain information might be avoided.

Physicians can say that it is in a patient's ***best interest*** to have detailed, computerized medical records. And, of course, those records would be trusted and secured and treated as carefully as their health. But we must find a way to make the whole system treat those records as confidentially as a doctor is sworn to do. Questions that need to be considered are:

- What avenues of abuse do having a person's complete medical record in a centralized database open up?
- Could a complete medical record get into a prospective employer's hands?
- Would prospective insurers balk at information regarding precautionary medical tests that may be decades old?

Clients of private insurers fear that insurers will provide personal health information to financial service providers, employers and marketing groups. They fear that employers will use health information when making hiring decisions as they already do with credit reports and other personal information.

Insurance companies have Web pages with detailed benefit information and various coverage scenarios for people to explore. They also have the ability, through what is known as a ***cookies file***, to track the people who visit their Web sites and even to evaluate their information-seeking habits. Cookies files are like ***off-ramps*** on the information superhighway that record where a browser has visited. Consumers surfing potential health-care plans will be learning about their health- care options and, conversely, the providers of this information will have the reciprocal opportunity to learn more about the interests and needs of their individual clients. Patrons of on-line systems should never forget that, while they are reading information on their screens, the provider of that information may be learning as much about them as they are about the provider. Ultimately, the office of the medical practitioner will have to operate under the same laws governing most other office environments. Technology should never compromise the trusted relationship between patients and physicians.

The Insurance Agent and Client Privacy

Protecting Confidentiality

The insurance industry has worked with personal information for a long time. One of its top priorities has been to protect the confidentiality of that information. The insurance agent understands that the ***consumer demand*** for new and affordable financial and insurance products is met efficiently when the consumer is willing to share information. He also knows that consumers ***desire*** to protect their privacy. The agent faces the challenge of reconciling two demands:

- Convenient, speedy service of new and affordable financial and insurance products
- Protection of the consumer's privacy

An insurer and agent should establish and maintain policies and practices to protect the confidentiality and security of financial information. He should also provide customers with a notice of his company's privacy policies at the beginning of the business relationship and continue to do so for at least once a year. Customers should be given the opportunity to direct that financial information not be shared for marketing purposes, unless the products and services being marketed are being offered through an affiliated institution.

Clients should be given access and correction rights to their financial information. The insurance company should have a provision that affirms its right to share financial information when it is necessary to issue contracts and to service its business.

The insurance industry believes that medical information should be subject to far greater restrictions than financial information. Life insurers have a long history of dealing with highly sensitive personal information. They have always protected consumers' medical information, and they will not depart from that tradition. They recognize consumers have special concerns regarding medical information. That is why the life insurance industry has adopted a broad and definitive statement of principles regarding the confidentiality of policyholders' medical records.

Nonpublic personal information is personally identifiable information that a consumer gives to an agent or broker. It can also be information that an agent or broker obtains from a transaction with the consumer or any service performed for the consumer. It can include a list, description or other grouping of consumers.

GLBA (Grahmm Leach Bliley Act) requires that insurance agents and brokers respect the privacy of consumers and customers by protecting the security and confidentiality of the nonpublic personal information. GLBA does make a distinction between a ***consumer*** and a ***customer***. Every individual having dealings with an agent or broker is a consumer but only consumers with a specific of ongoing relationship with the agent or broker are customers. GLBA requires insurance agents to provide initial and annual privacy notices and opt out notices to ***all customers***. It also requires the agent to sent notice to non-customers only if the agent intends to disclose the consumer's information to unaffiliated third parties.

Compliance with Privacy Laws

Insurance companies should seek to find a commonsense approach to implementing the new privacy laws in a way that assures consumers adequate notice of privacy policies by insurers without requiring members to duplicate their companies' privacy notices. This approach will save agencies thousands of dollars each year in postage and other mailing costs, as well as thousands of hours of agency staff members' time.

The privacy rules apply to ***any person or entity*** that is licensed or otherwise authorized to conduct business by their State Department of Insurance. However, an agent that discloses protected financial information ***only*** to the insurance company on whose behalf the information was collected does not have to comply with the notice and opt out requirements so long as the company itself complies with the notice requirements

If the agent shares the information with anyone other than an insurance company, the agent must provide separate notices and opt out opportunities as required by the rules In addition, if an agent, for a fee, provides any other services to an individual such as financial, investment or economic advisory services relating to an insurance product, that individual becomes the agent's customer and must be provided with all required notices about the agent's privacy policy and, if the agent plans to share information with any third party, the opportunity to opt out.

It will be up to the company and the agent to determine who will provide the notice on behalf of the company. The initial notice required by the rules must be given as soon as a person becomes a customer. Some companies may require the agent to provide the initial notice. In that case, it will be the company's responsibility to provide the agent with the notice form to be used. However, after that, it is expected that most companies will probably maintain responsibility to provide follow up and annual notices required by the rule.

As stated previously, the privacy rules apply to agents. However, the rule provides that an independent agent sharing information with multiple insurance companies in order to obtain the best price quote for a client does not need to provide notices to the client. It is the responsibility of each insurance company to comply with the notice requirements as to that client. Note that under the rules, the client will be considered a consumer of each company to whom the client's information is provided, and if the client purchases coverage from one of the companies, the client becomes the customer of that company. However, if the agent discloses or plans to disclose that information to anyone other than the companies, the agent must send that client all required notices and provide the client with the opportunity to opt out.

Because each agency's operations are different, and because the law is designed to reflect all of the different types of information sharing in the marketplace, there is no one single privacy notice agencies can use to comply with the federal law. Each agency will need to develop its own internal privacy policy and consumer privacy notice.

Conflicts

While privacy rules are being refined, there are several issues that represent potential conflict for agents:

For example, the privacy rules under HIPAA state that items such as a person's name, address, social security number and payment history are protected "health information" subject to an ***opt-in standard***. Therefore, HIPAA would prohibit any sharing of this information with a third party unless an express release is signed by your client. Many states, however, would consider these same items as "financial information" subject to ***opt-out standards*** where the sharing of client information is allowed until he "opts-out".

Another potential conflict might arise where you might be trying to assist your client by communicating with a third party such as a pharmacy or some aspect of claims processing with an out-sourced company. Be very careful that you have disclosed your intentions to share personal financial and health data or obtained client authorization to do so.

Also be cognizant of privacy law language to avoid potential problems. For example, some rules indicate you should have client ***consent*** to share their nonpublic information; others require ***authorization***. There is a considerable difference!

Semantics become yet another potential conflict when you compare privacy rules that indicate that agents are exempt from disclosure when working on behalf of a compliant carrier; yet, DHHS regulations seem to say that the assessment of whether an entity is covered is more a function of use rather than definition. They exempt, for example, the sharing of client data for treatment, payment and health care operations. Nothing was said, however, about underwriting. Are you exempt?

These potential conflicts are ALL good reasons to develop and maintain a good privacy policy – just in case!

Developing a Privacy Policy

The most important step an insurance agent can take toward satisfying the GLBA privacy rules is to develop a ***detailed policy*** for handling ***nonpublic personal information***. In

developing a privacy policy, an agency should remember that the disclosure of the policy might be treated as a contract between the agency and its clients. In addition, an agency should consider taking the following steps when developing its privacy policy.

- The agent should consider including an alternative dispute resolution provision that could help to reduce the costs of defending against future challenges. He should also consider consolidating multiple privacy policies into a single disclosure form in order to avoid confusion and conflicting obligations.

- The insurance company should organize quality assurance programs to ensure that each customer is given the requisite notice and that all other elements of its policies are maintained and followed at all times. The privacy policy may create new liabilities for the company. The agent needs to be sure that his company's errors and omissions insurance is adequate to address these issues.

Marketing Personal Information

The goal of privacy regulations is to give consumers an affirmative opportunity upfront to decide whether they want their information shared or not for marketing purposes. The consumer is to be given the opportunity to opt-in or opt-out, because once their information is disclosed, it will be very difficult to re-protect the information. The purpose of these regulations is not to prohibit companies from offering products, or to prevent insurers or doctors from participating in disease management activities or from mailing appointment reminders or other information to consumers. They are not trying to keep consumers from getting helpful information.

Misrepresentation

While we are on the subject of rules, it is important to realize that representing yourself as someone or something ***other than who you are*** in order to obtain personal financial information can also be a violation of privacy laws. Consider, for example, the case of a marketing scheme known as a "living trust mill". Agents in California were involved in soliciting senior citizens at seminars, purportedly to design and educate about the benefits of a living trust. In other words, representatives misrepresented themselves as experts in estate planning. In fact, their true goal was to discover the extent of client assets in order to sell them annuities. The insurer and its agents were found guilty of deceptive training practices and violating provisions of the Insurance Information Privacy Act. Don't let this happen to you!

Agent Disclosures and Privacy Rules

Privacy Terms

To best understand client disclosure requirements, let's first define some terms that are part of the privacy regulations:

Affiliate: A company that controls, is controlled by or is under common control with another company. For instance, under the Gramm-Leach-Bliley Act, insurers and banks can become affiliates. Affiliates may also be parent companies owned by your agency or common companies under the same holding company structure.

Consumers: Individuals who are seeking to obtain a product or service from an insurance company through your agency are called ***consumers***. For example, an individual who has submitted an application for insurance is a consumer of the company to which he has applied. A prospect for your products and a beneficiary or claimant under an insurance policy are also considered to be a ***consumer***.

Customers: These are consumers with whom you and your insurer have an on-going relationship or those who obtain financial, investment or economic advisory services relating to an insurance product or service from you for a fee. People who buy policies and investments, from you are ***customers***.

Covered Entity: Financial privacy rules require that all "covered entities" issue or provide privacy disclosures. Covered entity includes any individual or entity that receives authorization from the Department of Insurance.

Insurers: This class includes insurance companies, financial institutions or other entities required to comply with the privacy regulation.

Licensees: These are individuals regulated by the Department of Insurance. All licensees are required to comply with privacy disclosures unless exempt.

Nonaffiliated third party: This is a company that is not affiliated with an insurer, agent or agency.

Nonpublic personal information: Nonpublic personal financial information is information that identifies an individual member. It may include an individual's name, address, telephone number and social security number, or it may relate to an individual's ownership of a policy, the provision of insurance services or the payment for insurance services. Nonpublic personal financial information does not include publicly available information, or statistical information that does not identify individual persons.

Opt-Out: The general rule is that information about a person will be shared unless the person notifies the holder of information that he wants his information protected. To "opt-out" is to put an agent or company on notice that a customer prohibits his personal financial information from being shared with non-affiliated third parties.

Opt-In: Under an "opt-in" standard, the general rule is that protected information is not shared unless the person who is the subject of the information signs an authorization or consent that expressly permits the sharing of his protected information with a third party.

Privacy Policy Statement: A disclosure form handed to clients or posted on a website that describes an agent's intention to share or not to share any nonpublic information about his clients with a non-affiliated third party. Statements may describe the personal information typically collected in the process of providing insurance, a list of non-affiliated parties who may share nonpublic information, a notification right for the client to "opt-out" (an instruction the agent not to share this information), normal practices concerning confidentiality and security for any nonpublic information collected, policy concerning dispute resolution, the right to sell information when the agent's business is sold or transferred, the right to change the stated privacy policy and a place for clients to acknowledge the privacy policy disclosure.

General Client Privacy Rules

For Consumers: Licensees may ***not*** disclose any nonpublic personal information about a consumer to a nonaffiliated third party unless permission is granted by the consumer.

Licensees must provide consumers a privacy policy and an opt-out notice along with a reasonable time to opt-out prior to the sharing of information.

Licensees may not disclose any nonpublic personal financial or health information about a consumer to a nonaffiliated third party, unless:

- The consumer received a notice prior to the disclosure
- The consumer received an explanation of the opt-out procedure
- The consumer had a reasonable opportunity to opt-out prior to disclosure and
- The consume did not opt-out

The GLBA notice obligation ***requires*** all insurers and financial institutions (including insurance agents) to provide an ***understandable notice*** of their privacy practices to their customers when a customer relationship is established and at least once a year thereafter. This obligation does not require agencies to adopt specific information handling practices. It only requires that they disclose the practices in which they engage. In other words, most agents can satisfy client privacy requirements by issuing or posting a simple disclosure form (two samples are provided below).

For Customers: A customer must be given an annual notice of the licensee's privacy policies and practices until such time as the customer relationship terminates.

A licensee may not disclose any nonpublic personal information about a customer to a nonaffiliated third party unless a notice is provided.

A privacy notice must contain a description of privacy policies ad practices, an opt-out notice, and a reasonable time to opt-out prior to the disclosure of information.

Licensees may not disclose any nonpublic personal financial or health information about a customer to a nonaffiliated third party, unless:

- The customer received a notice prior to the disclosure
- The customer received an explanation of the opt-out procedure
- The customer had a reasonable opportunity to opt-out prior to disclosure an
- The customer did not opt-out

Exemptions: In general, most federal and state privacy regulations apply to agents. However, an agent does not have to comply with special disclosures and opt-out requirements if:

- The agent is appointed with a company or designated with an agency (principal) that complies with, and provides all of the notices required by the regulations, and

- The agent does not disclose protected, personal financial information to any person othr than the principal or its affiliates.

In other words, if an agent wishes to disclose a consumer or customer's protected information to an entity other than the insurance company with which the agent is appointed, or the agency with which the agent is designated, the agent must give the consumer a copy of the agent's privacy notice and an opportunity to prohibit the disclosure of that information to non-affiliated parties.

In theory, this would seem to exempt most agents from the disclosure requirements. However, the question remains, are the principals (your insurer or agency) making the required disclosures in the necessary format? Can you rely on them to make them annually where needed? Any doubts? Use your own disclosure.

Required Recipients

Unless the underwriter or insurance agency qualifies for the special agent exception, they must provide a privacy notice to any individual who purchases a financial product or service through that agency that is to be used primarily for personal family or household. ***All customers*** are entitled to receive a GLBA privacy notice at the beginning of the customer relationship.

A privacy notice must also be provided to all ***consumers*** if the agency is going to share their information with a non-affiliated organization. If the agency is not going to share the information of its consumers with a non-affiliated organization, it does not owe the consumer a privacy notice.

Required Disclosure Information

In most instances, federal and state privacy regulations do not make ***specific*** requirements about the type of privacy policy that an insurance agency must use. It only tells them what facts it must disclose. To be effective, however, disclosure must be clear about it's intent. It must be understandable and designed in a manner that calls attention to it. A disclosure will be easy to find, read, and understand if it uses short and clear explanatory sentences or bullet lists in simple language.

Here is a short list of features you might include in your privacy notices:

- Categories of nonpublic personal financial information collected.
- Categories of nonpublic personal financial information collected.
- Categories of affiliates and nonaffiliated third parties to who information is disclosed, except as part of an insurance transaction.
- Categories of nonpublic personal financial information about former customers disclosed and to whom disclosed.
- Categories of information disclosed and to whom disclosed as a result of contractual relationships or servicing or joint marketing.
- Explanation of consumers' right to opt-out of disclosure of his nonpublic personal financial information to nonaffiliated third parties and the methods to utilize to opt-out.
- Policies and practices for protecting the confidentiality and security of nonpublic personal financial information.

- If making disclosures (information about customers) as part of insurance transaction, that the licensee makes disclosures to other affiliated or nonaffiliated third parties, as permitted by law.

The disclosure ***must include*** the types of nonpublic personal information that the agency collects. This would describe the nature of the information collected and the way in which it is collected. The disclosure must also mention the types of nonpublic information that may be disclosed and the categories of affiliates and non-affiliated third parties to whom the disclosures may be made.

The agency ***must describe*** in the disclosure its policies and practices in sharing nonpublic personal information about former customers and consumers. If these policies and practices are the same for both groups, the same clauses may be used for both.

The notice ***must list*** the categories of nonpublic personal information disclosed according to agreements with third party service providers and joint marketers, and the categories of third parties providing the services. The notice must disclose the consumer's right to opt out of the disclosure of nonpublic personal information to non-affiliated third parties.

The notice ***must include*** any disclosures regarding affiliate information that the agency is providing. The notice must disclose the agency's policies and practices in protecting the confidentiality, integrity and quality of the nonpublic personal information it collects.

Required Distribution

Preferably, the insurance agency should ***disclose*** its privacy policy ***when a customer relationship is established and once a year thereafter***. There are different ways of providing the initial notice to customers.

The agency may choose to provide their own notice. They may provide a joint notice to the customer that represents both the carrier and the insurance agency. They may give the carrier's notice to the individual.

Regardless of which option the agency chooses, the initial notice can be provided when a purchased policy is delivered or when an agreement to provide other insurance services is completed. The notice itself can be given along with other materials that an agency delivers to the customer such as with a bill for premiums.

The ***annual notice*** may be delivered in the same way. GLBA does not require the insurance agency to provide the annual privacy notice to a former customer. Agencies that provide title insurance or other real estate settlement services in which the contact with the insured is limited to the time when the policy is sold are not required to deliver the annual privacy notice.

Agencies who sell group insurance policies are required to deliver a privacy notice to the plan sponsor. They do not need to deliver a notice to plan participants as long as they do not disclose the participants' personal information to non-affiliated organizations.

Financial Privacy Questions and Answers

The following are general questions and answers concerning privacy notices. Please bear in mind that your individual state may have their own specifications that may meet or exceed these requirements. Also, do not act on these answers in personal or client matters unless you first check with a competent professional and/or company superior.

Do agents need privacy policies?

Yes. Agents are financial institutions and should have privacy policies in compliance with GLBA. However, keep in mind that an agent is exempt from the notice and opt out provisions if the conditions set forth in the definition of "licensee" are satisfied.

I'm a paid representative of one insurance company and I only represent that company and its line of insurance and financial services products. What are my responsibilities under this new privacy rule?

You are subject to the regulation, but you are not required to comply with the notice and out-out requirements of the regulation if:

- The company with which you are appointed complies with the regulation; and
- You do not disclose protected information to any person other than that company or its affiliates.

I'm an independent agent and therefore represent a variety of insurance companies. What are my responsibilities under the privacy rule?

Just like other agents, you are subject to the regulation, but you are not required to comply with the notice and out-out requirements of the regulation if:

- The company or companies for which you are appointed or the agency with whci you are designated, with respect to a particular consumer or customer complies with the regulation; and
- You do not disclose protected information to any person other than that company or companies, agency or affiliates of that company or agency.

I'm an independent agent and need to share consumer information with many insurers in order to get the best prices for my clients. Is this permissible under the privacy regulations?

Yes, an agent may share nonpublic personal financial information with multiple companies in an effort to compare prices at the consumer's request. In such situations, the individual will be a consumer of each of the companies and will be entitled to privacy and opt-out notices from any of the companies that wishes to share the individual's protected financial information with non-affiliated third parties.

What about disclosing personal health information?

NO. The notice provisions of the privacy regulation do not cover health information, In most states, an agent may not disclose the nonpublic personal health information of a consumer or

customer to an affiliate or non-affiliated third party unless an authorization is given from the individual whose information is sought to be disclosed. An authorization to disclose nonpublic health information must include:

- The identity of the consumer or customer.
- A description of the type of information to be disclosed.
- General descriptions of parties receiving the information.
- The consumer's or customer's signature.
- The length of time the authorization is valid and the procedure for revoking the authorization.

Do I have to go back to every one of my existing clients and tell them about this new privacy rule?

Maybe. You're required to provide privacy and opt-out notices to a client if the client is considered your "customer". However, if you are appointed with a company or designated with an agency that is meeting the privacy regulation and you do not disclose protected information, you are probably exempt.

Every company is different. Of the companies I represent, how am I supposed to know which ones send out notices?

Like all aspects of the agent-agency or agent-company relationship, effective compliance with privacy regulations will require on-going communication and coordination between the parties.

What if one or more of my clients didn't receive a notice from a company? Who is responsible?

In general, a failure to provide a required notice is a violation of agency rules subject to enforcement by the Department of Insurance. In addition, enforcement action for unfair trade practice can also be taken. An individual whose information has been share in violation of the rules may also bring civil action against a covered entity regardless of any action taken by the State. Specific compliance violations will most likely be decided on a case-by-case basis.

The bottom line? It is the responsibility of YOU, the agent, to determine whether the company's or agency's notice is sufficient to exempt you from providing your own notification. If, on the other hand, your standard procedure is to provide a privacy notice to every client, you would have a good argument that you are NOT responsible for the company's omission.

I am an agent who NEVER intends to disclose or share my client's personal financial information with anybody except my own company? Do I still need a privacy notice?

As long as your company provides responsible and proper notices, you are probably exempt. However, why not provide a simplified notice that spells out the types of personal financial information you collect in the process of selling insurance, your policies and practices with respect to protecting the confidentiality of nonpublic personal information and a statement that the disclosures made to affiliated or non-affiliated parties are permitted by law. In any

case, you can promote customer goodwill by doing so. And, if all or most of your competitors provide privacy notices and you don't, will your clients begin to wonder why?

What about phone-in requests for information on insurance products. Do we have to tell these callers the privacy policy of each of the company?

Not normally. If these individuals are simply requesting information and not purchasing a product, they are likely to be considered consumers. However, at the point where you collect nonpublic personal financial information and you are going to share it with a non-affiliated third party, you will be required to provide a privacy and opt-out notice. If you do not intend to share the protected information, it is not necessary

When the individual actually purchases a product from you over the telephone, he is considered a customer. Normally, customers are entitled to privacy and opt-out notices at the time the customer relationship is established. With a telephone transaction, however, delivery of notices can be delayed with customer consent.

The same obligations would apply to the companies fr which you are appoint as an agent.

I'm an independent agent and I perform servicing and processing functions for several insurers. Does the exchange of private information require notification?

No. An insurer can share nonpublic financial information with agents acting as service providers or third parties that perform services for the company or functions on the company's behalf. The only requirements are that the company must provide an initial notice to the individual, and, where third parties are involved, must enter into a written agreement prohibiting the third party from using the information other than to carry out the purpose for which it was intended. Of course, reuse and redisclosure provisions apply to the company.

Is the agent an affiliate of the company for which it is acting as agent?

No.

Can an insurance company share information for marketing purposes with its agent?

Yes, a company can share information for marketing purposes about a particular individual for whom the agent is acting as agent. In this situation, the agent would not be the company's service provider and would not have to enter into a confidentiality agreement.

Can an agent share information for marketing purposes with a company for which it is acting as agent?

Not unless such information sharing has been disclosed to the consumer through either the company's or the agent's privacy notice.

If an agent discloses information to a non-affiliated third party, does he have notice and opt out obligations to the consumer/ customer? In other words, by such disclosure does the agent lose the exemption gained under the "licensee" definition?

No, if the disclosure is within the scope of its agency relationship with the principal and the agent complies with the privacy notice provided by the principal to the consumer. However, the agent loses the exemption if the disclosure is made for the agent's own purposes.

How long does a customer's request to "opt-out" last?

An opt-out is effective until the customer r consumer revokes it in writing.

Are brokers subject to the agent exemption definition of "licensee"?

In many states, brokers are considered "producers" and treated like agents for purposes of the privacy regulation. In most cases, an insurance broker or who can demonstrate that they were a representative of the principal would be subject to the agent exemption.

Are independent adjusters treated like agents?

Yes.

Does agent exemption apply when business is through a clustered arrangement or broker?

Yes.

Does agent exemption apply when agency assets are sold, but not the business?

Yes.

Can an agent share with its affiliates or just the principal's affiliates? Does it matter if the agent's affiliate is a bank?

Agents who are taking advantage of the exemption in the "licensee" definition may disclose nonpublic personal financial information only to the principal and the principal's affiliates. If the agent chooses to disclose to its affiliates, the agent is subject to the notice provisions of the regulation.

What does a privacy notice look like?

We have provided two samples below for your review and inspection by a competent professional. In a nutshell, the notice must be clearly written and conspicuous ad contain information about the types of information you collect, how it is normally protected, what might be disclosed to a third party and who they are and an opportunity to opt-out of any sharing.

Where can privacy notice be disclosed (application, prospectus, newsletter, renewal notices, direct mail, with opt out notice)?

Generally, this issue must be decided on a case by case basis. If a licensee is unsure as to whether its manner of distribution for privacy notices is acceptable, the licensee should discuss with the regulator. If the licensee operates in several states, the licensee should discuss with the regulator of each of these states. Keep in mind that the model privacy

regulation provides that a privacy notice can be disclosed in a prospectus or newsletter or sent with a renewal notice, direct mail campaign or opt out notice.

Can I send privacy notices, opt-out notices and health information authorizations together in the same mailing? Can they be sent with other customer mailings?

Privacy, opt-out and health authorizations notices can be sent together or separately, and they can be sent with other customer mailings. In addition, affiliated companies may send notices together, or they can send combined notices. No matter how they are sent, however, all notices must identify the companies and policies to which they apply. They must be accurate, and they must be clear and conspicuous so that the customer can read and understand them.

If my customer is conducting some personal business, say at his attorney's office, and calls my office to fax over a copy of his policy to the attorney, would this be an exception under the privacy rules?

Yes, a notice and opportunity to opt-out of the sharing of consumer's information would not be necessary, as the agent is sharing the information at the consumer's request. However, it might be a good idea to note the client's file about the request.

If a customer's policy is subject to renewal, can I request quotes from various insurance companies in an effort to shop the coverage without providing notice to the customer and an opportunity to opt-out?

Yes, if the customer has requested the shopping of his insurance coverage. If the customer has not requested renewal quotes, his information cannot be shared with companies unless a privacy notice and opt0out has been provided.

What if I'm asked to share a client's personal financial information with the Department of Insurance?

It's ok. Sharing information with regulatory authorities has jurisdiction over company or agent disclosures.

Can licensees require consumers/customers to disclose social security numbers in order to opt out (or opt in)?

Requiring a consumer's social security number in order for that consumer to exercise the consumer's opt out right is inconsistent with the language and the intent of the model regulation. Although an opt out notice can include a request for a social security number, compliance with such request must be optional on the part of the consumer. In addition, the fact that it is optional must be disclosed to the consumer, and an opt out notice without a social security number must be treated as a valid exercise of the consumer's opt out right. If a voicemail system or other automated response system is used for exercising the opt out, it must be accessible without the consumer/customer having to provide a social security number.

Who gets the notice when the policyholder of an individual life policy is different from the insured?

The policyholder is a "customer" of the licensee as that term is defined in the model regulation and is therefore entitled to receive initial and annual notices. An insured is a "consumer" of the licensee if the licensee discloses nonpublic personal financial information about the insured to a nonaffiliated third party. An insured that is a consumer is entitled to initial notice and the opportunity to opt out.

How does the new regulation impact the disclosure of information about beneficiaries?

A beneficiary of a life insurance policy is considered a consumer under the regulation if you disclose or share any protected information. As a consumer, the beneficiary is entitled to a privacy notice and opportunity to opt-out of the disclosure. If you do not share nonpublic personal information about beneficiaries with non-affiliated third parties you have no obligation to notice them.

Does access to third party claimant information give rise to privacy obligations for agents?

A claimant under any insurance policy is considered a consumer under the regulation if you disclose or share any protected information. As a consumer, the beneficiary is entitled to a privacy notice and opportunity to opt-out of the disclosure. If you do not share nonpublic personal information about claimants with non-affiliated third parties you have no obligation to notice them.

Insurers may give agents access to records that contain third party claim information for the agent's client. Access to such information does not give rise to any privacy obligations beyond the general obligation to protect the confidentiality and security of personal information. However, such information could not be disclosed to non-affiliated third parties outside the exceptions without giving notice and opportunity to opt out.

My appointed company provides on-going settlement option for beneficiaries and claimants. Is that person a consumer or customer?

Beneficiaries and claimants that submit a claim under a policy choosing a settlement option involving an on-going relationship with an insurer are considered consumers not customers. Thus, the company and agent will be required to provide the individuals with privacy notices and an opportunity to opt out.

Are HMOs required to send initial notice/opt out to subscribers and dependents?

For individual coverage, yes. The definition of "licensee" encompasses HMOs even in states that do not regulate HMOs as insurers. Group HMO coverage, however, is regulated like any other group plan, if an HMO sends initial and annual notices to the group policyholder and does not share any nonpublic personal financial information outside the exceptions to the rule, then the HMO has no notice/opt out obligations.

Do notice and opt out provisions apply to single premium policies and paid-up policies?

The privacy notice and the opt out notice do not have to be provided to paid-up policies or single premium policies if there has been no contact with the policyholder within the last

twelve months prior to July 1, 2001. These policies are typically considered "dormant." Similarly, if the policy becomes paid-up or a consumer purchases a single premium policy after July 1, 2001, notice must be provided until there is no longer contact outside of providing a privacy notice or opt out notice with the policyholder for twelve months.

I am a licensed insurance agent and I sell variable annuities. Am I required to comply with the privacy rule?

You are subject to the regulation, but you are not required to comply with the notice and out-out requirements of the regulation if:

- The company with which you are appointed complies with the regulation; and
- You do not disclose protected information to any person other than that company or its affiliates.

Are health insurers required to comply with GLBA and the financial provisions of the model regulation (notice and opt out) if they only have identifying information (name/ address/ social security number) that, by itself is not financial or health information?

Health insurers would be hard pressed to prove that they do not possess nonpublic personal financial information. For example, unlisted telephone numbers and social security numbers are nonpublic personal financial information. This information cannot be disclosed outside the exceptions unless the consumer has been given notice and the opportunity to opt out.

Are large employer groups (50+ plans under ERISA) required to send notice and opt out to consumers/customers? In other words, is an insurer that provides coverage to the ERISA group required to comply with the privacy rule with respect to information gathered from the large group?

Yes, to the same extent as any other group holder. The privacy regulation is not preempted by ERISA.

Could there ever be a situation in which a group plan shares information outside the exceptions (thus giving rise to notice and opt out requirements), but the group plan does not have enough information about the individual to contact him? Could this scenario arise with claimants/beneficiaries?

This is an unlikely scenario, but if such a situation were to exist, the group holder must take reasonable measures to obtain enough information to contact the individual.

Is a privacy notice permitted under section to the workers' compensation policyholder?

The workers' compensation plan participant is the workers' compensation policyholder. Notices may be sent to such policyholders.

How do I determine if the privacy notice regulations apply to a particular professional or institution?

Ask the following three questions: (i) is the professional or institution a licensee? (ii) is the licensee providing an insurance product or service? (iii) is the licensee providing the

insurance product or service to a consumer? If the answer to these questions is "yes," the regulation clearly applies.

It may be difficult to determine if the individual is a "consumer" of the licensee. In such situations, if the licensee is acting as the individual's insurer and holds nonpublic personal information about the individual, the licensee is required to comply with the regulation.

All commercial lines are subject to the regulation for individual non-commercial claimants. Specific examples include: TPAs (licensed; unlicensed; TPAs for self-insured plans); MGAs; Charitable annuity societies/donor annuity organizations; Service contract providers; Prepaid health services plans; Premium finance companies (if policy placed for personal use); Independent adjusters of worker's compensation claims; Financial guaranty insurance; Title insurance; Surety bonds (if bond placed for personal uses).

Interestingly, viatical settlements, key man insurance and business auto policies are excluded. As are personal umbrella policies, professional liability coverages and most they are commercial lines that are not used for personal, family or household purposes.

In essence, if nonpublic personal information is collected in the underwriting of such policies, such information is not protected under the regulation.

A TPA that is not required to be licensed is providing services to a partially self-funded group with stop-loss reinsurance from an insurer who says the stop-loss contract is not a group plan. Is the broker/agent on the stop-loss required to send notice to the plan/group sponsor or employer? What if agent/broker has no protected information?

If the stop-loss insurer or producer holds nonpublic personal information about covered employees, the stop-loss insurer is "acting as an insurer" for the employer, and must treat the employer like any other group policyholder under the regulation: if the stop-loss insurer sends initial and annual notices to the group policyholder and does not share any nonpublic personal financial information outside the exceptions to the rule, then the insurer has no notice/opt out obligations. The stop-loss producer might be able to rely on the agent exemption if it meets all the requirements. In this scenario, the TPA is not required to be licensed and therefore is not subject to the regulation.

A trust hires a broker to find group health coverage for employees. The broker goes to an independent agent to find coverage. Is the independent agent a "service provider"?

No.

In cases involving a sub-producer, general agent and an insurer in the placement of a risk, must all provide the privacy notices?

The agent exception in the "licensee" definition applies in this situation in cases in which a policy is run from the sub-producer through the general agent to the insurer.

Under what circumstances is a licensee considered to be working as an agent/employee/other representative of another licensee and can therefore rely on the

principal licensee's notices to customers and consumers instead of issuing his/her own notices?

Determining whether an agent/employee/other representative of a licensee can rely on the exception in the "licensee" definition depends on what that agent/employee/other representative is doing for the licensee. It is a factual determination requiring analysis on a case-by-case basis.

If a licensee is considered to be an employee, agent or representative of another licensee for compliance purposes, is the licensee then able to operate under the disclosure exceptions of the regulation?

Yes, an agent/employee/other representative can operate under both the "licensee" exemption and the exception. Under the standard interpretation of the agent/principal relationship, agent can act on behalf of the principal, with the same powers, and the same limitations on powers, as the principal. If the agent discloses nonpublic personal information outside those limits, the agent must comply with the notice and opt out requirements of the regulation.

Can licensee share health information with its affiliate if both licensee and affiliate are working on same claim?

Yes, to the same extent as any other party providing claims services.

In one state, insurers are refusing to give hospitals claim information claiming that disclosure is prohibited under GLBA and state privacy rules. True?

It depends on the reasons the hospitals are requesting claim information. When in doubt, get authorization.

Once a licensee is in compliance with the HHS privacy regulation (and is then deemed "in compliance"), does the state or HHS enforce? Who enforces against a licensee that is not subject to the HHS regulation but chooses to comply with that regulation rather than the model regulation?

Because the HHS privacy rule is incorporated by reference into the regulation, the state and HHS have concurrent jurisdiction when the licensee is subject to the HHS regulation. The state has exclusive jurisdiction if the licensee is not subject to the HHS regulation and is complying with HHS standards for the purpose of satisfying its obligations under the regulation.

Does the regulation permit disclosure of account numbers used among companies in affinity plans?

Yes.

May companies share nonpublic personal financial information for policyholder service functions or for purposes of risk management and loss control (e.g., loss runs) under the business purpose exceptions?

The phrase “policyholder service functions” is too general to determine whether or not a specific function falls under the initial notice and opt out exceptions. More information is needed to make that determination.

Risk management and loss control would both fall under general servicing and processing exceptions

What our my obligations if I receive nonpublic personal information from another entity?

Your use and disclosure of that information is limited to the original financial institution who gave it to you; affiliates; or to any other excepted entity.

I receive information from banks and securities firms that are themselves subject to privacy regulations. What rules do I follow?

Most institutions must abide by reuse and re-disclosure of protected client information. Generally, these rules permit you only to share nonpublic information with the original financial institution you received it from.

Can my company charge lower rates to policyholders that permit their information to be shared?

No. Premium rates cannot be based on an individual’s choice to prohibit or allow the sharing of his information. However, this does not prevent a company from offering discounts for other reasons. What reasons? Well, we all know that insurers cannot discriminate against a consumer for prohibiting the disclosure of their personal information by raising rates or dropping coverage. However, the same insurer does not have to offer them the special offers that might be available to customers who permit their personal information to be disclosed.

Sample Privacy Disclosures

To aid agents understand features and wording of required privacy disclosures, we are providing an actual sample on the next page.

IMPORTANT: Prior using any information or disclosure form, consult with a competent attorney or professional before using these forms in personal or client matters.

Sample Disclosure #1

Purpose of This Notice

As provided by law, we are generally prohibited from sharing nonpublic personal information about you with a third party unless we provide you with this notice of our privacy policies and practices describing the type of information that we collect about you and the categories of persons or entities to whom that information may be disclosed. Accordingly, we are providing you with this document, which notifies you of the privacy policies and practices of (agency).

Furthermore, we wish to inform you that we do not share your personal information with any non-affiliated third parties for any purpose that is not specifically authorized by law unless we obtain your affirmative permission.

Privacy Policies and Practices

Information we collect:

We collect non-public personal information about you from the following sources:

- *Information we receive from you on applications for insurance or from other insurance forms you complete.*
- *Information we receive from the companies we represent which provide insurance policies to you.*
- *Information from consumer reporting agencies.*
- *Information about your transactions with us, the companies we represent.*
- *Information from other sources, such as employers or government agencies.*
- *Information from visits to our Website.*

The type of information we collect is related to the insurance you requested from us and may include your name, address, social security number, driver's license number, ownership of property, marital status, health information, and other information required to get insurance coverage for you.

Unless it is specifically stated otherwise in an amended Privacy Policy Notice, no additional information will be collected about you. We may collect nonpublic personal information from individuals other than those proposed for coverage.

Information From Credit Reports or Investigative Consumer Reports:

If you authorize us to do so, we may obtain information about you from credit reports or other investigative consumer reports prepared by third parties at our request. If you authorize us to request such information and we request such information, you should be aware that:

- *You have the right to request to be interviewed in connection with the preparation of an investigative consumer report.*
- *Upon request, you are entitled to receive a copy of the consumer reports.*
- *The information obtained from the reports prepared by a third party may be retained by the third party and disclosed to other persons.*

Information we may disclose to third parties:

In the course of our general business practices, we may disclose the information that we collect (as described above) about you or others without your permission to the following types of institutions for the reasons described:

- *To a third party if the disclosure will enable that party to perform a business, professional or insurance function for us.*
- *To an insurance institution, agent, or credit reporting agency in order to detect or prevent criminal activity, fraud or misrepresentation in connection with an insurance transaction.*
- *To an insurance institution, agent, or credit reporting agency for either this agency or the entity to whom we disclose the information to perform a function in connection with an insurance transaction involving you.*
- *To a medical care institution or medical professional in order to verify coverage or benefits, inform you of a medical problem of which you may not be aware, or conduct an audit that would enable us to verify treatment.*
- *To an insurance regulatory authority, law enforcement, or other governmental authority in order to protect our interests in preventing or prosecuting fraud, or if we believe that you have conducted illegal activities.*
- *To a group policyholder for the purpose of reporting claims experience or conducting an audit of our operations or services.*
- *To an actuarial or research organization for the purpose of conducting actuarial or research studies.*
- I*n addition to those circumstances listed above, and unless you direct us not to by completing the attached Opt Out Form, we may disclose certain information about you to third parties whose only use of the information will be for the purpose of marketing a product or service. Under no circumstances will we disclose for marketing purposes: any medical information, information relating to a claim for a benefit or a civil or criminal proceeding involving you, personal information relating to your character, personal habits, mode of living or general reputation*

Right to access and amend your personal information:

You have the right to request access to the personal information that we record about you. Your right includes the right to know the source of the information and the identity of the persons, institutions or types of institutions to whom we have disclosed such information within two (2) years prior to your request. Your right includes the right to view such information and copy it in person, or request that a copy of it be sent to you by mail (for

which we may charge you a reasonable fee to cover our costs). Your right also includes the right to request corrections, amendments or deletions of any information in our possession. The procedures that you must follow to request access to or an amendment of your information are as follows:

To obtain access to your information: You should submit a request in writing to the (insurance agency). The request should include your name, address, social security number, telephone number, and the recorded information to which you would like access. The request should state whether you would like access in person or a copy of the information sent to you by mail. Upon receipt of your request, we will contact you within thirty business days to arrange providing you with access in person or the copies that you have requested.

To correct, amend, or delete any of your information: You should submit a request in writing to (the insurance agency). The request should include your name, address, social security number, telephone number, the specific information in dispute, and the identity of the document or record that contains the disputed information. Upon receipt of your request, we will contact you within thirty business days to notify you either that we have made the correction, amendment or deletion, or that we refuse to do so and the reasons for the refusal, which you will have an opportunity to challenge

Our practices regarding information confidentiality and security:

We restrict access to nonpublic personal information about you to those employees who need to know that information in order to provide products or services to you. We maintain physical, electronic, and organizational safeguards to protect information about you.

Sample Privacy Disclosure #2

Dear Clients:

As a current customer of our agency, we take this opportunity to both thank you and share with you the importance in which we hold the privacy and confidentiality of your insurance and personal information. XXX Agency, as a member of the financial services industry, has been and continues to be subject to federal and state privacy laws regarding the collection and exchange of your insurance information.

Working with you, XXX Agency gathers the necessary information from you and other public and insurance sources to execute the insurance market search and placement for the insurance coverages your needs/risk exposures require. We collect nonpublic personal information about you from the following sources:

- *Information we receive from you on applications or other forms;*
- *Information about your transactions with us, our affiliates or others; and*
- *Information we receive from a consumer reporting agency.*

In doing so, XXX Agency exchanges such information only with other insurance related parties that are similarly obligated under state and federal privacy laws and have in place the appropriate procedures to keep all treatments and exchanges of your information with in the requirements of these laws.

We may disclose the following kinds of nonpublic personal information about you:

- *Information we receive from you on applications or other forms, such as your name, address, social security number, assets, income, and beneficiary information;*
- *Information about your transactions with us, our affiliates or others, such as your policy coverage, premiums, and payment history; and*
- *Information we receive from a consumer reporting agency, such as your creditworthiness and credit history.*

OR

We may disclose all of the information we collect, as described above. And as we place your insurance with these carriers, both our agency and the carriers work together (as well as individually) to retain uses for only those activities required to underwrite, issue and services your policy of insurance, as well as conduct claims activities - should that be necessary on your behalf. We restrict access to nonpublic personal information about you to those employees who need to know that information to provide products or services to you. We maintain physical, electronic, and procedural safeguards that comply with federal regulations to guard your nonpublic personal information.

As the scope of our agency business and your needs expand, XXX Agency is proud to advise you that we are formally engaged in joint marketing ventures with additional financial service providers. The businesses listed here are tops in their field of expertise and round out the scope of product and services we can offer to you. This permits us to better respond to the multi-financial services needs that you shared with us. We may disclose nonpublic personal information about you to the following types of third parties:

- *Financial service providers, such as life insurers, automobile insurers, mortgage bankers, securities broker-dealers, and insurance agents;*
- *Non-financial companies, such as retailers, direct marketers, airlines, and publishers; and*
- *Others, such as non-profit organizations.*

We may also disclose nonpublic personal information about you to nonaffiliated third parties as permitted by law.

We may disclose the following information to companies that perform marketing services on our behalf or to other financial institutions with which we have joint marketing agreements:

- *Information we receive from you on applications or other forms, such as your name, address, social security number, assets, income, and beneficiary information;*
- *Information about your transactions with us, our affiliates or others, such as your policy coverage, premium, and payment history; and*
- *Information we receive from a consumer reporting agency, such as your creditworthiness and credit history.*

OR

We may disclose all of the information we collect, as described above to companies that perform marketing services on our behalf or to other financial institutions with whom we have joint marketing agreements.

All of these professional financial services operations are subject to state and federal privacy laws and are bound by their agreement with us to also comply with the insurance requirements in this area as well. Should you purchase their product or service, a copy of their privacy practices will be sent to you.

If you prefer that we not disclose nonpublic personal information about you to nonaffiliated third parties, you may opt out of those disclosures, that is, you may direct us not to make those disclosures (other than disclosures permitted by law). ***If you wish to opt out of disclosures to nonaffiliated third parties, you may call the following toll-free number: (insert number).***

We know that you have other choices when it comes to insurance and financial services. That is why we at XXX Agency appreciate your decision to place your financial service needs with us. We value you and your business, and look forward to a continuing client relationship with you. XXX Agency wants to earn your partnership to explore your financial service needs, determine the various placement options that may respond to these needs and over time build the type of financial service portfolio you need to secure your family needs and assets.

Should you have any questions, please do not hesitate to call me.

Sincerely,
Agency-Owner Principal

CHAPTER FIVE

Loss Control Practices

The total impact of the events leading to 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.

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

Risk Management

Risk management occupies an important place in the broad definition of loss control conduct--that devoted to ***minimizing the adverse effects of accidental loss*** on the organization. Given this focus on accidental losses, risk management--as a managerial or administrative process--may be defined as a process that includes the four functions of planning, organizing, leading, and controlling the activities of an organization in order to minimize the adverse effects of accidental losses on the organization at reasonable cost. This definition stresses the managerial aspects of risk management in carrying out decisions with respect to potential accidental losses.

Risk management also may be defined in terms of making these decisions. As a decision-making process, risk management is a sequence of five steps:

- ***Identifying exposures to a loss that may interfere with a person's / organization's basic objectives***
- ***Examining alternative risk management techniques for dealing with these exposures***
- ***Selecting the apparently best risk management technique's***
- ***Implementing the chosen risk management technique(s)***

- ***Monitoring the results of the chosen technique(s) to ensure that the risk management program remains effective***

Risk management focuses on unplanned or accidental losses, not all losses. However, risk management professionals hold a range of viewpoints on the proper scope of the term "accidental" and, therefore, on the scope of the risk management function. In the narrowest, most traditional view, the term "accidental" limits the scope of risk management concerns to situations involving only pure risks.

Pure risk situations offer only two possible outcomes: ***loss*** *or* ***no loss***. The ***best*** an individual or organization can hope for when dealing with a pure risk is to maintain one's present position in confronting such perils as fire, machinery breakdown, illness, or being named a defendant in a lawsuit. This view excludes from the scope of risk management all exposures to loss from so-called ***business risks*** or ***speculative risks***. Such exposures arise from uncertain situations in which three types of outcomes are possible: 1) gain, 2) loss, or 3) no gain or loss.

Individuals and organizations often undertake business or speculative risks willingly in the hope of gaining from their ventures. Marketing a new or redesigned product, lowering prices to attract new customers, or buying or selling a corporate bond are management decisions that individuals or organizations make in search or gain. In the traditional view, the risk management professional's responsibility is to control financial recovery from these pure risks, not to help achieve any gains from taking speculative risks.

In the broad view of risk management, fires, injuries, earthquakes, liability claims, and other sudden, destructive events are classified as ***casualty risks***. The categories of loss exposures within this broader interpretation of ***accidental loss*** include those arising from end-of life risks, health risks, liquidity risks, market risks, political risks, and technological risks.

Both safety management and insurance concentrate solely on pure risk situations that offer no opportunities for profit or other gain. Those who would eliminate all distinctions between pure and speculative risks assert that a risk management professional's fundamental concern should be an organization's or person's overall capacity to cope with losses, regardless of whether those losses stem from such casualties as unplanned life events, fires and lawsuits or from poor business decisions in managing speculative risks. Comprehensive risk management should pay equal attention to managing all types of loss exposures.

Isolated from one another, exposures to neither pure nor speculative risks can be managed properly. Making sound decisions about exposures to pure risks requires knowing an individual's or organization's activities and dealing with those potential accidental losses in ways that enhance the overall operating efficiency of the organization. While risk management focuses primarily on those loss exposures arising out of pure risks of accidental loss as a consequence, risk management enables an individual or organization to meet its business or other goals in ways that enhance operating efficiency or satisfy a personal comfort level.

Identifying Loss Exposures

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 organization faces at a particular time.
- Test the significance of these actual loss exposures by the degree to which they may interfere with the achievement of the organization's basic objectives.

A loss exposure is a possibility of loss, or more specifically, the possibility of financial loss that a particular entity (organization or individual) faces as the result of a particular peril or risk striking. Every loss exposure has ***three dimensions***:

- The type of value exposed to loss
- The peril causing loss
- The extent of the potential

Loss exposures are typically categorized in terms of their first dimension -- the nature of the value exposed to loss. All financial losses that are the concern of risk management, excluding losses of purely sentimental value, can be categorized as *property losses, net income loss, liability losses, or personnel losses.*

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

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

Liability loss exposure is a factor here because some of the patients felt that the hospital had not taken appropriate precautions to protect its patients against foreseeable hazards from the nearby railroad tracks. Employees or a head of household 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 hospital executive or technician may have been sickened by toxic fumes and unable to come to work for the two weeks required to clean the parking lot. Then each of these two organizations would have suffered a personnel loss.

Loss histories are a record of past losses for an important indicator of accidental losses that may strike an organization or family. Prior accidents and lawsuits may well repeat themselves unless the organization's operations or a family's lifestyles have changed in some fundamental way. 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 a business loss exposure. These financial statements must include balance sheets, profit and loss statements, and funds flow

statements for a series of years. Profit and loss statements are often called income statements, and funds flow statements may be labeled sources and uses of funds.

Any document that tells something about an organization's operations, such as contracts, correspondence, minutes of meetings, and internal memoranda, also tell something about the organization's loss exposures.

Flowcharts are an approach to analyzing loss exposure by viewing an organization as a unit into which values flow, through which they are processed and increased, and out of which these greater values flow. In this perspective, an accident is an interruption of flows. The extent and duration of interruption roughly indicate the severity of the resulting loss. Flowcharts may show details of the process by which each of the organization's products is manufactured, how personnel and materials move among the organization's locations, or the flow of raw materials and finished products from suppliers through marketing channels to the final customer.

Personal inspections are conducted to identify potential exposures because no amount of theory and no set of classifications can fully predict all possibilities of loss.

Consulting with experts within and outside the organization plays a part in identifying exposure to loss. The risk management professional from a particular organization should strive to be a generalist with a working knowledge of all the diverse loss exposures that the organization or individual faces. However, to complement this broad knowledge of the organization, the risk management professional should be able to tap the special knowledge of experts both within and outside the organization on its particular loss exposures.

Risk Handling

Many insurance professions use the word "risk" to refer to an insured or a prospect for insurance, or to the peril that is being insured. They will say that a particular person or property is a good risk or a bad risk, meaning that they have made an evaluation of the underwriting characteristics of that person or property for a particular insurance policy. This differs from the strict insurance definition.

Risk means the uncertainty regarding financial loss. For example, if an individual decides to burn down his own home and sprays gasoline on the house and applies a torch the loss is certain. The event is purposeful in nature and there is no uncertainty. In insurance terms there is no risk of loss by fire. When a house fire is started by faulty electrical circuitry or a lightning strike, the even is sudden and unexpected. The owner of the house and the financial institution that holds the loan on the house both suffer a financial loss. The loss is uncertain and accidental.

Speculative risk involves the chance of both loss and profit. Investing in the stock market is an example of speculative risk. Speculative risks are ***not*** insurable. ***Pure risk*** involves only the chance of loss; there is never a possibility of gain or profit. The risk associated with the chance of being robbed is an example of pure risk. There is no opportunity for gain if the even does not occur – only an opportunity for loss if the robbery does occur. Only pure risks are insurable. The ***purpose*** of insurance is to protect the insured against ***losses*** caused by pure risk.

There are ***five*** basic ways to handle risk:

- Some risks, or loss exposures, may be transferred to another person or entity.
- A risk may be retained. The individual or business may choose to retain all (self-insured) or part (deductible) of that risk. Retention may be passive (the company or person is not aware that the risk exists, does not insure it and must pay if a loss occurs) or it may be active (the company or person is aware of the risk and accepts it).
- Avoid as many risks as possible. Few risks can be handled in this manner.
- Insurance is a financial device for transferring or shifting risk from an individual or entity to a large group with the same risk.
- Losses can be reduced or prevented by training, by installing safety devices, and/or by lowering the frequency and/or severity of loss. ***Loss control is managing the risk.***

Risk control can be defined as any conscious action (or decision not to act) that reduces the frequency, severity, or unpredictability of accidental losses.

Actual Harm

Risk control focuses 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. Risk financing techniques are not risk control techniques.

Specified Exposures

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.

Examining Alternative Techniques

Risk management involves either ***stopping*** losses from happening or ***paying*** for those losses that inevitable do occur. Risk control techniques include risk management designed to ***minimize the frequency or severity*** of accidental losses or to make losses more predictable.

Exposure avoidance eliminates entirely any possibility of loss. It is achieved either by abandoning or never undertaking an activity or an asset. ***Loss prevention*** aims to reduce the frequency or the likelihood of a particular loss. ***Loss reduction*** aims to lower the severity of a particular loss.

Segregation of loss exposures involves arranging an organization's activities and resources so that no single event can cause simultaneous losses to all of them. ***Duplication***, on the other hand, implies reliance on "back-up" -- spares or duplicates used only if primary assets or activities suffer loss. ***Contractual transfer*** of an asset or an activity for risk control is a transfer of legal and financial responsibility for a loss.

Selecting the Best Technique

Selecting the best risk management technique or combination of risk control and risk financing techniques, which is often the case, is a two-step activity.

- Forecast the effects the available risk management options are likely to have on the organization's ability to fulfill its objectives.
- Define and apply criteria that measure how well each alternative risk management technique contributes to each organizational objective in cost-effective ways.

Implementing the Chosen Technique

A risk management program must from the start be planned and organized on the principle that every risk management technique an organization chooses to use must be one it can successfully implement and monitor. A technique that cannot be put into practice and then assessed for its effectiveness cannot be part of a well-managed program.

In the implementation step, a risk management professional must devote attention to both the technical risk management decisions that he or she must personally make to put a chosen technique into practice and the managerial decisions that must be made in cooperation with other managers throughout the organization to implement the chosen technique.

Monitoring and Improving the Program

Once implemented, a risk management program needs to be monitored to ensure that it is achieving the results expected of it and to adjust the program for changes in loss exposures and the availability or costs of alternative risk management techniques. The monitoring and adjusting process requires each of the following elements of the general management function: (1) standards of what constitutes acceptable performance; (2) comparison of actual results with these standards; (3) correction or substandard performance and alteration of unrealistic standards.

Safety Management

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 focus of many involve the following areas of safety analysis:

Accident Theories

Haddon's energy-release theory--This theory views accidents as results of uncontrolled energy impinging on animate or inanimate structures that cannot withstand that energy. It suggests a number of strategies for preventing or reducing the damage that released energy might cause.

Heinrich's domino theory--This theory developed mainly from studying workplace accidents and injuries. It presumes that accidents are the end result of a chain of events (like falling dominoes), the most crucial of which represents an unsafe act of condition.

General methods of industrial hygiene control--Suggested by studies of work injuries and illness, these methods recommend substituting less hazardous materials, changing or isolating hazardous processes, wearing personal protective equipment, and using other physical and administrative controls to reduce workplace accidents and illnesses.

The system safety approach--This approach analyzes every organization, every operation within that organization, and the economy as a whole as a system of interrelated components (all needing to function properly to prevent accidents). This approach tries to predict where an accident might disrupt the system and how that accident might be prevented.

The crisis management approach -- This approach also views organizations as systems with five elements (organizational structure, personnel, production facilities, operating funds, and markets for outputs and raw materials.) These elements must be preserved by prompt, preplanned actions that are appropriate to the peril causing the crisis. These actions must be taken before and immediately after a major accident if the organization is to survive that accident.

These theories of accident causation and control were developed before, and are independent of, risk control techniques. Risk control techniques reduce accident frequency, severity, or unpredictability through exposure avoidance, loss prevention, loss reduction, segregation of exposure units through separation or duplication, and contractual transfer.

Many companies and their employees know and have testified that excellence-in-safety has proven a road to success with great returns. Those who understand the commitment have integrated safety as a process which permeates every aspect of the company's business and which is integral to its business plan. The commitment brings employees, labor, and management into a work culture of ownership, empowerment, trust, and pride where a real partnership and team exist - all working toward the same goal- an internalized excellence in safety as a way of life. Building a total safety culture process reinforces employees to actively care for the safety and health of themselves, their co-workers, and the work environment they work and live in. For all these safety best practice companies, the working together has forged a positive and productive employee relation's atmosphere in all aspects of work.

Safety as an Investment

Safety best practices represent a paradigm shift in thinking about safety. Part of this shift strongly suggests that safety should not be thought of as an ***expense***, but rather as ***earnings or a return on investment*** vehicle, with substantial returns over the long term. Safety best practice companies who know this from experience and have reached beyond compliance swear by the difference their commitment and investment have made on bottom line results. The winners are employees, companies, and their stockholders.

Examples 1: *A manufacturer with 600 employees, has sustained lost workday case rates 73% below average for 15 years (the equivalent of preventing 600 injuries), saving an average of more than $1 million per year in direct and indirect costs.* ***2)*** *A chemical company member with 1000 employees kept lost workday injury rates 93% below the average for its industry throughout 15 years (the equivalent of preventing 400 injures), saving more than $10 million.*

Example 2: *A health care provider awards its members airline miles and even merchandise bonus awards for exercising! The theory goes that someone interested enough to participate is more likely to take better care of themselves in the long run; reducing medical costs and perhaps a little more conscious of dangerous situations.*

Safety as a Partnership

The Occupational Safety and Health Administration (OSHA) acknowledges that compliance alone cannot accomplish all the goals of protecting America's workforce. Safety best practices represent another paradigm shift in thinking about safety: safety belongs to everyone, bound together as partners, united in one purpose. Partnership is its heart. It moves employees and labor into a cooperative partnership with management, and vice

versa. It also moves government (OSHA and DOE) from the traditionally perceived role of adversary and enforcer into the cooperative partnership with management, employees, and labor. In one company, this partnership and sense of ownership for safety is so deep that its employee handbook includes a written statement, giving employees the right and responsibility to stop unsafe work and ensure a safe work environment at all times. Safety is embraced by all as a value, and as a culture. These cooperative partnerships become central to the recognition of outstanding safety and health programs.

Creating this kind of partnership begins with employees taking care of employees. This leads to a concern for customers. Meeting customers' needs produces a better bottom line for the company. And everyone benefits from that. Success is rarely a solo performance. It's usually a joint venture. That's true of virtually every enterprise. And it's true of safety best practices. The key is partnership.

Recognizing Causes of Accidents

An unsafe act, an unsafe condition, and an accident are all symptoms of something wrong in the management system. Certain circumstances will produce severe injuries. These circumstances can be identifies and controlled. Safety should be ***manned*** like any other company function. Management should direct the safety effort by setting achievable goals and by planning, organizing, leading, and controlling to achieve them. The key to effective line safety performance is having management specify procedures for accountability. The function of safety is to locate and define the operational errors that allow accidents to occur. This can be carried out in two ways:

- By asking why accidents happen, and searching for their root causes
- By asking whether certain known effective controls are being used

The Agent's Role

The agent should anticipate and work to solve customers' concerns by providing the advice to optimize a company's safety management system or provide a back-up plan for a family's unplanned emergencies. 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

Agent Communication

The starting point for the development of any safety or risk solution must be ***dialogue*****.** All clients have a unique set of risks and the agent will need to work with each one to obtain a

clear picture of their risk exposure and an overview of their circumstances. This will include information on claims history, financial environment, and loss control activities.

One of the most effective ways to reduce the cost of risk is to ***prevent*** losses occurring. The agent will work with the client to create a loss control program. It does not always cost a great deal of money to improve risk. Often an improvement in the way resources are employed can bring a noticeable reduction in losses. Once a loss has occurred, there is still scope for reducing the overall cost of risk by ***effective claims management***. Claims management is more than simply handling a claim. The cost of the loss may depend on how a claim is managed and it may have consequences, which are not financial. An effective claims management approach is to aim to minimize the cost of losses, while ensuring that the final result is fair for all parties.

Developing the best way to finance the ***losses that are unavoidable*** will entail a flexible ***mixture*** of self-insurance and purchased insurance together with aggregate protection. The agent should present clients with a number of options to choose from which have been developed especially with their circumstances in mind, not by the rigid application of a pre-determined formula. The client's ultimate financial liability for his losses will be determined at the outset and guaranteed by aggregate stop loss protection set at a realistic level.

A Loss Control Department

To be effective a loss control department should operate as a full-fledged department rather than as simply an adjunct to the underwriting or claims department. This is indicative of the priority given to the services provided by this segment of the risk management process. The primary function of this department is to provide ***consultative*** loss control assistance. In order to keep abreast of client needs and situations where loss control assistance is required, the department should maintain close ***communication*** with the claims departments.

Loss control is an innovative approach to reducing the potential for property damage, employee injuries or other losses in the business environment. A well-designed loss control program can contribute to a businesses bottom line, through enhanced corporate productivity and profits, while offering customers and employees a safer environment. An evaluation of how an organization's loss control procedures commingle with their overall operation could make it possible for the company to:

- Be more pro-active in controlling or lowering their insurance costs
- Reduce their exposure to uninsurable losses
- Lessen the threat of a catastrophic loss that might interrupt their business operation
- Provide a safer environment for their employees and customers

An insurance company that provides consultative loss control services can assist clients by conducting physical surveys of their business operation. Surveys are conducted as deemed necessary by the department, and/or requested by clients.

Physical surveys may point out potentially hazardous conditions that presently exist in a business such as: insufficient and or blocked emergency exits, material handling problems, exposed machinery parts, incorrectly stored chemicals, or a sprinkler system that is not adequately designed for their occupancy.

Ergonomic reviews examine material handling procedures, product flow, and corresponding lifting tasks. Often times this analysis can suggest ways that an organization can reduce the potential for back injuries in their business with a few, relatively inexpensive corrective measures.

Loss Control Assistance

General Safety Reviews

Assistance in the development of effective loss control programs can include home and plant inspection procedures. Communication can include the following:

- Home and fire safety issues
- Advising on OSHA regulation compliance
- Assistance in reviewing machine guarding, lock out /tag out procedures
- Suggestions on proper personal protective equipment and material handling equipment
- Ergonomic procedures for various job assignments to reduce injuries
- Assistance in developing a Hazard Communication Program Outline of Loss Control Services
- Occupational health hazard reviews
- Assistance with accident investigation procedures which follow-up on the cause and remedy of accidents
- Assistance with periodic safety meetings, providing appropriate handouts and/or make suggestions for video or other training methods

An important part of safety reviews is conducting an accident analysis for all lines of coverage using in house or insurance carrier loss runs. The purpose of this analysis is to identify loss trends and root causes, and point out the uninsured costs associated with the loss experience. Then the agent can make suggestions for developing internal accident analysis procedures, and monitoring the effectiveness of present loss control efforts.

Property Protection

The agent can assist in helping the client to protect their property by coordinating the following communication:

- Conduct property surveys to assist accounts with identifying possible fire hazards
- Assist clients in reviewing product storage methods and heights to mitigate fire potential
- Evaluate all types of sprinkler systems for various occupancies, i.e. warehousing, cooking/kitchens, computer rooms, etc. to determine adequacy
- Assist clients with interpretation of various fire codes and standards
- Develop specific self inspection forms to assist clients in conducting scheduled property inspections or to maintain fire protection equipment
- Assist clients with pre-emergency planning

Fleet Operations

Many businesses lose sight of the fact that the vehicles they use in their operation enable them to operate more efficiently, enhancing profits. If these vehicles were eliminated from a companies operation, the overall operations would either be hindered or non-existent. For this reason, fleet safety must be part of a corporations loss control program. Through the following communication techniques the agent can assist the client in improving their loss control:

- Assist all clients with incorporating fleet safety into their overall corporate safety program.
- Assist clients in developing proper procedures for driver selection and training.
- Conduct comprehensive audits of fleet safety programs to pinpoint deficiencies and areas that do not conform to corporate culture.
- Assist clients with the development of forms and programs to facilitate vehicle maintenance, accident reporting and investigation, and driver supervision
- Assist clients with route analysis and product delivery, pick up scheduling.
- Assist clients with interpretation of state and federal DOT regulations.

Products Liability

Social and economic trends, ever increasing consumer awareness and the doctrine of the ***strict liability*** doctrine by the courts contributes to a "pro claimant" atmosphere for product liability claims. As a result, a wide range of real and imagined product defects have been brought before the courts. Product liability claims can impair a corporation's bottom line by way of actual claim settlement costs, losses due to product recalls, increased production costs to comply with product safety requirements and loss of sales due to negative publicity.

The insurance agent can help with Products Loss Control by communicating in the following ways:

- Assistance with the product design phase to analyze product hazards
- Assistance with product quality control and performance control
- Assistance with developing user information, labeling, instructions and advertising material
- Evaluate the record keeping procedures used in conjunction with the product, which assists with complaint and claims handling
- Analyze product packaging and shipping materials

General Health, Liability and Security

Injuries to the public can impact a company's bottom line, either from the actual cost of the accident, or the negative communication and goodwill. A loss control department can help by:

- Conducting premises surveys to assess hazardous conditions and identify areas where the public could be injured
- Reviewing procedures for controlling visitors on premise, and off premise exposures to the company

- Conducting assessments of the overall security in all areas of premises, i.e. buildings, parking areas, off site locations etc., to determine premises vulnerability and the probability of burglary/robbery occurrences

Insurance That Fails To Insure

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

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 v. 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 v. 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 *Conflict Reduction* section (next chapter) 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 it is evident 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 v. 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 inititally determine pertinent aspects of the insurance risk for purposes of decising 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 incontestability, "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.

CHAPTER SIX
CONFLICT REDUCTION PRACTICES

It is estimated that one in seven agents face an some kind of legal or 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.

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 (see Compliance Practices). Then, pull out your agency agreement and ***read it . . . right now***!!! And, 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. Countless lawsuits, for instance, surface due to something an agent wrote down in an application causing the policy to void or a claim denied. The insured typically denies they responded in that manner. If applications were made out in an insured's own handwriting, however, there is little they can say.

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. And while we're on the subject, ***spend more time with client applications***. 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 a position and reasoning. For instance, assuming your state regulator and company approve, the applicant could be asked to write "I have read everything on this page. The answers are true".

Step 8
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 9
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:

The Agent & Client Duties

The agent/broker generally assumes only those duties normally found in any agency relationship. Your agency contract is a good source of basic duties. Overall, the basic duty of agents is to select a company and a coverage and bind it (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 v 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 v 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 v 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 v 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 v 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

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?

Client Disclosure

Many agents have also 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.

Sample Agent / Client Disclosure
(Speak to an attorney before using ANY disclosure form)

Dear Client:

As you know, we are an insurance agency and not an insurance company. Our service to you includes the pricing and presentation of various insurance programs which may fit your needs, and the transmittal of your application to the insurance company. There are, however, limitations to our service, including the following:

1) Premium quotation and coverage are controlled by the insurance company and may be subject to change. We do not warrant or guarantee that a premium or coverage quoted by an insurance company will be identical to the ultimate premiums or coverage of the policy as issued by the company. There is no coverage promised or implied beyond the policy as written and endorsed. Your acceptance of the policy replaces all other agreements, either oral or written.

2) While we are pleased to provide to you and explain the industry ratings of a particular company or alternate insurers, we do not make any independent investigation of a specific company's solvency or financial stability. We do not warrant or guarantee that any insurance company will remain solvent, and we will not be liable to any insurance applicant or insured for the failure or inability of an insurance company to pay claims.

3) Insurance companies rely on the truthfulness and accuracy of information provided in the application. It is your sole responsibility to complete the application accurately, and if the insurance company should deny a claim based on its contention that the application has not been truthfully or accurately completed, we take no responsibility for such inaccuracy.

We ask that our client applicants signify their understanding of the foregoing points and their agreement to defend, indemnify, and hold us harmless against any loss or liability which may arise from the applicant's failure to truthfully and accurately complete the application, by signing and dating this letter in the place provided below and returning the copy to us. Kindly do so at your earliest convenience.

Accepted by _____

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 v 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 v 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. For example, in McDaniel v Sheperd - 1991, an agent approached an injured insured, told her not to get an attorney, offered to get her an attorney, and offered her money in exchange for a release of liability for all known and unknown personal injuries she incurred in an accident. The court pursued him for constructive fraud. This type of activity is a clear violation of an errors and omissions contractual promise and a sure way for coverage to be canceled.

Also remember that cooperation extends to any settlement offer proposed by your errors and omissions company. If your E&O insurer suggests a settlement offer that you publicly disagree with, and the case ended with a higher judgement, 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.

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.

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

Automated Equipment

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

Application For Insurance

Complete and legible copies of the original application for coverage are extremely important. They presumably show the "intent" of the insured when he took out the policy, what he communicated to the agent regarding his wishes, whether the agent followed his wishes as to coverage requested and whether the insurance company followed the wishes of the agent who requested a policy of insurance pursuant to the wishes of the insured. Also, a material misrepresentation of fact by the insured in his application may cause the policy to be declared void (American Family Mutual Insurance Co v 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 v 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.

Effective Verbal Communication

Verbal communication is critical to effective loss control. Many claims can be avoided if the agent will take the time to confirm all parties' understanding in each transaction.

In order to do this the agent should always ***repeat*** his understanding to the client when handling an instruction or request. The agent should never assume any detail about the insured property.

When he is recommending certain coverage, he must thoroughly ***explain*** the options and the consequences of each decision. He must be sure that the client ***understands*** his current coverage.

Effective Written Communication

Documentation is written confirmation on all verbal instructions. It is also a written record of all that that has been done, and what needs to be done in the future. Lawyers are always instructing their clients to ***document***.

Methods: Insurance agents should document all instructions and transactions. He should be sure and obtain the client's signature whenever necessary, even if it has to be on a piece of scratch paper. The note should be specific with details, date and time, and then signed by both the insured and the agent.

Normally ***standardized forms*** are the preferred method of documentation. These should all have a section for remarks and the insured's signature. ***Letters*** are another way of written communication with the client. The letter reinforces or acknowledges what has already been discussed verbally. Many times this can alert either the agent or the client to an error or misunderstanding in their communication. A signed release from the insured should be used for special requests or rejections of coverage.

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.

Purpose*:** If an ***insurer refuses to provide coverage, the agent should communicate that information in writing so that the client does not assume that he has coverage when he does not. If a ***client rejects coverage*** by the insurer, that rejection should be confirmed in writing from the insurance agency.

Coverage limits especially for bodily injury or property damage limits should be in writing on a sign-off form. These forms are a communication device to indicate to the client that higher limits are available. They should be signed at every renewal for every level of coverage. A signed application is no longer sufficient proof that the limits are the insured's intent.

The agent should discuss the limitations of the coverage in writing. This can be done with a phrase such as "If there are any other exclusions or limitations in the policy that you would like to have explained, please call me".

A ***quote*** is an estimate of the price for coverage the insured needs or wants. It is a statement of options available and the decisions made by the insured. It describes in detail the offer of coverage by a particular insurer. It is not evidence that coverage is in effect or a substitute for a signed application. A quote, known also as a proposal or illustration, will communicate what the insurer is recommending, and what the cost of the coverage will be.

The quote or proposal should be in standard format and language. It should communicate specifically to the client what he should do to effect coverage. All options and limitations should be listed clearly. There should be a disclaimer regarding the purpose of the quote included.

Effective Fax Machine Communication

It is very important for the agent to understand the loss exposures involved with communicating via a fax machine. These exposures depend upon how faxes are transmitted and received.

Both the agent and the client should communicate about the confidentiality level of the information being faxed. Both should approve the sending of the material, and be notified ahead of time that confidential material is being faxed. The faxes should be delivered immediately to the appropriate person, and responded to. Important documents require a confirmation of receipt.

Fax signatures may be considered legal, but whenever possible all forms should have original signatures. Fax confirmation of date and time can be critical; so they should always be stapled to the document or the document should be stamped with the date. The sender should be notified if a fax does not come through properly.

A faxed request for coverage that is received in the agent's office after hours does not confirm coverage. However, even though the fax may communicate an offer of a risk, the insurer has not accepted that offer. Because of this potential in miscommunication, it is wise to leave the fax machine on even when the insurance agency is closed.

Effective Telephone Communication

Speaking over the telephone has become so common that it is easy to forget that it can be the cause of serious errors in communication. One of the ways to avoid misunderstanding is to document telephone conversations. Activity records of all telephone conversations can be an effective tool in defending an agency against lawsuits. The agent should never depend solely upon answering machines or voice mail for records of communication. There is too much room for error. Pocket recorders are the most reliable means of verbal records.

Documentation is especially critical in conversations requiring action. No action should be taken based merely on a telephone conversation. If a change in coverage has been discussed, no action should be taken until a signed and dated confirmation is received from the insured.

Another danger in telephone communication is incomplete information. The agent should have a standard form that he follows in leaving telephone messages which includes all the

necessary information such as date, time, name of caller and company, purpose of the call, request for return call, etc. and a return phone number.

E-Mail

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

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

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

Operations Manual

As you read above, ***standard operating procedures*** are steps that you follow consistently in selling and serving clients. Standard procedures can be critical in establishing your notes and records as usable evidence in a trial. Further, it can be suggested that an agent who is careful to follow set procedures is usually found to be more credible in his own defense. Both are important reasons to document procedures in an ***operations manual***. Some errors and omission insurers are requiring agents to have and see their operations manual before coverage can commence. You should also be aware that in an insurance dispute, the existence of such a manual may be uncovered. From a ***defense standpoint***, the manual and your adherence to it may prove that you are a diligent agent. From a plaintiff's vantage, non-compliance of policy procedures that you establish may work against you.

Your operations manual should cover procedures for dealing with client applications, claims, policies and certificates, insurance companies and any special services you plan to offer. The following is a basic outline of information that could be included in your manual. Because agencies and insurances differ widely, you will want to add issues that are specific to your business before implementing any procedures.

- Client needs and requests should always be noted in the file. Many agents routinely take 5 minutes after a client interview or phone call to document the needs and requests of the client in the file. Even if you have to shut the door and set the answering machine, this is important.
- Always be consistent. If you ask one client to accept or deny a specific endorsement or make sure that you ask the same question of others.
- Note the date or nature of all correspondence that notifies a client that his application has been accepted or denied. Equally important is logging notification of clients or potential clients that coverage is NOT available.
- Create a "hot list" or "follow-up" file for ALL transactions that require additional review. A contact management or database system is excellent for noting the need to review the

client file within 10 days, 20 days or on a specific date to check a renewal, ordered endorsement, 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.
- Claims should receive immediate attention and all requests should be promptly sent to the insurer. A follow-up note to the file should be prepared. Don't tell the client that the claim will be paid unless you are absolutely sure. Don't offer any legal advice to the client. Compare claim awards to policy limits for accuracy.

CHAPTER SEVEN

CONSUMER PROTECTION PRACTICES

Rules and regulations vary from state to state. There are, however, widely accepted codes of behavior expected from licensed agents that fall under the category of consumer protection. Some of these laws live and breathe ***outside*** the venue of insurance codes. However, they are just as lethal and can't be ignored.

Conflicts that surface in the consumer protection area are usually the result of violations in advertising and deceptive or unfair trade practices. Agents in the real world find it near impossible to know each and every consumer statute, yet a single mistake could jeopardize a career and personal assets. Sometimes, it is the tiny indiscretions in business that create the problem. For example, placing a small and seemingly harmless "sub-title" on your letterhead that says "Professional Services Guaranteed" could hold you accountable for more than you bargained. Knowing what is expected of agents in the consumer protection arena is the best place to reduce and avoid these problems.

Insurance Advertising

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

What is Advertising?

Advertising includes ***all materials*** designed to create ***public interest*** in an insurer, its products, an agent or broker. This may include, but is not limited to: Product Brochures, Prospect Letters, Sales Presentations, Agent Recruiting Materials, Newsletters, Business Cards, Trade Publication Ads, Point-of-Sale Illustrations, Print/Radio/TV/Internet Advertising, Stationary, Telemarketing, Telephone Conversations, Yellow Page Ads, Videos, etc. Most insurance companies require agents submit these forms of advertising to compliance departments for approval prior to publishing.

Blind ads which do not identify product features or rates are particularly vulnerable to mistakes since they are typically not reviewed by compliance departments, although many insurers will look them over as a courtesy. Due to violations in this area of advertising, many states now require an agent's license number be displayed in ALL forms of communication, including blind ads.

What Isn't Advertising?

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

Advertising Compliance

The consequences of using nonapproved advertising are both severe and damaging. Insurance regulators concerned about an advertisement's content may require that ALL future advertising for the entire company be submitted for ***prior state approval***. This would be disruptive and time-consuming. Additionally, a violation in advertising may carry fines of $1,000 or more ***per violation***. As an example, 1,000 misleading flyers could be assessed a fine of ***$1 million*** ($1,000 X 1,000). To avoid these kinds of conflicts advertising should comply on several fronts:

Identity of Insurer or Product

If advertising focuses on a specific company it is advised that the FULL NAME of the company be used along with the home office address (City and State). Initials or abbreviations are not acceptable to most companies or insurance regulators.

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

Accuracy and Truthfulness

As a general rule, the advertising piece, when examined as a whole, cannot lead a person of average intelligence to any false conclusions. These conclusions can be based on the literal meanings of words in the ad and impressions from pictures or graphics as well as materials and descriptions omitted from the advertising piece. In one case (McConnell v. Ehrlich - 1963) the agent lost his license for using prospecting letters that closely resembled official correspondence from the Department of Motor Vehicles.

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

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

Illustrations and Quotes

There are many proposals by states, professional groups and organizations like the National Association of Insurance Commissioners. Most require that agents disclose all assumptions in the illustration or quote and explain and highlight any guaranteed portions as opposed to anticipated results. Almost as important is whether *nonguaranteed* elements of the policy are shown with *equal prominence and close proximity* to the *guaranteed* elements.

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

Comparisons, Ratings and Competition References

Comparisons made between policies and investment products, e.g., comparing an annuity to a savings account or a split limit quote to a single limit estimate, must be complete, accurate and not misleading. Agents have lost their license by using solicitations and letters that inferred that insurance is available at lower rates than others because of a special “volume plan”. All statistical information should be recent, relevant and the source and date identified. Any reference to a commercial rating should be clear in describing the scope and extent of the rating. If an A.M. Best, S&P, Moody’s or other rating is advertised, the appropriate disclosures should be given.

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

Disclosures

If you display a rating from a commercial company you should use a disclosure similar to this:

“A.M. Best has assigned (Company) an “A” (Excellent) rating, reflecting their current opinion of the financial strength and operating performance of (Company) relative to norms of the insurance industry. A.M. Best utilizes 15 rating classifications from A++ to F.

If your agency is located in a bank or other prominent corporate institution, the following disclosure is appropriate:

Contracts are products of the insurance industry, and are not guaranteed by any bank or company, or insured by the FDIC.

Also, if your product aligns with estate planning, financial planning, taxes or asset protection, you might display the following caveat:

> *Neither (Company) nor any of its agents give legal, tax or investment advice. Consult a qualified advisor.*

Testimonials and Endorsements

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

More Unfair Insurance Practices

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

Agents in question of unfair trade practice methods are typically subject to a hearing, usually before the State Department of Insurance, to show cause why a cease and desist order should not be made by the appropriate regulatory agency or board. After a hearing, if it is determined that the agent's actions violate the rules of unfair competition and practices, a formal cease and desist order may be served -- ***a warning***. Violating such a cease and desist order is typically subject to various dollar penalties and administrative penalties such as injunctions, loss or suspension of license, and severe civil penalties such as high dollar fines, damage awards, and court fees to the injured parties. In addition to advertising, discussed above, areas of specific importance include:

Identification

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

Defamation

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

Boycott, Coercion & Intimidation

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

False Financial Statements

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

Stock Operations

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

Discrimination

An agent clearly violates insurance law in making or permitting any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any contract of life insurance or life annuity or in the dividends or other benefits payable by such contracts. Similarly, there shall be no discrimination between individuals of the same class and of essentially the same casualty hazard in the amount of premium, policy fees, or rates charged for any policy or contract of accident or health insurance or in the benefits payable under such contracts. Discrimination can also occur where individuals of the same class and of essentially the same hazards are refused renewability of a policy, subject to reduced coverage or canceled because of geographic location.

Rebates

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

Deceptive Name or Symbol

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

Deceptive or Unfair Business Practices

In addition to specified insurance codes, insurance agents must answer to generalized consumer protection laws carrying titles such as "Deceptive Trade Practices" or "Unfair Trade Practices". For the most part, these ***consumer*** laws apply to insurance and agents because an insurance policy is deemed a ***service*** and the purchaser of a policy is deemed a ***consumer***. Therefore, insurance services fall within the meaning of widely adopted consumer protection acts. Agents are also pursued under consumer protection laws because some insurance codes do not specifically address certain questionable acts by agents where the misrepresentation or fraud occurs outside the limits of insurance business. In such cases, the damaged insureds or policy owners were not considered to be "consumers". By including the purchase of insurance services as a consumer transaction, the additional protection of deceptive or unfair trade practices acts can be invoked.

The Uniform Consumer Sales Practices Act

The UCSPA was enacted by the federal government and adopted by many states to protect consumers from deceptive marketing practices and establish a uniform policy. The essence of this legislation, as well as local and state laws, is that "buyer beware" is an ***old attitude*** now replaced by real laws and enforceable legal limits. The courts frown on oppressive and

unconscionable acts and consider it the duty of any sales person and agent to disclose information available to him which gives him an unfair advantage in a sale. False statements constitute fraud, and the fine print in contracts may be construed, under certain conditions, as an intent to conceal.

Unlawful Trade Practices

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

- Passing off services as those of another.
- Causing confusion or misunderstanding as to the source, sponsorship, approval or certification of services offered.
- Causing confusion or misunderstanding as to affiliation, connection or association with another.
- Using deceptive representations or designations of geographic origin in connection with services.
- Representing that services have sponsorship, approval, characteristics or benefits which they do not have.
- Disparaging services or the business of another by a false or misleading representation of facts.
- Advertising services with intent not to sell them as advertised.
- Advertising services with intent not to supply a reasonable expectable public demand, unless the advertisements disclose a limitation on quantity.
- Representing that an agreement confers or involves rights, remedies or obligations which it does not have or involve, or which are prohibited by law.
- Misrepresenting the authority of a salesman or agent to negotiate the final terms or execution of a consumer transaction.
- Failure to disclose information concerning services which was known at the time of the transaction if such failure was intended to induce the consumer into a transaction which the consumer would not have entered had the information been disclosed.
- Advertising under the guise of obtaining sales personnel when in fact the purpose is to first sell a service to the sales personnel applicant.
- Making false or misleading statements of fact concerning the price or rate of services.
- Employing "bait and switch" advertising in an effort to sell services other than those advertised on different terms or rates.
- Requiring tie-in sales or other undisclosed conditions to be met prior to selling the advertised services.
- Refusing to take orders for the advertised services within reasonable time.
- Showing defective services which are unusable or impractical for the purposes set forth in the advertisement.
- Failure to make deliveries of the services advertised within a reasonable time or make a refund.
- Soliciting by telephone or door-to-door as a seller, unless, within thirty seconds after beginning the conversation the agent identifies himself, whom he represents and the purpose of the call.
- Contriving, setting up or promoting any pyramid promotional scheme.

- Advertising services that are guaranteed without clearly and conspicuously disclosing the nature and extent of the guarantee, any material conditions or limitations in the guarantee, the manner in which the guarantor will perform and the identification of the guarantor.

Burden of Proof

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

Legal Remedies

Whenever the courts or consumer protection division of an insurance department have reason to believe that any person is engaging in, has engaged in, or is about to engage in any act or practice that may violate a trade or practices act, and that proceedings would be in the public interest, the division may bring action in the name of the state against the person to restrain by temporary restraining order, temporary injunction, or permanent injunction the use of such method, act or practice. In addition, there may be a request by the consumer protection division, requesting a civil penalty for each violation, possibly $2,000, with a maximum total not exceed an established amount (typically $10,000). These procedures may be taken without notification to such person that court action is or may be under consideration. Usually, however, there is a small waiting period, seven days or more, prior to instituting court actions.

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

The United States Post Office

The Postal Service has jurisdiction over situations where the mail is used to transfer money for products or services. It administers a powerful law but has insufficient resources to deal with the vast number of frauds it encounters.

Most mail-order schemes attempt to exploit people's fears. Their promoters are usually "hit-and-run" artists who hope to make a profit before the Postal Service stops their false ads. When a scheme is detected, postal inspectors can file a complaint or seek an agreement with the perpetrator. When a complaint is contested, a hearing is held by an administrative law judge. If the evidence is sufficient, this judge will issue a ***False Representation Order (FRO)*** enabling the Postal Service to block and return money sent through the mail in response to the misleading ads. Although the order can be appealed to the courts, very few companies do this. Each voluntary agreement and FRO is accompanied by a cease-and-desist order that forbids both the challenged acts and similar acts. Under the Mail Order Consumer Protection Amendments of 1983, if this order is violated, the agency can seek a civil penalty in federal court of up to $11,000 per day for each violation.

Unfair Competition and Business Practices By Insurers

Agents should know that the insurance companies they represent are also subject to the insurance and practice rules above, as well as to specific deceptive or misleading acts in the

areas of advertising, settlement practices, reporting procedures, discrimination (by race, disability, rates, renewal, benefits), investment practices, reinsurance restrictions, liquidations and more.

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

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

Unauthorized Insurer False Advertising

The purpose of consumer protection laws in this area is obvious -- insurers not authorized to transact business in the state should not place, send or falsify any advertising designed to induce residents of the state to purchase insurance. This legislation is usually directed at "foreign or alien insurers" and defines advertising to include ads in the newspaper, magazine, radio, television and illustrations, circulars and pamphlets. Violations can also include the misrepresenting of the insurer's financial condition, terms and benefits of the insurance contract issued or dividend benefits distributed.

Unfair Settlement Practices

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

- Knowingly misrepresenting to claimants pertinent facts or policy provisions relating to coverages.
- Failing to acknowledge with reasonable promptness pertinent communications with respect to claims arising under its policies.
- Failing to adopt and implement reasonable standards for prompt investigation of claims arising under its policies
- Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims submitted in which liability has become reasonably clear.
- Compelling policy holders to institute lawsuits to recover amounts due under its policies by offering substantially less than the amounts ultimately recovered in the suits brought by these policy holders.
- Failures of any insurer to maintain a complete record of all the complaints which it has received during recent years (usually three years) or since the date of its last examination by the commissioner. This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of these complaints and the time it took to process each complaint.

Discrimination by Handicap

An insurer doing business in a state may not refuse to insure, continue to insure or limit the amount, extent, or kind of coverage available to an individual, or charge an individual a different rate for the same coverage solely because of handicap or partial handicap, except

where the refusal, limitation, or rate differential is based on sound actuarial principles or is related to actual or reasonable anticipated experience.

Discrimination by HIV Testing

In recent years, HIV-related testing in connection with an application for insurance has become commonplace. If an insurer requests or requires applicants to take an HIV-related test, he must do so on a nondiscriminatory basis. An HIV-related test may be required only if the test is based on the person's current medical condition or medical history or if the underwriting guidelines for the coverage amounts require all persons within the risk class to be tested. Additional stipulations require that an insurer may not make a decision to require or request an HIV-related test based solely on marital status, occupation, gender, beneficiary designation or zip code. Further, the uses that will be made of the test must be explained to the proposed insured or any other person legally authorized to consent to the test and a written authorization must be obtained from that person by the insurer.

An insurer may not inquire whether a person applying for insurance has already tested negative from a previous HIV test. The insurer may inquire if an applicant has ever tested positive on an HIV-related test or has been diagnosed as having HIV or AIDS. The results of an HIV test are considered confidential, and an insurer may not release or disclose the test results or allow the test results to become known, except where required by law or by written permission from the proposed insured. Then and only then can results be released, but only to the proposed insured, a licensed physician, an insurance medical information exchange, a reinsurer or an outside legal counsel who needs the information to represent the insurer in an action by the proposed insured.

Discrimination in Rates or Renewal

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

Benefits Protection

Insurers are duty bound to protect all money or benefits of any kind, including policy proceeds and cash values to be paid or rendered to the insured or any beneficiary under a life insurance policy or annuity contract. In essence, these benefits must inure exclusively to the person designated in the policy or annuity contract. They must be exempt from attachment, garnishment or seizure to pay any debt or liability of the insured or beneficiary either before or after the money or benefits are paid. They are also exempt from demands of a bankruptcy proceeding of the insured or beneficiary.

Health Policy Benefits

In the health insurance industry, benefit payments are commonly assigned to a physician or other form of health care provider who furnishes health care services to the insured. An insurer may not prohibit or restrict the written assignment of benefits. When such an assignment is requested, the benefit payments shall be made directly by the insurer to the physician or health care provider and the insurer is relieved of any further obligation. Of course, the payment of benefits under an assignment does not relieve the covered person

from any responsibility for the payment of deductibles and copayments. Further, a physician or health care provider may not waive copayments or deductibles by acceptance of an assignment.

Contract Entirety

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

Insurer Mergers

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

Reinsurance Assumptions

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

Despite the practice of assumption reinsurance, some members of Congress in recent years have objected to the process, since there is no requirement to inform policy holders in advance that the insurance company behind their policy is relinquishing responsibility to another company, that is, the reinsurer. The reasoning behind their concern is that policy holders who have purchased coverage based on the financial condition and reputation of one company may suddenly find themselves insured by another company without warning or knowledge of the new company's abilities to pay their claims. To date, however, there is no definitive legislation passed to change reinsurance assumption.

INDEX