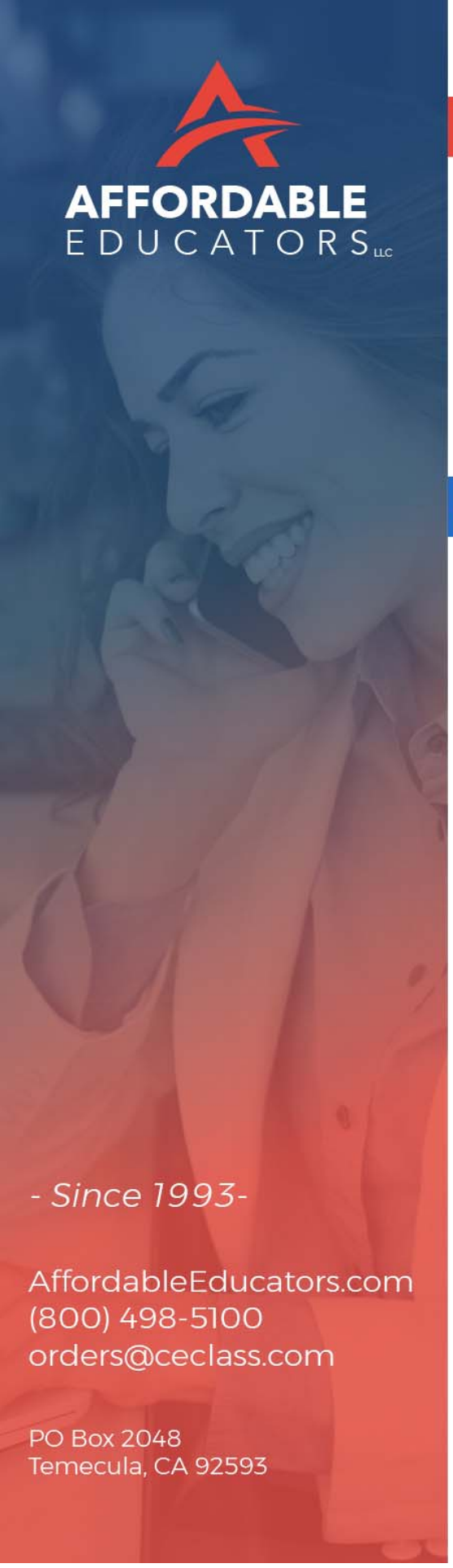

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AGENTS ON TRIAL

COURSE INSTRUCTIONS

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Introduction

Imagine that your everyday decisions were under constant scrutiny by an expert on insurance matters. Imagine again that the entire focus of a professional, trained in insurance litigation, was to critique the minute-by-minute actions you performed for a client on a specific day. . . two or three years back! Imagine further that a slight oversight ***in favor*** of your client's insurance purchase is ultimately the basis of his malpractice claim against you. Can't happen? Think again.

You could be facing many of these same things as an ***agent on trial***. Would you pass the muster at every juncture? How much would it cost to defend yourself? Could there are things you can do to reduce a negative outcome or major financial judgment against you?

This course will attempt to answer these questions using real court case examples and the actual experiences of producing insurance agents. As you will soon see, some legal problems are ***self-inflicted*** by agents themselves; some result by being in the path of the problem without a proper defense or procedure system in place; others are simply human error. . . they're part of the business . . . part of life. In later sections, we will explore your ***legal conduct*** as an agent and ways to ***minimize conflict*** among clients and insurers alike.

It is important to note that the content in *THIS COURSE DOES NOT CONSTITUTE LEGAL ADVICE*. We leave that to trained legal professionals. Rather, the purpose of this course is to alert you to the flashpoints that boil to the surface when an insurance legal issue is pending.

The Litigation Wave

It is probably no surprise to readers that lawsuits today are filed at five times the rate of 30 and 40 years ago. What is somewhat surprising is the fact that less than 2 percent of all lawsuits actually make it to trial. So, when you peruse the 200 or so court cases in this course, know that it is only the tip of a giant iceberg. Be advised, insurance agents all around you are sued in great number everyday, yet you will only hear about the 2 percent that made it trial! The rest were settled out of court, dismissed by judges or settled by the court prior to trial. The end result is still troubling: A lot of agent lawsuits at a high cost to defend and settle.

The recent trend in insurance law cases has been away from traditional approaches rooted in some form of clear ***breach of contract***, like failing to submit an application for coverage, towards a view that insurance policies are something way more than a private transaction between the insured and the insurance company. ***New approaches*** tie together the true nature of the ***relationship between the agent, insurer and its insureds***. Issues like your perceived intentions, how long you have helped a client, their dependence on your knowledge and/or the simple fact that you have an insurance license are now part of your exposure.

Courts and juries are also recognizing that insurance contracts are NOT freely negotiated agreements entered into by parties of equal status. They subscribe to the theory that insurers and the agents that represent them possess ***special knowledge***, and have ***great influence*** on insurance purchasing decisions. Further, the conditions of an insurance contract are, for

the most part, dictated by the insurance companies and that the insured cannot "bargain" over anything more than the monetary amount of the coverage they buy--and rarely that! Buying insurance, may not meet the mutual agreement standard that exists in many product or service industries. In essence, the old ***buyer beware*** caveat may not apply since the bias knowledge seems to reside with the agents and insurers.

What does this mean? It probably means that the sympathies of courts and juries will lean toward consumers and not agents and their companies. So, the new sales caveat should probably read "agent beware"!

What Happens in Court?

Just about anything you do is fair game for attorneys and the court system. Agent "faux pas" of every kind have been documented and categorized in great detail in thousands of lawsuits. Worse yet, we learn that 98 percent of all legal actions never make it to court . . . they're settled or thrown out as frivolous. So, it's easy to see the breadth of the legal actions against agents.

The Dispute

Even the cases that ***don't*** make it to trial can involve tens of thousands of dollars in legal fees with attorney-client meetings, discovery, legal posturing and mandatory, pre-trial settlement conferences held in front of a judge. The process is guaranteed to consume an enormous amount of time and fees. The cost of trail can double and triple these expenses and time.

So, how does it start? In virtually every insurance dispute, the ***trigger*** is some kind of coverage limitation or outright denial of a claim. This should not be surprising to you because at any given time, a client's ***insurance continuum*** may find him ***fully insured***, ***underinsured***, ***unable to be insured*** or his policy or company may simply ***fail to insure***. Coverage gaps may be attributed to policy interpretation; an agent's negligence or mistake; a client's misrepresentation or mistake; deeper issues such as inadequate or defective protection or a clear inability of the insurer to pay (insolvency).

Sometimes, an insurance shortfall 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. Then too, there are times when the coverage

A Word On Agent Cooperation

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 or attorney before discussing major legal matters with clients or your represented companies. Don't try to settle a legal conflict yourself, it could void your E&O policy. Don't make any promises to clients about resolving the matter or give them legal advice. Don't ever try to ***cover-up*** mistakes -- it almost always backfires. If your E&O carrier wants to settle, rather than fight, it is probably better to agree. If you don't, you could be liable for any judgments that exceed the settlement figure they already proposed.

purchased or sold to a client exceeded what was needed in one type of insurance ***at the expense*** of another coverage being underfunded and under-covered, e.g., a high premium whole life policy leaves no monthly budget for health insurance, r an auto policy with low deductibles is recommended 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 is the right thing to do, agents need to consider the balancing of coverage to avoid critical shortfalls.

The Dispute Process

The disp0ute process might start with a phone call from an angry client or a demand letter asking you to do something about a problem. Despite your best efforts, the dispute may gather steam where the insured and the carrier do not agree on the interpretation of coverage. It is not unusual for multiple parties, including you, to get involved and be involved and/or named.

You'll know when things are getting serious if you receive a ***PRP (Potentially Responsible Party) Letter***. They are usually written by and attorney and tend to imply that you may have some exposure in this dispute. Never discount or ignore a letter like this. Although they are not an actual claim, the courts interpret them to be the start of legal action. Lack of response can contribute to your potential liability. Why? Because it is assumed that NO innocent party would allow an allegation to go unanswered. Of course, you will want to check with competent legal advice before writing any letter of response to one of these letters.

Where coverage disagreements persist beyond an initial settlement, policyholders 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.

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.

Duty to Defend

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

Coverage disputes are likely to develop and do, when an insurance company attempts to ***shield*** itself from any defense of an insured whatsoever, or when it withdraws from an action after it determines there is no basis for recovery. Other conflicts center around whether an insurer must defend only against an action that is a actual lawsuit seeking damages or be required to defend against all claims which may result in liability. In general, courts assume a ***connection*** between the filing of a complaint and the triggering of a duty to defend by an insurer.

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 policyholder 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 that would defeat coverage. A majority of 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 or agent 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. Bad faith actions should be avoided at all costs because they allow for punitive damages.

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 policyholder to prove coverage by producing an executed insurance policy. If a policy has been lost or destroyed, the policyholder must satisfy ***two requirements to prove coverage***. First, the policyholder 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 policyholder 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.

The Court System

An understanding of the court structure and the nature of judicial proceedings are essential for the agent to understand. In each of the states of this country there are ***two separate systems of law*** in force, namely, state law and federal law. Federal law operates uniformly throughout the United States, with few exceptions. State law, however, may vary considerably from state to state since each state has its own constitution, statutes and court decisions.

Both the national and state governments are controlled in what they can do by provisions in their respective constitutions. The fundamental difference between the two constitutions is that the Constitution of the United States is a grant of power to Congress, i.e., ***Congress*** has the power that has been expressly conferred upon it, whereas the state constitution is a limitation of power, i.e. the ***state legislature*** has the powers that have not been denied it. Thus, unless

restricted by the federal or state constitution, the state legislature has any power it chooses to exercise.

In certain types of proceedings the federal courts have exclusive jurisdiction; however, in most frequent situations where parties become involved in court action, the state courts have jurisdiction.

In most ***States***, there are ***three systems*** that make up the State Courts System: Trial Courts (Small claims, municipal and superior), Appellate Courts and Supreme Court. Disputes are first heard at trial level and progress to Appellate and supreme based on the type of case and appeals that are made on decisions in the lower courts.

The following dollar amounts are typical guidelines in deciding which state court a claim may be entered.

- $5,000 or less -- Small claims court (excluding evictions)
- $25,000 or less -- Municipal court, including evictions, misdemeanor and criminal cases.
- Over $25,000 -- Superior court including divorces, adoptions,

Federal courts also have ***three tiers***: Federal District Courts, Courts of Appeal and Supreme Court. In several types of cases, the federal courts have exclusive jurisdiction. These include actions involving bankruptcy and overall civil actions. Federal cases are commenced in the local United States District Court. The United States is divided into about 100 districts, each with its own district court.

The highest and "last resort" court is the Supreme Court of the United States. This court is made up of nine judges, appointed for life by the President. Most cases that reach the Supreme Court are on appeal from a lower federal court, or from state supreme court where a question of federal law is involved.

CHAPTER ONE

Agents On Trial

A few years ago, no one knew what ***market conduct*** meant. Today there are class action suits and negligence claims filed against insurers and agents alike amounting to millions of dollars for a variety of sales and legal conduct violations. Of course, agent conflict is nothing new. Our research found cases dating back to the early 1800's. What is different between cases of today and the ones that occurred years ago is the trend toward fiduciary responsibility. In essence, the courts are viewing agents as ***more than mere salesmen***. Recent cases, for example, lean toward the precedent that agents, as insurance professionals, ***should have known*** something was wrong compared to years ago where agent liability was generally limited to issues of ***outright negligence***. There ***is*** a world of difference between the two that is best explained by the ***legal precedent theory***. In a nutshell, because our legal system makes legal decisions based on precedents, it is destined to constantly expand. Each decision in the chain sets the stage for the next step of expansion. The result can be demonstrated court cases. In Southwest v Binsfield (1995), for example, the agent ***should have known*** that a specific coverage option was important to the business he insured. In Brill v Guardian Life (1995) the agent ***breached his fiduciary duty*** by not using an ***optional*** conditional receipt. Clearly, these cases represent an expansion of agent liability . . . from decades-old "contract" issues to fiduciary duties. Dozens of cases may have proceeded these cases: in each, the level of agent duty was notched higher and higher as attorneys convinced attorneys that agents should be held more accountable.

Agent accountability today may also come with a high price tag. Consider the following court cases where the actual dollar losses incurred by client victims was extremely low compared to the ***high punitive damages*** levied against agents and their insurers:

State Farm v Grimes	*$1,900 Actual losses*	*$1.25 Million Punitive Award*
Independent v Peavy	*$412 Actual losses*	*$250,000 Punitive damages*
National Life v Miller	*$258 Actual losses*	*$350,000 Punitive damages*

As you read these amounts you may be thinking that the damages were high because insurance companies have ***deep pockets***. They can afford to pay these sums of money, which is why juries awarded them. However, you must also keep in mind that virtually every agency agreement in existence has some kind of ***indemnification clause*** or wording that entitles the insurer to demand reimbursement from you, the agent, for malpractice, negligence or action leading to a jury award. In other words, if you have a contributing exposure to a problem that caused the insurer to pay-out big bucks, you probably have the same exposure when the ***insurer*** comes after you personally!

It's Not What You Think!

In reading court cases, keep in mind that a decision that did NOT result in agent liability years ago might indeed represent exposure today, mostly because of the legal precedent theory and the fact that courts and juries in more recent years show a willingness to ***sanction*** this expansion. The court cases mentioned above are proof of this.

Further, don't discount a court case because it appears old. In Daniel v. Brickman (1998), a court made a decision that effected an insurance agent based on a trial decision made in 1917! You will also read about cases where the agent "won" the case. Well, don't forget, he did not escape the huge cost of a trial or legal fees that may not be recoverable. A lot of agents fail to insure for this contingency and errors and omissions carriers can also refuse to cover the claim.

Also, don't assume that a ***casualty*** court case has no application to you if you sell ***life insurance*** and vica versa. In fact, in National v. Valley Forge Life (2002), the actions of a ***real estate agent*** were analyzed in a decision against an ***insurance agent***! So, many legal matters concerning duties or negligence are fully portable and transferable between classes of agent.

Finally, be aware that some court decisions appear to "clear" the agent of wrongdoing. These decisions can result from issues extraneous to the case or a technicality. But, there is always the possibility of an ***appeal***. In fact, many of the cases we researched were appeal cases that initially dismissed the agent of any wrongdoing. A different judge and jury can reverse these decisions and find you liable even if you prevailed at the original trial.

Trial Issues

A majority of current agent lawsuits we researched center on the following issues:

Applications: Seemingly small things like taking charge of the application, your interpretation or advice on an underwriting issue or an honest mistake in transmitting paperwork can be blown completely out of proportion in court.

Authority: Look for legal maneuvering to establish that YOU have been authorized by your principal to act in the way you did. Clients who convince the court that they were made to believe an agent possesses this authority can win!

Conditional Coverage: What should you know about conditional coverage? At best, it is temporary. It is your job to read and understand the conditional receipt or special terms of the insurance application, agency agreements, applicable state codes and adequately explain the limits of this coverage to your clients.

Failure to Procure Coverage: When an agent negligently fails to obtain coverage for a client, he steps in the shoes of the insurance company and becomes liable for the loss or damage up to the limits of the policy until insurance is found.

Misrepresentation & Negligence: Misrepresentation and negligence in the insurance business cover a wide variety of problems. Insurers use untrue representations made by you to deny coverage thus making you, the agent, as liable as the insurer! Insureds can use agent misrepresentations as a defense to force payment of policy proceeds. Why would the insurer pay? Possibly to avoid a bad faith lawsuit or they might think it would be easier to pay then turn around and sue you for indemnification under terms of your agency agreement. In most misrepresentation and negligence issues, the standard for what is reasonable is never clear.

Fraud & Abuse: As an agent, you have an obligation to be alert to the possibility of fraud and abuse and you are required to report any knowledge or reasonable belief that such acts have

been committed. The deception can occur at many levels: from the application to the claim. And, of course the fraud and abuse may be the doing of the agent himself through misrepresentation of policy terms or values, false statements about coverage, misstatements on applications, back-dating applications, signing client names and much more.

Gaps in Coverage: There are situations where agents may be liable to an insured for the damage suffered by his failing to inform him as to a potential source of loss or gap in coverage and by his failing to recommend insurance to cover it. Your individual ***standard of care*** is critical to determining your exposure.

Policy Cancellations: Insurance coverage is often denied based on a policy expiration or cancellation. More likely than not, the decision to cancel is unilateral, meaning the action is taken solely by the insured or the insurer. Rarely is it a mutual event and rarely is it straightforward despite state rules on grace periods and timely notice. Either way, the result is a failure in coverage that presents significant liability for agents.

Anti-Stacking: A consumer might rely on a representation, by an insurer's agent, that coverages in multiple policies of insurance will be cumulative - that is, that the consumer may obtain benefits under more than one policy - even though there are anti-stacking provisions in each policy. Bottom line? When an insurance agent knows that the customer is relying upon his expertise, the agent may have a duty to exercise reasonable care in advising the customer of these issues.

Reasonable Expectations: No matter how clear the language, all policies contain areas of ambiguity. When conflicts arise, the courts generally turn to theories of reasonable expectation. In a nutshell, if a policy could imply to a reasonable or average policy holder that coverage is in force, yet that exact language does not exist in the policy, then coverage DOES extend to the policyholder. In other words, the courts generally favor the insured. As you might imagine, it's easy for agents to be involved in claims from contract ambiguity.

Insurer Claims: When most agents ponder professional liability, they think client lawsuits. But agents and brokers also face exposure from the insurers they represent. When agents are sued by their insurer it is most likely for a violation of the law of agency or terms of their agency agreement involving matters such as: indemnification (reimbursement for claim losses paid to policyholders), privacy (speaking out when you shouldn't), agent promises, supplemental agreements and more. Your agency agreement will also spell out the consequence of these violations including the ability of the insurer to terminate you ***at will***.

Important Terms

When you read court cases you will see many legal terms. Some, like breach of contract, misrepresentation, etc., may be familiar to you, while others seem a little more mysterious. Here are some legal definitions that are common in the insurance litigation world:

Reformation: When a party believes that a policy does not reflect the actual agreement made between the parties, he may ask for a ***policy reformation***. This is another way of saying . . . *make the policy reflect the agreement we made.* A single client, for example, buys a life insurance policy from you naming his sisters as the primary beneficiaries. A few years later he marries and adds his wife through a change in beneficiary form. You submit it to the company.

At his death, however, the company records only show the sisters as beneficiaries. The wife sues for the policy to be ***reformed*** to reflect the true intent of the client.

A party seeking policy reformation must generally show proof that is clear, unequivocal, and decisive, and more than a mere preponderance, that a prior agreement existed and that the contract does not reflect that agreement because of fraud or mistake

Ratification: Ratification is the adoption or confirmation by a principal of an unauthorized act performed on its behalf by an agent. Ratification occurs when a principal is aware of the material facts of an unauthorized transaction, and either fails to disavow the unauthorized transaction, or retains its benefits. For example, let's say your client receives premium notices specifying $1,020 due. However, you and your manager are convinced the client should only pay $975. So, you advise him to disregard the company's notice and pay $975. If the company cancels your client, his attorney will no doubt plead that the actions of you and your manger, representatives of the company, ***ratified*** the actions of your client.

Ratification may be express or implied. However, ratification by silence will be found only when a principal's conduct is inconsistent with non-affirmation of the unauthorized transaction and a third party relies on that conduct to its detriment.

Estoppel: Concerning insurance, estoppel is a ***clean hands*** concept that says insured is generally unaware of the conditions that may jeopardize his coverage. He relies to a great extent on the presentation of the insurer and his agent. If his reliance causes a problem, the law of estoppel permit him to force the company to make good on their promises.

As an example, assume that an agent knows something about a client, like a bad driving record or a pre-existing condition, that contributed to a claim. Because he is a representative of the company, the insurer might be ***estopped*** from using the bad driving record or pre-existing condition to develop a defense for denying the claim on the basis that the client lied on his application.

The courts are split on the question of an insured's innocence if a denial of claim stems from the insured's own lack of knowledge from failure to read the policy. However, a clear majority accept the reality that insureds are generally unknowledgeable in insurance matters and incapable of understanding complex policy language. Thus, ***buyer beware*** is rarely an imposed concept when consumers request estoppel protection.

Punitive Damages: These are typically high dollar awards well in excess of a client's actual out-of-pocket damages. A punitive damage award requires a knowing ***deliberate action***, rather than an isolated clerical error or an incorrect decision. Cases where they are awarded usually require that:

1) *The insurer lacked an arguable or legitimate basis for denying the claim, and*
2) *The insurer committed a willful or malicious wrong, or acted with gross and reckless disregard for the insured's rights.*

In other words, an award of punitive damages requires a finding of an intentional wrong or reckless disregard for the insured's rights that give rise to an independent tort, separate from breach of contract, based on a preponderance of the evidence.

Courts often make the distinction between ***legal fraud*** and ***willful fraud*** in determining the amount of punitive damages. How does one distinguish between the two types of fraud? An agent who perpetrates fraud, ***knows*** that his representations were false. An insurer who is effected by the agent representation ***should have known*** their agent was misrepresenting them. The latter suggests negligence, which constitutes only ***legal fraud***, for which punitive damages are not recoverable.

Case law also supports the award of punitive damages where an agent has knowledge of a ***preexisting condition*** of the insured but fails to communicate that knowledge to the insurance company and subsequently, the insurer refuses a claim because of the preexisting condition.

Risk Aversion: Insurance agents are known for their ***creative marketing***. Many times, an agent's "pitch" can be somewhat misleading. Take the case where a client is convinced that he would be far better off to switch from Agent B to Agent A because A's new policy is superior. If it is, in fact, not superior, Agent A has deceived his customer by appealing to his "risk adverse" nature . . . the old "confidence game" . . . and, most insureds are "risk adverse" by nature versus a gambler who is "risk preferring" by nature.

Authority Cases

The apparent authority of an insurance agent is such authority as the insurance company ***knowingly permits such agent to assume***, or such authority as a reasonably prudent man, using diligence and discretion, in view of the company's conduct, would naturally suppose the agent to possess. This is true regardless of whether he violates limitations upon his authority, as long as it is not known to the insured that he has exceeded his authority.

What kind of acts denote ***authority***? This could be as simple as posting a company logo on a business card or an office plaque, accepting premiums and forwarding them to the company using proprietary company forms, binding authority, etc.

The important element of authority is the reasonable belief that an individual is an agent of the principal. It is essential that there be some form of ***communication, direct or indirect***, by the principal, which instills reasonable belief in the mind of the third party. Statements or manifestations made by the agent are not sufficient to create an apparent agency relationship.

Prior dealings with the same company where premiums, applications and binding authority were granted are particularly solid evidence that an agent has apparent authority.

Lantz v Guarantee Sec Life Insurance (1990)

This is an interesting case that proves how easily authority from company to agent can be construed.

Between March, 1985 and December, 1986, on four separate occasions, Lantz gave Donald Coots approximately $ 66,000 to invest in annuities on her behalf. Coots told Lantz that money invested with him was insured "like in a bank" and that her principal was guaranteed. Lantz never asked and Coots never volunteered the name of the company providing the annuity. In her deposition, Lantz testified that she asked others, including a local banker, about Coots, found no one who was negative toward him and that she trusted Coots. She knew Coots was a licensed insurance agent.

Lantz's trust was misplaced. It is unclear as to what happened with the funds but it is undisputed that Coots did not invest any money on behalf of Mrs. Lantz. However, he did provide her documents purporting to be "single premium deferred annuity disclosure" statements. None of these documents contained the name of any company.

Subsequently, Lantz became suspicious and asked Coots to provide her with information about her investments. Finally, in October, 1987, Coots gave Lantz a packet of documents which he claimed represented the four investments. Some of the documents were printed on GSLIC letterhead. Lantz contacted GSLIC and discovered that GSLIC had no record of these investments.

As a result of this incident and several others, Lantz filed a multi-count complaint against multiple parties. Lantz alleged that Guarantee Security gave Coots ***apparent or actual authority*** to act on behalf of Guarantee Security with respect to Coots misconduct in handling Lantz's funds. Additional motions involved a cause of action against Coots for fraud and theft.

In its answer GSLIC stated that Coots was authorized to perform certain services on behalf of GSLIC. However, the scope of Coots' authority was set forth in Coots' contract with GSLIC:

We hereby appoint you as our General Agent to solicit, personally and through Sales Representatives, applications for policies of life, health insurance and annuities, to collect the first premiums on such policies and remit same to us immediately, and to make proper delivery of policies issues by us on such applications;

GSLIC asked the court to drop the suit on the grounds that actual authority cannot be proven unless Lantz can demonstrate that Coots' actions were within his actual or apparent authority from Guarantee. In fact, she had no idea that Coots even was an agent for Guarantee. Further, Coots never held himself out to plaintiff as an agent of Guarantee. She did not know that he represented Guarantee until October 16, 1987. She made her last investment with him on December 29, 1986. The court agreed and allowed GSLIC out of the lawsuit.

On ***appeal***, however, a different outcome occurred.

Lantz contended that GSLIC is liable as a principal for Coots' unauthorized acts because Coots was a ***general agent*** for GSLIC. Further, a contract existed between Lantz and Coots. Lantz gave Coots funds to invest. Coots represented that he had authority to invest and that he would do so. She knew Coots sold annuity products and that he was licensed to sell these products. Coots assured Lantz that her principal was guaranteed and the money was guaranteed as if at a bank. Lantz testified that she invested in a "single premium deferred annuity" which is consistent with the lump sum payment given to Coots and within his authority to accept as the first premium.

Clearly, there was a contract and it is undisputed that Coots was a general agent of GSLIC.

Even though Lantz did not know with whom her funds were to be invested, Lantz contends that her knowledge that Coots was a licensed agent or that she trusted him to invest her funds. Further, Lantz argues that Coots' ***subsequent representations*** that her funds were safely invested with GSLIC was evidenced by documentation boasting the GSLIC letterhead present an issue of material fact that authority existed.

The court was still suspect and discussed a previous case Randall v Alan L. Rankins Ins (1987) where apparent authority was established through ***indicia*** of that included, but not limited to: 1) a principal's sign indicating the general agency status of the agent; 2) the principal's stationery; 3) a document containing the signature of the agent as an agent for the principal; 4) the agent's and the insured's ***prior dealings*** with the principal and 5) printed application forms bearing the principal's name. If indicia of authority such as these were present, even when the plaintiff was unaware of the principal's identity, it would be appropriate to assume ***authority existed***.

The court further reasoned that local agents such as Coots are often licensed as general agents for several companies. And, It is within the power of the principal to ***choose*** its general agents. In fact, GSLIC's contract with its general agents contains an ***indemnification clause*** which, Kiernan testified, would require an agent to indemnify GSLIC should the agent act outside the scope of his authority. Under these facts, the reasonableness of Lantz's reliance on Coots' authority as a licensed agent needs to be determined at another trial. A question of fact also remains as to the various indicia of authority that caused Lantz's reliance. The court also could not deny that the principles of agency are inapplicable solely because Lantz was unaware of the name of Coots principal whom she believed to be safeguarding her investments.

Accordingly, the court found in reasonable grounds for Lantz's appeal thereby reversing the previous court release of GSLIC. No further information could found about either party, or the agent, so we could assume a settlement of some kind was accepted.

Pepkowski v Life of Indiana (1989)

This case is almost 180 degrees from the Lantz case above. Here, plaintiff Kim Pepkowski appealed a trial court's decision to release Life of Indiana from a lawsuit resulting from the denial of her claim for hospitalization and medical insurance benefits under a group insurance contract issued to plaintiff, as an employee of co-defendant Donald Webber Mortgage Company (Webber).

When the plaintiff was first employed by Webber, September 3, 1985, she was covered by a private health insurance policy due to terminate at the end of September. Webber had a group insurance policy plan with Life of Indiana, which was administered by Quinet. The policy provided that an employee who had worked at Webber for 30 days and who was accepted for enrollment by Life of Indiana was eligible for coverage on the 15th day of the month following an initial 30-day waiting period, which began running on the first day of employment. Eligibility for coverage was based on the acceptance of an employee's application and the payment of the premium.

When the plaintiff inquired as to Webber's insurance coverage, she was referred to Wytrykus, an employee of Webber. Wytrykus helped the plaintiff complete an application, gave her a booklet detailing the policy benefits, and sent her application to the insurance company. She alleges that Wytrykus told her that the insurance coverage would begin October 1, 1985. In reliance thereon, plaintiff terminated her private insurance coverage. On October 9, 1985, plaintiff was seriously injured in an automobile accident. Her claim for benefits was thereafter denied by Life of Indiana and Quinet on the basis that her coverage did not begin until October 15, 1985.

Pepowski essentially ignored the 30-day waiting period language, asserting her detrimental

reliance on Wytrykus's assurances of the earlier coverage date, along with other facts. Thus, her thinking is that any liability of Life of Indiana and Quinet derives solely from plaintiff's contention that Wytrykus acted as their agent. It is important to note, however, that neither Life of Indiana nor Quinet made any false representations concerning the coverage date. Plaintiff's information about the group policy came from Wytrykus, and, Wytrykus was employed by Webber, not by Life of Indiana nor Quinet. Wytrykus had never sold insurance for Life of Indiana or Quinet, nor received any compensation from them.

The plaintiff asserts that the following facts created a genuine issue for trial with regard to agency:

- Wytrykus provided the application form and benefits booklet
- He assisted the plaintiff in completing the form and mailed it directly to Life of Indiana and Quinet
- The plaintiff was not contacted by any other insurance agent regarding her coverage
- Life of Indiana and Quinet accepted the application.

Thus, the only "manifestations" (evidence if you will) by Life of Indiana and Quinet, are their permitting Wytrykus to possess their application form and benefits booklet and their accepting the application. These acts, according to the court in this case, were not a sufficient to clothe Wytrykus with apparent authority to bind Life of Indiana and Quinet. Pepowski was unsuccessful in her claim.

Gallant Insurance v Isaac (2000)

This case will make you tremble in your shoes. It is clear and away every agent's nightmare concerning those you entrust to handle your business when you can't . . .

On the last day of her insurance coverage, Isaac (the insured) traded her 1986 Pontiac Fiero for a 1988 Pontiac Grand Prix. To obtain the newly purchased car, the financing bank required Isaac to obtain full coverage on it. That same day, Isaac contacted Thompson-Harris to notify it that she was purchasing the new car, and to discuss enhancing the existing insurance policy to meet bank requirements. Isaac told a Thompson-Harris employee that she must obtain ***full insurance coverage*** as a condition to receiving a loan. She also told the employee at Thompson-Harris that her current coverage expires on December 3, 1994, the next day.

In response, the Thompson-Harris employee informed Isaac that because their agency was about to close for the weekend, she would immediately ***bind coverage*** on the 1988 Grand Prix. They decided that Isaac would come in to Thompson-Harris on Monday, December 5, 1994, to complete the paperwork and pay the down payment on the premium. The employee also informed Isaac that the new coverage on her Pontiac Grand Prix would include the same coverage existing from her Pontiac Fiero, along with additional coverage to comply with conditions set by the bank.

The next day, on December 3, 1994, a different employee completed the "Personal Policy Change Request." This form deleted the 1987 Pontiac Fiero from Isaac's Policy and replaced it with the 1988 Pontiac Grand Prix. It also added additional coverage to the policy as well as additional loss payee / lienholder. The Personal Policy Change Request listed the "Agency" and "Producer" as Thompson-Harris, and stated that the "effective date of change" was December 3, 1994. Towards the bottom of the form, the Thompson-Harris employee typed

"she will be in at 9:00 a.m. Monday, 12/5/94, to down on renewal. What is new rate? Thanks." This form, which requested the listed changes, was faxed to Insurance Brokers of Indiana, Inc., on December 3, 1994.

On Sunday, December 4, 1994, while driving her Pontiac Grand Prix, Isaac collided with another car in which Davis was a passenger. The next day, as planned, Isaac went to Thompson-Harris and paid $133.00 down payment on the new insurance policy. She also reported the accident. Thompson-Harris completed an "Indiana Operator's Vehicle Crash Report," which notified the State Police that Isaac had insurance coverage at the time of the accident, on December, 4, 1994. Thompson-Harris completed that form on behalf of Gallant. Later, on or about December 22, 1994, Gallant renewed Isaac's insurance policy, with an effective period of December 6, 1994 to June 6, 1995.

Soon afterwards, Gallant asked the court to be relieved of any coverage of Isaac's accident because the policy was not in force. In response, Isaac and Davis each filed their own motions. The courts initially agreed with the insured and granted coverage.

Gallant appealed this decision contending that Isaac's insurance coverage had lapsed at the time Isaac's accident occurred because the policy renewal premium was not paid as dictated in the policy. It was undisputed that Thompson-Harris is Gallant's independent insurance agent. However, Gallant insists that Thompson-Harris had no authority to renew the insurance policy or orally contract in a manner contrary to what the policy states without the approval of Gallant's producing agent, Insurance Brokers of Indiana, Inc.

Agent's Authority to Bind Gallant

Gallant argues that Thompson-Harris had no actual or apparent authority to renew the insurance policy or orally contract to do so.

The court, however, believed that the agent's power in this case stems not from authority, but from the agency relation itself. This inherent authority theory exists for the protection of persons harmed by or dealing with a principal's servant or agent.

This "status 'based' . . . vicarious liability rests upon certain important social and commercial policies," primarily that the '"business enterprise should bear the burden of the losses created by the mistakes of over zealousness of its agents [because such liability] stimulates the watchfulness of the employer in selecting and supervising the agents.'"

Inherent authority exists to hold an agent's principal liable when the acts in question

(1) Usually accompany or are incidental to transactions which the agent is authorized to conduct, even though they are forbidden by the principal;
(2) the third party believes that the agent is authorized to do them;
(3) and that third party has no notice that the agent is not so authorized.

In this case, Thompson-Harris's renewal of Isaac's insurance policy constitutes an act which usually accompanies or is incidental to insurance transactions that it is authorized to conduct. Examining Gallant and Thompson-Harris's agency relation reveals that, as an agent, Thompson-Harris ***was authorized to bind Gallant*** on new insurance policies, as well as interim policy endorsements, such as changing and adding new drivers, or changing or adding the vehicle insured. For example, Thompson-Harris ***had authority to write an application***.

That application "had to be either called to [Insurance Brokers of Indiana, Inc.] or faxed to them to bind coverage." In general, the power to bind its principal came into being once Thompson-Harris faxed the necessary paperwork to Gallant's producing agent and payment was made.

Thompson-Harris also had a ***common practice*** of telling its insured that they were bound despite not receiving payment until later, violating instructions by Gallant and provisions found in the policy. For example, the Record indicates that Thompson-Harris would "orally tell the insured that the new schedule vehicle was bound for coverage." Thompson-Harris would then delay that communication on to Gallant, which would then issue the endorsement.

Thus, even though the ***verbal binding*** was in violation of Gallant's orders, it was a fairly common practice at Thompson-Harris. Therefore, Thompson-Harris acted within the ***usual and ordinary scope of its authority***.

Third Party's Reasonable Belief

Isaac could have reasonably believed that Thompson-Harris had authority to orally bind coverage. Why? Because Isaac's ***past dealings*** were all through Thompson-Harris, whether involving payment of premiums, changing or including a driver, or requesting a new estimate. Direct communication between Gallant and Isaac never occurred. Thus, it was reasonable for Isaac to take at face value Thompson-Harris's communication that coverage was bound, and that she could come in at the end of the weekend to pay for the policy renewal. The reasonableness of Isaac's belief is bolstered by the fact that Thompson-Harris completed all the paperwork necessary and faxed the "Personal Policy Change Request," requesting at the bottom of the page an estimate and noting that Isaac will be in on December 5th, after the weekend, to pay.

Notice that Agent was not Authorized

Isaac lacked any notice that Thompson-Harris did not have authority to verbally bind coverage. Certainly, Isaac was unaware that Thompson-Harris had limited authority or was acting in violation to its agency agreement to bind insurance coverage without actual payment. Further, Isaac had no reason to know that when Thompson-Harris bound coverage Gallant must still endorse that verbal binding. Therefore, Isaac did not have notice that Thompson-Harris was not authorized to verbally bind coverage, without payment.

If Gallant or its producing agent ***informed*** insured individuals or potential clients that Thompson-Harris could not verbally bind coverage, or if Thompson-Harris was required to give such notice, Gallant would have satisfied the notice requirement. Instead, however, Thompson-Harris was left unsupervised to establish common practice in violation of Gallant's granted authority.

Conclusion

The court determined that Thompson-Harris was not authorized to verbally bind coverage without first receiving payment. Gallant, however, is the business enterprise better situated to "bear the burden of the losses created by the mistakes" of Thompson-Harris's over zealousness. Such liability may stimulate Gallant's watchfulness in selecting and supervising its agents, as well as taking affirmative acts to avoid mishaps as we witnessed here. Isaac's insurance policy was in full force and effect on December 3, 1994, because Thompson-Harris had the inherent authority to bind coverage by Gallant verbally.

What happened to Thompson-Harris? Nothing was noted in the case documents. However, Gallant could easily have terminated the relationship or pursue some form of indemnification suit on some form of agency agreement violation.

Application Cases

Insurance conflicts develop from many angles. The application is just one.

Some problems accrue to ***legal issues***, others procedures. ***Statements*** made by insureds on an application, for example, are generally interpreted by courts to be legal ***representations*** (opinions) not **warranties**. The difference is important because a representation is somewhat defensible, a warranty is presumed to be conclusive. Perhaps there are ***statements*** that you made to a client regarding a certain line on the ***application*** that is in direct conflict with policy coverage. The effect is to either ***extend coverage*** unwillingly or to set up a situation for a potential claim. Agents have also proclaimed to know how underwriting would handle an applicants information. When a claim was rejected, the agent became the insurer instead of the insurance company.

Procedures are important too. Consider, for instance, what would happen if you promised conditional coverage but the third page of your client's faxed application to an insurer failed to arrive? Then too, there are issues like . . . Did the client actually read the application before signing? Or, who took charge of filling out the application?

Omissions are yet another area of concern where your advice to leave out a tiny bit of information you thought unimportant caused a claim to be denied. Or, how about forgetting to communicate some personal knowledge you have about a client's condition or property with the app?

To help in these matters, some insurers have designed simple, easily understood applications . . . with prominently displayed explanations of both the limitations as to when coverage will commence. Insurers employing this approach have adopted specific measures designed to assure that applicant expectations are uniform.

Another, and often overlooked method of reducing conflicts at the application stage is extremely simple -- ***spend at least 50% more time than you do now with applications***. Make them tight; iron-clad. Here are some examples of why:

American Income Life v. Hollins (1999)

Deloise Hollins has suffered from lower abdominal pain, vaginal burning, and nausea since the age of seventeen. When these problems would flare up, she would seek treatment, and the problem would clear up for a while. In her early thirties, the problems began worsening. In fact, in early 1992 she sought treatment at the local emergency room.

Hollins had no medical coverage, so she contacted Amos Jones, an insurance agent for American, whom she had already known for several years. A meeting with several family members was arranged where Jones asked several medical history questions. Witnesses testified that Hollins disclosed to her current and past ***female problems***, i.e., that her ovaries and fallopian tubes were infected. Jones allegedly responded that her female problems would

be covered by the policy as long as she had not undergone surgery for them, which she had not. No documents were left with Hollins at this time.

At the trial, it was brought out that during this meeting, Hollins was seated next to Jones. However, she testified that she did not look to see what he wrote on the application and she signed it without checking it for accuracy. As it turned out, the application disclosed only one "check-up".

Some time later, Jones delivered the policy.

Amos Jones died on July 25, 1997, and therefore did not testify at trial, though he denied the allegations in a deposition.

A few months later, an ultrasound revealed fibroid tumors on Hollins's ovaries and bladder. Hollins was eventually required to undergo surgery for her condition, which had been diagnosed as pelvic inflammatory disease, followed by a hospital stay of four days. Hollins filed required claim forms which were denied based on an investigation of her prior medical history.

The primary issue in this case is: Did Hollins's prior medical history rendered her insurance policy ***voidable*** due to a misrepresentation in the application, and her claim invalid based on the preexisting condition provision of the policy.

In general, the courts have said that in cases ***where the agent takes charge*** of the application or suggests the answers to the question, the company shall not void the policy as long as full disclosures were made by the applicant (McCann v. Gulf Nat'l Life Ins. Co. - 1990)

Furthermore, ***where the insured gives correct information*** to the company's agent who, in turn, fills out the application, leaving out or altering certain information, there has been no misrepresentation (by the applicant). The fact that the applicant signs the application ***without reading it*** does not bar her from attempting to prove that the answers contained therein do not accurately reflect the information she gave the agent. (Pongetti v. First Continental Life & Acc. Ins. Co. - 1988)

In this case, it is clear that Hollins's sought treatment for medical problems five times. It is also argued a fact that the insurance agent, Jones, took charge of the application process. He asked Hollins the questions set forth in the application and filled in the answers for her on the form. Hollins told him that she had experienced female problems since the age of seventeen, that she was currently experiencing them, and the she had seen and was continuing to see a doctor in regard to these problems. The only disclosure of this information on the application was a ***single check-up*** on January 14, 1992, the date of application. Hollins testified that she signed the application without double-checking the information written on the form by Jones. She and three other witnesses testified to these events. American was therefore not entitled to rescind this policy based on material misrepresentations in the application.

In addition to these facts, the record reveals that Hollins owned an additional policy with American, and in 1990 submitted a claim form in which she divulged that she had experienced "female problems." She had also informed American of her female problems when she purchased a policy from it in 1987. American therefore had actual knowledge of Hollins' problems before issuing the policy sold by Jones in 1992.

Post-Claims Underwriting

Only after the filing of the claim at issue was Hollins's medical information reviewed by American's underwriting department, which determined that it "would have declined to issue until resolution of diagnosis of female problem." Based on this determination, Hollins' policy was then rescinded.

This procedure is called ***post-claim underwriting*** and it is highly criticized by the courts and industry:

We have condemned this practice of post-claim underwriting and cautioned insurers to abstain from such practices in the future. "An insurer has an obligation to its insureds to do its underwriting at the time a policy application is made, not after a claim is filed. (Lewis v. Equity Nat'l Life Ins. Co. - 1994)

Prexisting Conditions

After finding that the policy was not properly rescinded, the court's next challenge was to determine whether Hollins' female problems were properly excluded from coverage by the policy as preexisting conditions. The front page of the insurance policy at issue contains a provision that expressly ***excludes*** conditions for which medical advice or treatment was received in the two years prior to the effective date of coverage.

The courts have sided with insurers (Pongetti v. First Continental Life & Acc. Ins. Co. - 1988), if "no evidence existed which would indicate that the agent had actual authority to extend the coverage of the policy to risks which were specifically excluded by the policy". To ***prevail***, however, the Nichols v Shelter Life Ins (1991) case required the plaintiff show:

1) Acts or conduct on the part of the principal indicating the agent's authority,
2) Reasonable reliance on those acts, and,
3) Detriment as a result of such reliance.

In Barhonovich v. American (1991), the insured did ***not*** have the right to rely on fraudulent statements made by the insurance agent, since they were in ***direct conflict*** with the terms of the policy. In that case, the insured purchased a policy that stated on its face that the payment term was for "LIFE." Approximately fifteen years later an agent told him that he need not pay premiums any longer.

This case is different from Hollins in that she was not given notice of any preexisting exclusion at the time of relying on the agent's misrepresentation. Therefore, she was not bound by the exclusion.

Fraud

Hollins's claim for fraud is founded on the statement made to her by Jones at the time of completing her policy application. She and three other witnesses testified that Hollins described her history of female problems to Jones, who responded that as long as she had not undergone surgery for these problems, they would be covered by the policy.

A ***claim of fraud*** must satisfy nine elements (Martin v. Winfield - 1984):

1) A representation must be made,
2) The representation must be false,
3) The representation must be material,
4) The speaker must have knowledge of its falsity or ignorance of its truth,
5) The speaker's must intend that the hearer act upon it in the manner reasonably contemplated,
6) The hearer must be ignorant of its falsity,
7) The hearer relied in it being the truth
8) The hearer has a right to rely thereon, and
9) The hearer incurs consequent and proximate injury.

American argued that "Hollins failed to establish each of those elements." Further, American contends that the policy itself states that its agents do not have this authority, and that this knowledge is imputed to Hollins. As discussed in above, Jones was acting under the apparent authority to make the statement to Hollins that her condition would be covered before she was ever provided with the policy, and she was entitled to rely on it. Also, when this statement was made to Hollins, she had not been informed of the limitations on Jones's authority to make such statements, and she was not provided with notification of the preexisting condition exclusion. She was therefore entitled to rely on the statement that her condition would be covered.

So, the jury found that American's agent, acting with his scope of apparent authority, ***fraudulently misstated*** to Hollins that her female problems would be covered by the policy as long as she had not undergone surgery for them prior to purchasing the policy. It also found that the agent had taken control of completing the application for Hollins and that he did not correctly record the information given to him regarding her female problems.

Punitive Damages

Hollins asked for more than just payment of her $400 in medical bills; she wanted punitive damages in the amount of $100,000. Was she entitled? In State Farm Mut Auto v. Grimes - 1998, a court held that a punitive damage award requires a knowing deliberate action, rather than an isolated clerical error:

The law of this State does not impose punitive damages in cases in which a carrier is determined to have merely reached an incorrect decision in denying a given claim. The issue of punitive damages should not be submitted to the jury unless the trial court determines that there are jury issues with regard to whether:

- *The insurer lacked an arguable or legitimate basis for denying the claim, and*
- *The insurer committed a willful or malicious wrong, or acted with gross and reckless disregard for the insured's rights.*

In other words, an award of punitive damages requires a ***finding of an intentional wrong or reckless disregard*** for the insured's rights that give rise to an independent tort, separate from breach of contract, based on a preponderance of the evidence.

Case law also supports the award of punitive damages where an agent has knowledge of a preexisting condition of the insured but fails to communicate that knowledge to the insurance

company and subsequently, the insurer refuses a claim because of the preexisting condition. (McCann v. Gulf Nat'l Life Ins. Co. - 1985)

In this case, the jury found that American lacked an ***arguable basis for denying the claim*** and that it did so with malice or with such gross negligence as to amount to a reckless disregard for her rights. As a result, the two-prong test discussed in Grimes above had been met. Also, because of the misrepresentations of its agent, American rescinded Hollins's policy due to incorrect information in the application and refused her claim because of the preexisting condition. Punitive damages were awarded.

The amount of a punitive damage award were based on the following:

- First, the amount should punish the insurer and deter it from engaging in similar actions in the future.
- Second, the amount should serve as a deterrent for others.
- Third, the amount should account for the insurer's financial worth.
- Fourth, the amount should compensate the plaintiff for her public service in holding the insurer accountable.

American argued that the punitive award of $100,000 was unconstitutionally out of proportion with the actual damages of $400. It notes that the punitive damages verdict is 250 times that of the compensatory, and it claims that this disparity in violation of the United States Supreme Court's holding in Gore. In that case, the Supreme Court observed that the constitutional line is not clearly drawn and cannot be determined by simple mathematical formula. It went on to hold that the award in that case, 500 times the actual damages, was clearly unacceptable.

However, the court decided that a $100,000 award would not harm a $63 million company like American. And, they felt it was important to ***send a message*** to other insurers about post-claims underwriting. Hollins was granted her $100,000 punitive award.

Malone v. Basey (2002)

Basey purchased a car which was insured by Steve Malone with Indiana Farmers Insurance. Basey tendered a premium payment and Malone indicated that he would secure automobile insurance. Malone was acting within the ***usual and ordinary scope of his duties and responsibilities*** as an insurance agent when he took the premium from Anna Basey and forwarded the application of insurance by fax to Gallant Insurance Company through Insurance Brokers of Indiana, Inc.

Gallant issued a policy of insurance covering Basey. Shortly after, however, Gallant sent a letter to the Baseys indicating that it had erroneously issued a policy of insurance with declaration page indicating an effective date of November 2, 1997. This letter indicated that the policy was being cancelled effective December 12, 1997, because the insurance application was incomplete. On December 11, 1997, Gallant re-issued a new policy effective (bound) November 4, 1997 through November 4, 1998. Anna's premium payment was applied toward the corrected policy. However, on November 2, Anna lost control of her vehicle and caused a one-car accident.

It is undisputed that Malone ***did not provide*** the entire and complete application for insurance. In fact, Malone admitted in his letter to the State Insurance Department that, "the third page of

the application did not go through (the fax machine) on 11/1/97." Malone further stated in his letter that this page was re-faxed on November 3, 1997. However, IBI processed it as a new application for insurance and bound it effective November 4, 1997 through November 4, 1998.

At this time, Gallant's binding underwriting guidelines were as follows:

To bind coverage, call our 24-hour binder phone or send a facsimile transmittal of the completed application or endorsement. New or endorsement coverage is considered bound as of the date and time requested, provided:

1) *Application or endorsement is received in our office within ten (10) days of the call or fax; and*
2) *Application or endorsement is completed and signed by the applicant and/or producer (an incomplete application will be returned unbound); and*
3) *Applicant makes the required payment on the date of the application or endorsement.*

Malone followed Gallant's binding procedures. The application for insurance was completed and signed by Anna. Basey also tendered the required payment on the date of her application for insurance. Basey further stated that after tendering the premium payment, she assumed that she was ***covered*** when she left Malone's office.

The Claim

After denying her damages, Basey filed a claim against Malone and Gallant alleging they negligently failed to procure automobile insurance for her. The complaint also alleged that Gallant failed to properly investigate and settle a known loss and thus acted in bad faith.

As a matter of law, the trial court believed and ruled as follows:

1) There exists no genuine issue of material fact and [the Baseys] are entitled to judgment as a matter of law on the issue that the Gallant automobile insurance policy to [Anna] was bound and effective as of November 1, 1997, based upon the apparent authority of Defendant Steve Malone, as an agent, to bind Gallant Insurance Co.

2) There being no just reason for delay, judgment is entered for [the Baseys] and against [Gallant and Warrior] on the issue that the Gallant automobile insurance policy issued to [Anna] was bound and effective as of November 1, 1997.

So, in the first round, Basey won outright. However, Gallant appealed.

Gallant argued that the trial court's entry of partial summary judgment in favor of the Baseys was ***contrary to law***. Specifically, an independent agent is the agent of the insured and has no authority to bind the insurer. Therefore, Malone was the ***agent of Anna*** and did not have the apparent authority to bind Gallant.

Generally, an insurance agent representing several companies is considered to be an insurance broker. An insurance agent or broker who undertakes to procure insurance for another is an agent of the proposed insured (Anderson Mattress Co. v. First State Ins. Co. - 1993) However, courts have consistently determined that an insurance broker becomes the agent of the insurer when an insurance policy is issued.

When a broker makes [an] application for insurance and the insurance policy is issued, the broker is the agent of the insurer and can bind it within the scope of his authority. (Aetna Ins. Co. of the Midwest v. Rodriguez -1988).

In the present case, Malone operates an independent insurance agency and is considered a broker because his agency represents several insurers. When Malone submitted an application for insurance on behalf of Anna and an insurance policy was issued he became Malone an agent of Gallant and can bind it within the scope of his authority.

The courts went on to ***define authority***:

Apparent authority is the authority that a third person ***reasonably believes*** *an agent to possess because of some manifestation from his principal. The necessary manifestation is one made by the principal to a third party, who in turn is instilled with a reasonable belief that another individual is an agent of the principal. It is essential that there be some form of communication, direct or indirect, by the principal, which instills a reasonable belief in the mind of the third party. Statements or manifestations made by the agent are not sufficient to create an apparent agency relationship. (Pepkowski v. Life of Indiana Ins. Co. - 1989).*

What is manifestation in this case? The evidence reflects that apparent authority was present because Gallant placed Malone in a position to perform acts or make representations that appear reasonable to Anna. The evidence demonstrates sufficient manifestations endowing Malone with apparent authority. As stated above, Malone acted within the usual scope of his duties and responsibilities as an insurance agent for Gallant when he took the premium from Anna and forwarded the application of insurance to IBI. The record shows that Malone ***regularly*** accepted premium payments for Gallant.

He believed that accepting payments for Gallant was a normal act of an insurance transaction that he was authorized to conduct on behalf of Gallant. Furthermore, the record reflects that on November 1, 1997, Malone had the ability to bind Gallant for the purposes of issuing policies of insurance pursuant to certain Gallant Underwriting Guidelines.

It also appears that Gallant ***authorized*** Malone to bind insurance through a ***course of prior dealings***. Prior to November 1, 1997, Malone bound insurance policies for Gallant when customers came into his office, paid a premium, and signed an application for insurance. Gallant ***never objected*** or indicated that Malone was not capable of or did not have the authority to place people with insurance from Gallant. Malone obviously had a history of providing Gallant with new customers by accepting their money and tendering it to Gallant with signed applications for insurance. ***Gallant placed Malone in a position to perform*** the acts of accepting money, completing applications for insurance, and binding policies of insurance. These acts appear reasonable to a person, like Anna, and are sufficient manifestations of apparent authority.

Malone never indicated to Anna or her father that the insurance policy for her 1993 Chevrolet Camaro was not bound and/or covered by Gallant. Malone said nothing, nor provided Anna with any information that would indicate, that he was not an agent authorized to bind a policy of insurance with Gallant upon payment of her premium. Rather, Malone accepted Anna's premium payment in the amount of $308.00 and specifically indicated that he "would make sure that insurance was secured" for Anna's vehicle.

The personal automobile application form utilized by Malone to secure automobile insurance for Anna contained a box indicating that the company, "CO", that Anna was submitting her application for insurance was "Gallant" and the "PLAN" was for "Auto" insurance. The second page of the personal automobile application was signed by Anna and stated that the binder date was November 1, 1997 at 11:00 am. Additionally, the Gallant Insurance Company Auto Application contained the following in the bottom right hand corner: "Bound By: Fax, Initials: SM, Dated: 11-1-97, Time: 11:00 am."

Clearly, the application completed by Malone and Anna shows that Malone was acting as an agent of Gallant.

Here, ***Gallant's Binding Procedures*** clearly state that new coverage is considered bound as of the date and time requested provided: 1) the application is received in Gallant's office within ten (10) business days of the fax; 2) the application is completed and signed by the applicant and/or producer; and 3) the applicant makes the required payment on the date of the application or endorsement. Malone assisted Anna in completing and signing the application for insurance forms, accepted Anna's premium payment, and faxed the application to IBI all on November 1, 1997. Further, the application appears to have been received in Gallant's office within ten (10) business days of the fax because the policy was bound as a result of Malone's actions.

From this evidence, the court determined that the Gallant automobile insurance policy issued to Anna was bound and effective as of November 1, 1997, based on the apparent authority of Malone, as an agent, to bind Gallant.

Conditional Coverage Cases

Insurance coverage traditionally begins when a policy is accepted and the premium paid.

However, in cases where a formal policy cannot issued immediately because of administrative delays or the necessity for normal investigation, the practice of issuing cursory or conditional coverage has developed in order to provide the insured some level of coverage and to prevent the loss of a customer.

Requirements of conditional coverage 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.

What you should know about conditional coverage

At best, it is temporary. It is your job to read and understand the conditional receipt or special terms of the insurance application, agency agreements, applicable state codes and adequately explain the limits of this coverage to your clients.

In an attempt to limit or control insurer abuse of conditional coverage, courts now use a ***strict interpretation*** stance. Ambiguities are often resolved in favor of the insured.

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.

National Inspection v. Valley Forge Life - 2002

William Gaines originally filled out an application for ***key man insurance*** with his company, National Inspection, named as the intended beneficiary. Agent Straub of Valley Forge Life accepted a check for three months of premiums from Gaines. However, he technically should not have done so because Gaines answered a certain question in the application as affirmative. More on this later.

In addition, Straub did not disclose to Gaines or National that this insurance was contingent in any way and in fact stated that upon the acceptance of the check the company would be covered and if the individuals died the next day that the insurance would be in effect.

Straub's writing agency (Financial Brokerage) also acknowledged receipt of Gaines application and Valley cashed the checks. A short time later, both Financial Brokerage and Valley advised Straub that underwriting is investigating the application's positive response in the application.

Gaines died suddenly before the policy was issued but within the 90-day period described by the conditional receipt.

Coverage or not?

According to the court, the ***general rule governing conditional coverage*** circumstances was stated in Service v. Pyramid Life - 1968:

The provisions of a binding receipt issued for payment of the first premium upon application for life insurance, in accordance with the facts and conditions more particularly stated in the opinion, are construed as providing temporary insurance protection ***until such time*** *as the insurer has considered the application and announced its determination to accept or reject the risk, and the insurer* ***cannot*** *terminate the risk so assumed unless the insured is notified in his lifetime that his application was rejected.*

With regard to ***receipts for premium payments*** made the court said:

It is the practice of many life insurance companies to state in their applications that the contract of insurance shall not take effect until the application has been approved by the company, the first premium paid by the applicant, and the policy delivered. Where this is the situation a period intervenes between the signing of the application by the applicant and the delivery of the policy. During this period no money has been advanced to the insurance company, and no insurance is in effect. This interval, of a few days to several weeks, depending upon the time consumed in investigation and physical examination of the applicant, in passing upon his application at the home office, and in the traveling of the application and policy to and from the home office, is undesirable from the point of view of the insurer as well as the applicant. The disadvantage to the applicant consists in the fact he is not covered by insurance during this

period, while the disadvantage to the insurer consists in the fact that during this period the applicant possesses the power to revoke the offer made in his application. This disadvantage is a real one as far as the insurer is concerned, because the applicant may decide to exercise his power, either because he chooses not to carry any insurance at all, or because he chooses to purchase it from a rival company. In that event the company suffers to lose what it has expended for the investigation and medical examination of the applicant, aside from the loss of business itself.

To alleviate this situation insurance companies have seized upon the idea of issuing binding receipts to the applicant upon the payment of the first premium. These binding receipts, or conditional receipts, as they are sometimes called, usually contain a provision to the effect that the insurance shall be considered as in force from the date of the receipt, or the date of the medical examination, ***provided*** *the application is approved and accepted at the home office of the insurer.*

The issuance of these binding receipts effectively does away with the disadvantage threatening the insurer. The applicant to whom the binding receipt is issued feels contractually obligated to perform, and it serves to give the insurer the use of premium money at the earliest date possible. It further offers a selling point of which no agent fails to make the utmost in his talks with prospective customers.

With regard to ***courts' handling of the binding receipts***, the court observed:

There is a great confusion of authority as to the effect to be given such receipts. Because of the similarity of wording usually found in them, attempts have been made to generalize their operation. If these apparently conflicting authorities are examined, however, it becomes clear that these receipts are not capable of general treatment, but ***must be individually interpreted*** *to give them the effect which the parties intended them to have in each case. The fundamental question is: What was their intention?*

The conditional premium receipt that was given in return for the initial premium payment for Gaines states in part:

IMPORTANT: This receipt does NOT automatically create interim insurance coverage. NO INSURANCE IS EVER IN FORCE under this receipt until after ALL of its conditions are met.

NO AGENT OF THE COMPANY AND NO BROKER IS AUTHORIZED TO ALTER OR WAIVE ANY CONDITIONS OF THIS RECEIPT.

I. CONDITIONS REQUIRED FOR INSURANCE COVERAGE TO GO INTO EFFECT

It is understood and agreed that ***ALL of the following conditions*** *must be COMPLETELY satisfied for insurance coverage to take effect:*

A. The amount paid in exchange for this Receipt must equal at least the Minimum Premium for the Quarterly Mode (for Universal Life only) or 1/12 of the annual premium (for all other plans of insurance) for the policy applied for in the application.

B. The application and all medical underwriting requirements specified by the company rules and standards must be completed.

C. On the Underwriting Date, as defined in Section II below, both Proposed Insureds 1 and 2 must be a standard risk according to the Company's underwriting rules and standards for the plan and amount of insurance applied for in the application.

II. EFFECTIVE DATE OF CONDITIONAL COVERAGE

If all the Conditions in Section I are COMPLETELY satisfied, then insurance coverage will begin on the LATER of the following dates:

A. The Underwriting Date, or
B. The Policy Date, if any, requested in the application.

IV. LIABILITY NOT ASSUMED

If the Company determines that on the Underwriting Date, as defined in Section II, that either Proposed Insured 1 or 2 is not a standard risk according to the Company's underwriting rules and standards for the plan and amount of insurance applied for in the application and if either Proposed Insured 1 or 2 dies before the Underwriting Date, then the Company assumes NO liability under this receipt and application for life insurance.

V. TERMINATION OF COVERAGE

Any coverage which takes effect through this Receipt will terminate on the EARLIEST of the following dates:

A. Ninety (90) days after the date of this Receipt.

B. The expiration of the period for which Minimum Premium has been paid (for Universal Life only) or the fraction of one year that the payment made bears to the annual premium for the policy applied for (for all other plans of insurance).

C. The date the policy goes into effect.

D. The date that the Company determines that either Proposed Insured 1 or 2 are not entitled under the Company's underwriting rules and standards for insurance on the plan and amount of insurance applied for. In that case no insurance becomes effective and the amount paid will be returned to the Owner.

ANY DELAY IN RETURNING THE AMOUNT PAID WILL NOT BE CONSTRUED AS APPROVAL OF THE APPLICATION.

If coverage under the receipt terminates as provided in Section V above, any policy issued by the Company will not take effect until, during the lifetime of Proposed Insured 1 and 2, both the policy is delivered to the Owner and the first premium is paid, and then only if there has been no change in the health of either the Proposed Insured 1 and 2 since the date of this receipt.

The language of this conditional receipt seem fairly clear. No interim coverage is implied and insurance is not in force until all conditions are met.

However, many ***state regulations*** also say that when an application and premium are accepted, coverage will be deemed to remain in effect until the applicant has been notified of

an adverse underwriting decision in writing accompanied by the return of the unearned premium. In this case, neither Gaines or National were notified in writing of an adverse underwriting decision.

The "Yes" Response

But, what about the question in the application where Gaines responded "yes". It read as follows:

In the past 90 days, has any person proposed for insurance been admitted to a hospital or other medical facility, been advised to be admitted, contemplated surgery, or had surgery performed or recommended?

The application further says:

If either question in this section is answered 'Yes' or left blank, a premium payment cannot be accepted with this application and any conditional receipt is void."

In this case, ***despite*** Gaines' affirmative answer, his application and premium were ***accepted***. Thus, by state law coverage was deemed to be temporarily in effect for Gaines and none of the exceptional circumstances identified above seems to apply.

In another twist to this case, a clause in the ***conditional receipt*** reads as follows:

"The liability of the Company under this Receipt and application for life insurance and accidental death benefits will not exceed $ 1,000,000 reduced by (1) any insurance issued by the Company on the life of the Proposed Insured within 90 days preceding the date of this receipt and (2) by any death benefit payable under all other Receipts and applications currently pending with the Company."

As it turns out, just before Gaines died, underwriting sent a notice to Straub's agency indicating only $234,500 of insurance, not the original $500,000 was approved for Gaines due to his salary level. Thus, Valley gave written notice that limited the amount of coverage under the premium receipt. However, the court did not agree, because the premium was also not returned. Valley owed the full $500,000!

Court Conclusion

What happened to agent Straub? After all, Valley alleged that Straub was not authorized to take Gaines' application or the initial premium for his coverage, and, in fact, Straub was expressly unauthorized to do so. Thus, according to Valley, Straub ***violated the terms of his producer contract***. By doing so, he negligently performed his duties as a Valley agent and he had a duty to reimburse CNA for any loss it suffered as a result of his improper conduct.

Well, by the skin of his teeth, Straub was released from Valley's claim for indemnification because he was ***not the proximate cause of Valley's loss***. The legal principle upon which the district court based its decision is that on ***theories of contract***, ***negligence***, and ***indemnification*** a principal is not entitled to indemnification unless the agent's error is the ***proximate cause*** of the principal's loss.

The courts further say:

Under agency law, once a principal knows of an agent's unauthorized actions, it cannot sit back and see if it will benefit or suffer from the agent's actions. Instead, a principal who receives notice of an unauthorized act of an agent must promptly repudiate the agent's actions or it is presumed that the principal ratified the act. ***Ratification*** *is the adoption or confirmation by a principal of an unauthorized act performed on its behalf by an agent.*

The ***general rule*** *is that an 'agent may be subject to liability to his principal because he has made an unauthorized contract for which his principal is liable. However, the ratification or other affirmance by a principal of an unauthorized act done by an agent in excess of his or her power to bind the principal releases the agent from liability for damages to the principal for having violated a duty to the principal.*

Straub's ***unauthorized*** acceptance of Gaines' application and initial premium was ***ratified*** rather than ***repudiated*** by the principal.

Peerless Insurance v. Young - 2002

Young applied for insurance with the Assigned Risk Plan through an insurance broker, paid the broker $507 and was given a temporary insurance card which stated that coverage would become effective upon vehicle registration or at such earlier date as the Assigned Risk Plan might designate.

Young was shortly thereafter involved in a car accident. However, since the vehicle was not registered on the date of the accident, and this was a requirement on the assignment card from the Assigned Risk Plan, his claim was denied.

Young conceded that the issuance of a temporary insurance card does not ***trigger coverage***. ***Coverage*** is only effective from the date of receipt of the request in the Plan office and then only if the ***vehicle*** has already been registered. He did argue, however, that certain oral representations made by the insurance broker bound the insurer to provide coverage from the date of application. However, he failed to demonstrate any exceptional circumstance and the court rules that no coverage was available.

Lucini v. Buck - 1992

In 1985, the Bucks' daughter developed an interest in horses. The Bucks bought her a horse in 1985 for $5,000. She began competing in show jumping. As her skills improved, the Bucks purchased more expensive horses. During 1987 through 1988, they purchased three more horses with prices ranging from $18,000 to $37,500.

Because of the value of these horses, the Bucks purchased equine mortality insurance to cover them. The Bucks always obtained their insurance through Lucini-Parish Insurance (LPI) and always followed the ***same procedure*** to obtain the insurance. Mrs. Buck would direct one of her employees to contact LPI and to request that LPI procure equine mortality insurance to cover the animal. The Bucks' employee would send the necessary documents, and LPI would procure the insurance, usually through Lloyds of London. The Bucks never negotiated the costs or the duration of the insurance. Mrs. Buck simply paid the premiums when she received them.

In May 1989, the Bucks became interested in purchasing a thoroughbred horse named Bluegrass. The Bucks had three veterinarians examine the horse and each determined that the

horse was in good health. On Thursday, June 29, 1989, Mrs. Buck decided to purchase Bluegrass for $75,000. On Friday, June 30, she called her office and directed Nancy Potts ("Potts") to inform LPI that they were going to buy the horse and needed to add him to their existing policy (which was issued by Lloyds of London).

Potts called a customer service representative at LPI informing her about the value of Bluegrass and that the horse, which was stabled in California, would be arriving in Reno early Saturday morning. She requested that Bluegrass be added to the Bucks' existing policy and asked the rep ***what documents LPI needed*** to accomplish this request. The agent's rep responded that she needed a ***veterinarian's certificate and the bill of sale***.

Because the Bucks did not yet have the bill of sale, Potts called back and asked if a copy of the $75,000 check would be sufficient. According to Potts, the agent responded affirmatively. Potts then believed that once she faxed the necessary documents to LPI, Bluegrass would be insured. Likewise, through their course of dealings, the Bucks thought that once they sent the requisite documents to LPI, the in-question animal would be insured.

Unbeknown to the Bucks, LPI ***lacked binding authority*** with respect to equine mortality insurance. It is also important to note that Mrs. Buck's business utilized LPI to insure or procure insurance for boats, homes, automobiles and business parks.

Potts faxed the veterinarian's certificate and a copy of the check to LPI on Friday afternoon. On the next day (Saturday), the agent found the documents on the fax. She mailed them, via regular mail, to a local agent with binding authority.

On the following Tuesday Mrs. Buck received a telephone call advising her that Bluegrass was sick, and late that evening a veterinarian informed Mrs. Buck that Bluegrass had died. Mrs. Buck called LPI and was informed by the agent that Bluegrass had not yet been insured.

The Claim

The Bucks submitted a claim which was denied. The Bucks brought this action against LPI for negligently failing to procure insurance, and that LPI made negligent misrepresentations and a jury agreed. LPI appealed the verdict arguing that even if it had procured the requested insurance, the Bucks' claim would have been denied because they did not establish that Bluegrass was in ***sound health*** at the time insurance could have been effective, a ***condition precedent to coverage***.

LPI said that the Bucks did not satisfy the sound health condition, reasoning that the earliest date that Lloyds of London could have approved the policy was July 3, 1989, but that the horse died of a two-day disease (according to an inadmissible document) on July 4, 1989.

The Decision

However, the court overruled this argument because it was determined in court that Lloyds of London considered the condition of ***sound health*** satisfied if the veterinarian's certificate was provided and if no one knew of the horse's illness at the inception of the policy. The Bucks provided a veterinarian's certificate of sound health and did not know of Bluegrass' illness until July 4.

Additionally, the effective date for a prior equine mortality insurance policy which LPI had procured for the Bucks was made retroactive. That policy was approved by Lloyds of London on May 18, 1988, but the effective date was May 16, 1988 -- the date the agent sent the veterinarian's certificate and the horse's registration to the local agent with binding authority.

Valiant v. Birdsong - 1987

Agent Charles Birdson was sued ***by his own insurer*** for ***exceeding his binding authority***. Following are findings that surfaced during the trial:

(1) Gary Thomas approached Birdsong about securing insurance for his home.

(2) Mr. Thomas' home was located in a very rural area.

(3) Mr. Thomas' home was a double-wide mobile home that had been set on a brick foundation. It had a porch on the front of it, and across the back it had another porch and two extra bedrooms added on to the mobile home. On the end of the trailer, a deck with an above-ground swimming pool had been built. The trailer also had a roof built over it.

(4) Mr. Birdsong personally viewed Mr. Thomas' home prior to procuring insurance for it. Furthermore, Mr. Thomas described his home in detail to Mr. Birdsong, when he applied for insurance with the Birdsong-McKenney Agency. Mr. Thomas also stated to Mr. Birdsong at that time that his home was a mobile home that had been ***modified*** with certain improvements.

(5) After taking Mr. Thomas' application for insurance, Birdsong bound coverage for the property.

(6) Valient's carrier notified Birdsong that it was ***declining to cover*** the property because it was too far from a protected town. However, a clause in the policy allowed coverage to remain in effect for 30 days.

(7) Birdsong thereafter initiated another policy of insurance with Valiant, retroactively binding Valiant using a different protection class.

(8) The Thomas residence was destroyed by fire shortly after the new policy was bound but before the previous policy's 30 day cancellation ended.

The Claim

Essentially, there were two policies in effect when the property burned, so Valient paid over $70,000 to the homeowner. However, Valient quickly filed a claim for indemnification against agent Birdson on two fronts: He acted outside the scope of his agency and exceeded his authority to bind.

Valient cited BSF, Inc. v. Cason - 1985 that concluded "an agent who negligently induces the insurer to issue a policy in consequence of which the insurer sustains a loss himself is liable to the insurer for such wrongful conduct."

Valiant also claimed that Birdsong exceeded his authority to bind the risk in question, and that as a result of this conduct, he bound Valiant to cover a risk that it ***would not otherwise have insured***. Valiant claims that Birdsong exceeded its authority in the following ways:

- Mr. Thomas' residence was a mobile home;
- Coverage on Mr. Thomas' home had been previously "cancelled, declined, or refused" by another insurance carrier;
- The mobile home had a swimming pool which was not fully fenced;
- The mobile home had an ISO rating of 9, as opposed to the 7 as reflected on the application; and,
- The home was not situated in either a named subdivision or a built-up locality.

Birdsong claimed he was not properly made aware of these binding guidelines; only some older binding guidelines. The court disagreed. Even the old binding guidelines were clear that Birdson did not have authority to bind a mobile home without first clearing it with Valient. Further, Birdsong ***knew*** of the mobile home nature of the risk in question, and it is clear that he ***exceeded his authority*** by binding that risk prior to seeking approval from Valiant and was negligent in not disclosing these facts to Valiant.

It was also clear that coverage on Mr. Thomas' residence had been "cancelled, declined, or refused by another company" prior to Birdsong placing coverage with Valiant. This was yet another clear ***violation of Valient's binding guidelines*** that should have been discussed with Valient before coverage was bound.

Finally, Birdsong's representation that the Thomas residence maintained an ISO rating of 7, as opposed to 9, is material if the binding guidelines prohibited him from insuring that type of risk. The binding guidelines provide in this regard that, protection class 9 risks may be written when -- the dwelling is situated in a built up locality and is not over 20 years old -- a responding Fire Department is within 5 miles -- a water supply is available from fire hydrants or a fire department tanker truck of at least 1000 gallon capacity.

In fact, the Thomas residence was located in an extremely rural area, and that it was impossible for the court to find that the home was in a built up locality. Binding Valiant to this risk was, therefore, again both negligent and outside the scope of Birdsong's agency agreement.

The Decision

The court further finds that had Valiant been made aware of these facts, and had it acted reasonably and in good faith, it ***would have declined*** to insure the Thomas residence. Accordingly, the court concluded that Charles A. Birdsong was liable for over $70,000 in indemnification costs plus interest.

Failure To Procure Coverage Cases

An estimated 60 percent of all claims result from agent malpractice in failing to procure coverage.

What goes wrong? Well, it can be as simple as forgetting to place the coverage or failure to perform some function related to coverage like forwarding the premium payment(s). Liability may also result from an agreement to procure a desired coverage at the lowest obtainable premium rate.

In general, when an agent negligently fails to obtain coverage for a client, he ***steps in the shoes of the insurance company*** and becomes liable for the loss or damage up to the limits of the policy until insurance is found.

Daniel v. Brickman - 1998

Armando Daniel agreed to help his son Julio purchase of a home. Insurance coverage was requested through agent Guy Brickman. The request, made by a secretary at the title company, listed Armando as the homeowner, and it also specifically provided that: "the son is going to live at the property." The application that was sent to Florida Residential Property and Casualty Joint Underwriting Association by Brickman also reflected that Armando was the owner, but it indicated that the home was to be used as his ***primary residence***. The coverage listed Armando as the named insured.

In August of 1995 a fire broke out at the residence, in conjunction with a theft, and a second theft occurred while the home was vacated. Armando made a claim under his homeowner's policy for damage to the structure, damage to or loss of Julio's personal property within the structure, as well as the couple's additional living expenses. The insurer determined that because Armando did not reside in the home, as provided in the policy, Julio was not an insured.

Daniels then filed a suit seeking to ***reform*** or change the policy to include Julio as an insured claiming Julio was an ***intended third-party beneficiary*** of the insurance contract. After discovery established that Armando had never resided in the home, the insured filed its Counterclaim for Rescission of the policy. The Daniels amended their complaint asserting a claim for negligence against both the insurer and agent for the failure to obtain appropriate insurance.

The court did not initially look favorably on Daniel's requests. Citing an old 1917 case, Rosenthal v. First National Fire they determined that the failure of a policy to express the intended contract of the parties must be occasioned by a ***mutual mistake*** to justify a reformation of the contract. The court did not feel this was the case here. Likewise, the Daniels' claim of the couple's third party beneficiary status failed because the contract did not clearly express that it intended to primarily and directly benefit Julio.

The Daniels claims of negligence, however, was a different story. The court believed that a cause of action exists when an insurance agent negligently fails to obtain requested insurance (Farm Ins v. Bass - 1992). Brickman acted negligently in procuring the insurance requested by the Daniels. More specifically, his actions in not questioning that "the son is going to live the property" is a breach of his responsibility.

Misrepresentation & Negligence Cases

A ***misrepresentation*** is something you say or do that is ***misleading*** and ***material*** to the risk and is ***relied*** upon by an insurer or insured. Insurers use untrue representations made by you to deny coverage thus making you, the agent, as liable as the insurer! Insureds can use agent misrepresentations as a defense to force payment of policy proceeds. Why would the insurer pay? Possibly to avoid a bad faith lawsuit or they might think it would be easier to pay then turn around and sue you for indemnification under terms of your agency agreement. Think it doesn't happen? Read on.

Negligence is the act of an unreasonable and imprudent person. Often it results from carelessness, but it may be due to forgetfulness, bad temper, ignorance, bad judgment or stupidity. Negligence ***never involves intent***. Insureds may pursue you for a whole host of negligence issues: Presumed negligence, imputed negligence, contributory negligence, comparative negligence, last chance negligence and more! The standard for what is reasonable is never clear. Often, where a judge believes the standard of care is clear, he will decide if negligence has occurred. Where there is room for disagreement, negligence issues are typically decided by jury.

Misrepresentation and negligence in the insurance business cover a wide variety of problems. Wrongdoing has occurred where agents promised to procure ***complete*** coverage, when it fact, it fell short in a very critical area (Riddle-Duckworth Inc v. Sullivan - 1969). In Hardt v. Brink, the agent failed to advise the insured cover a property the agent personally knew he owned. Another agent obtained a policy for a client knowing it would NOT provide the coverage he desired (Rider v. Lynch - 1964). In Walker v. Pacific Indemnity - 1960, the agent negligently obtained a policy with smaller limits of coverage that had been agreed upon. In yet another case, an agent notified the client that his original company was insolvent and that a replacement policy would be needed. The agent replaced the policy with a new policy having less coverage. Another broker was held personally liable for $150,000 difference between an insured's primary and excess coverage claim (Reserve Ins Co v. Pisciotta - 1982). Liability was also present in the case where a lending institution, licensed to sell credit life, failed to offer it to a client who later died (Keene Investment Corp v.Martin - 1963). Misrepresentation was on the minds of jurors in a case where life insurance premiums were so high they had be bank financed. The agent claimed this $150,000 policy was suitable for an individual earning less than $10,000 per year (Anderson v. Knox - 1961). Still another case of misrepresentation involved an application for life insurance with some critical "missing blanks" concerning preexisting health conditions which the agent told the deceased and his widow were not necessary. Coverage was denied. (Ward v. Durham Life - 1989).

Let's look closer at some cases to see how negligence and misrepresentation come about:

Cooper v. Berkshire Life (2002)

Cooper purchased a "vanishing premium" life insurance policy from Berkshire Life Insurance Company insuring the lives of himself and his wife Annette Cooper. Steinhardt and Fish, were agents of Berkshire who represented that he ***only would have to pay premiums for ten years***. Cooper donated one of the policies to the Associated Jewish Charities of Baltimore ("Associated"), and the other to The Joseph & Annette Cooper 1990 Insurance Trust (the "Trust").

After later finding out that the policies required premium payments for at least ***seventeen years***, Cooper, joined by his wife, Associated, and the Trust (collectively, the "Coopers"), filed a complaint against Berkshire, Steinhardt, and Fish. They alleged fraud, fraudulent concealment, negligent misrepresentation, breach of contract, imposition of constructive trust, declaratory and injunctive relief, reformation, and violation of the State's Consumer Protection Statute. This should give you an idea of how many angles attorneys have in these matters!

Following were issues raised in court:

1.. Is there a question of fact whether Berkshire's policies - with "disappearing premium illustrations" attached inside - were so clear that Cooper could ***not reasonably have relied*** on the premium illustrations in making his decision to purchase?

2. Does the economic loss doctrine bar the Coopers' tort claims? (*The economic loss doctrine bars negligence claims when there is no claim of personal injury or a defective product).*

3. Is there a question of fact whether Berkshire's policies - with "disappearing premium illustrations" attached inside - were so clear that the Coopers ***should have known*** of their claims when they received the policies?

The Policies

Cooper, on the advice of his estate planning attorney, decided to purchase a $ 1 million second-to-die life insurance policy for himself and his wife, which he planned to donate to a trust that would pay estate taxes for his heirs. *A second-to-die policy is one that does not pay the death benefit until both insureds have died.*

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***.

The Coopers were ***unsophisticated*** regarding life insurance, and unfamiliar with the technical language of the policies. Fish and Steinhardt also showed Cooper the first page of a computer-generated "disappearing premium" sales illustration, which demonstrated that a $1 million policy would cost only $ 9,000 a year for nine years. It displayed columns showing the "Scheduled Annual Outlay" for each year, as well as the "Dividend End of Prior Yr." The "Scheduled Annual Outlay" column showed $ 9,000 for each of the first nine years, and "0" for years ten through thirty.

On this illustration, at the bottom of the page, appeared the words:

This illustration is not complete without the accompanying Supplemental Footnote Page." At the top of the page, the illustration said: "Dividends applied to purchase paid up additions.

Too Good To Be True

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. After Cooper told Steinhardt and Fish of his decision, he was informed that, in the interim, the premiums had increased. The $1 million policy would cost $10,700 a year for ten years, and the $1.5 million would cost $16,000 a year for ten years. Because he was still satisfied with the revised prices, he advised the insurance agents to have the policies issued. Although not the owners of the policies, the Coopers still planned to pay all premiums through contributions to the Trust and to Associated.

Disclosures

The $1.5 million policy was delivered to Cooper. A policy summary on the cover page stated that "*Premiums Payable as Specified or Until Death of Survivor*." The cover page also notified the policyholder of his right to cancel the policy within a ten-day "free-look" period. On the same page, the policyholder is advised: "*READ THIS POLICY CAREFULLY*." On the next page of the policy, the "Policy Specifications" page, under the heading "YEARS PAYABLE," appears the word "LIFE."

Attached inside the back cover of the policy was a disappearing premium illustration, consisting of eight pages, showing that the "Out of Pocket Outlay" would be $16,000 a year for ten years. Additional language in the illustration footnotes read as follows:

This illustration is not a contract. It is a projection of values based on a combination of guaranteed values and contingent values such as dividends. Dividends and dividend purchases are neither estimated or guaranteed but are based on current company experience. . . . The current dividend scale is interest-sensitive which means significant changes in interest rates may affect future dividends.

When asked if he read this footnote, Cooper responded "I probably did, but I don't remember it." Cooper stored them in his office safe until the litigation began. The $ 1 million policy was delivered directly to Associated without ever being shown to Cooper, and he did not see it until the litigation began.

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.

Negligence & Misrepresentation

The Coopers assert 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.

To sustain an action for fraudulent misrepresentation, the Coopers must prove:

(1) That the representation made is false;
(2) That its falsity was either known to the agents, or the misrepresentation was made with such a reckless indifference to truth as to be equivalent to actual knowledge;
(3) That it was made for the purpose of defrauding Cooper;
(4) That Cooper not only relied upon the misrepresentation, but had a right to rely upon it in the full belief of its truth, and that he would not have done the thing from which the injury resulted had not such misrepresentation been made; and
(5) That he actually suffered damage directly resulting from such fraudulent misrepresentation."

More Arguments

Bershire argued that:

*It is the **obligation of the insured** to read and understand the terms of his insurance policy, unless the policy is so constructed that a reasonable man would not attempt to read it. . . . If the terms of the policy are inconsistent with his desires, he is required to notify the insurer of the inconsistency and of his refusal to accept the condition.'*

The Coopers argued, that the illustration indicating there would be no more premiums at the end of 10 years was part of the contract because language at the front of the policy read:

The policy, the attached application, and any other attached agreements make up the entire contract.

Berkshire then read the following footnote from the illustration:

This illustration is not a contract. It is a projection of values based on a combination of guaranteed values and contingent values such as dividends. Dividends and dividend purchases are neither estimated or guaranteed but are based on current company experience. . . . The current dividend scale is interest-sensitive which means significant changes in interest rates may affect future dividends.

They further cited a 1993 case (Northwestern Mutual Life) that concluded *an insured cannot rely on oral statements regarding guarantee of vanishing premiums that contradicted the language of the policy.* The Cooper policy clearly states that the ***dividends would vary***, and thus the projections could not be relied upon to restrict the premium outlay to the first ten years.

Coopers came back with the issue of conflicting illustrations.

A Word On Illustrations & Quotes

You can clear up many illustration conflicts by requesting a copy of illustrations you intend to handle ahead of time. Carry a ***specimen policy*** to compare with specific illustrations to properly answer any client questions. Clear up questions and conflicts early.

Before you present an illustration, make sure all pages are printed and any ***projected rates***, ***exclusions and assumptions*** are disclosed and discussed with clients.

For life illustrations, look for sudden jumps in cash values or premiums. Are the projections in line with current expectations?

For casualty, make sure the quote matches the requested coverage and the principal is disclosed. Do words imply that the client is bound?

The assumptions underlying Berkshire's illustrations were inconsistent with Berkshire's own internal forecasts, estimates, analyses and projections. This "inaccurate illustration" claim stands independently from the "guaranteed illustration" claim.

Further, they said Berkshire failed to disclose to the Coopers . . . [that] the dividend scales used to illustrate the performance of Berkshire's policies included interest rate assumptions

that were not supported by Berkshire's current investment results, lacked any reasonable basis in fact, and would decrease in future policy years

Without disclosure of the foregoing material facts and information, the "disappearing premium" sales scheme was inherently false, misleading and deceptive.

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.

Claims Against The Agents

After reviewing several other cases (both Life and Casualty), the Court adopted a ***general rule concerning actions against agents***:

It is generally accepted . . . that, when an insurance broker is employed to obtain a policy that covers certain risks and the broker fails (1) to obtain a policy that covers those risks and (2) to inform the (insured) that the policy does not cover the risks sought to be covered, an action may lie against the broker, either in contract or in tort. . . .

*The alleged **duty [of the client] to read the policy** . . . lies at the heart of the contributory negligence defense asserted to a claim of negligence on the part of the broker. . . . A fair reading of the cases and the more recent commentary as to negligence actions suggests that the duty is not necessarily to read the policy but simply to **act reasonably under the circumstances**. In some settings, acting reasonably may well require the insured to check parts of the policy or accompanying documents; in many settings, it will not. The duty to check the policy is essentially the flip side of the extent to which the insured reasonably may rely on the agent, broker, or insurer's having produced the terms and coverages for which the insured bargained or applied.*

The Coopers alleged that the agents "***cultivated a relationship of trust and confidence*** in the Coopers through their ***self-proclaimed expertise***," and "held themselves out as highly-skilled insurance experts, possessing the ***special knowledge and expertise*** needed to interpret and understand the complex and sophisticated funding methods and mechanics of the disappearing premium policies." The Coopers also alleged that these agents were social friends prior to their business relationship. Cooper stated in his affidavit that he chose Fish and Steinhardt because he wanted them, as friends, to benefit from the commissions that would be generated from his purchase of the two policies.

Fish and Steinhardt asserted that Cooper's reliance cannot be reasonable in light of his acknowledgment during questioning by defense counsel that the "deal" was "too good to be true."

The court said:

With respect to Fish and Steinhardt, we easily can answer this argument because insurance agents and brokers clearly owe a professional's duty to the insured. An agent, employed to effect insurance, must exercise such reasonable skill and ordinary diligence as may fairly be expected from a person in his profession or situation, in doing what is necessary to effect a policy, in seeing that it effectually covers the property to be insured, in selecting the insurer and so on.

The Statute Of Limitations

There was much discussion in this case concerning the Statute of Limitations. Normally, a civil action must be filed within three years, measured from the date it accrues unless another provision of the Code provides a different period of time within which an action shall be commenced. The cause of action is triggered when the claimant knew or reasonably should have known of the wrong.

Berkshire and the agents felt that Coopers were on ***inquiry notice*** of their claims in 1990, because: (1) the sales illustration was "too good to be true;" (2) it would be unreasonable for anyone to expect that dividends would remain as illustrated, given inevitable changes in the economy; (3) there were no guarantees in the policies that premiums were due for only ten years; (4) the first page of the policies lists "life" under the heading "Years Payable;" (5) the bottom of the Illustration page specifies that "this illustration is not complete without the accompanying Supplemental Footnote Page;" and (6) the Supplemental Footnote Page, enclosed with the $1.5 million policy, says: "This illustration is not a contract."

Continous Representation Doctrine

In most contract disputes, the statute of limitations tolls or begins when a breach occurs -- even though no damage occurs until later.

Continuous representation, however, provides that when a professional's wrongful conduct is part of the dispute, the statute of limitations ***extends*** until the relationship is terminated. An example would be you helping an insured with information he is using to file a claim. You have extended the time limit he can sue you for your part in the problem.

Attorneys in disputes will many times get the parties to sign a ***standstill agreement*** to clarify when the statute of limitation period begins and ends.

In this case, however, there was an alleged ***inaccurate illustration*** claims against Berkshire that could represent negligence or fraud. Thus, the statute of limitations would not begin to run until the Coopers were put on notice of their claim by some other method.

What about the agents?

Fish and Steinhardt were friends of Cooper, and held themselves out as experts in the field of life insurance. So, the court felt that a heightened duty by the insurance agents existed. This, in turn, allows ***greater reliance*** by the insured, and creates a correspondingly lesser standard of vigilance in detecting that the issued policy did not live up to the agents' representations. Given this greater duty, and corresponding greater level of ***justifiable reliance***, the court determined that the policy did not conform with their representations. However, the statute of limitations issue was put off for a later trial.

Conclusion

The Coopers' claims against Berkshire were limited to the "inaccurate illustration" claims. Claims against Fish and Steinhardt were not limited. They included fraud, fraudulent concealment, negligent misrepresentation, and breach of contract. However, because defenses against such claims were not the business of the trial court they were forwarded to another trial.

No further action has been recorded. But, can you imagine the attorney fees, court costs and potential liability faced by these agents?

Jackson National Life v. Cabrera (2002)

A $1,000,000 life insurance policy was issued in 1987 with Maria Cabrera as the sole beneficiary. The insured, Carlos Cabrera, then made several changes to the policy, adding his children, his mother, his sister and his brother, Francisco, as beneficiaries. In 1992, the policy was again changed, removing Maria Cabrera and her children as beneficiaries. There were no further changes to the policy prior to Carlos Cabrera's death.

Maria Cabrera challenged the validity of the 1992 policy change. The form changing the policy bore Carlos Cabrera's signature. The original insurance agent, however, had secured several blank forms with Carlos Cabrera's signature. Since he was involved in another alleged fraud Carlos Cabrera went to a new insurance agent in 1995.

He told the new agent that his wife, children, mother, sister and brother were the beneficiaries, and he gave the percentage each was to receive according to the last policy change he had made before the 1992 change. When he came to the new agent's office, he brought a bag of documents relating to the policy. This bag contained documentation of all the policy changes except the 1992 change.

The court believed that this evidence gives rise to a genuine issue of material fact whether Carlos Cabrera actually made the 1992 changes to his policy that excluded hs wife.

As for Jackson National, the court dismissed it from the suit, because it had deposited the death benefit and past interest with the court.

What about the agent fraud claims against the original agent? The court rules that any duty to file against him was a duty to Carlos Cabrera as the owner of the policy, not to the purported beneficiaries of the policy since the beneficiaries have no vested interest in a life insurance policy while the insured is alive.

Andrew Jackson Life v. Williams - 1990

Al Page and David Smith, agents for Andrew Jackson Life Insurance Company 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 contrived by Andrew Jackson. The agents explained that purchasers of the product would receive allegedly ***better coverage*** than that provided by American Income Insurance Company ("American Income"), 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 Andrew Jackson's 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 Andrew Jackson's policies.

Risk Aversion

"Risk aversion" may be understood through the following illustration.

An individual has a choice: (1) of receiving $ 5.00, or (2) of receiving a 5% chance of winning $ 100.00. Both choices are the same to the extent that $ 5.00 "is the expected benefit" of a 5% chance of winning $ 100.00. Some individuals may, some of the time, be indifferent when faced with the option of choosing to receive a "certain amount" (i.e., $ 5.00) or its "uncertain or expected equivalent" (i.e., 5% chance of winning $ 100.00); these individuals are so-called "risk neutral." Many individuals are "risk averse"; they would choose the certain amount. And those who are "risk preferring" would choose the uncertain or expected equivalent. Law-and-economic theorists generally contend that, by definition, insurers are risk neutral (though their risks are "infinitesimal"); insureds are risk averse; and gamblers are risk preferring.

Peace of Mind

The "peace of mind" concept was poignantly described by Justice Lent of the Oregon Supreme Court:

That insurers sell their product as being not only an agreement to indemnify the insured for certain kinds of loss but also to relieve the purchaser from anxiety concerning all aspects of claims is readily apparent in our society. One cannot watch televised entertainment for very long without being exposed to commercials for the sale of insurance which, for example, indicate that the purchaser will be in "good hands," that he will have the assistance of a troop of mounted cavalry, that he [will have] "a piece of the rock," or that "like a good neighbor" the insurer will be there. As such advertisements reflect, the relationship between insurer and insured does not merely concern indemnity for monetary loss [risk aversion].

The Sale

Based on the information the agents provided, permission to offer their retirement program was granted. With their "foot in Universal's door," the aggressive agents incurred no difficulty in persuading Universal employees to "lend an ear." As employees passed through clock alley (a place where most Universal employees passed daily at the company), their attention was captured by an array of alluring wares displayed on the table. These wares included televisions, radios, money, and teddy bears, and were provided as door prizes (i.e., "gimmicks") -- which anyone willing to stop and listen to the agents' offers could win. Basically, the offers included the same information conveyed during meetings with company officials.

Willie Williams, a forklift operator at Universal, was one of the many who were persuaded to sign his payroll-deduction card and to drop his American Income policy through guarantees of immediate "enrollment" in Andrew Jackson's "retirement program." Notably, the application was filled out by an agent as Willie and his wife Jerlean responded to questions. Upon completing the transaction, the agents told Willie that he could "pick [his] policy up within two to three at the plant." But several weeks passed, and Willie had not received his policy as promised. On February 11, 1985, Jerlean died of a heart attack. Willie again inquired if his policy had arrived -- "because [he] needed the $ 1,000" check from the immediate cash benefit plan "to pay for funeral arrangements." And once again, the reply was: "[I]t [will] probably be in this week; just check back [later]."

The policy never arrived; instead, Andrew Jackson executives attempted to induce Willie to settle for $1,000 and to sign a release which would have relinquished his rights to receive the full amount of benefits due him under his policy. Willie refused to settle, to which one company executive admonished: "[I]f you don't take this, you might . . . get nothing." But Willie, adamant in his refusal to settle, rationalized: "I'm in a bind, but, my God" -- "compared to the [death benefits I contracted for] this thousand dollars is nothing . . . [and] I just as soon to do without it." Restated, Willie felt that Andrew Jackson was trying to take advantage of him and use his financial dire straits to compel him to settle. And in light of his heavy financial burdens, accepting the $1,000-settlement offer would hardly make a difference; therefore, he'd rather than "leave it" than "take it." It was simply a matter of principle.

On May 3, 1985, Andrew Jackson mailed Willie a letter officially ***denying his claim*** for the death benefits. Andrew Jackson provided the following logic for its denial: (1) Willie applied for a policy which expressly declares it "will not take effect until it has been delivered" and . . . until the first premium has been paid . . . while the . . . Insureds are alive. . . and . . . prior to any change in health as shown in the application"; (2) The underwriting process was ongoing when Jerlean died, therefore, a contract had not been formed and an actual policy delivered; (3) The underwriting process nonetheless continued, and was eventually completed; and (4) Based on the information adduced during the underwriting process, Jerlean was determined to be "uninsurable" because she had a heart condition which was undisclosed. Andrew Jackson concluded its letter by noting: "Since we are unable to accept your application, we are returning [seven premiums in] the amount of $ 76.44 which ha[ve] been paid" by your employer through payroll deductions.

Willie attempted to avert litigation. He informed Andrew Jackson that, prior to Jerlean's death, its agents unequivocally formed a contract with him -- notwithstanding Jerlean's disclosure to the agents that she had a heart condition. In essence, Willie contended that Andrew Jackson was accountable for any misrepresentations they may have made to him regarding policy conditions or to it their principal regarding Jerlean's health. Willie's attempt was to no avail.

The Suit

On August 26, 1986, Willie filed a complaint contending that he contracted with authorized agents of Andrew Jackson for immediate enrollment in the "retirement program" and, that the insurer ***breached its contractual obligations*** by denying his claim -- and for "no logical, arguable reason." Willie also contended the breach was "prompted by willful and conscience wrong or by actual malice and fraud or by conduct so grossly negligent and inexcusable" that he is entitled to compensatory damages in the amount of $27,705, and to punitive damages "in the sum of $250,000" (punitive), in addition to costs and interest.

Andrew Jackson countered that conditions of insurability were not met in Willie's case, that it formed no contract with Willie, that its agents are limited to mere solicitation of applications, and that none of its agents is authorized to waive existent conditions or to form binding contracts on its behalf. Therefore, Andrew Jackson concluded that it cannot be held responsible for "any and all wrongful acts" of its agents.

During the course of the trial, Andrew Jackson twice moved for a directed verdict; the motions were denied. After three days of lengthy testimony, the jury returned a verdict in favor of Willie for $28,000 in compensatory damages and $200,000 in punitive damages.

Andrew Jackson appealed.

Was There A Contract?

Under ***generally accepted law***, a ***completed application*** may be forwarded to the insurer for assessment of the risks, after which the insurer may decide to form a contract by accepting the applicant's offer. In one case, a contract was made when the client verbally agreed to refrain from seeking coverage elsewhere. See Kewin v. Massachusetts Mut. Life Ins. Co. -- 1980.

Through an alternative transaction, the insurer may initially make the offer, and the potential insured may form a contract by accepting. Completion of an application (or some other form) and remittance of the specified premium generally constitute an acceptance.

Andrew Jackson contends that it employs the former type of transaction; that ***it never accepted Willie's offer*** and; consequently, that formation of a contract never occurred. The evidence, however, is otherwise indicative; the agents unequivocally employed the latter type of bargaining transaction.

The agents expressed their assent to specific and definite terms; that is, they extended Willie an offer to form a contract and thus become enrolled in Andrew Jackson's retirement program. More specifically, the ***offer was conditioned on completion of an application, remittance of a premium*** (or signing of a payroll deduction card), and assent to essential terms delineated in the application. Formation of an insurance contract requires that these essential terms be specific, either expressly or by implication, as to the subject matter, period, rate, and amount of insurance.

Also, there must generally be a ***complete understanding***, as to these matters: subject of insurance, risk, premium, duration of risk, and amount of insurance -- preferably, something in writing or print. Willie, Jerlean, and their five children were named as insureds along with general information pertaining to the insureds' gender, age, birth place and date, height, weight, and relevant medical history was provided. Further, the ***policy description was***

specific -- a "Joint Duration II" worth $27,705 upon the death of either Willie or Jerlean and a "Children's Term Benefit" worth $6,000 upon the death of a child. Finally, the premium amount was calculated at $10.92 -- to be paid on a weekly basis through payroll deductions.

Another condition seems to be reflected in the record. The agents seem to have extended their offer of immediate coverage to those, who at the time, held American Income policies. Whatever the case may be, the agents knew Willie held an American Income policy when they extended an offer to him. And a notation was made on the application indicating that the coverage being purchased would replace coverage under an American Income policy.

Acceptance of the offer (mutual assent or "meeting of the minds") was manifested through Willie's: (1) remittance of seven premiums deducted from his paycheck, and (2) completion of the application that contained the essential terms.

Consideration is also legally sufficient in light of both the benefit to Andrew Jackson and the detriment to Willie. Courts have held that payment of a premium is necessary as a ***condition precedent*** to an enforceable contract of insurance. . . . By accepting these premiums, the agent represents to the parties that their policies were both existing and current.

The Damages

Evidence revealed that Willie relied on the agents' misrepresentations to his detriment; his reliance resulted in both ***tangible and intangible losses***. One tangible loss was incurred when Willie allowed his then-held American Income "whole life" policy to lapse and, as a consequence, he permanently lost several years of investment or "cash value build-up" in his policy. And as noted, Willie also lost use of seven withheld premiums, which were eventually returned devoid of interest. One intangible loss was incurred when Willie, believing he was covered under the Andrew Jackson policy, did not seek risk aversion or peace of mind from other insurance companies for himself or his family.

Andrew Jackson's contention that no contract was formed (i.e., that no policy was issued) is simply contrary to the evidence adduced during discovery and trial. In fact, documents were produced at trial that even referred to specific policy number issued to Willie and Jerlean.

The Outcome

In sum, the evidence supports the first jury's verdict; Andrew Jackson was properly found to be bound by the contract formed by its apparently authorized agents. In addition, the punitive damages were affirmed. Nothing was noted about the agent liability in this case, however it is easy to imagine termination and/or an indemnification lawsuit.

Barton v. Alexander Hamilton Life - 2003

Roger McCall was a licensed life insurance agent and/or broker with Alexander Hamilton Life. McCall sold Richard Barton a life insurance policy issued by Hamilton as the insurer. 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.

This new trial is an attempt to collect ***punitive damages***.

To justify his position, Barton attempted to associate McCall as a ***regional manager*** with Hamilton, not just an appointed agent. One of the significant things he used was McCall's agency agreement that points out that Mr. McCall was able to appoint subagents. He further relies on the fact that Mr. McCall was a member of the President's Council, an incentive organization for top producing agents. As a member of the council, Mr. McCall would be in a better position to talk to top management. As an illustration, Mr. Barton cites testimony that Mr. McCall called him from a convention, put a person identified as the company president on the telephone, and that person gave him reassurances about the performance of his policy.

Testimony at the trial uncovered several cases where McCall obtained policy loans by forging policyholder's signatures to the applications, made other withdrawals without the policyholder's consent, misappropriated premium money, and generally betrayed his position of trust. The losses amounted to roughly $ 1,200,000, and Hamilton reimbursed policyholders in roughly that amount. McCall subsequently served a jail term for his crimes. There was, however, no evidence that Hamilton was aware of these breaches before Mr. Barton's complaint.

The Law

Courts generally support a ***punitive damage*** award against a corporation where a ***misdeed has been ratified*** by a ***managing agent*** of the corporation. Normally, a managing agent is an employee of the corporation who exercises substantial discretionary authority over significant portions of the corporation's business. Such an employee may be an officer of the corporation, or person in a lesser position. Although it is possible that a nonemployee, such as a director, could be found to be a managing agent, it is doubtful that rank and file employees carry the same status.

Accordingly, the court found that ***McCall was not a managing agent*** of Hamilton.

Alternatively, Mr. Barton argued that Hamilton ratified the fraudulent conduct of McCall. But the evidence does not support this claim. The evidence also does not show that Hamilton was aware of any fraudulent conduct by Mr. McCall until Mr. Barton complained to Hamilton about an unauthorized loan that Mr. McCall had taken against Mr. Barton's policy. The evidence DID support the conclusion that Mr. McCall was an independent insurance broker who was cheating both his clients and the insurance company he represented.

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."

The Court Speaks

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 part of Mr. McCall's conduct while disavowing the remainder.

Mr. Barton alleged further that McCall was misrepresenting the terms of the policies, and that he is entitled to benefit-of-the-bargain damages calculated as if the misrepresentations had been true, i.e., the representation that he had a paid-up policy and the representation that the policy had a significant investment component at 15 percent interest. The jury agreed with him and awarded damages for his alleged loss. But the misrepresentations were not authorized or approved by Hamilton, and they do not provide a basis for an award of punitive damages.

Canales v. Wilson - 2003

Canales bought a van in and approached Jeff Wilson of Wilson Southland to obtain insurance for it. Canales had known Wilson, who is an independent insurance agent, for several years and had obtained other policies through him. Because Canales neither spoke nor read English, he brought interpreter Maria Escamilla with him to see Wilson.

Canales recalled that he had sought "automobile insurance, including casualty loss coverage, which would cover [his] van in the trips from Dalton to various places in Mexico and back." According to Canales, Wilson told Escamilla and him that Canal would write a policy covering the van in both the United States and Mexico, but the premiums would be expensive. Canales agreed to pay them. Escamilla testified that she understood from meeting with Wilson that the policy would cover the van while it was in Mexico. Wilson, however, testified that he told Canales and Escamilla that "coverage was not effective in Mexico."

The policy stated that it "applies only to loss which occurs . . . while the covered automobile is within the United States of America, its territories or possessions, or Canada." Canales admitted that he never read the policy, and no one read it to him. Escamilla testified that she would have read the policy to Canales if he had asked her to do so.

The Law

Generally, an ***insured is obligated to examine*** an insurance policy and to ***reject*** it if it does not furnish the desired coverage. This ***rule does not apply when*** (1) the agent has held himself out as an expert and the insured has reasonably relied on the agent's expertise to identify and procure the correct type or amount of insurance or (2) "the evidence reflects a

special relationship of trust or other unusual circumstances which would have prevented or excused [the insured] of his duty to exercise ordinary diligence." Neither exception applies here. See McCoury v. Allstate Ins. Co. - 2002.

According to Canales's affidavit, he knew what kind of insurance policy he wanted for the van before he approached Wilson. Thus, he did not rely on Wilson's expertise to identify and procure the correct type of insurance for him.

Nor is there evidence that Canales enjoyed a ***confidential relationship*** with Wilson. A confidential relationship exists "where one party is so situated as to exercise a ***controlling influence*** over the will, conduct, and interest of another or where, from a similar relationship of mutual confidence, the law requires the utmost good faith." The party asserting the existence of a confidential relationship has the burden of establishing its existence.

To support his claim of a confidential relationship, Canales contended that he had ***dealt with Wilson in the past*** and had come to trust him; that he was "***unsophisticated*** in matters of insurance"; and that he did not speak English. These facts do not demonstrate a confidential relationship. That two people have transacted business in the past and "have come to repose trust and confidence in each other as the result of such dealings is not sufficient, in and of itself, to warrant a finding that a confidential relationship exists between them." Despite Canales's alleged lack of sophistication about insurance, he admittedly did not rely on Wilson to determine the kind of policy he needed for the van. And he compensated for his lack of familiarity with English by bringing Escamilla to his meeting with Wilson. Thus, the undisputed facts demonstrate no confidential relationship between Canales and Wilson that would have denied Canales's own duty to read the policy.

Wilson testified that Wilson Southland employed a fluent Spanish speaker to work as an interpreter in its office. Canales's decision to ***bring his own interpreter***, rather than use the one provided by the agency, is further evidence that his relationship with Wilson was arms-length rather than confidential.

The policy clearly and unambiguously stated that coverage applied only to losses incurred in the United States or Canada. Although Canales could not read English, he used an interpreter who testified that she would have read the policy to him if asked to do so.

The Outcome

The thrust of this case lies in Canales duty to read his own insurance policy. Had he done so, his reliance on Wilson's alleged misrepresentations about its contents would not be an issue.

Safeco v. Lovely - 1982

Safeco initially brought an action against insureds, Leonard Doran, Paul Doran, Lovely Agency and McHenry to have a policy of farm liability insurance voided because of misrepresentations in Doran's application for insurance. Safeco later learned that the misrepresentations were made by McHenry, as an employee of Lovely Agency.

Safeco paid a $300,000 wrongful death claim to the Dorans and dismissed them from the lawsuit. Safeco then filed an amended complaint against McHenry and Lovely Agency alleging negligence, breach of duty, misrepresentations and seeking damages.

Some Facts

The Lovely Agency was an independent agency authorized to solicit applications for a number of insurance companies, including Safeco. McHenry was employed by Lovely Agency to sell insurance. Leonard Doran and his son, Paul Doran, were ranchers in the area. Dorans wanted to buy a comprehensive farm insurance policy, but because of the poor driving records they were refused and referred to McHenry.

McHenry met with Dorans to discuss their insurance needs. As a result, Leonard Doran agreed to purchase a farm insurance policy through Lovely Agency. Leonard Doran testified at trial that he had signed an application for insurance through Safeco, although that application was not produced at trial nor was an explanation given for its disappearance.

The application submitted to Safeco and the ones which were later produced at trial were not signed by Dorans. McHenry admitted to twice forging the signature of Leonard Doran to applications. The forged applications contained several misrepresentations of the Dorans' driving records, as well as misrepresentations of Dorans' insurance history. Specifically, the forged applications showed three speeding violations for Leonard Doran, when there were actually four and only one speeding violation for Paul Doran when there were actually four. The forged applications failed to mention the facts that Paul Doran's driver's license had been suspended in 1977 for 6 months or that Paul Doran had been cited for driving while intoxicated only a few days before the signature date on one of the forged applications. The forged applications also failed to mention that Dorans had not had vehicle insurance for approximately the past 15 years.

Safeco reviewed the application as submitted and determined that Leonard and Paul Doran were to be included as the named insureds on a policy. Leonard Doran delivered a check in payment of the premium for $1,600 to McHenry. Safeco issued a policy effective June 19, 1979, through June 19, 1980.

On August 22, 1979, Paul Doran was involved in an accident while driving a road grader on the Doran's property. As a result, Donald Sorum was killed. Sorum's estate brought a wrongful death action against Leonard Doran. A subsequent investigation by Safeco uncovered the misrepresentations on the insurance applications. Safeco, believing that the Dorans were primarily responsible for the misrepresentations, initiated an action against Dorans, Lovely Agency and McHenry to have the insurance policy declared void.

Safeco later discovered that Leonard Doran's signature on the application had been forged by McHenry, and that McHenry was primarily responsible for the misrepresentation. Safeco then settled the wrongful death claim against Dorans by paying the Sorum estate the maximum policy amount of $300,000. Safeco then filed an amended complaint dismissing Dorans and seeking damages from Lovely Agency and McHenry as defendants.

At the initial trial, it was learned that Paul Doran owned one of the vehicles covered by the policy, but his name did not appear as a potential insured on the application submitted to Safeco. When Safeco processed the application, a Safeco administrative employee inserted Paul Doran's name into the application and Paul Doran's name appears as an insured on the policy. Much was made by the trial court of the fact that Paul Doran's name was inserted into the application by a Safeco employee. However, the trial court ruled that act placed Safeco in ***pari delicto (equally at fault)*** with McHenry and Lovely Agency. On appeal, another court

found this to be error and rule as a matter of law that Safeco was not in pari delicto with McHenry and Lovely Agency.

At the time Donald Sorum was killed, Paul Doran was working on the Doran property. The accident would have been covered by the farm liability insurance regardless of whether Paul Doran's name appeared on the policy as an insured. The obligations of the parties were in no way affected by the inclusion of Paul Doran's name on the application and later on the policy of insurance. McHenry and Lovely Agency failed to establish a causal connection between the appearance of Paul Doran's name on the policy as an insured and the loss. Such a causal connection must necessarily exist to support a finding that Safeco was in pari delicto with McHenry and Lovely Agency.

Ratification

In many cases, attorneys try to show that the insurer ratified or authorized the actions of its agents. The initial trial court believed that Safeco did in fact ratify the acts of McHenry and Lovely Agency. However, the appeals court disagreed on the basis that in order for ***ratification*** to exist ***three elements*** must occur:

(1) Acceptance by the principal of the benefits of the agent's act,
(2) With full knowledge of the facts and,
(3) Circumstances or an affirmative election indicating an intention to adopt the unauthorized arrangement.

McHenry and Lovely Agency base their argument for ratification on the fact that Safeco accepted a premium payment and renewed Doran's insurance policy. Whatever Safeco's reason for accepting the premium and renewing the policy we note that prior to either event, Safeco had already filed an action in the trial court to have the policy declared void.

Acceptance of the benefits of the agents' acts, in this case the premium payment, is evidence of only one element of the proof of ratification. McHenry and Lovely Agency did not prove the other two elements essential to a ratification; that Safeco ratified with full knowledge and that circumstances show an intent of Safeco to ratify. The act of filing an action to have a policy declared void can hardly be construed as an intent to ratify that policy.

The decision of the initial trial was reversed paving the way for Safeco to initiate a new trial for damages.

Fraud & Abuse Cases

Insurance fraud and abuse can occur at any level . . . from application to the insurance claim . . . to the settlement phase. The deception can be the doing of the agent, the insured or the insurer. Or, it can be attributed to the collusion of these parties.

Officials and experts suggest that the best way for agents to avoid being part of the problem is to put your ***own "house" in order*** first:

- Honesty and integrity is your primary obligation. Avoid any appearance of impropriety. Don't be guilty of what it is we are trying to eradicate. Remember that when gifts, tickets,

free meals, or vacations are offered or accepted as compensation, inducement, or reward for the referral or settlement of a claim, it is a felony.

- Do not accept application or underwriting information that you know to be false as a basis for determining policy premiums or coverage. That is an unlawful act.

- Do not accept or make any material representations that you know to be false as justification to accept or deny a claim for benefits. Also, do not make knowingly false statements with regard to entitlement to benefits with the intent of discouraging an insured from claiming benefits or pursuing a claim.

Beyond these personal responsibilities you have an obligation as an agent is to ***be alert for the possibility of fraud***. Your thoroughness in gathering information in support of an application or claim can be vital in any prosecution of such a crime or in your own defense as a potential participant.

The ***agent's file*** is critical in any instance of deception. In any legal action involving an questionable insurance transaction or claim, a plaintiff's attorney will always attempt to get a copy of this file. It will show the agent's knowledge of the insured's intent for specific coverage, communications between the agent and client and communications between the agent and underwriting. Considering this exposure, agents may want to make consistent and accurate notes to their file using ***standard operating procedures***, i.e., following the same order of processing business for every client. By law, insurance companies also have access to your files including e-mail, faxes and post-it notes.

You are also required to report suspected fraud when you have knowledge of or a reasonable belief that a fraudulent act has been committed. Reports should be submitted simultaneously to the Department of Insurance and the local district attorney's office. This is not optional; it is mandated in most states. This requirement carries with it the responsibility to assure that all reports are made in good faith, without malice, and are based on facts obtained by reasonable efforts.

What is Fraud? What is Abuse?

Insurance abuse is any practice that uses the system in a way that is ***contrary*** to either the intended purpose of the system or the law. This includes some behavior that is not criminal and some that is. ***Fraud*** occurs when someone knowingly lies to obtain some benefit or advantage, or to cause some benefit that is due to be denied. If there is no lie, there may be abuse but it is not fraud.

Examples: Filing a claim that is not warranted or violating the rules of industry, in the absence of fraud (a lie) or kickbacks, may be abuse but it is not criminal. Overtreatment by a physician might represent only a difference in opinion; although it could appear excessive and possibly abusive, it does not necessarily constitute fraud. Typical abuses of the system also include magnification of complaints or disability that fall short of an outright lie, or an overutilization of benefits. For instance, soft tissue injuries give rise to subjective complaints that cannot be either proven or disproven.

The presence or absence of a specific, probable lie is the deciding factor. ***To separate fraud from abuse***, it is necessary to look for the lie or misrepresentation, whether written or oral.

Examples: Returning to work while receiving temporary disability payment might be abuse, or it might be fraud, depending upon the circumstances. As the law now stands, claimants have no legal obligation to advise anyone when they return to work, nor do they have an obligation to certify their continuing disability status. If temporary disability payments continue when the claimant has returned to work and no one ever asks the claimant "are you working?" -- there is an abuse of temporary disability benefits, but there is no lie and therefore no fraud.

However, using the same example, if someone, such as the adjuster or the doctor, specifically asks the claimant "are you currently working?" -- and the claimant replies "no" and thus lies, and that lie is relied upon to determine the amount and payment of temporary disability -- there is fraud.

Though not legally a fraud, offering or accepting kickbacks for the referral or settlement of cases is a reportable and highly prosecutable crime. Kickbacks indirectly feed the problem of fraud and, as a result, cause damage to our society and our economy. Consequently, the legislature has determined that both fraud and the kickbacks that can contribute to it are punishable criminal acts; a single fraudulent transaction can be punished by up to 5 years in prison.

Key Elements

In separating criminal fraud from abuse, remember these ***key elements***; with fraud . . .

- There is always a false representation -- the lie.
- The lie must be intentional or knowingly made.
- The lie must be made for the purpose of obtaining a benefit the claimant is not due, denying a benefit that is due, or obtaining insurance at less than the proper rate.
- The lie must be material, that is, it must make a difference: "If the truth had been told, would you have done anything differently?"

Until there is a conviction in a court of law, there is only ***suspected fraud***. Use discretion and avoid accusations of fraud -- or you could find yourself and your company party to a libel or slander suit. Your civil immunity protections for reporting suspected fraud are limited and only cover you when reporting to an authorized governmental agency.

Reporting and Enforcing Fraud and Abuse

No insurance carrier, agent, self-insured employer, or third-party administrator has the right or authority to make any agreement to not report or pursue suspected fraud. To do so would be considered completely illegal. Insurance fraud at any level is a criminal act and is in the purview of only prosecutorial agencies such as district attorneys, the State Attorney General, and the U.S. Attorney.

Venues of fraud enforcement include the following:

Mail Fraud. Federal statutes making it a crime to send documents intended to defraud through the U.S. mail are used to prosecute those who attempt insurance fraud, even when they do not succeed. An expanded mail fraud statute includes materials sent or delivered by any private or commercial interstate carrier, meaning that people who did not use the U.S. mails so as to avoid charges of mail fraud do not have that out.

The Federal Crime Bill. This bill makes it a federal crime to misappropriate funds from an insurer, file false financial reports, obstruct insurance regulation and attempt to deceive regulators about the insolvency of an insurer. Sections of the federal crime bill address false entries of a material (important) fact in the books, records, and statements of an insurer if the entry is meant to deceive interested parties about the solvency of the company; as well as making it a crime to use, or even attempt to use, force or threats to corruptly influence, impede or obstruct any insurance regulatory proceedings or any insurance regulator or examiner.

Further, the bill defines most proceedings before state insurance regulators as official proceedings, a definition that protects witnesses who attend or testify at said proceedings. Another important section of the crime bill prohibits ex-convicts whose felony crimes involved dishonesty or breach of trust from being in the insurance business, unless written exceptions are made by the appropriate state official. Persons convicted of charges under this bill usually get up to 10 years in prison, although they can get as much as 15 years behind bars. And, civil actions and injunctions can also be used against those who violate these new criminal insurance fraud statutes. The maximum penalty in a civil action is either the amount the person received or offered for the prohibited conduct, or $50,000, whichever sum is higher. Admittedly, however, it is only the largest and most significant cases that get to court, the cost of litigation in both time and money militating against taking "minor" cases that far.

State Insurance Laws. Current laws on the books also impose penalties for the following:

(1) Knowingly present or cause to be presented any false or fraudulent claim for the payment of a loss or injury, including payment of a loss or injury under a contract of insurance.

(2) Knowingly present multiple claims for the same loss or injury, including presentation of multiple claims to more than one insurer, with an intent to defraud.

(3) Knowingly cause or participate in a vehicular collision, or any other vehicular accident, for the purpose of presenting any false or fraudulent claim.

(4) Knowingly present a false or fraudulent claim for the payments of a loss for theft, destruction, damage, or conversion of a motor vehicle, a motor vehicle part, or contents of a motor vehicle.

(5) Knowingly prepare, make, or subscribe any writing, with the intent to present or use it, or to allow it to be presented in support of any false or fraudulent claim.

(6) Knowingly make or cause to be made any false or fraudulent claim for payment of a health care benefit.

(7) Knowingly submit a claim for a health care benefit which was not used by, or on behalf of, the claimant.

(8) Knowingly present multiple claims for payment of the same health care benefit with an intent to defraud.

(9) Knowingly present for payment any undercharges for health care benefits on behalf of a specific claimant unless any known overcharges for health care benefits for that claimant are presented for reconciliation at that same time.

(10) Present or cause to be presented any written or oral statement as part of, or in support of or opposition to, a claim for payment or other benefit pursuant to an insurance policy, knowing that the statement contains any false or misleading information concerning any material fact.

(11) Prepare or make any written or oral statement that is intended to be presented to any insurer or any insurance claimant in connection with, or in support of or opposition to, any claim or payment or other benefit pursuant to an insurance policy, knowing that the statement contains any false or misleading information concerning any material fact.

(12) Conceal or knowingly fail to disclose the occurrence of an event that affects any person's initial or continued right or entitlement to any insurance benefit or payment, or the amount of any benefit or payment to which the person is entitled.

(13) Prepare or make any written or oral statement, intended to be presented to any insurer or producer for the purpose of obtaining a motor vehicle insurance policy, that the person to be the insured resides or is domiciled in this state when, in fact, that person resides or is domiciled in a state other than this state.

Every person who violates the above rules is guilty of a felony punishable by imprisonment in the state prison for two, three, or five years, and by a fine not exceeding fifty thousand dollars ($50,000), unless the value of the fraud exceeds fifty thousand dollars ($50,000), in which event the fine may not exceed double of the value of the fraud.

Tort and Punitive Awards. Increasingly, the amount of money juries award when claimants sue may have a bearing on the amount of fraud and abuse that occurs. When a claimant takes an insurer, agent or less-than-honest client to court in such a case, the party is vulnerable to two types of financial penalties -- tort damages and punitive damages. Tort damages will be awarded if the defendant is found guilty of not honoring the contract. Punitive damages may also be awarded . . . and, these costs may be huge in comparison to the actual damages. Consider, for example, the severity of some recent damage awards against insurance agents and insurers:

State Farm v Grimes -- $1,900 actual client losses / $1.25 million in damages awarded.
Independent Life v. Peavy -- $412 actual losses / $250,000 in jury damage awards.
National Life v. Miller -- $258 actual losses / $350,000 in damages.

Sentencing. The severity of the sentences and the penalties depends, of course, on the severity of the crimes with which they are charged. Insurance fraud can bring charges of conspiracy, extortion, theft, violations of federal securities laws, obstruction of justice, and bank, wire and mail fraud. These are often known as "white collar" crimes, because they are committed by people of education and, usually, executive position. Although violence may not be involved, and no one is murdered during the commission of these crimes, still, when one considers the social cost of such crimes, it is clear that the individuals committing them deserve penalties as severe as the consequences of their acts.

RICO Laws. Cases of fraudulent claims ranged from highly sophisticated professional rings down to the usually honest policyholder trying to get the best of a bad car deal. The ***Racketeer Influenced and Corrupt Practices Act (RICO)*** is now used in cases of insurance fraud. The act allows damages to be awarded, and also the forfeiture of a criminal's assets. Plus, the injured party may collect damages and take over the assets of ANYONE involved in

the conspiracy to commit fraud, not only the named insured. For example, when 21 companies and individuals were convicted of conspiracy to commit fraud by falsifying auto accident and theft claims, a U.S. court awarded the insurer plaintiff $1.7 million in damages.

State Fraud Bureaus. These government organizations, with which insurance companies cooperate, complement the industry's efforts to communicate the ramifications of insurance fraud. The New York Fraud Bureau, for example, recently entered into an agreement with the NICB to produce a series of advertisements offering rewards to callers who report suspected fraud. The California Department of Insurance Fraud recently initiated an out-reach program to aggressively reach and train local law enforcement to become more aware of staged automobile collisions and the growing problem they are causing on street and highways. During the training, officers are taught to spot certain red flags which could indicate whether the accident they've responded to is staged, and they are also given pointers on how to proceed with their investigation once they believe they may have come across a staged collision. A positive effect of this program is how it has assisted officers in uncovering additional cases and suspects that have been tied into cases already under investigation.

Insurance Commissioners. Perhaps one of the fastest-growing areas in the fight to reduce insurance fraud is occurring among the commissioners who are the watchdogs for the industry. There is a connection between the threatened insolvency of an insurance company, and the possibility that its executives are committing fraud. And although companies that become insolvent are not always rife with fraud, in 41% of fraud allegations from l976 to l991, the insurers involved were inadequately pricing their products and overstating their assets -- a sure road to insolvency, and very definitely fraud.

National Association of Insurance Commissioners (NAIC) not only pushed hard for the insurance provisions in the federal crime bill, but also has initiatives which help state regulators seek out insurance executive fraud. Further, the insurance industry has a Coalition Against Insurer Fraud (CAIF), one of whose activities was drawing up a model insurance fraud law addressing both claims fraud and insurer fraud. Such laws help stop fraudulent individuals by giving prosecutors and courts clear guidelines under which they may proceed.

The Justice Department. The Justice Department has a program titled National Level Insurance Fraud Working Group which uses FBI investigators as well as those from the Department of Labor and the Department of Treasury, the U S Postal Service and the Securities and Exchange Commission (SEC), to share information about instances of insurance fraud, and to get information from state regulators, as well as from insurers.

Sub Rosa Investigations. According to the dictionary, sub rosa is an old Latin term meaning "under the rose," the rose being an ancient symbol of secrecy or privacy. In modern terms, it refers to the surreptitious filming or still photographing of a subject who is under investigation, what law enforcement calls surveillance video. A sub rosa investigation is potentially one of the most valuable tools a claims handler can employ. It is often true that "A picture is worth a thousand words." Film or video evidence can be very useful in criminal court. But there's also another saying: "Don't believe everything you hear -- and only half of what you see." Sub rosa evidence, like all forms of evidence, may be open to interpretation. An effective sub rosa investigation takes time, planning, and preparation. It is important to remember that not every suspected fraud case will be a good candidate for sub rosa investigation. Once again, the basic elements of fraud are: The lie; knowingly told; for the purpose of obtaining benefits not due; and the lie is material.

The USA Patriot Act. The Patriot Act requires all financial institutions to collect customer information, verifies identity, checks against governmental lists, and stores all of the information for five years after an account is closed. The primary purpose, as it relates to insurance, is to establish anti-money laundering operations that might be used to finance terrorism. All employees, officers and staff are encouraged to help identify money laundering risks and minimize opportunities for individuals to abuse financial and insurance systems. Since insurance products are not easily converted to cash and agents are rarely involved in the claims paying side of the business, they are considered exempt from the intricate reporting requirements of the Act. However, it always help to support the uncovering of deceptive activities to keep your eyes open.

The Agent's Role

Insurance Codes in most states ***require all insurance carriers, agents, self-insured employers, and all third-party administrators to report suspected fraud*** to the State Fraud Division and the district attorney's office within 30 days after the duty arises. This means that if you, utilizing the various "red flags" and other warnings presented here, have come across some aspect of a fraudulent claim, and you believe it needs to be reported, and you are doing so without malice, then your duty is to make an initial report to your company's ***Special Investigative Unit***. If your company is not required to maintain an SIU function, then the report must be filed simultaneously with the Fraud Division and the office of the district attorney in whose jurisdiction the fraudulent act was committed. And these filing must be made within 30 days of knowledge. The Fraud Division and the district attorney hold a joint responsibility to take your fraud report and act upon it accordingly. At this point it cannot hurt to put forth this reminder: The referral of a case to the Fraud Division or the district attorney's office does not mean a specific person or facility is guilty of fraud.

A preliminary evaluation by the Fraud Division will determine whether your particular case merits a criminal investigation and, ultimately, criminal prosecution. The cases that receive the highest priority are the most egregious in nature -- the larger criminal conspiracies that are more likely to be prosecutable.

How To Report Abuse

Most states have special forms to report suspected fraud. Take care in providing accurate, detailed answers to all the questions. Keep copies for your records. Be sure to indicate on the form whether additional follow-up will be completed. The originals are sent to your state's Fraud Division and a copy is to be sent to the appropriate district attorney's office. Specify to which district attorney the case has been sent. The SIU is your conduit to the Fraud Division, and its regulations cover moving the referral through channels.

The Immunity Provision

Most Insurance Codes provides you with immunity from civil suit when referring suspected fraud to the Fraud Division and the district attorney's office. This immunity covers not only insurance agents, but carriers, self-insured employers, third-party administrators, private investigators retained by you to seek out additional information, and the government agencies involved in the investigation process. However, as broad as it is, the immunity protects you only as long as the fraud referral is done ***without malice*** and it is ***consistent***, that is, it applies to everyone in the same manner. This means that a specific doctor or attorney cannot be

targeted for investigation simply because they receive the lion's share of payouts on your claims processing.

The Agent As Witness

To the extent that you have heard the defendant say or do certain things, or to the extent that you are familiar with and are bringing to court or have presented to the court various documents, you may be called as a witness. You may be a ***source of information*** in that you can provide foundation for various documents.

Under previous law, only the custodian of the records could qualify business records. But to the extent that you have files that are under your control during the claims process, you may be the custodian of records for those files. You will be asked for information on how a claim file is prepared and how the documents are received and maintained, in order to satisfy the court that these records are reliable and should be admitted into evidence.

It is important that you know how your company's system works, because you will be called upon to not only describe the documents for what they are but also relate to the court the underlying system and show that the system is a reliable one.

All of these measures are helping and will continue to help reduce insurance fraud. Ultimately, however, it is the insurance industry itself which is in the best position to combat fraud. Over the years, insurance executives and employees have accumulated a great deal of experience and expertise that can not only help devise anti-fraud procedures, but can also lead to industry wide standards concerning the conduct of everyone in the field, and also the accountability of every executive and employee in maintaining a fraud-free operation.

When used as expert witnesses in court cases, members of the insurance community can help judges and jurors understand the difference between what the industry as a whole accepts as standard practice, and the way the defendant behaved.

Enforcement is the final step. This step, too, has becoming increasingly effective as even those whose frauds did not succeed are tried, convicted, and punished.

And, with the advanced computer systems the insurance industry now has, keeping track of a large amount of data, cross-referencing claims and other information, and doing sophisticated financial analyses is possible. All of these help detect fraud.

On a more personal level, it is essential that all policyholders become fully aware of how much fraud costs each of them. Agents must do a thorough job in educating their clients, helping them understand the precise nature of the policies they buy, and just what the policies will cover if a loss occurs.

Agent Fraud

Our section about insurance fraud and abuse would not be complete without a major discussion on the misdeeds of agents. Consider the following types of agent fraud:

Misrepresentation of Value: An agent sold annuity policies to mostly retired clients where the average purchase was about $20,000. The agent typically represented that the principal was available at anytime and the accumulation value of the contracts were guaranteed to grow to

certain levels. Both representations were so false so as to prove a fraudulent scheme for which the agent was liable.

Paid-Up Policies: An agent sold whole life policies under the assumption that coverage would be "fully paid" in six years. After six years it became apparent that the policies would not come close to being paid up. The courts determined that the agent's actions constituted fraud.

False Statements by Agent: An agent sold disability policies to his clients on the basis that coverage could be extended for life for an additional premium, when in fact, the policy and rider required a higher level of disability occur before life benefits could be awarded. The court was clear to point out that any agent who does not understand the ***differences*** between two products he is selling is subject to liability for fraud.

Agent Mistatements on Application: An agent helped a client fill out an application for homeowner's coverage. The client supplied information that he had previous claims and was canceled by another carrier. A loss resulted and the insurance company refused the claim upon learning that the agent ***intentionally*** omitted the client's claim experience. The agent was accused of fraud.

Agent Back-Dating: An agent received an initial premium from a client three months prior to a fire that damaged the client's home. Upon learning of the fire, the agent scurried to obtain insurance he had neglected to purchase by altering his postage meter to give the appearance that he processed the application two days prior to the fire. The insurance company received the application three days after the fire and uncovered the fraud.

Signature Fraud: A policy was sold with $100,000 in uninsured motorist coverage. When the client submitted a claim, the insurance company produced a "Reduction Agreement" which reduced coverage down to only $25,000. The agreement purported to bear the signature of the client although he denied signing them. Eventually, the courts determined that the agent had ***signed the client's name*** thereby committing fraud.

Now let's look closer as to how these types of issues effected agents in some real world fraud and abuse cases:

Cronin v. Washington National Insur - 1993

Daphne Cronin arranged for group health insurance for herself and her employer with Agent William Cargill. After she was forced to stop working in order to maintain her amateur equestrian status, Cronin contacted Cargill to inquire about an individual health policy. Through Cargill, she applied for permanent health insurance, but was rejected by one of Cargill's three regular carriers because of her high-risk equestrian activities. The only other policy available from Cargill's regular carriers was a six-month, nonrenewable major medical policy offered by Washington National Insurance Company. This policy, known as the "Intermed" policy, was ***intended to be used as temporary, interim coverage*** only.

During the next year, Cargill sold Cronin a series of four Intermed policies; each was approved by Washington National. Shortly after the fourth policy term expired, Cronin was seriously injured in a horseback riding accident and rendered a quadriplegic. The hospital where she received treatment advised her father that there was no coverage. Agent Cargill also confirmed this but told her father he thought he could ***fix it*** if someone brought him a check. Later that day, Cronin's friend delivered a check for $217.14, the amount of another Intermed

policy premium, and dated and signed the application that Cargill had already completed. As Cargill directed, Dane backdated both her check and the application to March 1, 1988; Cargill also set his postage meter to March 1, 1988.

An employee of Washington National testified that Cronin's fifth Intermed policy application was rejected for two reasons: internal company guidelines prohibited the issuance of more than a year of continuous Intermed coverage without a three-month break, and it was apparent that Cronin herself had not signed the application. Washington National refused to pay any of Cronin's medical expenses.

The First Trial

Cronin sued Cargill for breach of an oral contract to procure insurance, and Washington National on the theory that Cargill acted as its actual or apparent agent. Cronin also claimed that Cargill was negligent in that he ***failed to procure*** insurance to cover the March 5 accident as he had promised on March 7, failed to timely notify her of his inability to procure insurance, failed to notify her before her fourth policy expired, and failed to obtain insurance that would be appropriate for her long-term needs. Washington National cross-claimed against Cargill, alleging that if it was liable at all, its liability was secondary to that of Cargill.

The jury returned verdicts for Cronin against Cargill and Washington National, and it dropped Washington National's cross-claim against agent Cargill. The jury also found that Cargill was negligent, but Cronin was twenty-five percent comparatively negligent. During the damages phase of the trial, the district court entered a partial directed verdict in favor of Cargill on Cronin's claim for future damages.

Damages were assessed at $203,000; the district court deducted twenty-five percent because of Cronin's comparative negligence, and entered judgment for $152,250. The district court later awarded Cronin $10,393.64 in costs and $60,900 in attorney's fees.

The Appeal

All three parties appealed and a new trail commenced in 1993.

At the first trial, Cronin claimed that Washington National was liable for Cargill's breach of an oral contract to insure because Cargill was Washington National's actual or ***apparent agent***. The first court determined that that there was insufficient evidence presented at trial to support either conclusion. However, the law distinguishes between insurance agents, who represent insurance companies, and insurance brokers, who represent clients in obtaining insurance. Cargill was a licensed insurance broker, not an agent. Furthermore, Cargill's brokerage commission agreement with Washington National provided:

No authority is granted to make, alter or discharge contracts for the company or for the general agent, or to waive forfeitures, grant permits, name special rates, or bind the company in any way, or under any circumstances to receipt for deferred or renewal premiums, or make any endorsements on the policies of the company, or to receive any monies due or to become due to the company.

The brokerage agreement specifically stated that Cargill was not authorized to enter into contracts on behalf of Washington National. It is clear that Cargill did not act as Washington

National's actual agent when he allegedly agreed to provide Cronin insurance covering an accident that had already occurred.

The appeals court concluded that there was insufficient evidence to support the jury's verdict on the theory that Cargill acted with apparent authority. Apparent or ostensible authority might result from conduct by Washington National as principal that caused a third person, Cronin, reasonably to believe that a particular person had authority to make representations as its agent. Washington National had ***no contact*** with Cronin or her father until after Cargill's March 7, 1988 promise with respect to procuring insurance for her. Cargill had ***no Washington National signs, letterhead, business cards, or other similar indicia***. The only materials that Washington National provided Cargill were blank Washington National ***insurance application forms***.

In the first trial, Cronin also argued, and the district court found, that Washington National's acceptance of four consecutive Intermed policy applications created a jury question as to whether Cronin reasonably believed that she would receive another policy simply by tendering the premium to Cargill.

The appeals court again disagreed. The evidence showed that Cronin understood that each policy had to be separately applied for and approved by Washington National. The fact that Washington National had issued four Intermed policies to Cronin did not obligate it to approve a fifth application. Washington National did nothing that would cause Cronin reasonably to believe that Cargill was its agent; Cargill's own representations could not create apparent agency.

The ***bottom line*** of all these legal bantering? The appeals court found that Washington National was not liable for the claim and Washington's claim against agent Cargill should not have been dismissed.

A Word On Oral Contracts

Many states require that contracts of insurance be in writing. Oral contracts are considered enforceable as long as they can be performed in one year.

Most oral contracts in insurance are used to "bind" or provide temporary insurance. However, agents have been known to make ***oral promises*** like "you are covered immediately" when actual coverage may not start for 24 hours; or "you are completely covered" when, in fact, insurable value or insurable interest was never investigated.

Remember, you can be held personally responsible for any promises you make, oral or written, that ***exceed*** the limits of the policy you are selling.

The Claim Against The Agent

Cronin alleges that Cargill breached an ***oral contract*** to procure insurance that he formed with Cronin through her agent and father, Dr. Patrick Cronin, when Dr. Cronin telephoned Cargill following his daughter's accident. Dr. Cronin testified that after a hospital representative alerted him that there was a problem with Daphne's insurance, he telephoned Cargill in Massachusetts. Cargill asked Dr. Cronin to get him a check for "a little over two hundred dollars." Dr. Cronin testified to the following:

Well, I said is that, what difference will the check make? And he said well, I think I can fix it. And I said does that mean that Daphne will get her benefits, and he said yes. He said when

can Mrs. Dane bring me the check? ... I said what about this insurance, what sort of insurance is it and what will it cover? And he says, he said it's a very good policy, it pays a million dollars. And I said well, what, you know, what's the company, and he said it's Washington National and they're a very good company.

The appeals court did not believe that this exchange amounted to an oral contract to procure insurance. In fact, Cronin admitted that when she applied for the previous policies, Cargill had told her that Washington National might deny her application and refuse to issue her a policy. She also admitted that she knew when she made her applications to Washington National that Washington National had the authority to approve or deny the applications. Further, it was clear to Dr. Cronin that Daphne's fourth insurance policy had expired. Finally, Dr. Cronin knew at the time of his crucial conversation with Cargill that the loss had already occurred and that Cargill was contemplating backdating the check which would accompany the insurance application.

In light of all the circumstances, including the common sense knowledge that no insurance company would ordinarily contract to insure a ***pre-existing loss***. The first court made a mistake in deciding that Cargill's comments to Dr. Cronin amounted to a ***contract to procure insurance*** for Daphne Cronin.

In the first trial, Cronin also claimed that Cargill was negligent in failing to find insurance that would adequately meet her long-term needs (the negligent procurement claim), and that Cargill was negligent in failing to notify her before her fourth policy expired and assist her in obtaining a renewal.

Two negligence claims against Cargill were presented at the first trial: 1) that Cargill was negligent in failing to procure insurance following the accident, and 2) Cargill was negligent in failing to inform her promptly when he discovered that he could not procure insurance for her. The appeals court determined that both of these claims are frivolous and should not have been permitted to go to the jury.

With respect to the negligent procurement claim, the first court could not find agent Cargill liable for future damages because an ***essential element was missing***: Cronin had to show she would have been accepted into another insurance program and been successful with her claim. Cronin's expert, Gordon Anthony, who admitted that he had no underwriting experience, was not qualified to testify that other insurance was available to Cronin. The appeals court agreed.

Negligent Failure to Warn

In the first trial, Cronin also claimed that Cargill negligently failed to warn her that her fourth Intermed policy was about to expire, and assist her in obtaining a renewal thereof. Agent Cargill pointed out, there is ***no statutory duty to notify*** an insured party of an insurance policy's pending expiration. Cronin also conceded that the policy itself did not place such a duty upon

Duty To Notify

Ordinarily an agent is under no obligation or statutory duty to notify an insured of a policy's impending cancellation.

However, if an agent has a history with a client of automatically and voluntarily renewing or reminding them to renew a policy, he can assume exposure for the ***one and only time*** he forgot.

Cargill. However, it was undisputed that ***Cargill had contacted Cronin before each of her other three policies expired***, and had solicited her application for a new policy at that time. The case of Barfield v. Langley - 1983 was used to demonstrate that:

"It is axiomatic [widely accepted] that an action undertaken for the benefit of another, even gratuitously, must be performed in accordance with an obligation to exercise reasonable care."

Based on this case precedent, the jury could have found that Cargill ***assumed the duty to notify Cronin*** each time her insurance policy was about to expire.

At trial, Cargill testified that he telephoned Cronin's house in Massachusetts before her fourth policy expired. Cargill spoke to the tenants who were renting Cronin's house while she competed in Florida and South Carolina. They gave Cargill an address in South Carolina; he sent a letter to "Daphne Cronin, 607 Banks Mill Road, South Carolina." The letter was returned by the post office; Cargill filed the letter away and did nothing further to contact Cronin. The appeals court believed that a reasonable jury could have found that Cargill was negligent. The address Cargill was given did not have a city or zip code. The jury could have found that he should have called Cronin's house again or contacted Cronin's friend, Arlene Full, whom Cargill knew well, to get a more complete address or to leave a message for Cronin.

Furthermore, the jury could have found that had Cronin herself completed an application ***before*** her fourth Intermed policy expired, Washington National would have issued a fifth policy, despite its internal guidelines. Why? Because Washington National had already violated its guidelines twice before. Thus, a reasonable jury could find that Cargill's breach was the ***proximate cause*** of Cronin's damages.

For these reasons, the appeals court confirmed the judgment in favor of Cronin and against agent Cargill on the claim that Cargill negligently failed to warn Cronin that the policy was about to expire and assist her in obtaining a renewal. In addition to this information, the appeals court also learned that Cronin had a long-standing relationship with agent Cargill during which she relied on him for advice.

Damages Against Cargill

Agent Cargill argued at the first trial that Cronin did not present sufficient evidence to prove the amount of her damages. The appeals court disagreed. During the damages phase of the trial, Cronin entered invoices totaling $283,193.00 into evidence. Her father testified that $203,698.81 was spent for hospital and doctor's charges, and for prescription medicine.

A copy of the Intermed insurance policy was also entered into evidence. An insurance expert for Washington National testified that $74,676.64 in expenses would have been covered by the policy, and that up to $83,898.88 in expenses that were not itemized could have been covered.

Cronin also argued that a plaintiff need not present expert testimony concerning which expenses would be covered by a particular policy. A lay jury is capable of reading the policy and evaluating invoices to decide which expenses would be covered. The appeals court agreed.

Comparative Fault

Because the appeals court reversed the original jury verdict against National, the only remaining basis for recovery is Cronin's negligence claim against the agent. The appeals court agreed with the district court's order that Cronin take some responsibility in this matter. So, they deducted the same twenty-five percent from the jury award, reflecting the fact that the jury found Cronin twenty-five percent comparatively negligent.

Collateral Sources

Certain state statutes require that a damage award be reduced to account for certain collateral sources of recovery. In this case, Cronin received $13,352.58 in Social Security disability insurance payments and $7,500 from a private life and accident insurance policy. The statute specifically describes these payments as ***collateral sources*** that should reduce the amount Cronin collects on her claims. Therefore, Cronin's recovery was reduced by another $ 20,852.58. Cronin also received $47,481.50 in Medicaid payments. However, the statute specifically exempts Medicaid payments from consideration as collateral sources.

Attorney's Fees and Costs

The first judge awarded Cronin attorney's fees in the amount of $60,900 against National. However, since the appeals court determined that National was not liable, this amount was not awarded. In addition, close to $10,000 in expert witness fees were reversed since they exceed the per diem allowance of $30.

Conclusion

The big loser in this case was the agent. In essence, his poor decision to backdate the application for a pre-existing injury put him in the position of ***personally insuring*** his client's losses.

Baker v. Preferred Risk Insurance - 1978

Preferred Risk hired agent William Carpenter to solicit insurance business on a non-exclusive basis. It supplied Carpenter with standard agency application forms for fire and automobile insurance, policy change requests, binders and receipts. Carpenter's ***contracted authority*** was stated as follows:

The PREFERRED RISK MUTUAL INSURANCE COMPANY (hereinafter, the Company) does hereby appoint the party signatory to this contract (hereinafter, the Agent) as its limited agent to solicit for said Company acceptable applications for insurance and to render such service to policyholders of the Company as may properly and reasonably be given by an Agent of the Company subject to regulations and instructions contained in the manuals, articles of incorporation, by-laws, or other instructions or modifications thereof, as may from time to time be promulgated by the Company, including the terms and conditions of this contract, for those purposes only.

Nothing contained herein is intended or shall be construed to create the relations of employer and employee.

Although Carpenter did not have the authority to issue policies, Preferred Risk did confer upon him the right to issue binders that would have the effect of creating insurance coverage for a period of 30 days.

Baker and Company engaged in the business of financing insurance premiums. ***Premium financing*** involves an advance by the finance company to the insurance company or its agent of the premium due for the full term of the policy. This advance is then repaid by the insured to the finance company in amortized monthly installments that include an additional amount to cover financing charges. The finance company is secured in making this advance payment by obtaining the right to cancel the policy and to receive the return premium due upon cancellation if timely repayments are not made.

To promote their business, Baker employed a representative to contact insurance agents throughout the state and urged them to use Baker to service their customers who wished to finance premiums. Baker's representative supplied these agents with a Baker premium financing kit consisting of instructions and forms to accomplish the financing. Included in each kit were forms referred to as the ***Power of Attorney Letter***. This letter described the advance payment which Baker had made on a specific policy of insurance, stated that the premium on this policy was being financed by Baker, and requested the company to list Baker on its records as "Power of Attorney to request cancellation of the policy if the terms of the [financing] contract are not complied with." Acknowledgement by the insurance company to Baker on a copy of the form was requested. Carpenter was one of many insurance agents contacted by Baker's representative and supplied with premium financing kits.

Carpenter conceived and executed a ***scheme*** whereby he would make up fictitious insureds, purport to issue policies to them, finance the premium with Baker, obtain payment of the premium specified to himself, direct Baker to send the "Power of Attorney" form to Preferred Risk at his own address, and wrongfully acknowledge receipt of Baker's "Power of Attorney" letter for Preferred Risk.

Preferred Risk never expressly conferred authority on Carpenter to perform such an acknowledgement function in its behalf. Indeed, Preferred Risk gave Carpenter no instructions on premium financing procedures, though it concedes that Carpenter had authority to perform premium financing. Between January and June of 1973, Carpenter confected 146 fraudulent premium financing transactions. He processed the documents in Preferred Risk's office and used its part-time secretary to prepare them. For several months Carpenter made lump sum payments to Baker to meet installments due and keep the fraud concealed. No part of the premium financing income received by Carpenter on any transaction was ever forwarded to Preferred Risk. The state manager for Preferred Risk, on a routine visit to their Columbus office, discovered the scheme and terminated Carpenter's agency. As the fraudulent financing transactions became delinquent on Baker's records, it gave notice of cancellation under its "Power of Attorney" and demanded the return premiums. Preferred Risk refused the demand and this action resulted.

All of Carpenter's bogus transactions involved financing an annual term policy despite the fact that Preferred Risk wrote only six-month term policies. Apparently, at the beginning of the scheme's operation, some policies may have actually been issued, but the bulk of the transactions were total frauds in which no binder or policy ever issued, the insured was fictitious, and the acknowledgement by Preferred Risk of Baker's "Power of Attorney" letter was either issued improperly by Carpenter or never received by Baker. Most of the letter forms Baker did obtain contained no policy numbers. Many of them specified one of two common

post office boxes as the address of the insured. Some addresses were in care of Carpenter's agency. Baker never requested a copy of Carpenter's agency agreement or communicated with anyone representing Preferred Risk other than Carpenter.

The question before the jury was whether or not Carpenter had ***apparent authority***, making Preferred liable for his misdeeds. Baker's attorney presented the following facts: Carpenter had actual authority to operate an insurance agency in an office rented by Preferred Risk, utilizing a secretary employed in part by the company. He was also actually authorized to solicit insurance business for Preferred Risk, to issue binders obligating the company to cover risks for periods up to 30 days, to notify lending institutions that such coverage existed, to perform services for customers, and to ***engage in premium financing***.

It is interesting that the fact that Baker dealt with Carpenter alone did not foreclose the existence of his possible apparent authority. Why? Because Preferred Risk invested Carpenter with ***agency credentials***.

There is no doubt in this case that Carpenter's actions were fraud and the cause of the losses. Likewise, Preferred argued that the exercise of any of several reasonable precautions by Baker would have detected Carpenter's fraud or curtailed the losses it caused.

The Outcome

The court noted that abundant evidence existed to support a finding of ***implied actual authority*** on the part of defendant's agent, ***because he could accept a power of attorney letter***; therefore, Preferred was responsible for the $68,000 in losses.

Nothing was mentioned about the agent. However, we suspect that the local district attorney was informed and an action for reimbursement commenced shortly thereafter.

Gilmore v. Constitution Life - 1974

Merritt Victor Gilmore purchased a policy of life insurance from the Sterling Life Insurance Company. Gilmore had only an eighth grade education and at the time of trial had been retired for several years. The policy purchased had a maturity value of $15,880. Sometime after issuing Gilmore the policy of insurance, Sterling Life Insurance Company was acquired by the Constitution Life Insurance Company.

Lejzor Bryks was and agent with Constitution who eventually met Gilmore offered to assist Gilmore in connection with his insurance needs. Specifically, Bryks at their first advised Gilmore that if he paid his annual premium payment on the old Sterling policy at that time, instead of waiting, he would be able to obtain the ***full*** maturity cash value of the policy a year earlier.

This was admittedly a false representation by Bryks. Gilmore, however, relied on Bryks' statement, and thereupon made out his personal check in favor of Constitution for the annual premium, which he gave to Bryks. Bryks later endorsed this check on behalf of Constitution and deposited it in an account that years earlier was authorized by Constitution. Bryks had the authority to deposit in that account checks made payable to Constitution, and also having the authority to draw on the account, both on his sole signature.

Gilmore also purchased a health and accident policy from Constitution through Bryks, and the premium for this policy was paid for at that time by a check made payable to Constitution which Bryks deposited in the same account.

Bryks also convinced Gilmore to sign a blank form authorizing Constitution to cash in the value of his policy. However, when Bryks filled out the application form, which Gilmore had signed in blank, the amount that was to be received was only a partial surrender amounting to about 90% of the full matured value.

In due time Constitution prepared a check in the amount of $14,659.40 payable to Gilmore and gave the check to Bryks for delivery to Gilmore. Bryks, however, did not deliver the check to Gilmore, but forged Gilmore's endorsement and deposited it in the Constitution account. Bryks then contacted Gilmore and persuaded Gilmore not to take the entire amount of his policy in cash, but to take $10,000 of these proceeds and buy a so-called "certificate" which would draw 8% interest. Gilmore agreed to this, and accepted a $10,000 certificate and a check for $5,569.30 for the balance due on the surrender of his Sterling policy, the total of these two amounts equalling the full maturity value of the policy. In buying the certificate Gilmore testified that he thought he was "investing" or "lending" to Constitution. It subsequently developed that these certificates were Bryks' ***own invention***, and that Constitution had no knowledge of Bryks' activities in thus selling certificates, which he apparently sold not only to Gilmore, but to others as well.

In December 1968 Bryks suggested to Gilmore that he buy another $5000 certificate, which he did. And again, in June 1969, at Bryks' suggestion Gilmore bought another $5000 certificate. In each instance Gilmore paid for the certificate with a check made payable to Constitution, which Bryks then deposited in the bank account.

Bryks paid Gilmore interest on these certificates commencing with the issuance of the first certificate and continuing through December 1971. During 1969, for example, Gilmore received $1400 as interest on the certificates, and at the end of 1969 he received in the mail a Form 1099 showing the amount of $1400 as interest for him to report on his income tax.

On October 29, 1971, Bryks wrote Gilmore and enclosed one certificate for $20,000, requesting that Gilmore return the three outstanding certificates, which totaled $20,000. This Gilmore did. Soon after, Bryks was terminated by Constitution and committed suicide. When the interest payments were no longer forth-coming, Gilmore contacted Constitution. The latter denied knowledge of its agent's fraud and disavowed liability on its part.

Gilmore brought suit against Constitution, seeking to recover the $20,000 that he had given Bryks in return for the three certificates. At trial Gilmore did not, and could not, produce the first three certificates which he had purchased from Bryks. As indicated, these three had been surrendered to Bryks in return for the one $20,000 certificate. The latter certificate was produced upon trial. This fourth certificate made no reference, as such, to Constitution, but did recite that Gilmore had previously given Bryks $20,000 "towards our special fund on which we are paying 8% interest per annum" (emphasis added). Gilmore had no recollection as to the exact language used in the first three certificates, though they were said to be similar in appearance to the fourth certificate. He did recall, however, that the first three certificates, unlike the fourth, were on ***Constitution's stationery***.

The Trial

At the first the trial, the court concluded that in selling the certificates to Gilmore, Bryks was acting within his apparent authority as a general agent for Constitution, and accordingly entered judgment for Gilmore against Constitution in the amount of $10,960.92 and costs. Gilmore's original claim had been reduced by the sum of $10,000 which he had received from the bank by way of settlement, the bank having previously accepted for deposit the check bearing Gilmore's forged endorsement.
Constitution appealed this judgement but it was still held that Constitution had clothed its agent, Bryks, with such authority that in committing the frauds against Gilmore in December 1968 and June 1969, Bryks was apparently acting within his authority as a general agent for Constitution and that the latter was accordingly liable to Gilmore.

Facts supporting this outcome include the following:

1) The court determined that Constitution ***entrusted its agent***, Bryks, with the proceeds of the Sterling policy for delivery to Gilmore. If Constitution had mailed the check to Gilmore, Bryks' fraud scheme would have been nipped in the very beginning.

2) The fact that the check was made payable to Gilmore, and that Constitution had no reason to expect that Bryks would forge Gilmore's endorsement, does not deny the fact that ***Constitution nonetheless wanted its agent to personally deliver the proceeds*** of his policy to Gilmore. And when an agent is delivering a check for the proceeds of an insurance policy to its erstwhile policyholder, to us it would be normal, and not highly unusual, for the agent to attempt to persuade the policyholder to reinvest with the company, in one way or another, at least a portion of the proceeds of the surrendered policy. "Buying a Piece of the Rock," for example, is virtually a household expression at the moment. So, when Bryks had some $14,000 for delivery to Gilmore, it was as we see it a normal, natural thing for him to attempt to interest Gilmore in "lending," or "investing," at least a portion of the proceeds with his principal, at an attractive 8% interest rate.

3) Additionally, the court found that Bryks was a ***general agent*** for Constitution for some thirteen years, and during that time Constitution's supervision of Bryks lay somewhere between minimal and nonexistent.

Standard Funding v. Lewitt - 1997

Plaintiff Standard Funding Corporation, an insurance premium financing company, entered into a series of financing agreements with Lewitt Agency, Inc. to finance the premiums on insurance polices of defendant Public Service Mutual Insurance Company. Standard Funding had provided Lewitt with its financing agreement forms which Lewitt and the prospective insureds were to complete and sign. Before entering into the first financing agreement with Lewitt, Standard Funding contacted Public Service Mutual whose personnel confirmed that Lewitt was an agent in good standing with the company, licensed to sell all lines of business.

Pursuant to the financing agreements, Standard Funding would finance the bulk of an insured's initial insurance policy premium in exchange for a security interest in all unearned premiums. The insured would agree to repay Standard Funding on an installment schedule; if the insured defaulted, the financing agreement gave Standard Funding the authority to cancel the insurance policy and assert a right to all unearned premiums due under the policy.

During 1989 Lewitt entered into deals with Standard to finance premiums ranging from $15,500 to $153,500 for policies purportedly issued by Public Service Mutual. Lewitt tendered two executed financing agreements to Standard Funding. Each form, which was signed by Lewitt and the insured, indicated that Public Service Mutual had issued policies to the insureds and that the insureds had paid approximately 25% of the premiums to the insurance company. Standard Funding accepted the financing agreements, and in accordance with their terms, issued two checks to Lewitt totaling $ 23,325. Standard Funding then sent Public Service Mutual "Notice of Financing" forms containing copies of the checks issued to Lewitt. In mid-December, Lewitt completed two additional financing agreements for the financing of Public Service Mutual premiums and received two checks from Standard Funding in the total amount of $ 204,000. Again, Standard Funding sent notice of financing forms with copies of the checks to Public Service Mutual. Public Service Mutual did not respond to any of the notices.

After Standard Funding failed to receive payments from the alleged insureds, it contacted Public Service Mutual who investigated the matter and discovered that these four financing agreements covered ***fictitious policies and false insureds***. No policies were ever issued in connection with these agreements and Public Service Mutual received no premiums for them. Public Service Mutual thereafter terminated Lewitt's agency contract.

Standard Funding commenced this damages action against Lewitt and Public Service Mutual. The claim against Public Service Mutual was premised on the theory that the insurer was liable for the fraudulent acts of Lewitt acting as its agent. Lewitt filed for bankruptcy so Public Service was the focus of the claim for $227,325.

The Trial

The court at the first trial found that although the financing agreements between Lewitt and Standard Funding were outside the scope of Lewitt's actual authority, ***Standard Funding had reasonably relied upon Lewitt's authority*** to issue Public Service Mutual policies and collect premiums in tendering its checks to Lewitt, and thus, Public Service Mutual was liable under the doctrine of apparent authority.

On ***appeal***, however, a second court hearing concluded that ***Lewitt had neither actual nor apparent authority to enter into the financing agreements*** on behalf of Public Service Mutual for the following reason:

There is no basis to conclude that the agency contract between Lewitt and Public Service Mutual endowed Lewitt with actual authority to procure on behalf of Public Service Mutual the financing of premiums for proposed insureds. The agency agreement granted Lewitt authority to "solicit and accept proposals for insurance covering such risks as the Company may authorize to be insured in the [agent's] territory ... subject [to] all the terms, covenants and conditions of this agreement." Under the terms of its agency agreement, Lewitt was also endowed with "full power and authority to receive, collect and receipt for premiums on insurance tendered by the Agent to and accepted by the Company." Thus, Lewitt was expressly authorized only to issue insurance policies and to receive and collect premiums; nothing in the agency agreement authorized Lewitt to negotiate or enter into premium financing agreements on behalf of Public Service Mutual.

The court rejected the theory that premium financing is an activity incidental to or reasonably necessary for the performance of an agent's express powers. In support, they cited the case of First Trust & Deposit Co. v Middlesex Mut. Fire Ins. Co. where insurance agent's frauds

perpetrated in the context of premium financing were not within the scope of the agent's actual authority.

This Court also determined that Lewitt's activities in entering into the premium financing agreements with Standard Funding fall ***outside the scope of activities authorized by its agency*** agreement since Public Service Mutual made no representations regarding Lewitt's authority to procure on its behalf premium financing for its proposed insureds. Rather, Public Service Mutual's representations were limited to Lewitt's power to write insurance policies and accept premiums for them. Moreover, all representations in the premium financing agreements were purely those of the agent.

These financing agreements set forth the obligations of the insured and contained a warranty clause entitled "Brokers and/or Agents Representations and Undertaking" whereby the signatory agent or broker agreed to "warrant the validity of this agreement and the truth of the facts contained therein," including the genuineness of the insured's signature and the fact that an individual policy had been issued. The only signatures required on the form were those of the "Broker or Agent" and the "Insured."

Correspondingly, the checks issued by Standard Funding pursuant to the financing agreements were payable solely to Lewitt.

The only explicit representation Standard Funding can point to in order to establish apparent authority is Public Service Mutual's certification that Lewitt was an agent in good standing authorized to write all lines of business for it. The court determined that in merely confirming Lewitt's good repute and status as an agent to write insurance policies, Public Service Mutual did not clothe Lewitt's representations in the premium financing agreements with apparent authority.

What about the fact that Public Service Mutual received notices of financing as a basis for imposing liability? Well, the court said that the notices of financing stated that payment from Standard Financing was "subject to your acceptance of the terms and conditions of the premium finance agreement." It is undisputed that Public Service Mutual never signified any acceptance of the terms and conditions of the financing agreements, as the notices required. Thus, no express ratification by Public Service Mutual ever took place.

DeSoto Life v. Johnson - 1945

The insured made no false statement as to his previous condition of health. According to the undisputed facts, he made a full, frank, and ***honest disclosure*** to the insurer's insurance agent ***as to previous attacks of arthritis***, and the insured answered all questions correctly. The

Failing To Disclose Known Risks

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

However, being sure that you avoid incorrect information in an application may not be enough.

After all, encouraging an applicant to leave an incomplete answer or not disclosing personal knowledge relevant to an insured's underwriting is just as deceptive as a lie or false statement.

Hiding special knowledge, such as a client's ***pre-existing condition*** may also subject you to ***punitive damages***.

insurance agent, knowing all the facts as to the insured's physical condition and his past illness with arthritis, ***made false statements and answers*** in the application without the knowledge of the insured. His apparent motive was to make a ***commission at any price***.

The insurance agent was a stranger to the insured, and there was no evidence of collusion between them. The court determined that the false statements in the application were those of the agent and that they could not be charged to the insured. The insurer was forced to pay the benefits of the policy and the agent was liable for his fraud.

Devita v. Foster - 1993

Vincent Devita had done business for over 15 years with independent insurance agent Foster. In fact, he became dependent on his advice. On the recommendation of the agent, the insured bought an annuity and paid $20,000 to Foster for the policy. The check was made out to the ***agent's own business***, not the insurer. When the annuity payments were sporadic and inconsistent, the insured called the insurer and was told that no such annuity existed. The insured brought an action against the insurer and the insurance agent for fraud. The insurer was dismissed from the case since there was no agency relationship proven. The agent disappeared and could not be brought to trial.

In order for the insurer to be found responsible, the insured had to prove that Foster had either actual or apparent authority. To be bound by the acts of his agent under the theory of ***apparent agency***, evidence must affirmatively show: (1) that the principal held the agent out to the public as possessing sufficient authority to embrace the particular act in question, or knowingly permitted him to act as having such authority, and (2) that the person dealing with the agent knew of those facts and acting in good faith had reason to believe and did believe that the agent possessed the necessary authority. The insured could not prove this.

Considering whether Foster had any apparent authority to bind the insurer required the court to look, not at Foster's conduct, but rather, at the insurer's conduct. Here, there is no evidence the insurer did anything to give the insured the impression that Fosterhad apparent authority. The insurer never held Foster out to be its agent. Nor was there any communication between the insurer and the insured. In essence, the insurer did nothing to give the appearance of Foster having any authority to enter into the annuity contract on its behalf.

The insured's belief that Foster had authority to act came entirely from Foster's ***fraudulent conduct*** which was designed to misguide his trust. For example, when Devita visited Foster's office, Foster purportedly called the insurer to inquire about annuity interest rates. The insured, however, did not talk to anyone and does not know to whom Foster was actually speaking. The alleged annuity agreement was simply a packet of materials prepared by Foster to look like an annuity contract. In addition, client Devita failed to protect himself by reading the application for the annuity which stated:

I agree that if money is paid with this application, Golden Rule [the insurer] will be liable only as set forth in the receipt given, which receipt must be signed by both Golden Rule's Secretary and the agent or broker to whom the money is paid.

When the insured paid the $20,000 to Foster he did not receive a Golden Rule receipt signed by the Secretary as required by the annuity application.

Giles v. Hayes - 1996

Ms. Giles experienced a house fire. While her house was being rebuilt, her insurance company notified her it would not renew the policy when it expired. After receiving this notice, she contacted a number of insurance agents about writing coverage for her. She testified that when she called Mr. Hayes she told him in their initial conversation about her fire loss and her insurance carrier's notifying her it would not renew her policy when it expired. She also testified Mr. Hayes came to her house and took her application. He asked her the pertinent questions on the application and she gave correct answers. After answering the questions, she ***signed the application without reading it***. Although she was given a carbon copy of the application at the time it was signed, she did not know the application contained ***incorrect answers***.

When the insured filed a claim for a burglary loss, the insurer denied the claim on the ground that the policy was ***void*** because the insured made ***material misrepresentations*** in her application for the policy. The insured first filed an action against the insurer to recover under the policy. However, this first hearing concluded that the insurer was right; the policy was void.

Action Against The Agent

The insured then brought an ***action against the agent***, accusing him of fraud in filling out the insured's application for the homeowners' policy. At issue in the action against the agent was whether the agent perpetrated a fraud on the insured by willfully misrepresenting her responses. Agent Hayes claims he wrote down what the insured told him.

Due to the some legal snafu's in this case, the court demanded another trial to determine if agent fraud existed. Sounds like an expensive defense. It also sounds like a reason to have clients fill out the application in their own handwriting.

Guaranty Life v. Feigley - 1960

Here is another case where the client testified that information on the application was ***fraudulently changed by the agent***. Mrs. Feigley, as the beneficiary sued on a life insurance policy issued on the life of plaintiff's husband who died 12 days after the policy issued. The company admitted the execution of the policy, the payment of premium, the death of deceased, the capacity of the plaintiff and the company's refusal to pay. It asserted that the claim was denied because the Mrs. Feigley falsely and fraudulently represented to the company that her husband was in good health when in fact his health was seriously bad.

A Word On Statute of Limitations

Insurance policies frequently require that any action or lawsuit must be filed within one to two years of the date of loss. Courts have extended these periods where issues of fraud, incapacity or insanity come into play. Or, when an insurer or agent has been instrumental in inducing an insured to postpone filing an action by holding out the promise of settlement.

It is important to note, however, that a policy's statute of limitation is not always ***cut and dry***. Policies frequently contain ***special limitations*** that severely truncate the normal period. For instance, an insured may immediately notify an insurer about a loss, but the policy may require him to actually ***file an action*** much earlier than one might ordinarily commence. Thus, an insured who might normally try to negotiate his problem, may inadvertently run through his statute of limitations period more quickly.

The jury, however, disagreed. They believed that the ***agent*** wrote down false answers when the plaintiff gave him true ones. The insurer then suggested that even though its agent wrote false answers when Mrs. Feigley gave him true ones, there would still be no recovery since the ***plaintiff and the agent must have conspired to defraud*** the company.

Again, the jury disagreed finding that the insurer was responsible on the life claim. There is no indication that the insurer pursued the agent for indemnification. However, this is always a possibility.

Hearn v. Rickenbacker - 1985

This is an unusual case where a homeowner suffered a major loss due to fire. His claim was denied because the policy had been cancelled due to ***nonpayment of premium***. To compound the problem, for some reason, the insured did not present his claim within the 12-month statute of limitation. Sounds pretty cut and dry right? No payment; beyond the statute in filing?

Well, the insured said that he was ***defrauded by the agent*** and that extends the filing deadline. He contends that he paid a full year's premium to agent Rickenbacker who only forwarded half of the amount and did not forward the other half until the policy was cancelled. Without actually deciding on the fraud issue, the court did agree that this could be a material fact that should be decided in another trial.

So, more costs and more attorney fees and a possible settlement were in the future of both the agent and his insurer.

National Security Insurance v. Beasley - 1981

Agent White agreed to sell Beasley a hospitalization policy. While filling out the application for insurance, White asked Beasley if she suffered from arthritis. Beasley testified that she told White that she had been treated for "a touch of arthritis." She also testified to the effect that she told White that she had been unable to obtain insurance from other companies and that she asked him whether her physical condition would prevent her from getting a policy from National Security. Beasley testified that White asked her additional questions concerning her arthritis and its diagnosis and treatment and that he, upon hearing her answers, marked "no" on the application in response to its question concerning arthritis.

Beasley then testified that she asked White if he was sure that the company would pay off and that White had answered "yes." There is also evidence indicating that White, with regard to the arthritis question, remarked that "what they [the company] don't know won't hurt them."

Beasley paid an initial premium of $19. The policy went into effect and was in force when Beasley was hospitalized for lower back pain. Her claim was denied on the ground that the hospitalization was due to a ***pre-existing condition*** that was not covered by the policy.

Beasley's medical records, which were in evidence, disclose that she had been treated for low back pain since prior to the application and that the current problem may have been due to arthritis.

Despite this evidence, the court decided that Beasley was entitled to at least ***nominal damages***. However, punitive damages were not awarded. So, the parties went back to court. If there is evidence from which the jury can conclude that the fraud was malicious, oppressive, or gross and that the representations were made intentionally and with knowledge of their falsity, major damages could be claimed.

The new trial determined that White ***was aware*** of Beasley's history of arthritis when he filled out her application for coverage. There was evidence indicating that White ***assured*** Beasley that her arthritis and his "no" answer on the application would not prevent coverage. There was also evidence that it was White's duty as soliciting agent for National Security to fill out applications for insurance. Finally, there was evidence indicative of White's attitude towards Beasley's insurance needs and her rights in general, specifically "what they don't know won't hurt them."

From this, the jury reasonably concluded that White knew that Beasley's arthritis would not be covered and that he intended to deceive her when he marked "no" on the application and told her that she would have coverage.

National Security contended that it should not be liable for the acts of White, its agent. However, the court used United Mine Workers v. Sams - 1980 to determine the following:

A principal is liable for his agent's fraud though committed without the principal's participation or consent, if it is done in the course of the agent's employment.

White made the alleged misrepresentation to Beasley while acting in the course of his employment. Therefore, the jury could properly find National Security liable for the acts of its agent, White.

Of course, almost any agency agreement would allow the insurer to recover its losses by indemnification from the agent.

Neece v. John Hancock Life - 1989

This action involves three life insurance policies, each issued by Hancock. The first policy was issued to Delbert Neece with a face value of $100,000; annual premium payments amounted to $11,228.25. The policy included a ***nonforfeiture option of reduced paid-up insurance*** in the event Delbert Neece defaulted on the premium payments. This meant that if Neece defaulted on premium payments, the policy would lapse and Hancock's liability to Neece would be limited to the reduced paid-up value plus interest at an agreed rate.

Delbert Neece paid the monthly premiums due on policy by taking out loans against the cash value of the policy. In 1985, he defaulted on his premium payments because the cash value of the policy was insufficient to support additional loans. Neece made no further premium payments after his default.

The second and third policies were issued to the Neeces in 1984. Jones, the Hancock sales representative who sold these policies to the Neeces, told them that they could each purchase a $500,000 insurance policy on the life of the other by paying total premiums of $106,000. Jones allegedly told the Neeces that these policies would remain in force for the rest of their lives with no premium payments required after the first year. The policies, however, explicitly provided that premiums were payable annually over a twenty-five year term. Specifically, the

policy issued to Alice Neece on the life of Delbert Neece provided for annual premium payments of $62,670.25 until Delbert Neece reached age 95. The policy issued to Delbert Neece on the life of Alice Neece called for annual premium payments of $43,707 for twenty-five years, and annual payments of $35,175 thereafter. Further, a schedule of annual premium payments was attached to each policy. And, each policy also contained provisions expressly limiting the authority of the insurance agent to waive or change any of the conditions set forth in the policy agreement.

The Neeces noticed the discrepancy between Jones' representations and the express payment provisions set forth in the policy agreements. Jones, however, assured the Neeces that they only were required to pay premiums in the first year of each policy. Relying on Jones' representations, the Neeces paid approximately $65,061 on Delbert's policy and $45,377 on Alice's policy.

The Neeces assumed that after they made these payments no further premiums were required. However, in April 1985, the Neeces received notices from Hancock informing them that additional premiums were due on both policies. Again, the Neeces attempted to ascertain their obligations under the two policies. This time they contacted Sekara, one of Hancock's general managers and the person responsible for supervising Jones. Sekara advised the Neeces to contact Jones. Jones, in turn, informed the Neeces that their policies were ***still operative*** and to ***disregard*** Hancock's requests for additional premium payments.

In October of 1985, Hancock informed Alice Neece that it terminated her policy because she had failed to make further premium payments in accord with that policy's premium payment schedule. Once more the Neeces contacted Jones who, by letter dated October 30, 1985, advised them to ***disregard*** Hancock's termination notice. Jones also assured the Neeces that both policies remained in effect.

However, on December 27, 1985, Hancock informed the Neeces that one of their policies had been changed to a reduced paid-up status in the amount of due to failure to pay premiums.

This was the last straw for the Neeces. After calls to Sekara went unanswered, the Neeces contacted Hancock's corporate headquarters claiming that Jones affirmatively misrepresented the terms of both policies. Hancock immediately conducted an investigation and advised the Neeces that Jones' representations, if made, were completely incorrect. The Neeces, however, insisted that Hancock provide them with three fully paid-up policies representing $1,100,000.

Hancock refused to provide the Neeces with $1,100,000 in coverage. Alice Neece claims that Hancock and Sekara ***ratified*** Jones' representations and are liable for fraud, negligent misrepresentation and violation of the state's Consumer Fraud. In addition to punitive damages, Neece seeks reformation (restoration) of the two insurance policies to conform to Jones' representations. Neece also claims that Hancock breached the terms of the first policy when it refused to pay the full, face amount of this policy upon Delbert Neece's death in November 1986.

Ratification

Ratification occurs when a principal is aware of the ***material facts*** of an ***unauthorized transaction***, and either ***fails to disavow*** the unauthorized transaction, or retains its benefits. A finding of ratification under many state laws depends upon a clearly evidenced intent to

abide and be bound by an agent's acts. Also, ratification may be express or implied. However, ratification by silence will be found only when a principal's conduct is inconsistent with non-affirmation of the unauthorized transaction and a third party relies on that conduct to its detriment.

The record in this case evidences a factual dispute as to whether Sekara ratified Jones' alleged fraud. Sekara joined Hancock's regional office after the Neeces purchased the insurance policies from Jones. However, during Sekara's tenure as general manager, Jones twice informed the Neeces that they were only required to pay total premiums of $106,000, and advised them to disregard Hancock's notices. Therefore, Jones allegedly ***perpetrated his fraud*** while ***under Sekara's direct supervision***.

Further, the record demonstrated that by letter dated October 31, 1985, the Neeces informed Sekara of the discrepancy between Jones' representations and the payment schedules set forth in the policy agreements. A. Sekara is not certain when he first learned of this discrepancy. However, it was undisputed that Sekara and Jones met with Hancock investigators in early 1986 to discuss the matter. Thus, Sekara's response was inconsistent with the record. Because Sekara ***took no steps to disassociate himself*** from Jones' alleged fraud, questions of fact exist as to whether he ratified Jones' acts and whether the Neeces relied upon this purported ratification.

The same cannot be said for Hancock. It is undisputed that Hancock's corporate headquarters first learned of Jones' alleged fraud on March 6, 1986, well after Hancock terminated a policy, and after it changed the status of another. The Neeces claim that Hancock actually learned of Jones' alleged fraud when they contacted Sekara and, because of its inaction, Hancock in effect ratified the fraud. This is an attempt to ***impute knowledge of an agent to its principal***. When a principal is a corporation, an agent's knowledge will be imputed to a principal only when warranted by the nature of the information, the circumstances in which the agent allegedly received it and the agent's position in the corporate hierarchy.

Knowledge is not imputed when an agent is allegedly engaged in ***fraud*** and has a motive for concealing the information. Because Sekara is accused of participating in Jones' fraud, his alleged knowledge ***may not*** be imputed to Hancock. Similarly, Hancock's conduct during the Neeces' ordeal does not support the Neeces' claim of ratification. For example, in 1985 when Jones was allegedly reassuring the Neeces that they did not need to pay further premiums, Hancock sent notices to the Neeces informing them that their policies were in danger of lapsing. It was also undisputed that when Hancock finally learned of Jones' alleged fraud, it acted swiftly and decisively to disavow his alleged misrepresentations. Hancock repeatedly informed the Neeces that Jones' representations, if made, were completely false. Under these circumstances, Hancock did not ratify Jones' fraud.

Alternatively, the Neeces argue that Hancock ratified Jones' conduct because it retained the benefits of his fraud. However, ***ratification by retention of benefits*** arises where a principal:

(1) Has full knowledge of all material facts;
(2) Expresses an intent to be bound by the agent's alleged misrepresentations;
(3) Would not be entitled to retain the benefits
unless the unauthorized act was ratified, and can make no claim to the benefits except through the unauthorized act; and
(4) Has the opportunity to return the benefits without loss.

Jones told Hancock investigators that he did not misrepresent the terms of the two insurance policies. Therefore, Hancock ***could not have known all the material facts***. Further, under principles of insurance law, Hancock was not required to remit the premiums already paid by the Neeces. These premiums compensated Hancock for insuring the Neeces during the two years that the policies remained in force.
Also, because the Neeces accepted the benefits of Hancock's coverage, they cannot now claim that Hancock wrongfully retained the benefits of Jones' alleged fraud.

Finally, there was no evidence in the record to suggest that the Neeces relied upon Hancock to their detriment. If anything, Hancock put the Neeces on notice of Jones' alleged fraud by ***explicitly stating*** in the policy agreements that agents had no authority to waive or vary the terms and conditions of the agreements,

Conclusion

For all the reasons above, the court felt that the Neeces failed to connect Hancock to Jones' alleged fraud. As to the actual policies, it was undisputed that the Neece's stopped paying premiums. So, Hancock was justified in lapsing the policy and reducing its paid-up value.

As to the agents Jones and Sekara, the court required a separate trial determine any alleged fraud or misrepresentation.

Pacific Mutual Insurance v. Haslip - 1989

Employees of a small incorporated community allowed its employees to purchase a group health insurance policy through the municipality. Originally that policy was issued by Blue Cross-Blue Shield months prior to 1981, however, Blue Cross cancelled the policy when several City employees dropped out of the plan, reducing the number of eligible employees participating in the plan below the minimum number of participants required by Blue Cross to maintain a group policy.

Lemmie Ruffin was a soliciting agent for Pacific Mutual. Ruffin sent a mail solicitation to the City asking if it was interested in discussing insurance. The City returned a card indicating that it was.

Ruffin first met with the mayor of the City, who gave him permission to solicit business from the City's employees. Before approaching the employees, Ruffin sought information about the employees from the city clerk. Ruffin always introduced himself as an agent with Pacific Mutual helping the city with a hospital plan.

In truth, while ***Pacific Mutual*** would issue individual life policies, it ***did not write group health policies for municipalities***. Pacific Mutual did, however, allow its agents to broker business with other insurance companies, and Ruffin was a licensed agent of Union Fidelity Life Insurance Company (hereinafter "Union Fidelity"), which did issue group health insurance through municipalities. Accordingly, Ruffin submitted a ***proposal*** to the City on a ***Pacific Mutual letterhead***; that proposal indicated that he would place life insurance with Pacific Mutual and health insurance with Union Fidelity. While Union Fidelity and Pacific Mutual are separate and distinct companies and have no affiliation, Ruffin, when asked, indicated that Union Fidelity was a ***subsidiary*** of Pacific Mutual.

Employees who opted to participate in the insurance plan paid their premiums by way of payroll deduction. These checks were sent to, or were picked up by, Ruffin, who prepared the billing each month on a Pacific Mutual letterhead. Within a few months of the effective date of the insurance policies, they were ***cancelled for nonpayment of premiums***. Neither the City nor its employees were made aware that the policies had lapsed, because, unknown to the City, Mr. Ruffin, with the help of Pacific Mutual's Birmingham manager, had had all correspondence between the insurers and the City employees funneled through a special office. In effect, the employees had been paying Ruffin, but their ***payments had not been forwarded to the insurers***.

As luck would have it, one of the employees participating in the insurance plan, entered a hospital incurring $2,500 in hospital bills and additional medical bills. Eventually, she learned her insurance had been cancelled. The hospital demanded $600 before it would agree to discharge her, and her doctor eventually turned her case over to a collection agency. In time, a deficiency judgment was rendered against here, and, as a result, her credit was adversely affected.

The employee and other members of the insurance plan sued Pacific Mutual and Lemmie Ruffin. The case was submitted to the jury on the plaintiffs' claim of fraud and a jury awarded damages in excess of $1 million.

Should Have Known

Pacific Mutual appealed on the basis that such high damages could only be justified if Pacific Mutual was aware of and supported a fraudulent scheme. In essence, they attempted to convince the court that if they were guilty it should be classed as ***legal fraud*** not ***willful fraud.*** And, legal fraud does not bear the burden of high punitive damages. Were they successful? Read on . . .

How does one distinguish between the two types of fraud? Agent Ruffin, ***knew*** that his representations to the plaintiffs were false. Pacific Mutual argued that any misrepresentations made by Ruffin ***should have been known***. The latter suggests negligence, which constitutes only "legal fraud": a misrepresentation made innocently or by mistake, for which punitive damages are not recoverable. Pacific Mutual used Continental Volkswagen, Inc. v. Soutullo - 1975 indicating that a cause of action for deceit or willful fraud, for which punitive damages are recoverable, requires proof that the defendant knew his representation was untrue at the time he made that representation or that he made the representation with reckless disregard for the truth.

The evidence submitted at trial indicated that Lemmie Ruffin forged signatures on applications in order to obtain a minimum number of applicants to meet Union Fidelity's membership requirements for establishing a group insurance plan; that the plan was cancelled within a few months of its inception for non-payment of premiums, even though participants in the plan had made their premium payments to Lemmie Ruffin; that Lemmie Ruffin continued to accept premium payments after notice of cancellation of the insurance plan had been received by his office; that premium payments collected by Lemmie Ruffin were deposited into his own account; and that Ruffin deposited funds refunded to participants by Union Fidelity into his wife's personal savings account.

Pacific Mutual's Liability

Obviously, Ruffin's representations were NOT made either innocently or mistakenly. And, the court further reasoned that the principal is liable for his agent's fraud committed within the actual or apparent scope of his employment, even where the fraud was committed strictly for the agent's own benefit and to the principal's detriment. Pacific Mutual was liable.

To this, Pacific Mutual responded that Ruffin was acting on behalf of other principals at the time he committed fraud, thereby ***abandoning his agency relationship*** with Pacific Mutual. The court again disagreed saying there is no question that sufficient evidence existed to support the jury's determination that Lemmie Ruffin was acting within the line and scope of their employment with Pacific Mutual when Ruffin made the representations to the plaintiffs that became the subject of this suit: Ruffin was a Pacific Mutual agent and an employee of the company; Ruffin's licensing was maintained by the Pacific Mutual office; Ruffin was furnished training and sales material by Pacific Mutual; Ruffin always introduced himself as "Lemmie Ruffin with Pacific Mutual"; Ruffin's reply card was mailed from, and was returned to, the Pacific Mutual office; Ruffin presented City employees with his Pacific Mutual business card; Ruffin never told anyone that the health insurance would be placed with a company other than Pacific Mutual; Ruffin's proposal was typed at Pacific Mutual's office on Pacific Mutual stationery; the monthly billing statements for premiums were prepared at, and mailed from, Pacific Mutual office on Pacific Mutual stationery; all of Lupia's business and all of Ruffin's business was carried on at Pacific Mutual offices; Pacific Mutual's home office had received complaints regarding Ruffin's fraudulent activities but had done nothing about them.

When all this evidence was submitted to the jury, they found that Lemmie Ruffin had not abandoned his agency relationship with Pacific Mutual, and that he had not acted alone.

Finally Fraud?

One of the final elements of proving fraud is whether or not the victim ***relied*** on the misrepresentation and whether that reliance was the cause of his damages. Again, evidence at the trial proved that when Lemmie Ruffin accepted the premium payments from his clients and indicated that their coverage was intact. The employees' reliance on this fact is a foregone conclusion.

Conclusion

Pacific Mutual was obligated to cover actual damages plus a high punitive award. No action against the agent was mentioned. However, based on the evidence and testimony, he was certainly liable.

Patriot General Insurance v. Millis - 1998

Millis went to the offices of the Espinal Insurance Agency to meet with its proprietor, Nidia Espinal. Millis explained to Espinal that he was seeking immediate insurance coverage for a car which he had just reconditioned and wished to drive that day. After Millis filled out a number of forms and made a $110 down payment to her agency, Espinal presented Millis with a proof of insurance card. This card listed Alexander Underwriters as the named insurer, listed a policy number, and stated that its effective date was the same day.

Unfortunately, ***Alexander Underwriters does not issue individual policies***; instead, it accepts applications from individual brokers and then finds other insurance companies willing to issue an individual policy. Millis stated that Patriot was never mentioned during this initial application process.

The following month, Millis made a premium payment on the policy to Espi. One month later, he again contacted Espinal and requested a copy of his policy, which Espinal assured him was in her office but which she failed to deliver. Shortly thereafter, Millis was involved in a wreck in which third parties were injured. These third parties threatened to sue Millis on the grounds that he had no insurance. Millis then attempted to contact Espinal again about getting a copy of the insurance policy he believed that she had acquired for him. Espinal evaded Millis for several days, assuring him that she had his policy but failing to produce it. Millis also contacted Alexander Underwriters, but they informed him that they had never received any application for insurance for his benefit.

Subsequently, Millis received a policy of insurance in the mail from Patriot. The effective date of said policy was dated one day before the accident. The application for this policy, which is also dated one day before the accident, contained signatures of both Millis and Espinal; however, Millis stated that Espinal never discussed Patriot with him, that he never signed the application document, and that he believed his signature was forged by Espinal. Soon after, Patriot terminated Espinal's contract.

Denial of Claim

After completing an investigation and interviewing Millis, Patriot discovered that the application had been submitted ***after*** Millis' accident and that Millis' signature had been ***forged***. As a result, Patriot returned premiums to Millis for which it had billed him and informed him that it did not intend to provide coverage for the accident. Patriot also filed an action to determine whether it was liable for coverage for the accident and to reform [change] the contract of insurance such that it would start on the day that the application was received.

The court responded that Espinal had the power to bind Patriot to acts that did not exceed her authority. It was also clear in this case that that Espinal fraudulently conveyed Millis' application for insurance to Patriot. Thus, she was ***not*** acting within her authority. However, any knowledge gained by an insurer's agent is imputed to the insurer, and the insurer may not deny coverage based on a fact not known to it but known to its agent (Meadows v. Douglas County Fed. Savings Assn. - 1983)

Further, the court said that in a matter arising out of the fraud, misconduct, or negligence of an agent of the company. If a party must suffer from this mistake, it must be the insurance company, [her] principal, not the insured who has acted in good faith.

Previous Problems

Another issue here is that Patriot had notice of ***previous problems*** with Espinal's agency. Despite this knowledge, it accepted the application for Millis submitted by her, and it billed and accepted premium payments from Millis as well. In other words, Patriot was on notice that its agent was neither competent nor trustworthy, yet it accepted Millis' application without prior investigation.

Outcome

If you've been paying attention, you learned that Patriot lost on all its arguments. As a principal, Patriot was responsible for the fraudulent acts of its agent. Again, however, the agent was clearly open to a major liability claim from her own insurer.

Ryan v. Gaylon - 1988

Agent Galyon became Ryan's insurance agent. As many 19-year olds do, Ryan faild to make a payment here and there causing her policy to cancel. When premums were paid, it was reinstated.

In 1985, Ryan phoned Galyon to inquire about the cost of insurance for a new Chevrolet Cavalier she was going to purchase. Ryan described the make, model and other details of the car to Galyon, but did not know the serial number of the vehicle. Galyon informed Ryan that the serial number was necessary to calculate the exact cost of a new monthly premium. Ryan was to call Galyon back regarding the serial number when she went to pick up her new car. When she hung up the phone, Ryan testified that she "thought that the insurance had been taken care of. . . ."

A few days later, Ryan and her friend went to the dealership to finalize the purchase, Both women were sitting in the office of car salesman when he called Galyon for the information that Boesenberg needed to complete an "agreement to provide insurance."

The Phone Call

The agent testified that he telephoned Galyon and spoke to his secretary. She informed him that Ryan ***was insured*** by Colonial, gave him the policy number and stated that the effective dates of monthly coverage were from 8/30/85 to 9/30/85. When he hung up, the salesman told Ryan "that she was covered, because that was related to me." This was overheard by Ryan's friend.

Gaylon's secretary, recalls telling the salesman that "Ron [Galyon] hadn't worked out the premium and for her [Ryan] to come down and they would take care of that. . . ." and that Ryan's file did not contain a paid renewal statement for August although it did contain such slips from prior months. However, the secretary also recalls saying that "if he wanted to presume it was paid and had crossed in the mail, then go ahead. . . ." But, she did not tell the salesman that Ryan was covered, nor did she give Boesenberg the effective dates of coverage.

Ryan and her friend drove away in Ryan's new car until she reached a nearby intersection. When she began to pull out, she was hit by a vehicle. Although Ryan sustained no physical injury, her car was damaged to the point that it could not be driven, and the friend was taken to the hospital for finger injuries.

Still Covered?

At the hospital, Ryan testified that she telephoned the Galyon agency and was told by the secretary that her last premium was unpaid but she was ***still covered***. She allegedly told Ryan to report her claim to the claims office and gave her the telephone number. The friend, who was standing nearby, during this phone conversation also heard Ryan say, "I am covered? Great."

The secretary had another version of this conversation. She testified that Ryan called the agency after the accident and Pawley said, "'Okay' and basically . . . just made a note and referred it on to Ron [Galyon]." Ryan called the claims office to report her insurance claim, but a few days later she received a letter denying coverage. Upon receipt of the letter, Ryan called Galyon because she "thought everything would have been taken care of and it was going to be fixed." However, once Ryan's claim was denied by Colonial, Galyon testified that he could have done nothing to procure coverage for Ryan.

Evidence At Trial

The evidence at the trial indicates that Ryan had received an ***insurance cancellation notice*** dated August 10, 1985, which stated that her Colonial policy "is cancelled for non-payment of premium effective 12:01 A.M. 08/20/85." Although Ryan testified that she did not "recall looking at it or reading it", she does not "deny receiving it." Therefore, it may be fairly stated that Ryan knew or reasonably should have known of the impending policy cancellation.

It may also be fairly inferred that Galyon, too, had or ***should have had knowledge*** of Ryan's policy cancellation through an "agent's activity form" sent out by Colonial.

In spite of the above evidence, Galyon testified that he "had not received anything to inform us [that the policy] had lapsed" until Colonial denied coverage for Ryan's claim.

Galyon explained the procedures used to obtain insurance on a new vehicle in two different situations: (1) where an individual has a policy in force when the new vehicle is purchased, and (2) where an individual had a policy which had expired prior to the purchase of the new vehicle. In the first situation, Galyon would merely write a memo informing Colonial to transfer coverage from the old car to the new. This is the procedure he followed in the case of Marjorie Ryan. In the second situation, Galyon would have had to prepare an entirely new insurance application.

Ryan's testimony discloses that she was ***unfamiliar*** with the aforementioned procedures used by agents to procure coverage for new vehicles. Ryan thought she would be covered by a "new policy with it being a new car. I thought I would get a new policy, but nobody explained it to me or told me." This assumption was reinforced by the conversation between Ryan and the secretary, which occurred at the hospital. Ryan recalls that "when I talked on the phone to her, when I told her from the hospital I had not paid a premium, she said, you'll be billed; and then I thought, well, I'm okay. I'd be billed for it."

Detrimental Reliance

Where the insured reasonably believes he is covered by virtue of representations by an insurance agent or broker, the failure of the broker to produce the coverage or else warn the client at once that coverage could not be obtained constitutes a failure to exercise the requisite skill or diligence required of a broker. One of the key elements in a ***detrimental reliance claim*** is whether or not the reliance placed on the agent caused the insured to miss the opportunity to obtain alternative coverage.

The Outcome

The court disputed Ron Galyon's testimony that his agency had received no notice of the expiration of appellant's insurance policy, the "agent's activity form", generated by Colonial. Additionally, Ron Galyon testified that ***he knew of appellant's irregular past payment record***. From this evidence, a jury could infer that the ***agent knew or should have known of the expiration of Ryan's policy*** yet neglected to inform her that a premium was due before coverage of her new vehicle would be provided by Colonial. Furthermore, according to Ryan's testimony, the agent's office advised her on several occasions that she was covered and would be billed for the premium.

Based on this evidence, the court decided that Ryan had placed detrimental reliance on the agent's assurance that coverage would be provided and premiums billed. The agent was liable for her damages.

Smith v. Republic National Insurance - 1971

Client Hugh Smith applied for an insurance policy issued by Republic National Insurance covering hospital and surgical expenses. After a 1968 hospital stay, Smith's benefits were refused due to ***misrepresentations*** in the application regarding a ***prior illness***. At the trial it was determined that certain of the answers contained in the application for insurance were in fact untrue. However, it was also determined that: (1) defendant's general ***agent asked questions*** of the plaintiff and ***filled in the blanks*** of the application form; (2) the general agent fraudulently entered false answers to some of the questions on the application form; (3) plaintiff was ***induced*** by the agent ***to sign*** the application ***without reading*** either the application or the certification above his name; and (4) plaintiff had no intent to misrepresent, omit, or conceal any facts nor to make any incorrect statements.

Smith apparently did not read the insurance policy or the application attached thereto when it was delivered to him or thereafter, although he was free to do so. He paid the premiums on the policy up to and including the time of hospitalization. The primary purpose of the trial was to determine if Smith's ***failure to read the application*** form after the policy was issued defeat his right to recover under the policy?

The Law

All statements and descriptions in any application for an insurance policy or in negotiations therefore, by or in behalf of the insured, shall be ***deemed to be representations*** and ***not warranties***. The difference is significant because a representation (opinion) can be defended, but a warranty is presumed as conclusive.

In general, misrepresentations, omissions, concealment of facts and incorrect statements ***shall not prevent a recovery*** under the policy unless:

1) Fraudulent.
2) Material either to the acceptance of the risk, or to the hazard assumed by the insurer.
3) The insurer in good faith would either not have issued the policy, or would not have issued a policy in as large an amount, or would not have provided coverage with respect to the hazard resulting in the loss, if the true facts had been made known to the insurer as required either by the application for the policy or otherwise.

Actual fraud requires an intent to deceive; ***legal fraud does not***. Where the facts involved in the questions in an application for insurance are of a type which would presumably be within the ***personal knowledge of the applicant***, and are such that the insurer would naturally contemplate that the applicant's answers represented actual facts, then the applicant is guilty of legal fraud if his representations are false, even in the absence of an intent to deceive. However, where the facts are merely an expression of opinion, actual fraud (i. e., intent to deceive) must be shown.

While Smith's exact answers are not available, the court determined that the incorrect answers in his application were NOT fraudulent.

Duty To Read Policy?

There is no question here that Smith received the policy. But, did he have a duty to read it and to correct any answers shown on the application which were incorrect? A 1934 case, Greber v. Equitable Life Assurance Society, sheds some light:,

When an insured receives a policy, it is his duty to read it or have it read, and, if an application incorporated therein does not contain correct answers to the questions asked by the medical examiner it is his duty to have it corrected.

Smith's attorney, however, pointed out something very significant about this case -- it ***focused on the applicant***, rather than the agent, as the responsible party.

In the Smith case, the applicant gave full and truthful answers to the questions asked of him by the agent. The agent, in filling out the application, fraudulently entered incorrect answers without the fault, knowledge, or collusion of the applicant. The agent also induced the applicant to sign the application without first reading either the application or the certification above his name.

Many decisions by the courts of a large number of jurisdictions support the view that where an insurer's agent enters false answers to questions contained in the insurance application, following and despite a truthful disclosure by, and without the knowledge of, the applicant or insured, who acted in good faith and was free of fraud or collusion, the ***insurer ordinarily is responsible for such erroneous answers and cannot defend an action*** on the policy issued. Why? Because, when the agent acts as the agent of the insurer in a transaction, the insurer is chargeable with his acts and conduct. In other words, in the eyes of the law the agent's knowledge is ***imputed*** to the insurer.

The court also reasoned that Smith had no reason to suspect the insurance agent of dishonest or fraudulent conduct, and he had a right to expect that the company which put the agent forward would at least not be permitted to rely upon its agent's fraud so as to rescind the policy. In other words, the company will not be heard to in effect say to the insured: "You have misplaced your trust in our agent, and, while we will escape the disappointment and losses occasioned thereby, you cannot. Your assumption that we would have in our employ only such agents as are trustworthy and honest is incorrect as we must now for the first time advise you." See Griego v. New York Life Insurance Co. - 1940.

Conclusion

The court found that the agent in this case, in filling out the application, fraudulently entered incorrect answers without the fault, knowledge, or collusion of the applicant. The agent also induced the applicant to sign the application without first reading either it or the certification above his name. Under these circumstances, they held that the defendant insurance company could NOT properly deny recovery under the policy.

The insurer was forced to pay due to the agent's wrongdoing and the agent was liable to his insurer.

Southern Life v. Turner - 1990

Agent Perry was hired by Southern as a salesman. His duties included servicing a "debit route," wherein he traveled from house to house on a weekly basis to collect premiums from Southern's policyholders. Turner was one of the policyholders on Perry's route. In 1985 she had purchased a life insurance policy on her aunt, Lucy Barrow, who was living with her at that time, naming herself as the beneficiary.

Southern also had another policy on Barrow's life with a Grace Banks, Barrow's daughter, as the beneficiary. Turner paid the premiums on both of those policies.

The testimony of Turner and that of Perry were in sharp conflict on almost every material fact regarding the course of their dealings. According to Turner's version of the facts, she ***paid*** the premiums that were due on both the Turner/Barrow policy and the Banks/Barrow policy on time up until the month that Barrow died, October 1986. She stated that, as far as she knew, those policies were in force at that time and had never lapsed. Turner stated that Perry never told her that the premium payments were behind or indicated that her policy was in danger of lapsing. That testimony was substantially corroborated by Turner's son, Alvin.

Jonas Bowen, the Southern agent in charge of the debit route before Perry, testified that Turner had ***always made her payments*** on time when he was servicing the debit route. Bowen also testified that it was Southern's practice to assign to the debit agent the responsibility of notifying the owners of policies with face values of less than $10,000 when their policies lapsed.

Perry testified that Turner was frequently late with premium payments and sometimes skipped them altogether. He stated that, eventually, both the Turner/Barrow policy and the Banks/Barrow policy had lapsed and were in danger of being terminated. Perry stated that he made Turner aware of the status of those policies and recommended that she apply all of the overage that had accumulated on both of the policies to the Banks/Barrow policy. According to Perry, he did not know that Turner was not the beneficiary of the Banks/Barrow policy. Perry testified that Turner agreed to his suggestion. Perry then applied the overage to the Banks/Barrow policy, but continued to collect premiums on both it and the Turner/Barrow policy.

"Overage" is the term Southern and Perry used to denominate funds paid by a policyholder who was attempting to become current on delinquent premium payments. Those funds would be held by the agent and set aside until the balance equaled the full amount owed on the policy. At that time it would be applied to the policy, which would then be considered back in force.

After Barrow died, Turner told Perry that she wished to file a claim on the Turner/Barrow policy. According to Turner's testimony, Perry came by her home in November 1986 and gathered all of the documents in Turner's possession that related to that policy. She said that those documents included a premium receipt card, the only evidence held by Turner that showed that she had made her premium payments. Perry testified that he did not take any documents relating to the Turner/Barrow policy from Turner's home and that he told Turner that he could not file a claim on the policy because it had lapsed.

Turner further testified that for months she heard nothing regarding the status of her claim. In March 1987, Turner went to Southern's district office in Opelika and inquired about her claim. At that meeting she was told that Southern had no record of the Turner/Barrow policy or of her claim. According to Turner, Perry came to her home the following month and explained the reason for the delay. She testified that Perry told her that Southern did not have $1,500 to pay her claim, but that he and his "boss man" had agreed to pay Turner $500 a month for three months to satisfy her claim. The following month, according to Turner, Perry came to her home and gave her an envelope containing $500 in $20 bills and asked her if she was "satisfied."

Turner's testimony concerning that visit by Perry, and the payment of $500, was corroborated by Alvin Turner and by Miller Ephraim, a family friend. Both men testified that they were present when Perry paid the $500, and both testified that they counted the money.

Miller Ephraim died before the trial began. His testimony had been procured by deposition some months before his death.

Turner testified that the following day she and Epharim went to the office of the Alabama Insurance Department in Montgomery. At that office, Turner said, she told Michael DeBellis of the Consumer Protection Division about her problems with Perry and Southern and showed him the envelope containing $500. She said that DeBellis told her he would look into her complaint, but that his investigation was dropped when DeBellis learned that Turner had retained a lawyer and filed an action against Perry and Southern.

Turner's original complaint contained allegations of breach of contract, conversion, and fraud. However, only the fraud count was submitted to the jury.

Perry denied offering to pay Turner $1,500 in installments and denied giving her $500 in May 1987.

The Trial

The trial judge presented Turner's claim to the jury with the following instruction:

In order to make the defendant, Southern Life and Health Insurance Company liable for any misconduct of Richard Perry, the plaintiff has to reasonably satisfy you from the evidence -- that Southern Life and Health, either authorized the wrongful conduct of Richard Perry, constituting the fraud, or if they didn't authorize it in advance, they must have ratified it after he did it. Ratification consisting of, number one, having knowledge of what he did, and with knowledge of what he did, they must have approved it, adopted it as their own, and accepted the benefits of it. And, without proving those things, Southern Life and Health Insurance Company cannot be held liable for the wrongful conduct of Richard Perry, even if you find he acted wrongly and committed the legal fraud.

However, this instruction did not allow the jury to consider the theory of ***respondeat superior***, which Turner requested the court to present to the jury. Under respondeat superior, a principal can be liable in tort for its agent's acts that are done within the scope of employment, either real or apparent, even though the principal did not authorize such acts or even expressly forbade them. No evidence of authorization or ratification is needed. That theory has been extended to cases where the fraud was committed for the agent's own benefit and to the principal's detriment. See Pacific Mutual Life Ins. Co. v. Haslip -1990.

The distinction between the ***law of agency and the law of respondeat superior*** is subtle.

The jury heard evidence from the plaintiff and other witnesses tending to indicate Southern's knowledge of Perry's fraud. The plaintiff and other persons clearly testified that Perry came to her home and gave her $500 and that Perry told her that he and "his boss man" had decided to pay her $1500 over a three-month period. Such evidence supports the inference that Perry had communicated his fraud to his superiors, and that this payment scheme was a attempt to "hush" the plaintiff.

In addition, the court noted that the route lists that were maintained at Southern's corporate offices clearly showed that Perry had diverted monies from the "overage" on the Turner/Barrow policy to the Barrow/Banks policy. Yet, when Turner's policy lapsed for failure to pay the premium, Southern provided no notice of lapse to Turner.

Southern also disclosed its knowledge of Perry's activities after Turner visited their office to inquire about a non-payment of claim on the first policy. She was informed that the policy had lapsed and that no claim for benefits had ever been filed. Moreover, testimony showed that it was only after her inquiry at office that Perry told her that he and "his boss man" would pay the plaintiff $500 a month for three months in settlement of her claim. Thus, the jury could reasonably infer from such evidence that Perry was notified of Turner's claim through the Southern office, and that therefore Southern was cognizant of and approved Perry's actions.

The Outcome

The above matters indicate at least a scintilla of evidence showing that Southern personnel had been informed of Perry's fraud and then schemed to conceal it by paying the plaintiff "hush money."

Not only was Southern obligated to pay the $1,500 limits of the policy, the court levied $500,000 in punitive damages!

Time Insurance v. Graves - 1987

Aubrey Holt who was an agent for Time Insurance Company. He said he was a general agent for Time, but his contract provided he was authorized to write and submit applications for insurance to Time and that he was responsible for "asking all questions and correctly recording all answers on applications for insurance and for immediately sending such applications to the Home Office of the Company. . . ."

Agent Lucas worked with Holt in obtaining new business. Since Lucas knew the Graves through a previous business relationship he approached concerning health insurance. Lucas ***knew*** that Linda Graves had been operated on for ***cancer***. However, he told her that he could insure her with Time and that this insurance would provide her coverage for her ***preexisting***

condition. The Graveses expressed concern about this since they ***already had insurance***, written by Pacific Mutual, which had been paying for Linda's visits to the doctor's office. So, Mr. Lucas took that policy and, after a couple of days, came back and told the Graveses that it would only be a change from one company to another.

In response to more questions, Lucas ***assured*** the Graveses that the Time policy would ***fully cover*** them and would pick up from where the other one left off. However, before either William or Linda Graves would agree to buy the insurance, Linda called her doctor's office, while Lucas was in the Graveses' store, and got a medical assistant to talk to Lucas over the telephone. The assistant testified that she told Lucas that Linda had an operation for removal of a cancer in 1977, and had received favorable reports from regular checkups since then, and she did not want to see Linda change insurance policies because of her condition. She testified that Lucas said there would be no problem, that Linda could be covered with Time insurance, and that there would be no rider providing that cancer would not be covered.
Both William and Linda Graves testified that Lucas took their application and that Aubrey Holt was not present and that he never talked to either of them about the application. They also testified that they correctly and truthfully answered each question asked by Mr. Lucas, that they signed the application but did not read it, and that they did not read the policy when it was delivered to them. The application, however, is not signed by Eddie Lucas, but by Aubrey Holt, and Holt admitted that Lucas brought the application to him with a portion of it filled out by Lucas. The ***application*** is dated March 21, 1981, and ***contains the following statement*** immediately over the signature of Holt:

Each application question was asked by me personally of the applicant(s) and all answers have been accurately recorded. I have witnessed the signing of this application by the applicant(s).

The application contains ***two questions*** which are ***incorrectly answered*** in the negative so as to reflect that no person proposed to be insured had suffered from a disorder of the generative organs or undergone surgery within the last ten years. Another question which asked if any person proposed to be insured had been diagnosed or treated for cancer, tumor, cyst, or growth, within the last ten years, ***was not answered***. Holt testified that he received an amendment to the application from the company that contained the question about cancer which had not been answered on the application. The ***amendment*** already had the word "no" typed on it and Holt said he got Mr. Graves to sign the amendment when he delivered the policy to Graves. The policy shows that William B. Graves is the insured and the application shows that Linda is his spouse and is to be insured also.

Graves testified that the amendment to the application contained his signature, but he did not remember signing it. He said he recalled signing some statements for Lucas; that he never signed anything for anyone else; that if Lucas asked him to sign some papers about the insurance, he signed them; and that he considered Lucas to be an honorable man. The amendment is addressed to Mr. Graves and contains no reference to Mrs. Graves.

The Claim

Graves also testified that he ***dropped his other insurance*** when he received the Time policy. The evidence also shows that Time tried to cancel its policy, more than a year after it was issued, because a claim had been filed for Mrs. Graves and the home office of Time learned of her past medical history from her doctor. This suit was then brought to recover for her medical expense. Mrs. Graves died shortly before this case was tried, and her husband was appointed

Special Administrator of her estate and made a party to this suit in that capacity. Linda's deposition was taken shortly before her death and a portion of that deposition was read into evidence at trial.

The jury returned a verdict in the amount asked for, and the judgment included statutory penalty and attorney's fees.

The Law

Where the fact is correctly stated by the applicant but a false answer is written into the application by the agent of the company without knowledge or collusion upon the part of the applicant, the company is, according to the generally accepted rule, bound. But on the other hand, if the agent in collusion with the applicant makes the false and fraudulent representations upon which the insurance is obtained, the fraud will vitiate the policy, even though the agent is acting within the apparent scope of his authority. See Aetna Life v. Routon - 1944.

The law in the above cases also applies where the agent, in filling out the application, ***relies*** upon information obtained from others rather than information from the applicant.

Where an agent is furnished with a blank application which he is authorized by the insurer to fill out, and he relies, in so doing, upon information obtained from others, rather than upon that obtained from the applicant, and a policy is issued thereon, the insurer cannot avoid liability on such policy, but is bound by its agent's acts, even where the applicant signs the application, provided he is ignorant of the false statements thereon. See Couch on Insurance - 1985.

Evidence was presented in this case to support a finding that Lucas filled out the application incorrectly, without Holt ever being present. Therefore the jury could have found the insurer bound by that application because the evidence will also support a finding that Holt, who had the contractual responsibility for "asking all questions and correctly recording all answers" signed the application relying upon information he received from Lucas and not upon information he received from the Graveses.

The Outcome

The evidence supported a finding that Time ***was bound by the information*** on the application, and the fact that information on the application was incorrect does NOT prevent a recovery on the policy.

Thus, Linda Graves was entitled for recovery for her medical expenses incurred for a condition that first manifested itself more than 15 days after the policy was in force.

While no outcome was found, the court discussed a potential action against agent Lucas.

Todd v. Modern Woodmen of America - 1993

Todd met Jimmy Chambers, an agent for Modern Woodmen, to discuss an ***investment opportunity***. A meeting took place at an office clearly identified by an exterior Modern Woodmen sign. The opportunity turned out to be a ***drop-in contract***: A $12,000 (single "drop-in") was to produce $650 per month plus a return of the $12,000 at the end of the year.

I order to get this deal, however, Todd needed to ***buy*** a Modern Woodmen life insurance policy. Todd tendered his $12,000 check and also purchased a life policy. However, he received no monthly payments which prompted him to cancel the policy and bring this lawsuit.

The Issue

Major discussion in this case focused on the fact that Chambers was ***not authorized*** by Modern to sell investments such as the "drop-in" contracts as they were considered ***outside the line and scope of his employment*** to do so. Further, Modern did not make any profit by the selling of these contracts.

Also at issue is the requirement that Todd buy a Modern Woodmen policy before he could be eligible to purchase the "drop-in" contracts. A jury could infer that Chambers was using the "drop-in" contracts to sell life insurance policies for Modern Woodmen. Likewise, a jury could also find that the ***actions of Chambers furthered the business*** of Modern Woodmen.

In addition, evidence was presented that proved Chambers was a ***soliciting agent*** of Modern Woodmen of America ***not an independent contractor***. This is an ***important fact*** because it helped establish the fact that Chambers, as a soliciting agent, ***could not bind*** Todd in the "drop-in" contract.

The Outcome

Although another trial was necessary to discover pertinent facts, the court ruled that Modern Woodmen was found not responsible to payback the amount of the "drop-in" contract since Chambers did not have authority, binding or otherwise, to commit Modern to this obligation. However, the court did rule that ***fraud*** was involved where a ***requirement*** existed to buy a Modern life policy to be eligible for the "drop-in".

Gaps In Coverage Cases

Ordinarily, an insurance agent assumes only those duties normally found in an ***agency relationship***, including the obligation to deal with his principal in good faith and to carry out instructions. There is no automatic duty assumed to ***advise*** the insured in the role of agent. However, where an agent also holds himself out as a ***consultant and counselor***, he does have a duty to advise the insured as to his insurance needs, particularly where such needs have been brought to the agent's attention, i.e., a specific coverage is requested. And in so doing, agents may be held to a ***higher standard of care*** than that required of the ordinary agent since he is acting as a specialist.

So, there are situations where agents may be liable to an insured for the damage suffered by his failing to inform him as to a potential source of loss or ***gap in coverage*** and by his failing to recommend insurance to cover it (Rawlings v Fruhwirth - 1990).

How would you know if you're responsible? Well, most courts subscribe to the theory that an agent's ***standard of care*** is that which a reasonably prudent person engaged in the insurance business would use under similar circumstances. This duty is ordinarily focused on the duties imposed in any agency relationship to act in good faith and follow instructions.

Sipos v Desel (1995)

Mary DeAngelis, and her husband had for several years purchased their automobile insurance from the defendants, Beardsley, Brown & Bassett through their agent, Ronald Lesko. In 1986 they purchased an ***umbrella policy*** through Mr. Lesko in the amount of $1,000,000.00. The policy ***required minimum coverage*** of $250,000.00 on all vehicles covered and owned by persons residing within the household at the time of applying for the excess coverage policy, i.e., (umbrella). The defendants forwarded Mr. and Mrs. DeAngelis a questionnaire to be filled out. They filled out the same to the best of their ability and returned it to Beardsley, Brown & Bassett care of Mr. Lesko. Several of the questions were left ***blank or incomplete***. Nevertheless, the policy was ***issued and renewed*** several times. At no time was there any discussion other than the initial request by Mr. DeAngelis relating to the coverage.

In 1986, Mary Ellen DeAngelis, the daughter, purchased a Volkswagen with the assistance of Mrs. DeAngelis. Title to the Volkswagen was in both their names. Insurance was obtained from Beardsley, Brown & Bassett. A policy was issued in the ***amount of $100,000.00***. At no time was any mention made of an umbrella policy and its ***limitation on coverage***. The policy was renewed several times and still no mention was made of any limitation on the umbrella policy even though Mrs. DeAngelis was an owner of the Volkswagen as well as a beneficiary of the umbrella policy.

In 1991, the Volkswagen was in an accident wherein the plaintiff in the underlying action, Katherine Sipos, suffered serious personal injuries. Suit was brought against the driver and owner. It was only then that the plaintiffs, Mr. and Mrs. DeAngelis, became aware of the ***gap*** in their policy.

As a result of the underlying suit and the gap in their insurance coverage, Mr. and Mrs. DeAngelis have filed this third party complaint alleging negligence and a breach of contract on the part of the third party defendants, Ronald Lesko and Beardsley, Brown & Bassett.

What is the ***agent's responsibility*** here?

The insurance agent "... owes a duty to his principal to exercise reasonable skill, care, and diligence in effecting the insurance, and any negligence or other breach of duty on his part which defeats the insurance which he undertakes to secure will render him liable to his principal for the resulting loss. Couch S. 481, 3 C.J. p. 1088.

Where he undertakes to procure a policy affording protection against a designated risk, the law imposes upon him an obligation to perform with reasonable care the duty he has assumed, and he may be held liable for loss properly attributable to his default. The principal may sue either for breach of the contract or in tort for breach of duty imposed by it.

At the time the Volkswagen was first insured, there was little or no evidence as to how the $100,000.00 amount of coverage came about. The testimony of Mr. DeAngelis that he did not think about it only that the car would be covered by the appropriate amount of insurance. He ***did not*** specifically request $100,000.00 of coverage and, historically, he had never owned a car which was insured for that little an amount.

Checks were issued for claims that were made on the Volkswagen policy. They were issued to Mr. and Mrs. DeAngelis even though the daughter had written complaining of this procedure.

The plaintiffs had been dealing with Mr. Lesko and Beardsley, Brown & Bassett since the middle seventies. At no time did they ever request that a policy be issued to insure an auto for $100,000.00. The other vehicles owned by them were insured for $250,000.00. Lesko and Beardsley, Brown & Barrett ***were aware*** of the umbrella policy and its limitations. The policies were ***renewed*** year in and year out.

Beardsley, Brown & Bassett issued the umbrella policy despite the fact that the questionnaire was incomplete. No further inquiry was made.

All of the insurance policies and their renewals were left in the hands of Mr. Lesko and Beardsley, Brown & Bassett. They in turn were totally familiar with the DeAngelis situation. They knew of the umbrella policy and its limitations. Nevertheless, they issued the policy for $100,000.00, leaving the plaintiff exposed as to liability in the amount of $50,000.00.

The court found that the defendants, Lesko and Beardsley, Brown & Bassett, were ***negligent*** in issuing the policy for $100,000.00, thus leaving a gap of $50,000.00 in their clients' coverage.

The defendants filed a special defense alleging that the plaintiffs DeAngelis were ***contributorily negligent*** in the handling of their insurance. The ***court agreed***. Percentage-wise, the court found the plaintiffs' negligence to be ***45% of the gap*** that occurred in their coverage or $22,500.00. Judgment may enter for the plaintiffs in the amount of $27,500.00.

Policy Cancellation Cases

Insurance coverage is often denied based on a policy expiration or cancellation. More likely than not, the decision to cancel is ***unilateral***, meaning the action is taken solely by the insured or the insurer. Rarely is it a mutual event.

Triggers of termination include failure to renew expired policies, non-payment of premiums, concealment or misrepresentation of material facts at the time the contract was issued, breach of warranty and more. Since most policies and state laws require grace periods or ***timely and sufficient notice*** to terminate coverage, it would seem that a policy cancellation is a fairly straightforward issue. Not so.

Lawsuits can center around the simplest things. For instance, would a courtesy letter from you indicating that a client's policy is about to expire be considered sufficient notice or the basis of an entire lawsuit? Is an oral cancellation notice as good as written? What if a cancellation is conducted in complete compliance with the policy language but the terms conflict with state law? Is the policy cancelled or in force? Read on to find out . . .

Potlatch v. Millers Mutual - 2000

Potlatch Grain and Seed purchased annual policies from Millers Mutual Fire Insurance Company through Millers' agent McDonald Insurance. For a variety of reasons not part of this case, Millers ***terminated*** its agency relationship with McDonald Insurance prompting McDonald to send the following letter to Potlatch:

Previously I sent you a note that your Warehouseman's bond is set to cancel on 07/29/98. I just wanted to remind you once again of this.

Also, your property and casualty insurance through Millers is also set to cancel on 07/29/98. We no longer represent Millers and perhaps you will be able to find a agent representing Millers closer to you and sign a broker letter. I will not pursue further action unless I hear from you.

Although the letter referred to the insurance as being ***set to cancel***, it is clear that McDonald Insurance meant the insurance was ***set to expire***. July 29,1998, was the expiration date of the policy.

In April 1998, Potlatch Grain authorized Guilfoy Insurance to shop for property and casualty insurance to cover the same property insured under the Millers policy. In early July, Potlatch Grain received a bid from Guilfoy Insurance for a policy of property and casualty insurance from American West Insurance (American West). On July 14, 1998, Potlatch Grain authorized Guilfoy Insurance to purchase coverage through American West, which Guilfoy Insurance did. The American West policy provided the same coverage as the Millers policy and commenced on July 29, 1998, the day the Millers policy expired.

Seems pretty standard so far, right?

Well, on August 5, 1998, Potlatch Grain had a fire in its crib warehouse and storage tanks. Potlatch Grain initially thought that the American West policy might not be in force because it had not yet negotiated payment terms with American West. Potlatch Grain submitted a proof of loss to American West, and it paid its policy limits which were less than the amount of damage. So, Potlatch Grain also submitted a proof of loss to Millers, along with a check in the amount of the prior year's premium payment. Millers denied coverage and returned the check along with a letter stating that the Millers policy had expired.

On December 21, 2000, Potlatch Grain legal action seeking to recover on the Millers policy. Initially, the court dismissed the suit on grounds that the policy had clearly expired. Potlatch appealed.

Several state laws were at issue, including:

Notice of nonrenewal

In this particular state an insurer may ***decline to renew*** a policy if the insurer delivers or mails to the first-named insured, at the last known mailing address, written notice that the insurer will not renew the policy. Such notice shall be mailed or delivered at least forty-five (45) days before the expiration date. If the notice is mailed less than forty-five (45) days before expiration, coverage shall remain in effect until forty-five (45) days after notice is mailed or delivered.

Earned premium for any period of coverage that extends beyond the expiration date shall be considered ***pro rata*** based upon the previous year's rate.

The ***transfer*** of a policyholder between companies within the same insurance group is ***not a nonrenewal*** or a refusal to renew. In addition, changes in deductibles, changes in premium, and changes in the amount of insurance or reductions in policy limits or coverage shall not be deemed to be nonrenewals or refusals to renew. Notice of nonrenewal is not required if:

a) The insurer or a company within the same insurance group has offered to issue a renewal policy; or
b) Where the named insured has obtained replacement coverage or has agreed in writing to obtain replacement coverage.

If an insurer provides the notice described above and thereafter the insurer extends the policy for ninety (90) days or less, an additional notice of nonrenewal is not required with respect to the extension.

Policy Language

The policy included an endorsement with the following provision:

If we elect not to renew this policy, we will mail or deliver to the first Named Insured shown in the Declarations, a written notice of intention not to renew at least 45 days prior to the expiration or anniversary date of the policy.

We will mail or deliver our notice to the first Named Insured's last mailing address known to us.

If notice is not mailed or delivered at least 45 days before the expiration or anniversary date of this policy, this policy will remain in effect until 45 days after notice is mailed or delivered. Earned premium for the extended period of coverage will be calculated pro rata at the rates applicable to the expiring policy.

We need not mail or deliver this notice if:

a. We have offered to renew this policy;
b. You have obtained replacement coverage; or
c. You have agreed in writing to obtain replacement coverage.

If notice is mailed, proof of mailing will be sufficient proof of notice.

Potlatch Grain argued that the letter sent to it by McDonald Insurance on July 16, 1998, was a ***notice of nonrenewal*** from Millers and that because the letter was mailed less than forty-five days before the policy's expiration date, the policy remained in effect for forty-five days after the notice was mailed. The policy was therefore in effect when the fire occurred.

Millers contended that the letter from McDonald Insurance was ***not*** a notice of nonrenewal from Millers because McDonald Insurance was no longer its agent and was not authorized by it to send the letter. Millers also asserted that because Potlatch Grain obtained ***replacement coverage*** before the loss, it was not required to send any notice. Potlatch Grain countered by arguing that whether or not the insurance it purchased from American West was replacement coverage or additional coverage is an issue of fact that must be resolved by the jury. Potlatch also argued that the statutory and policy provisions stating that the insurer need not give notice of nonrenewal if the insured has obtained replacement coverage should not apply in this case because Millers did not know whether or not Potlatch Grain had obtained replacement coverage.

Court Discussion

The court used Mutual Life v. Lincoln - 1997 to demonstrate that a contract is ***ambiguous*** if it is reasonably subject to conflicting interpretations. If the language of the contract is not ambiguous, coverage must be determined in accordance with the plain meaning of the words used.

In this case, Millers ***did not give notice of nonrenewal*** to Potlatch Grain. The only notice sent to Potlatch Grain regarding the expiration of the Millers policy was the letter sent by McDonald Insurance on July 16, 1998. There is nothing in the record indicating that McDonald Insurance was acting as an agent for Millers when it sent that letter. Indeed, in the letter McDonald Insurance stated, "We no longer represent Millers and perhaps you will be able to find a agent representing Millers closer to you and sign a broker letter."

Further, state law cited earlier indicated that notice of nonrenewal is not required where the named insured has obtained replacement coverage. The insurance policy likewise provides, *"We need not mail or deliver this notice [of intention not to renew] if: ... You have obtained replacement coverage."*

Both the statute and the insurance policy unambiguously provide that the insurer need not send notice of nonrenewal if the insured has obtained replacement coverage.

Potlatch now argued that its principals did not believe that the new policy was "replacement coverage". Rather, it was additional insurance. Following is testimony of Potlatch's manager:

I have never considered the American West policy as replacement coverage. Prior to the fire and shortly after August 5, 1998, I frankly did not know whether I had any insurance save and except what was stated in the state endorsement to the Millers Mutual Fire Insurance Company which indicated that insurance would remain in effect forty-five (45) days after notice. (The notice to which he referred was the letter from agent McDonald.)

The court did not believe Potlatch and dismissed the appeal, but only after a lot of time and expense had been laid out, including testimony by all agents involved.

This case demonstrates how a simple letter from the agent was used to build an entire case. Another court at another time could have considered the agent's letter to be sufficient notice, triggering a 45-day term until cancellation forcing Millers and probably McDonald to cover the gap in the loss.

Dodson v. JC Penny Life - 2002

The Dodsons purchased an accidental death and dismemberment insurance policy from J.C. Penney in 1998 that provided a $100,000 death benefit in the event of the husband's death, and a $50,000 benefit in the event of the wife's death. The monthly premium was billed to the Dodsons' J.C. Penney charge card. In June,1999, J.C. Penney solicited the Dodsons by mail offering to sell them additional death and dismemberment coverage. The offer advised the Dodsons to return a form attached to the mailing by August 9, 1999, if they wanted the additional coverage.

On June 30, 1999, Mr. Dodson called J.C. Penney's offices in Oklahoma City and spoke with J.C. Penney Life representative, Camilla Frazier. Ms. Frazier has no independent recollection

of the conversation with Mr. Dodson, but based upon entries made in her computer at the time of the call she testified Mr. Dodson called to ***cancel*** the death and dismemberment policy. Ms. Frazier's computer notes indicate Mr. Dodson had concerns about the policy and wanted it cancelled. She attempted to dissuade him but he said they had other coverage and did not need the policy. Ms. Frazier told Mr. Dodson the coverage would be in addition to any other similar coverage but he ***insisted on cancellation***. Finally, the computer notes reflect Mr. Dodson was given the option of canceling the policy immediately and receiving a rebate of the unused premium or allowing the policy to lapse as of the date the next premium was due (August 13, 1999). Mr. Dodson chose to allow the policy to lapse.

On September 11, 1999, the Dodsons were killed in an automobile accident. The Dodson children found J.C. Penney's offer of additional life insurance among their parents' personal effects. The Dodson children contacted J.C. Penney and made a claim for the policy proceeds but were told the policy had been cancelled effective August 13, 1999.

The Dodson children brought suit against J.C. Penney seeking to collect on the policy. J.C. Penney sought to dismiss the case arguing the undisputed facts showed the policy had been cancelled by the Dodsons effective August 13, 1999. The Dodson children argued there was a genuine question of material fact as to whether the Dodsons called to cancel the policy on June 30, 1999, or whether they simply called to decline the offer of additional coverage and the policy was mistakenly cancelled. They also argued J.C. Penney should be estopped from claiming the policy had been cancelled, because it failed to follow a company policy requiring ***written notice*** confirming cancellation be sent within 7 days of cancellation. Finally, the Dodson children argued that state law held that the statutory 31-day grace period extended coverage from August 13, 1999, the date the policy lapsed, until September 13, 1999, beyond the date the Dodsons were killed.

The district court held there was ***no issue of material fact*** concerning cancellation of the policy; estoppel did not apply because the Dodson children could not show ***detrimental reliance***; and the grace period did not apply because the policy had been cancelled by the Dodsons.

The Appeal Discussions

The group policy, excluding an annuity policy, shall contain a provision that the policyholder is entitled to a grace period of thirty-one (31) days for the payment of any premium due except the first, during which grace period the death benefit coverage shall continue in force unless the policyholder shall have given the insurer written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the policy.

The district court concluded the statute applied to policies for which a ***premium was due***, and, because Mr.Dodson cancelled the policy orally, ***no premium*** was due. The district court, however, failed to consider the additional statutory language requiring written notice from the Dodsons in advance of discontinuance.

The policy provides the following language:

You may cancel your coverage upon notice to us. Notice is deemed to be due or given when made in writing, communicated verbally by telephone or in person, or by any other means acceptable to us.

Insurance carriers transacting business in this state are required to include within their insurance contracts "such standard or uniform provisions as are required by the applicable provisions of this code pertaining to contracts of particular kinds of insurance." Among the provisions to be included in group life insurance policies is the grace period required. It unambiguously requires life insurance carriers to provide a ***31-day grace period***. Equally unambiguous is its message to life insurance carriers that the grace period applies "unless the policyholder shall have given the insurer ***written notice*** of discontinuance in advance of the date of discontinuance and in accordance with the terms of the policy."

The Decision

The court determined that in order for J.C. Penney to avoid the grace period, Mr. Dodson's cancellation had to meet the ***statutory requirements*** and be done in accordance with the terms of the policy. The court did not doubt Mr. Dodson's oral cancellation was unequivocal and fell within the terms of the policy. They found, however, that ***no written notice*** of discontinuance in advance of August 13, 1999, was provided. Thus, Mr. Dodson's oral cancellation of the policy, while perhaps effective for some other purpose, did not relieve J.C. Penney of its statutory duty to provide a 31-day grace period once the policy lapsed.

The Dodson children won their case. And, while no agent was sued here, it demonstrates that even though policy language is clear, if the terms of coverage do not comply with state law, you could lose.

Anti-Stacking Cases

The concepts of stacking and anti-stacking of insurance coverages are not familiar to consumers. Therefore, it is reasonable to conclude that a consumer might rely on a ***representation***, by an insurer's agent, that coverages in multiple policies of insurance will be ***cumulative*** -- that is, that the consumer may obtain benefits under more than one policy -- even though there are anti-stacking provisions in each policy.

Bottom line? When an insurance agent knows that the customer is relying upon his expertise, the agent may have a duty to exercise reasonable care in advising the customer of these issues.

Cornett v. State Farm Mutual Insurance - 2002

The Cornetts purchased four motor vehicle insurance policies from State Farm. One of these covered a 1995 Harley motorcycle. The others covered other vehicles owned by the Cornetts. The motorcycle policy included uninsured/underinsured motorist coverage with per person ***limits*** of $100,000 and per accident limits of $300,000. The other three policies each included uninsured/underinsured motorist coverage with per person limits of $50,000 and per accident limits of $100,000.

On March 3, 2000, with all of these policies being in effect, Ronald Cornett was rear-ended while he was stopped at a red light on his motorcycle. As a result, Ronald Cornett sustained serious injuries. The Cornetts settled with the responsilbe party for his policy limits of $25,000. The Cornetts then brought this action against State Farm and agent Kenneth Whitfield, setting forth claims for relief for: (1) return of insurance premiums based on a failure to disclose; (2) fraud; (3) negligence; (4) unjust enrichment; and (5) punitive damages.

In analyzing the Cornetts' claims for relief, there are two aspects of their uninsured/underinsured motorist coverage that must be considered. The first of these is the ***other-owned vehicle exclusion*** in each insurance policy. These exclusions provide, in pertinent part, as follows:

There is no [uninsured/underinsured motorist] coverage:

Because of the above-quoted exclusion, the Cornetts ***would not*** have had uninsured/underinsured motorist coverage for injuries they sustained while occupying one of their four vehicles, ***unless*** the policy insuring that vehicle included uninsured/underinsured motorist coverage.

The other aspect of the uninsured/underinsured motorist coverage that must be considered is the ***anti-stacking provision*** in each policy. Those provisions read, in pertinent part, as follows:

If two or more motor vehicle liability policies issued by us to you providing uninsured motor vehicle coverage apply to the same accident, the total limits of liability under all such policies shall not exceed that of the policy with the highest limit of liability."

Elsewhere in each policy, the following provision appears:

*The limits of liability **are not** increased because: more than one vehicle is insured under this policy; or more than one person is insured at the time of the accident * * **

*Subject to the above, the **most we pay** for all damages arising out of and due to bodily injury to one person is the **lesser of**: The difference between the 'each person' limits of liability of this coverage and the amount paid for that bodily injury by or for any person or organization who is or who may be held legally liable for the bodily injury; or the difference between the amount of damages for such bodily injury, and the amount paid for that bodily injury by or for any person or organization who is or who may be held legally liable for the bodily injury.*

In short, the other-owned vehicle exclusion ***requires*** the insured to have uninsured/underinsured motorist coverage for the vehicle occupied by the insured at the time of the accident and ***prevents*** the insured from recovering under the uninsured/underinsured motorist coverage pertaining to an insurance policy for some other vehicle. The anti-stacking provision prevents the insured from recovering uninsured/underinsured motorist coverage benefits under more than one policy for one accident.

The Claim

The Cornett's claim that Agent Whitfield, obtained premiums ***without*** effectively and unambiguously ***communicating*** to them that ***only*** one vehicle in the household need have uninsured/underinsured motorist coverage in order to provide such protection to all resident relatives in the household."

To this, State Farm pointed out, Whitfield would seriously have ***breached his duty*** to the Cornetts had he made that representation. Because ***each*** policy ***excluded*** uninsured/underinsured motorist coverage for the other three vehicles, each policy was

necessary to obtain uninsured/underinsured motorist coverage with respect to the particular vehicle covered by that policy. The court agreed.

Cornett next attempted to use anti-stacking legislation to recover under the principle that an insurer cannot stack insurance policies and allow the insured to pay separate premiums of which they could only recover under the policy for the motorcycle. The court again disagreed by pointing out that the Cornetts did, in fact, receive separate and distinct benefits from each policy. Each policy provided uninsured/underinsured motorist coverage for injuries sustained by the Cornetts while occupying the vehicle that was the subject of that particular policy, and they would not otherwise have been covered for injuries sustained while occupying that vehicle, notwithstanding the existence of the other policies.

Further, the state involved ***does*** allow insurance companies to offer policies that provide stacked coverages. The fact that the uninsured/underinsured motorist coverage in the Cornetts' policies are not stacked does not result from the statute, but from the policies themselves, which contain anti-stacking provisions. Because these are clearly set forth in the policies of insurance, the court saw we see no obligation on the part of State Farm to inform the Cornetts that these anti-stacking provisions are expressly permitted by law.

The Cornetts' next claim was for ***agent fraud***. They stated that the intent of the parties, which was misrepresented to them by Agent Whitfield, was that the Cornetts would ultimately be able to recover under the separate insurance policies because they were made to pay separate premiums on these policies. Barbara Cornett, further states that Plaintiffs relied on these statements. The implication is that Whitfield told the Cornetts that they would obtain ***multiple coverages***, notwithstanding the existence of the anti-stacking provisions. State Farm and Whitfield did not rebut this allegation which opened the door for the court to allow it. This also created an opportunity for the plaintiffs to recover punitive damages to be determined by another trial.

Reasonable Expectation Cases

No matter how clear the language, ***all policies*** contain areas of ***ambiguity***. When conflicts arise, the courts generally turn to ***theories of reasonable expectation***. In a nutshell, if a policy could imply to a reasonable or average policy holder that coverage is in force, yet that exact language does not exist in the policy, then coverage DOES extend to the policyholder. In other words, the courts generally favor the insured.

As you might imagine, it's easy for agents to be involved in claims from contract ambiguity. Such is the case in the following trial:

Passalacqua Corp v. AIG Claim Services - 2002

In this case, insurance coverage applied to leased computer equipment. However, the policy also provided that, if the computer equipment was owned by one ***other than the insured***, the owner would be compensated for the loss or damage. The Passalacqua Corp's ***expectations of coverage*** was that their lease would be paid off and they would get new computer equipment. However, there is nothing in the language of the contract that indicates that the owner/lessor of the leased property would be compensated and that the insurer would pay the insured/lessee for the cost of replacing the damaged leased equipment.

The court did not agree. They ruled that Passalacqua Corp's expectations were ***unreasonable***. In fact, it would mean they would be provided double recovery.

Next, Passalacqua Corp. went after the agency who provided the insurance for ***breach of contract*** because the insurance policy ***did not*** provide the coverage that plaintiff requested.

Again, the courts disagreed after learning that Passalacqua Corp. ***discussed*** the type of coverage that it preferred with the agent and did not look over the issued policy with any degree of detail. Also, Passalacqua did not recall whether Shaw told them that they were "fully covered."

So, even though the insured's expectations were ***high***, they were ***not*** in keeping with what a reasonable policy holder might interpret. Despite the positive outcome for the insurer and agent, a lot of court time and expenses were consumed.

Pressley v. Travelers Property - 2002

Under the language of the insurance policy, Brown was ***not a named insured*** and was not a member of Pressley's household entitled to benefits. Brown was killed when struck by a drunk driver. Pressley telephoned agent Evans to inform him of the accident and her mother's death. Evans informed Pressley that Brown ***had not been added*** to Pressley's insurance policy due to Pressley's failure to submit Brown's social security number and driver's license number. Therefore, as of the date of Brown's injury, she was ***not covered*** under Pressley's insurance policy as a named insured or as a member of Pressley's household.

Although Brown was not covered by Pressley's insurance policy as of the date of her injury, she was subsequently brought within the scope of coverage through a backdated modification of Pressley's policy. Evans called Travelers and requested that Brown be added to Pressley's. Travelers informed Evans that the change ***could be backdated*** to the date of the last change to Pressley's policy. Thus, Travelers effected the change to add Brown to Pressley's policy.

The effect of the backdated modification done in this case is to bring a non-covered injury within the scope of coverage of the insurance policy. Therefore, Brown's estate is entitled to collect the benefits due under the insurance policy even though she was not alive at the time she was added.

Oops!

Travelers contended that the agent, by accepting Evans' representations about Brown without seeking proof or confirmation, is fraud. However, since Travelers, was in a position to restrict backdating procedures or eliminate backdating altogether, it ***must bear the loss*** resulting from the misuse of its trust and confidence. Further, since Brown's injury was within the scope of Pressley's insurance policy under the language of the contract, the reasonable expectations doctrine is upheld.

Pitts v. American Security Life - 1991

American Security Life Insurance Company contends that a previous trial and court erred in holding it liable for the payment of benefits to Gregory Pitts under a group employee insurance policy. It claims that the policy was void because the employer made ***material misrepresentations*** that prevented the formation of a valid contract.

Background

Kenneth T. McKenzie was the founder and sole proprietor of a plumbing business. Later he included his two sons, Patrick L. McKenzie and Kenneth D. McKenzie, as partners in the business. In addition, he employed his sister, Diane McKenzie Rose, as secretary and bookkeeper.

Kenneth D. McKenzie ***left the business*** in 1974 to establish his own company, United Plumbing Company. Meanwhile, the other family members continued in the original business, eventually incorporating it as McKenzie, Inc. For its employees and their families, the company provided a health insurance policy underwritten by Lincoln National Life Insurance Company. The agent who sold this policy was George Melichar.

In 1983, McKenzie began to suffer with serious health problems. His wife, a dependent on the same policy, also had health problems. The couple's significant medical expenses resulted in large claims against Lincoln National. In 1985, the insurer doubled its premiums for employees of McKenzie, Inc.

As Kenneth T. McKenzie's health worsened, so did the finances of McKenzie, Inc. The company thus sought ***less expensive*** health coverage. Company officers called George Melichar, the agent who had sold the company its Lincoln National policy. Melichar arranged for the company to purchase a new group policy with American Security Life Insurance Company. That policy, was issued on July 26, 1985.

The new policy ***required*** that one hundred percent of the full-time employees -- those working at least thirty hours per week -- ***must*** be included in the group and that the employer must pay ***one hundred percent*** of all employee premiums. It also specified that the insured group must consist of ***at least ten employees***; otherwise, American Security could terminate the policy.

By October 1985, McKenzie, Inc. tottered on the brink of dissolution. A surety took over the company's primary contract, and several employees left. In fact, ***only*** four employees remained as insureds under the group policy. So, American Security notified McKenzie, Inc. that its group coverage would soon end under the terms of the policy.

Members of the McKenzie family were extremely concerned about losing health coverage for Kenneth T. McKenzie and his wife. In an effort to avoid termination of the policy, Diane McKenzie Rose told Melichar that McKenzie, Inc. planned to ***merge*** with United Plumbing. Together, she said, the two companies would have the ***ten employees*** required for continued coverage.

According to Diane McKenzie Rose, both Melichar and American Security approved of this solution. American Security contends, however, that it learned only that McKenzie, Inc. planned to change its name to United Plumbing Company. On November 19, 1985, United Plumbing assumed control of the new policy.

Diane McKenzie Rose submitted a list of ten purported employees of United Plumbing. The testimony at trial revealed that ***not*** all of these individuals were employees of United Plumbing pursuant to the definition of an employee under the policy. Moreover, some of the individuals listed were not employees of either McKenzie, Inc. or United Plumbing. The ***minimum requirement*** of ten employees was clearly ***not fulfilled***.

One of the ten individuals listed was Gregory Pitts, the plaintiff in this case. Pitts was a bona fide employee of United Plumbing when that company assumed the policy in November 1985. American Security argued at trial that if it had known of the misrepresentation implicit in the list of ten purported employees, it would have cancelled the policy in December 1985.
In late January 1986, Gregory Pitts was seriously injured in an accident. United Plumbing submitted claim forms for his medical expenses, and American Security promptly paid these expenses under the terms of the policy. American Security notified United Plumbing, however, that it intended to increase its premium rate beginning in August 1986 from $126.22 to approximately double that amount.

Still suffering from financial difficulties, the McKenzie family decided to seek less expensive coverage. The new policy, of course, would not have included Gregory Pitts, who had been ***totally disabled*** by the accident. If the existing policy were terminated, Gregory's father, George Pitts, would thus have been faced with virtually insurmountable medical expenses.

Desperate to keep the policy in force, George Pitts agreed to pay the entire amount of the increase if United Plumbing would continue to pay the original amount of the premiums. The testimony at trial revealed that United Plumbing paid American Security the entire new amount of premiums for August, September, and October of 1986. For all three months, George Pitts reimbursed United Plumbing for the amount of the increase and paid the original premium amount for Gregory Pitts.

After three months, George Pitts could no longer sustain the financial burden of paying about $1,500 per month to keep the American Security policy in effect. From November 1986 through March 1987, he paid United Plumbing $126.22, the original amount of the monthly premium before American Security had increased its rate. For five months, American Security received from United Plumbing a check for $126.22 per month -- a mere five percent of what the policy originally required. American Security held these checks instead of cashing them. Finally, in March 1987, American Security decided to terminate the policy effective June 30, 1987. Pursuant to the terms of the policy, the insurer extended benefit payments for three months after notice of termination.

After giving notice of termination, American Security cashed the five checks it had received from United Plumbing from November 1986 through March 1987. The insurer rationalized that since it had already paid over $100,000 in medical benefits, it could properly keep the premium payments -- even though they were inadequate to keep the policy in force -- to recoup some of its losses on the policy.

Just before the end of the three-month period of extended benefit payments, George Pitts sought injunctive relief against American Security in a Mississippi state court. Pitts claimed that since his son's right to benefits had vested, American Security could not terminate the policy.

The First Trial

The first court granted Pitts's request for punitive damages. American Security then filed a third-party action against its insurance agent, Melichar, claiming that Melichar had colluded with members of the McKenzie family to defraud the insurer. However, the judge exonerated Melichar.

The judge found that Pitts was entitled to ***continued benefits*** under the policy but not to attorney's fees. He concluded that Pitts was injured ***before*** cancellation of the policy and that he had a reasonable expectation of benefits under the policy. The judge also concluded that by accepting premium payments for only one employee for five months, American Security effectively agreed to provide coverage to a group of less than ten employees.

American Security argues that its policy was void from the beginning, because employees of McKenzie, Inc. made ***material misrepresentations*** that prevented the formation of a valid contract. The court agreed with the concept that had American known the truth -- that the insured did not have ten bona fide employees who were eligible for insurance -- it would have terminated the policy in December 1985, one month before Pitts was injured. The only reason that the insurer decided to continue coverage was that Diane McKenzie Rose claimed that the company, through its association with United Plumbing, could muster ten employees, thus meeting the requirements of continued coverage. However, despite this fact, the first court did not hold that the insurance contract was void.

The Appeal

The appeal trial court also was not convinced to void the policy. The judge cited two cases as support for his conclusion that Pitts was entitled to receive benefits. Each case concerned a contract that was ***voidable, not void***. In each case the court held that even though one party had rightfully avoided the contract before the medical claim arose, public policy prevented the insurer from denying benefits to the employee who had ***reasonably relied on the coverage***. (Brown v. Blue Cross Blue Shield - 1983 and Gulf Guar. Life Ins. Co. v. Kelley - 1980).

In addition, the appeals judge concluded that American Security ***had knowledge*** that McKenzie, Inc. had failed to meet the requirements of the policy. For example, Carolyn Copenhaver, a quality control supervisor for American Security, testified about a phone call that she made to McKenzie, Inc. to determine whether the company's application for insurance was in order.

Tina Lowery, a secretary for McKenzie, Inc., answered the call. Since the group administrator was out of the office, Lowery attempted to answer Copenhaver's questions about the company and its employees. Copenhaver asked Lowery why her name was omitted from the application for insurance. Lowery responded that she was covered through her spouse's insurance. This response, alone, should have alerted Copenhaver to the probability that the employer was not paying one hundred percent of the premiums, as required by the policy. Why would an employee turn down free coverage merely because she was covered as a dependent on another policy? In the same conversation, Lowery said that she was a full-time employee.

The next day, Copenhaver reached Kenneth Smith, the group administrator. According to Copenhaver, Smith told her that Lowery was excluded from the plan because she sometimes worked less than thirty hours a week and thus failed to meet the policy definition of a full-time employee. This statement was contradictory to the information that Lowery had given Copenhaver one day earlier. Even if these two conversations occurred exactly as Copenhaver testified, she should have investigated the discrepancy.

Copenhaver knew or should have known that McKenzie, Inc. was probably not fulfilling the requirements of the policy. Because Copenhaver was an agent of American Security, her knowledge can be imputed to the company.

Conclusion

Since the policy was merely ***voidable***, Pitts was entitled to coverage for all medical expenses attributable to the injury he sustained in January 1986 under the following:

- Pitts had a reasonable expectation of continued benefits;
- The entitlement to benefits vested at the time of the injury, which was before American Security decided to cancel the policy;
- The total disability resulting from the accident precluded Pitts from obtaining other coverage; and
- Pitts was innocent of any wrongdoing.

Furthermore, the court said that after American Security learned that the policy requirements had been breached, it could have protected any possible right to deny liability by executing an ***ordinary reservation of rights*** [a written notice to the insured that the insurer would continue to pay benefits until the issue of coverage is settled]. Instead, it accepted premium payments and paid medical benefits without reservation. It thus ***waived its right*** to assert a defense to its liability under the policy.

Damages and Attorney Fees

Pitts originally sought ***punitive damages*** for bad faith breach of contract which the court denied on the basis that the group health plan created by United Plumbing falls under ERISA guidelines which ***preempt*** common law issues such as punitive damages.

Similarly, the court denied attorney fees to Pitts based on the fact that there was no showing of bad faith or culpability on the part of American Security.

Conclusion

Employee Pitts retained his coverage and the agent escaped a major lawsuit. This case demonstrates the length that clients will go to retain coverage. Agents can easily and innocently become part of these schemes.

Rosenburg v. Lincoln American Life - 1989

The Rosenburgs, husband and wife, applied for what they were told was ***guaranteed coverage life insurance*** for their daughter, who had a heart defect, and paid several months' premiums on the policy. After their daughter died, the insurer refused the claim.

An initial trial determined that the Rosenburgs were entitled to the policy proceeds. However, the insurer appealed the case.

Background

Rosenburg, through his job as a police office signed up for a life insurance program on his daughter through his work. The plan was offered by agent Kevin Wedmore through a letter sent to all employees. The letter stated that $10,000 term insurance policies were "guarantee issue" ***regardless of the group participation level***. In other words, policies would issue to all

employees who applied, regardless of the number of eligible employees who applied for insurance under the program.

Eventually, Wedmore gave a presentation to the city council indicating again that the issuance of policies would be guaranteed (no underwriting). However, ***this time*** it was disclosed that ***40% of the employees*** and elected officials must participate.

A later presentation by a different agent also mentioned the 40% participation requirement but disclosed that the issuance of policies was for dependents was not guaranteed.

Employees who attended these presentations testified the agents also said that if people ***signed up that day***, they and their family would be insured at that moment and no medical exams would be required, even for those with medical problems. If they waited, however, insurance coverage probably would not be guaranteed without an exam.

At a presentation that Rosenburg attended he discussed with agent Paul John, that once the 40% participation rate was met, policies would be guaranteed issue without medical exams. Rosenburg later testified that he initially told John that he was not interested because, with the exception of his daughter Desiree, he and his family already had insurance. He explained his daughter's medical problems and indicated that it had been impossible to get insurance for her due to a heart defect. According to Rosenburg, John said that Lincoln's policy was different and that Desiree's application ***could not be refused***.

Rosenburg filled out the applications, including medical histories of Rosenburg and his children then signed a payroll deduction card. When he submitted these documents, John's supervisor, agent Charles Roberson, ***also confirmed*** that the insurance was guaranteed without regard to medical history and that a physical exam was not needed. In addition, Rosenburg testified that he asked both John and Roberson what would happen if he signed that day and something immediately happened to Desiree. According to Rosenburg, they said she would be covered.

A paragraph on the application read as follows:

The effective date of coverage will be the date of approval at the Home Office, subject to valid payment of the first premium.

The plaintiffs' applications were forwarded to Lincoln's Home Office and Desiree Rosenburg's a Lincoln underwriter who ordered a medical report from Desiree's doctor, Dr. Thomas Martin. After reviewing the report and based on underwriting manuals, Desiree's ***application was denied*** and the Rosenburgs received a rejection letter for Desiree on September 5, 1985, based on her medical history. Mr. Rosenburg then called Lincoln and was told that the coverage for dependents was not guaranteed and that any coverage for employees was only guaranteed if 40% of the eligible employees participated.

According to Mr. Rosenburg, the insurance company indicated to him that Lincoln's agent, John, had apparently misrepresented the policy to him.

The Claim

Rosenburg does not claim that, assuming a medical exam was a condition to Lincoln's approval of Desiree's application, the rejection based on the doctor's report and Lincoln's

policies was improper. Instead, they claim that the policy accepted by Lincoln had no condition with respect to Desiree's health or a medical report.

Before the Rosenburgs received a rejection letter, the Granite City Payroll Department withheld the first month's premium for all four policies from Mr. Rosenburg's paycheck. However, Lincoln sent a refund check representing the premium for Desiree's application to the Rosenburgs, treating it as an overpayment on Mr. Rosenburg's three other policies.
However, the Granite City Payroll Department withheld the money for Desiree's application from Mr. Rosenburg's account for the next two months until they received notice from Lincoln to discontinue deducting a premium for her application from his paycheck. Mr. Rosenburg did not cash the three premium refund checks. Desiree Rosenburg died on November 22, 1985. The Rosenburg's subsequent claim for insurance benefits was denied.

At the trial, several witnesses for Rosenburg testified stated that the terms of insurance were misrepresented, leading to a judgment in favor of Rosenburg with damages in the amount of $12,112.00, the value of the life insurance policy plus costs of $2,951, plus $10,065 in attorney fees and another $3,028 in penalties for refusing to pay the claim.

The Appeal

Lincoln appealed the first court decision based on a similar case (Wallace v. Prudential Insurance Company of America - 1973) where the plaintiff executed a family life insurance application, which included a policy on the life of his son, and simultaneously paid the first month's premium. The policy application, however, stated that it was conditional on the insurance company's acceptance. After examining the plaintiff's application, the insurance company requested further information. The information provided revealed that the plaintiff had suffered a gunshot wound and suggested that he might have had an alcohol problem. A medical exam was requested. Before the exam took place, the plaintiff's son was killed in a car accident. An examination of the plaintiff revealed alcohol abuse. Thereafter, the application was denied and the premium was returned.

Waiver of Conditions

Insurance law holds that in cases where the insurer is aware that it has valid grounds to rescind a policy or deny a claim yet it continues to imply coverage, by its own acts or acts of its agents, it may voluntarily surrender these rights. ***Loss of these rights*** is also evident where, with knowledge of the insurer, agents of the insurer continue to forgo a condition of coverage such as a medical exam, payment of the first premium, requirement for an alarm system, etc.

What Is Considered "Knowledge" by The Insurer?

In most cases, it is generally held that ***knowledge of a general or managing agent*** of the insurer ***constitutes knowledge of the insurer***, even if the agent fails to pass the information along to the insurer. Knowledge of a ***soliciting agent***, on the other hand, does not necessarily constitute knowledge of the insurer.

In the Rosenburg case, there was evidence presented that insurance agents told Mr. Rosenburg and other city employees that the insurance was guaranteed ***without regard*** to medical history, physical exams or employee participation and that the application would be effective as soon as it was signed and the premium was paid. In addition, Mr. John's presumed supervisor was apparently present during the signing of these applications. Thus,

evidence established that John had at least apparent authority, if not express authority, to ***waive certain conditions of the contract***.

The waiver issue was a question of fact for the jury to decide. Based on all the evidence including the testimony of Rosenburg and certain administrative employees at Lincoln there was sufficient evidence for the jury to conclude that ***there was a pattern*** by the some Lincoln agents ***to waive such conditions*** and that this ***waiver was encouraged***. The fact that Rosenburg signed applications which had answers to questions for those not applying for guaranteed insurance does not negate the waiver.

Unreasonably Withholding Benefits

Lincoln was also accused and penalized for not paying the initial claim. Lincoln contends that it did not engage in unreasonable and vexatious conduct in denying the Rosenburgs' claim for insurance benefits and in defending against this suit since there were actual good faith disputes occurring as to whether or not an insurance contract was binding at the time.

However, the court disagreed upon learning that there was evidence that ***Lincoln was well aware of its alleged misrepresentations*** to Granite City employees and to employees in other cities and ***allowed such conduct to continue***. In fact, one employee of Lincoln testified that she informed a Granite City employee, that Granite City may have been among those cities where Lincoln agents misrepresented the coverage for dependents.

Conclusion

There was no indication that agents in this case were sued, however, it would be easy to see they violated some portion of their agency agreement and could be brought to task or at least terminated.

Beister v. John Hancock Mutual Life - 1966

Eugene Beister made application for an insurance policy in the amount of $10,000 with the John Hancock and paid as a deposit on the premium the amount of $28.40. The application was taken by agent Harry R. Meister, a friend of applicant and his family.

After taking the first application for the insurance and noting the premium payment of $28.40, which represented one month's premium at age 26, the ***agent recommended*** to Beister that he ***predate*** the policy, presumably in order to obtain the premium rate at age 25 instead of 26. Beister accepted the recommendation of the agent and thereupon the agent prepared a new application form, discarding the old form, and then received the check from Beister in the amount of $28.40 without noting on the application form or the conditional receipt whether this was to be a part payment, a semi-annual, or a monthly payment. The agent informed Beister that when the policy arrived he would contact him.

The issuance of insurance was conditioned upon the approval of the risk by the home office of defendant. The home office required a complete physical examination, to which Beister submitted, and then later required a urinalysis, which requirement Beister also met. The application was approved on October 31, 1960 by the home office and Policy No. 7363667 was issued by the defendant and sent to its Omaha office for delivery and collection of the balance of a semi-annual premium due thereon in the amount of $134.10. The record does not

disclose the exact date on which this policy reached the Omaha office but presumably it was about the 3rd of November, it having been mailed on November 1, 1960.

Under the ***company's practice*** any policy issued would be placed in the agent's box at the Omaha office and the agent was then supposed to contact the person who had contracted for the insurance. If the agent ***did not pick up the policy***, usually within a week, the policy ordinarily would be mailed to the agent for delivery to the applicant. In this case the record is not clear whether the agent picked up the policy from the Omaha office or received the same through the mail. The agent's only recollection was that the policy came into his hands in the latter part of November or the first part of December.

The agent knew that the applicant's work entailed out-of-town travel over the east-end of the state and that the applicant frequently came to visit his parents on weekends at Omaha. The agent ***attempted*** on two different occasions to ***reach the applicant*** at his parent's home by ***telephoning*** him at that place. The agent, however, made ***no attempt*** to reach the applicant ***by mail*** either in Hastings or at his listed address in Omaha. When he did call at the Omaha address, he did not make any statement about the policy or leave any word or message concerning the policy with whomever he talked because the agent felt that the application and issuance of the policy was a personal matter for the insured and apparently should be treated confidentially. In other words, no message was left that the policy had been issued and was available for delivery at that time. The record shows that ***the applicant tried to get in touch*** with the agent several times in regard to the policy but the dates of such attempts are indefinite, so that it cannot be said from the record that the applicant contacted the agent after the agent had the policy in his possession. But, agent did recall applicant's visiting him at his home "on one or two different occasions" but did not remember the exact time.

Beister was killed in a car accident on December 14, 1960, his 26th birthday. The car apparently ran into a tree; no other car was involved in the accident. The agent after learning of Beister's death returned the policy to his Omaha office. Several weeks after the funeral, the parents discovered a conditional receipt issued by the defendant for the $28.40 initial deposit made in reference to the application for insurance.

The policy that was issued was predated to June 13, 1960, in accordance with the request made in the application. ***Predating was permissible*** in this state at the time up to a maximum of six months under the statutes of that State. Subsequently, demand for payment of the policy was made, and after refusal, a complaint filed.

The Claim

The insurance company's defense was that the applicant was fully informed of the fact that the semi-annual premium for the policy was $162.50 and that the total premium had to be paid ***before delivery*** to him of the policy and within sixty days from its effective date. The agent testified that he had ***no authority*** to deliver the policy without collecting the premium. The plaintiffs insist that the conditional receipt is ***ambiguous*** and is subject to the interpretation that the applicant had sixty days within which to pay the balance of the premium due after the policy had been approved; that it was not approved until about November 1, 1960 and that the applicant's death occurred within the sixty-day period mentioned in the conditional receipt. Plaintiffs also seek recovery on the ground that since defendant did not tender the policy or make any effort to collect the balance of the premium due on the policy the defendant is liable and should not be heard to claim (1) that the contract had lapsed prior to the death of the

applicant, or (2) that the policy was never in force by reason of the failure of any of the conditions set out in the instruments forming part of the contract of insurance.

In addition, the agent testified to the following:

I made it plain to Gene when the policy was delivered he would have to pay the difference between the sum which I already had in hand and the semi-annual premium at age twenty-five.

Also, language in the conditional receipt reads as follows:
The contract of insurance applied for shall take effect retroactively as the date of the application or the date of the medical examination, whichever is later, or if another date is requested as of such date, . . .

If the contract of insurance takes effect hereunder and said sum received is less than the said premium, THE BALANCE OF SAID PREMIUM MAY BE PAID DURING THE LIFETIME OF THE PROPOSED INSURED WITHIN SIXTY DAYS OF THE EFFECTIVE DATE OF THE CONTRACT, . . ."

Therefore, the insurance company assumed the "effective date of the contract" to be the predate of June 13 set out in the policy, and therefore contends that the sixty-day grace period allowed in the conditional receipt had lapsed before it began and there was no interim coverage at the time of the insured's death on December 14, 1960.

Coverage or not?

It is clear from the application that upon approval of insured's application accompanied by payment of more than $15 he ***was*** granted coverage, and this coverage was to run until there had been a lapse. The above-quoted clause indicates that the insured had sixty days from the "effective date of the contract" to pay the balance due and prevent the lapse from occurring.

The question then is, what is meant by the "effective date of the contract" from which is measured the sixty-day allowance? If the "effective date of the contract" refers to the date the contract came into existence by the acceptance of the application, there would be no lapse because the insured died (December 14, 1960) within sixty days of this date (October 31, 1960). However, if the "effective date of the contract" refers back to the prior paragraph which establishes the retroactive date of coverage as being the predate of June 13, then more than sixty days elapsed at the time of insured's death and there would be no coverage under the terms of the conditional receipt.

A pertinent part of the application reads as follows:

IF AT LEAST $15, IS PAID WITH THIS APPLICATION, THE CONTRACT OF INSURANCE SHALL TAKE EFFECT AS PROVIDED IN AND SUBJECT TO THE TERMS OF CONDITIONAL RECEIPT, OTHERWISE THE CONTRACT OF INSURANCE SHALL TAKE EFFECT AS OF THE DATE OF ISSUE OF THE POLICY but ***only*** *upon delivery to and receipt by the Applicant of the policy and payment of the premium thereon, . . .*

The court agreed with the company that the coverage took effect as of the June 13 predate, but acceptance of this point does not compel a holding that this predate is necessarily the "effective date of the contract" referred to in the sentence in question. In fact, a thorough

examination of the contract indicated to the court that the position taken by the insurance company is erroneous.

Why? Well, the first part of the sentence in which the questioned phrase is found contains these words, "If the contract of insurance takes effect, . . ." This phrase obviously refers to the point of time at which the application is ***accepted*** and a ***binding contract is formed***. This being known, the court looked to the last part of the same sentence in which they found the following phrase, "effective date of the contract." Since both of these phrases appear in the same sentence and have in common the key words of "contract" and "effect" the court could safely assume that they are used in the same context and therefore refer to the same point of time. Since there is this positive relationship between the two phrases, and since the first of these two phrases clearly refers to the date the contract came into existence, which was October 31, 1960, the court concluded that the "effective date of the contract" likewise refers to the October 31st date. Thus, the insured had sixty more days to pay the balance due -- well before the date of death.

True Intentions

Next, the court endeavored to find the true intentions of the parties. They did not believe the position urged by the insurance company is ***consistent*** with the intent of the parties and it is certainly not consistent with the normal experience and expectations of insureds in this area. When a person applies for insurance and pays a significant portion of the total semi-annual premium in advance, unless clearly stated otherwise, upon issuance of the policy he expects to receive protection from that point against future uncertainties.

The insurance company is free to ***dispel this expectation*** by clearly indicating to the insured that there is no coverage until the policy has been delivered to the insured and payment received. Far from dispelling insured's belief, however, the application and conditional receipt made a distinct differentiation between applicants who pay more than $15 with their application and those who pay less than that amount. For those who pay more, as did insured herein, the conditional receipt clearly states that upon company acceptance, coverage is granted with the insured having a sixty-day period to pay the balance due. There is absolutely no indication that this same term of insurance protection was not applicable in situations of predating.

Therefore, it appeared to the court that the insurance company likewise envisioned a prospective term of insurance with the insured being granted sixty days to pay the balance due. Rather than dispelling the insured's normal expectations of coverage, the contract gives every indication that the insured's expectations were well founded. Therefore, it would seem that the insured intended and expected to receive prospective coverage from the day the application was accepted and the policy prepared by the insurance company gave every indication that it likewise intended to grant that coverage.

This intention is not changed merely because the policy is predated. The normal connotation attached to predating is that the date set shall determine what date premium payments are due. It certainly would not be expected to have an adverse effect on future coverage which was otherwise afforded to the insured by the issuance of the policy.

The position taken by the company is further ***contrary to the normal experience*** and expectations in that it is the business of the insurance company to insure against future risks, and it is the purpose of premiums to cover the expense of bearing that risk. When one makes a premium payment that is applied to a past period, as the company here contends was done,

the company obviously assumes no risk in return for the premium payment. It is unlikely that the parties contemplated the insurance company assuming no risk nor giving up little, if anything, in return for the insured's partial payment.

What the court is saying is the company is urging a position that is contrary to the normal experience and expectations in this area, and to be effective it should have clearly set forth its position in the application and conditional receipt. Far from setting forth a contrary position here, however, the contract gives every outward indication that coverage was prospectively granted. This position of accepting a partial premium, without affording any coverage or assuming any risk, should be set forth without equivocation and without disarming clauses that leave the impression coverage is being afforded if application is accepted.

Conclusion

To summarize, in viewing the various rules of contract interpretation, the court concluded that the interpretation of the words "effective date of the contract" urged on us by the insurance company is not consistent with the normal connotation of these words either independently or in the context in which they are used. Furthermore, the company's interpretation is contrary to the normal expectations of the parties, violates simple logic, and renders absolutely meaningless two carefully drawn provisions of the contract.

Therefore, the interpretation of the "effective date of the contract" as the policy predate of June 13 cannot be the correct interpretation. On the other hand, the interpretation advanced by the insured's beneficiaries is the more acceptable one.

If the ***insurance company*** wants to insert ***conditions or restrictions*** which deny coverage until the full premium is received, it must word them in ***clear unambiguous language***. Failing to do so it cannot expect the courts to construe ambiguous terms in its favor to deny coverage to an unwary insured. With this approach the same result is reached. The ambiguity which clearly exists must be resolved in ***favor of the insured*** or his beneficiary and against the insurance company who is responsible for the ambiguity. The "effective date of the contract" must be interpreted as the date the contract came into being by the acceptance of the application, October 31, 1960. Thereafter, the insured had sixty days in which to make payment, which period of time had not lapsed at the time of his death on December 14, 1960. The beneficiaries are therefore entitled to recovery.

Macey v. Allstate Property & Casualty - 2002

Macey purchased multiple automobile insurance from Allstate through the Korbases. He purchased both liability and collision coverage. Macey would ***routinely sell and purchase cars***, then call the agent to delete or add the cars from the policy as necessary. Macey would often ***orally notify*** Allstate of these changes by calling the Korbases. On each occasion, he was "assured" that newly acquired cars were automatically covered by his policy even without notice to Allstate. In fact, his policy reads that "replacement" vehicles are automatically insured for both liability and collision.

Macey paid his insurance premiums monthly ***via the internet***. Occasionally, Allstate would ***not receive*** the electronic payment. On such occasions, Allstate ***notified plaintiff by mail***. Plaintiff then made an additional payment to satisfy the amount past due.

In July 2000, Macey paid his monthly premium via the internet as he had done before. His July payment was due July 29, 2000. Unknown to plaintiff, Allstate did not receive that payment yet the Korbases ***continued to assure him*** that his insurance was in effect and continuously protecting him." The Korbases made these assurances both ***orally and in writing***.

On July 30, 2000, plaintiff purchased a 1997 Saab automobile to replace an insured car. Plaintiff notified Allstate, through the Korbases, of his purchase. Again, the Korbases assured plaintiff that the 1997 Saab was insured immediately upon purchase. Among other things, Adam Korbas also told plaintiff for the first time that Allstate had not received his payment due July 29, 2000. Adam Korbas did not tell plaintiff that Allstate would not provide coverage or that his policy was cancelled. In fact, Adam Korbas assured plaintiff both orally and in writing that the 1997 Saab was insured as of July 29, 2000. Additionally, Allstate sent plaintiff a ***revised*** statement of "Policy Declarations" which also stated that the 1997 Saab was insured as of July 29, 2000.

Macey eventually ***re-transmitted the July 2000 payment*** and on reliance of Allstate and the Korbases' representations and assurances he believed the 1997 Saab was insured. On August 10, 2000, while driving the 1997 Saab, plaintiff was in a car accident.

Following the accident, Macey notified Allstate, through the Korbases, about the accident and the apparent losses he had incurred. At no time did the Korbases tell plaintiff that Allstate would assert that the policy had been cancelled before the accident. In fact, the ***agents continued to reassure*** plaintiff that his Allstate policy covered the losses he had incurred as a result of the accident. Relying on these representations and omissions, plaintiff choose to incur certain additional costs related to towing and storage of the "totaled" 1997 Saab that he would not have incurred had he known Allstate would deny coverage.

Allstate continued to delay paying on the claim until the carrier finally notified plaintiff of its position that the policy had lapsed and his losses, therefore, were not covered.

The Claim

Macey filed suit against Allstate alone for breach of written and oral contract, breach of written and oral insurance binder, breach of rights as third party beneficiary, insurance bad faith, declaratory judgment, and reformation.

He also filed against both Allstate and the Korbases for negligent misrepresentation, negligence and ***detrimental reliance***. The agents argued that under their state law, they could not be held personally liable for the conduct alleged in the complaint since they are mere agents. However, Macey argued that they "may be considered 'dual agents'" and, as such, could be held personally liable for the acts alleged in the Complaint.

In support of this position, they presented Briano v. Conseco Life Ins. Co., - 2000, which concluded that the courts would recognize a ***duty in a non-commercial insurance broker to warn his insured that the policy he secured for the insured would lapse***. The Briano opinion, however, offers little help to plaintiff's cause, however, because that court assumed, for purposes of its decision, that the non-diverse defendant was a broker, not just the carrier's agent, and that as a broker that defendant clearly could have some extra-contractual duties under state law to the insured. So, the primary target of the Briano court's inquiry was not on who could be sued (agent and carrier, or carrier only), but on the substantive scope of the broker's duty to his client, the insured.

Conclusion

Allstate claimed that only they could be held responsible under the law for the acts of the agents. The insured disagreed, arguing that the agents could be held personally liable for the acts of negligently misrepresenting the scope of the insured's automobile insurance policy.

The court, after analyzing several agent cases, found that the ***agents***, by ***reassuring*** to the insured that his automobile was ***covered*** by the policy, had a ***special duty*** to the insured to ***inform*** him that his policy had been ***cancelled*** and that his automobile was not covered by the insurance policy.

The extent of Allstate's liability and that of the agents, however needed to be determined in a separate trial.

Prudential v. Lilliard-Roberts -2002

Here is a recent mold case that demonstrates how two parties can fall "deep" into the cavities of legal maneuvers.

Prudential issued a homeowner's policy that the agent termed an ***all-risk policy***. Water damage occurred due to a roof leak and a sewer problem and a toxic mold invaded the home, forcing the insured and her family to move out into an apartment. The insurer claimed that no coverage existed for the insured's claim. The insurer's adjuster determined that all water damage resulted from defective and ***improper workmanship*** and repair to the roof and flashing surrounding the dormer and chimney.

Mold Law

Would an all-risk policy cover these items? Well, in the insured's state all risks property insurance indemnifies the insured against physical losses resulting from perils not excluded under the policy and perils are active physical forces which cause the loss of or damages to the insured property. As a result, the insured's burden is limited. The insured need only show that a physical loss occurred to covered property.

Physical loss can occur at the ***molecular level*** and can be ***undetectable in a cursory inspection***. However, mold damage may be distinguishable from odor damage: The recognition that physical damage or alternation of property may occur at the microscopic level does not get around the requirement that physical damage need be demonstrated. In methamphetamine damage cases, for example, the physical damage is demonstrated by the persistent, pervasive odor. In the absence of such odor, no physical damage could be found. The mere adherence of molecules to porous surfaces, without more, does not equate physical loss or damage.

In other cases, where a house has visible mold which may not be removable, the house has suffered "distinct and demonstrable" damage. That is sufficient to constitute a "direct" and "physical" loss. Many courts have deemed the inability to inhabit a building as a "direct, physical loss" covered by insurance.

In determining damage to personal property covered by insurance, the court must consider the nature and intended use of the property and the purpose of the insurance contract. What may

constitute damage in the retail clothing industry, for instance, might not constitute damage to the personal property of a homeowner.

Case Claims and Arguments

Prudential in this case argued the following issues:

(1) There was no direct physical loss
(2) The insurance policy excludes property damage resulting from water and sewage backup
(3) The insurance policy excludes property damage resulting from faulty workmanship
(4) The damage to the personal property was not caused by any named peril
(5) The insurance policy excludes damage to personal property caused by rain; and
(6) A proof of loss was not timely submitted

Lillard-Roberts contends that she is entitled to insurance coverage under the policy and alleges 10 affirmative defenses, including the ***invalidity of certain exclusions*** under state law, coverage through promissory estoppel or reformation, violation of the implied covenant of good faith and fair dealing, breach of the standard practices of the insurance industry, and unclean hands and/or unconscionability.

She also alleges fraud and misrepresentation, post-claim misrepresentations as to lack of coverage, pre-claim misrepresentations to induce purchase of the policy, outrageous conduct, breach of contract, negligence, declaratory relief, policy reformation and agent fraud and misrepresentation (both post- and pre-claim) and negligence . . . Wow!

Background

Lillard ***requested protection*** from loss to her home and contents to the ***greatest extent possible***, including water, flood, and earthquake damage. Agent Primozich assured Lillard-Roberts that Prudential would provide the maximum coverage. Lillard-Roberts did not carefully read the policy, but believed she had coverage for any damage resulting from water, roof or plumbing leaks. After Prudential issued the policy, Primozich visited Lillard-Roberts at home and assured her that her antiques and collectibles had coverage for full replacement cost.

Some time later, Lillard-Roberts noticed that water had seeped down the wall of her dining room. She called Primozich who, without visiting the house or sending an adjuster, advised her that she had no coverage and not to submit a claim. In February 2000, Lillard-Roberts sued the prior owners and home inspector, alleging that the prior owners knowingly and negligently repaired the roof and flashing around the upstairs dormer and chimney area, which resulted in water leakage and mold contamination.

Months later, the plumbing system failed, backed up into the main floor bathroom, and flooded the main floor with approximately one inch of sewer water. Primozich again denied Lillard-Roberts' claim under the insurance policy without any investigation. Lillard-Roberts was diagnosed with systemic fungal disease attributable to living in her house. On the advice of her physician and toxic mold expert, she and her family moved out of the house and into an apartment.

On January 13, 2001, Prudential received an insurance claim from Lillard-Roberts for damage to her dwelling, garage, and personal property that resulted from water, mold, and mycotoxin contamination. Prudential's adjuster concluded he had "no doubt that there is probably some

mold in the house," from water damage due to defective workmanship in a repair to the roof, flashing surrounding the dormer and chimney, and water intrusion.

On February 21, 2001, Prudential sent Lillard-Roberts a blank Proof of Loss form and requested that she provide a list of written materials and submit to an Examination Under Oath during the week of March 12, 2001. On March 28, 2001, a mold remediation specialist hired by Prudential, Brad Johnson ("Johnson") of Paul Carlson Associates, Inc., issued an Industrial Hygiene Report which concluded that "mold contamination and possible growth has occurred in the home, likely resulting from water infiltration into ceiling areas from ***chronic roof leaks***. This may be compounded by ***inadequate ventilation*** of attic and vaulted ceiling areas." The report also found that the sewer flooding, accumulation of pet and bird droppings throughout the house, and ***antique furnishings*** may have ***previously been contaminated*** and contributed to the mold presence.

Prudential also hired Talbott Associates Incorporated ("TAI") to determine if water intrusion was the cause of the mold growth and spores. In its report dated July 27, 2001, TAI stated that water leakage was "probably the result of inadequate flashing or flashing installation" around a dormer and nearby skylight and "inadequately maintained tile grouting inside [the] shower unit. It concluded that the home "has probably not been subject to quantities of mold growth which would lead to unhealthy conditions" and that "the amount of leakage evidence found is typical of many western homes in this state that have minor leakage problems."

Additional fungal studies found in three water-damaged areas caused by leaks in the roof and/or skylight and shower, "although there is no testing or data to show that toxins are present." It also concluded that "poor demolition practices used to find the water damage" likely dispersed the mold spores and found "potentially significant sources of fungal and bacterial contamination . . . animal feces and bird droppings."

Lillard's own investigation revealed a total of $127,000 in restoration costs were needed to bring the house back to habitable standards. Further, the amount could be more once the walls were opened. Another contractor believed the house, valued at $170,000, to be a total loss

Proposal & Arguments

Prudential was still ***not committing*** to coverage, but asked Lillard to submit a Proof of Loss form detailing estimated costs of repair. Lillard refused since the estimates she had indicated that costs could run higher once walls were opened.

Prudential filed a lawsuit to resolve the differences. They argued that the policy ***does not*** cover Lillard-Roberts' claim for mold damage to the dwelling and other structures because it is not a "direct" and "physical" loss. Lillard-Roberts counters that this is an "all-risks" policy under which coverage must be presumed unless specifically excluded from coverage. Lillard-Roberts further contends that the policy provides coverage for decontamination and restoration.

One ***listed exclusion*** in the policy is loss caused by "mold, fungus, spores, wet or dry rot, mildew, bacterium." However, Prudential is not relying on this exclusion because it is not "preceded by a sufficiently explanatory title printed or written in type not smaller than eight-point capital letters" as ***required the local state***.

The court concluded that "all risks property insurance indemnifies the insured against physical losses resulting from 'perils' not excluded under the policy" and that "perils are active physical forces which cause the loss of or damages to the insured property." So, the insured need only show that a physical loss occurred to covered property."

Prudential contends that a "direct" and "physical" loss requires physical damage close in time and place to the insured peril. Furthermore, "the inclusion of [the] word [physical] negates any possibility that the policy was intended to include 'consequential or intangible damage,' such as depreciation in value, within the term 'property damage.'" In Prudential's view, ***mold is equivalent to the existence of asbestos,*** which is not deemed a "direct" and "physical" loss.

However, there is no evidence here of physical loss, direct or otherwise. The building has remained physically intact and undamaged. The only loss is economic. The policy, by its own terms, covers only direct physical loss. The inclusion of the terms "direct" and "physical" could only have been intended to exclude indirect, nonphysical losses.

The court disagreed because the house has ***visible mold***, which may not be removable, the house has suffered "distinct and demonstrable" damage. That is sufficient to constitute a "direct" and "physical" loss.

With respect to coverage for personal property Prudential argued that the policy does not cover Lillard-Roberts' personal property because it has suffered no "direct" and "physical" loss due to mold and even if it has, it was due to one of the 16 specifically listed perils. Again, however, the court disagreed since mold spores can attach to any porous surface, including "cloth, carpets, leather, wood, sheet rock, insulation (and on human foods) when moist conditions exist," which may not be subject to remediation.

Exclusion for Water and Sewage Backup

The policy specifically ***excluded*** "loss caused directly or indirectly by any peril or event described below. Such loss is not covered even if some peril or event otherwise covered by this policy contributed concurrently or in any sequence in causing the loss"

Water Damage and Damage by Flowing Substances, meaning: water, sewage or any other substance which backs up through sewers or drains . . .

However, the court believes that at this point the evidence is disputed as to the cause of the mold contamination. Therefore, there is no decision here.

Exclusion for Faulty Workmanship

The policy also contains an exclusion for: Faulty, inadequate or defective design, specifications, workmanship, repair, construction, renovation, remodeling, grading, compaction; materials used in repair, construction, renovation or remodeling; . . . of part or all of any property whether on or off the residence premises.

Again, the court stated that the facts concerning actual workmanship issues ***are not sufficient*** to support a decision.

Named Peril and Rain Damage

The policy lists 16 perils which cover damage to personal property. Prudential argued that there is no evidence that any peril listed under Policy Coverage provides coverage for Lillard-Roberts' personal property. Additionally, Prudential argued that the policy specifically ***excludes*** damage to personal property caused by rain unless the rain enters through a roof opening caused by the force of wind or hail.

Still, the court refused to make a decision pending further investigation.

Failure to Submit Proof of Loss

Insurance companies routinely include a Proof of Loss in every policy provision that reads as follows:

Your Duties After Loss. *In case of a loss to covered property, you must see that the following are done: Send to us, within [90] days after our request, your signed, sworn proof of loss which sets forth, to the best of your knowledge and belief the . . .*

(1) The time and cause of loss;
(2) The interest of the insured and all others in the property involved and all liens on the property;
(3) Other insurance which may cover the loss;
(4) Changes in title or occupancy of the property during the term of the policy;
(5) Specifications of damaged buildings and detailed repair estimates;
(6) The inventory of damaged personal property described in 2e above;
(7) Receipts for additional living expenses incurred and records that support any fair rental value loss . . . .

Prudential argued that Lillard-Roberts refused to submit a ***properly completed*** Sworn Statement of Proof of Loss despite ***repeated*** requests to do so. Prudential believes that this breach of the insurance contract should bar any coverage because it has prejudiced its ability to adjust and investigate Lillard-Roberts' alleged loss.

Lillard-Roberts countered in her Motion for Partial Summary Judgment that she has substantially complied with the Proof of Loss requirements through a previous submission. Prudential claims that it rejected this earlier submission as defective because it merely lists the pertinent amounts of value and claims an amount "to be determined." Without a more detailed Proof of Loss, Prudential cannot set aside reserves to reimburse Lillard-Roberts for any losses which may be covered.

Again, the ***court disagreed*** on the strength that the full extent of damage has yet to be ascertained. Lillard-Roberts has acted to the ***best of her knowledge*** and belief by submitting all the information available. This information has been more than enough for Prudential to investigate the claim and form an estimate of its rights and liabilities. And assuming that the house, structures, and personal property are complete losses, as Lillard-Roberts contends, Prudential can easily set its reserves equal to the policy limits.

More Claims

Lillard-Roberts' alleged fraud and misrepresentation both pre-claim and post-claim based on misrepresentations to induce the purchase of the policy. When agent Primozich represented that the policy "provided the type and extent of coverage that she requested" she "***reasonably expected*** that she would be covered for any and all foreseeable losses to her home and contents, including damage arising from the accidental discharge of water through plumbing systems, water damage resulting from roof leaks and other problems that occurred after the policy was issued." If she had known of the lack of coverage, then she "could have purchased an insurance policy from another insurer that would have extended coverage for the kind of losses she suffered to her home and contents."

Prudential argued that this claim is ***untimely***, relying on a state law which bars claims exceeding two years after the date of discovery. Discovery is a two-step process and requires: (1) sufficient knowledge to put a reasonable person on guard or make an inquiry; and (2) with such knowledge, it appears that a reasonably diligent inquiry would disclose the fraud based on that person's knowledge. (Widing v. Schwabe, Williamson & Wyatt - 1998).

The ***statute of limitations*** begins to run when the plaintiff knows or in the exercise of reasonable care should have known facts which would make a reasonable person aware of a substantial possibility that each of the three elements (harm, causation, and tortuous conduct) exists.

Prudential contended that Lillard-Roberts ***should have known*** that her cause of action for fraud accrued in March 1998, when she admittedly read the insurance contract. Prudential believes that the policy's exclusions clearly and unambiguously exclude the causes of loss that Lillard-Roberts now, more than three and a half years later, alleges that she asked be included in her insurance contract.

The ***flaw*** in Prudential's argument is that although some of the policy's exclusions may clearly and unambiguously disclaim some losses from mold damage, not all types of losses from mold damage are clearly and unambiguously excluded, as evidenced by the disputed issues in this litigation. Furthermore, Lillard-Roberts had no reason to believe in March 1998 that she had a cause of action for fraud or misrepresentation. Instead, she first became aware of her damage and limited coverage on or after November 29, 1999, when she telephoned Primozich and learned that the water seeping down the wall of her dining room was not covered. Her counterclaim for misrepresentation was first filed on November 27, 2001, and was amended on December 11, 2001. This filing is within the two year statute of limitations.

However, even though this claim was considered timely, it was thrown out because Lillard relied on the agent Primozich's ***oral representations*** concerning the scope of coverage which are ***contrary to the policy***. Her claim under these circumstances, if any, is in the form of a claim against the agent for negligent failure to procure insurance, not against the insurer under the policy that was procured.

Post-Claim Misrepresentations?

Lillard claims that after she submitted her claims, Prudential and Primozich misrepresented the extent of Lillard-Roberts' coverage without making any investigation for the purpose of discouraging her from pursuing her claims. In particular, they misrepresented that the policy ***did not*** cover "the roof leak above her dining room that was reported on or about November

29, 1999," "the leak in and around windows and broken skylight," and "an accidental leak in the upstairs plumbing system near her shower, discovered in early 2001.

However, the court determined that because the extent of Lillard-Roberts' coverage is defined by the policy, she cannot seek a remedy for Prudential's violation of its duties and obligations arising out of the policy.

Conclusion

When all the dust settles on this one it is likely that Lillard will be paid for the cost to restore her home. The policy was somewhat ambiguous about mold coverage, but the agent made it clear that she was buying the ***best insurance [she] could possibly buy***, for coverage "against ***any losses*** that might typically happen to a home and its contents," and in particular for "protection from water damages to [her] home and contents, in whatever form it might come-rain, snow or flood." It was therefore, reasonable to expect that mold damage was covered. We would expect the agent will be on the line for some of the costs and damages on this one.

American Family v. Jeffrey - 2000

This case concerns disputed liability insurance coverage for a fatal collision between a dump truck operated in defendant Willie Jeffery's paving business and two other vehicles. The other defendants are the survivors of Teresa Burton, who was killed in the accident, and others injured in the accident. In an initial trial, the court demanded that American pay the limits of the policy. American now appeals this decision.

The Illusion of Coverage Theory

The primary issue of the original case was Jeffrey's expectations that coverage actually existed.

An insurance policy is ***illusory*** under most state laws if "a premium was paid for coverage which would not pay benefits under any reasonably expected set of circumstances." In originally concluding that Jeffery's CGL policy provided illusory coverage, the court relied on the policy's exclusions for injuries covered by workers' compensation, injuries or damage resulting from the use of "autos," defined to include the dump truck, and the exclusions for damage to property.

The court determined that the policy ***excluded coverage*** for the following types of claims:

- Property damage caused by Jeffery or one of his employees in performing the paving work; any damage from having to restore, repair, or replace property because Jeffery or one of his employees incorrectly performed paving work on the property;
- Property damage caused by Jeffery's use of his equipment; bodily injury to any of Jeffery's employees in the course of their employment;
- Bodily injury or property damage caused by the use of Jeffery's dump truck or other vehicles.

The court further concluded that the CGL policy would provide coverage ***only*** under a very narrow and unlikely set of circumstances: if Jeffery or an employee, through the use of

equipment other than "autos" (defined to include the dump truck), inflicted bodily injury on a person not employed by Jeffery while performing paving work.

In light of this conclusion, the court found that the evidence demonstrated "that the likelihood of Jeffery's 'commercial general liability' policy actually providing coverage to a real risk is ***sufficiently remote*** to render the policy illusory."

American Family argued that a finding of illusory coverage ordinarily requires consideration of the policy as a whole. The court only considered the automobile and workers' compensation exclusions, along with the property damage exclusions, which, by themselves does not render the CGL policy illusory.

The court agreed and reversed itself concluding that Jeffery's CGL policy would provide coverage only if Jeffery or an employee, through the use of equipment other than "autos," inflicted bodily injury on a person not employed by Jeffery while performing paving work. Although Jeffery's CGL policy would provide coverage under such circumstances, it would also provide coverage for certain property damage caused by Jeffery or his employee. Thus, if Jeffery or his employee damaged a parked car while using equipment to pave a parking lot, or ran over a mailbox or into the side of a house while using equipment to pave a driveway, Jeffery's CGL policy would provide coverage for the resulting property damage.

The fatal collision between Jeffery's dump truck and the Burton and Taylor vehicles falls within the "automobile" exclusion of the CGL policy as written. That exclusion unambiguously bars coverage and leaves such matters for a separate automobile policy which, in this case, was voided by Jeffery's ***misrepresentation of facts*** material to the extent of his business and the risks that American Family would accept under the policy.

Agent Promises

The issue might have stopped here if not for the allegations regarding agent promises. According to the defendents, American Family insurance agents made misrepresentations to the Jefferys regarding the coverage provided by the CGL policy. Renae Corrigan was one of the American Family agents who met with the Jefferys.

Jeffery testified that he and his wife met with Corrigan three or four different times in 1996 regarding insurance issues. When asked what the agent said about coverage, Jeffrey's replied: "She told me that it would cover, like he said, if you run your truck into a building and it burns someone's property down, or you run a piece of equipment into something and you damage someone else's property or someone. She basically explained that it covered ***anything*** to do with our business where it be equipment or a truck, one of the dump trucks."

If this were true, it clearly contradicts the automobile exclusion contained in the Jefferys' CGL policy, which excludes coverage for any property damage for bodily injury resulting from the "use" of any "auto."

Prior to the accident, the Jefferys also met and had their account transferred to Latricia Schooley, another "captive agent" for American Family, after they became displeased with the way Corrigan handled their account. After the accident, the Jeffrey testified that Schooley told them they had a $250,000 automobile policy and that if this did not provide enough coverage, they had an ***extra*** $500,000 under the CGL policy. This clearly would be an inaccurate statement about the terms of the CGL policy.

However, Schooley denies making this statement: "I told [the Jefferys] that the liability would not cover the accident; that the auto, which was separate from the general liability, would be the only coverage, the per occurrence limit."

Still, Schooley admitted that the Jeffrey seemed surprised and confused about what covered what. While this does not make the case for them, it does collaberate Jeffrey's earlier expectations about the policy.

Misrepresentation?

Based on this testimony, could a jury could find that American Family agents misrepresented to the Jefferys that the CGL policy would provide coverage for motor vehicle accidents?

American Family argued that even assuming its agents made misstatements about the Jefferys' coverage under the policy, these statements were not misrepresentations of past or existing fact because they pertained exclusively to the Jefferys' legal rights under the insurance contract. Only a misrepresentation of past or existing facts such as would give rise to a claim for fraud they claimed.

The court, however, believed that a jury could reasonably conclude from the agent's testimony that American Family insurance agents ***made false statements of fact*** about what coverage was actually provided by the CGL policy, i.e., what terms were contained in the insurance contract.

The question is, did the Jeffreys rely on these statements and therefore relieved of their duty to read and understand the terms of the CGL policy?

Jeffery is a sole proprietor who has a ***sixth grade education***. American Family drafted the CGL policy disputed here. On these facts alone, it is likely a jury could find that the Jefferys' ***reasonably relied*** on any misrepresentations made by American Family agents.

American Family argued, however, that even if its agents misrepresented the terms of the CGL policy, there is no evidence that the Jefferys relied on it. In fact, when the Jeffreys first began shopping for general liability insurance it was because it was required by some of their customers. Therefore, they were ***not induced*** *to buy American Family Agents.*

Conclusion

The court agreed that the previous trial decision concerning illusionary benefits was wrong. However, the issue of the agent statements swayed them from giving American a total victory. A new trial centering on representations made by agents was required.

CHAPTER TWO
Claims & The Agency Agreement

Agents don't often consider the company that employees them to be an adversary. In fact, when most agents ponder professional liability, they think client lawsuits. But there is clear and present exposure from the insurers they represent and the weapon of choice is the ***agency agreement***.

You already know that agents must be responsible to their carriers. Between agent and principal (the insurer), the ***fiduciary duty*** of the agent prevents him from competing with the principal concerning the subject matter of the agency or from making a "secret profit" other than what is stipulated or agreed as commissions. Fiduciary responsibility is especially pronounced when the agent writes insurance for himself (Southland Lloyd's Insurance v Tomberlain - 1996)

Beyond fiduciary matters, agents are bound to his insurer by other ***statutory duties***. They include:

- Duty of Care and Skill, *using standard care and skill*;
- Duty of Good Conduct *or acting so as not to bring disrepute 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 *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 and indemnification exposure (reimbursing the insurer for his loss) for the agent, even if the agent is not totally at fault.

Why would an insurer pay a questionable claim from an insured then turnaround and sue you?

Well, if they don't pay the insured and it is later determined they were wrong, they could risk a bad faith case that could make them liable for punitive damages costing several times the amount of the claim.

This does not mean to imply that as a matter of practice insurers pay claims and seek indemnification from their agents. However, as you will soon learn, the terms in agency agreement as well as errors and omissions policies are sophisticated documents with countless legal pathways. Yet, agents continue to view them as simple documents designed to establish an appointment relationship, set commission levels and the grant the right to sell.

A Word About Insurer Rights and Claims

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. For example, would you think you could terminated because your spouse started work for a competing insurance company? Would a personal bankruptcy terminate your agency contract? If you sold your agency and the new agent got terminated, would your renewals, or your security interest in them, be lost? If you cut a special deal with your carrier that made you a ton of money, could it all be lost if it wasn't contained in the agency agreement? If your agent partner quits the business, does your contract terminate? The answers lie in your agency agreements and the information below.

In the meantime, you should know that between agent and insurer, the obligations and duties of both must 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 and more.

You should also know that agency agreements are ***subject to change*** . . . perhaps yearly. Do you simply sign the agreement put before you? Or, do you read it and ask questions. You might be surprised to learn that it can be changed!

As accountability grows, some agency contracts are showing up with 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:

- At-will termination for any reason.
- 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!***

Let's look at some of the issues you can encounter and the kind of liability you commit to in an agency agreement:

Agent Promises

Our first case is pretty cut and dry. It illustrates the point the agency agreements are serious documents. You must be clear on how they affect your business and personal liability.

American Management Insurance Group v. Samuel Dunlap (1992).

Agent Dunlap entered into several agency agreements to handle various lines of business offered by American. With each, he signed a ***personal guaranty*** to cover unaccounted premiums. The guaranty provision read as follows:

To be executed in case of incorporated agencies, making individuals interested liable for premiums not accounted for by the Corporation: in Consideration of the Company appointing the above named Agent, and as an inducement to it to do so, South Central Insurance Agency, Inc. hereby guarantees the faithful performance of the obligations mentioned by such Agent and firmly bind South Central Insurance Agency, Inc. to pay any sum for which said Agent may become liable to pay to the Company by virtue of the agency created under the foregoing agreement and which said Agent shall fail or refuse to pay."

South Central Insurance Agency of Georgia, Inc. was Dunlap's agency name. So, Dunlap would sign agency agreements as president. However, the guaranty of unaccounted premiums portion he signed personally. The terms of the agency agreement called for Dunlap to collect premiums, retain commissions then place the remaining amount in trust for American. Here is the actual language:

The Agent agrees that all premiums received by the Agent shall be held by him as Trustee for the Company until delivered to it.

Starting in 1988, American claims that Dunlap was not remitting payment on all policies, would remit only partial payment or sometimes remit no payments for his monthly accounting statements. Attempts by AMIG, over a two year period, to resolve these collection problems failed and on March 19, 1990, American terminated SCIAC as a producing agent. AMIG later audited Dunlap's policy ***files and records***, as permitted by the ***agency agreements***. Soon after American instituted an action to

Piercing the Corporate Veil

Many agents incorporate in the hopes that any mistakes they make will be protected by the corporation. A corporation is a legal entity that exists separate and apart from its shareholders, officers, and directors. As a general rule, the aforementioned individuals are spared liability for the corporation's debts and obligations because of the corporate fiction. However, courts will "pierce the corporate veil" contrary to the established principle of limited corporate liability, under special circumstances. For instance, states have applied the concept of piercing the corporate veil to remedy injustices, which arise when a party "has overextended his privilege in the use of a corporate entity in order to defeat justice . . . or evade a contractual or tort responsibility.

recover the sums owed by Dunlap (approximately $150,000), plus attorneys fees and expenses. American alleged breach of contract and breach of fiduciary duty. They also asked the court for $500,000 in punitive damages.

The main issues in this case is, of course, the fact that the agent ***promised*** to remit premiums and didn't. Also at hand is the concept of whether or not Dunlap's corporation offered him protection from liability. In this case, the court found that no true distinction exists between Dunlap and either of the various corporate entities he formed; therefore, the corporate veil should be pierced.

Dunlap tried to further reduce his exposure by claiming he intended to sign the personal guaranty as an ***officer of the corporation***. The courts quickly dismissed this theory, as it has in other cases, since the purpose of the personal guaranty would be defeated by doing so. Concerning the premiums owed. A judgment was granted American.

Speaking to the punitive damages sought by American, Dunlap asserted that the suit is "strictly a suit founded in contract" and involves no tort. The court deferred this issue to a jury trial.

Szelenyi v. Morse, Payson & Noves (1991)

Agency agreements are typically written documents. However, this next case proves that not all terms of these agreements need to be reduced to writing to be ***enforceable*** . . .

Agents Morse, Payson and Noves were contracted with St. Paul insurance under a fairly typical agency agreement. Dr. Szelenyi was a long-term client of Morse forced to pay a large malpractice judgment that exceeded his liability coverage by more than $300,000. At a previous trial, the jury awarded damages in this amount to Dr. Szelenyi. In this case, the agents appealed to the court to reverse the decision.

The main topic of discussion in this case is whether or not the actions of the agents created ***additional or implied duties*** under their agency agreement.

In the previous trial, a jury found that there was an ***agreement*** between Dr. Szelenyi and Morse, Payson & Noyes which required the insurance agency to advise Dr. Szelenyi on the ***adequacy of his coverage*** under his professional liability insurance, or to provide him with information that would permit him to make an informed decision on the adequacy of his liability coverage.

Following is the annual procedure followed by agents in serving Dr. Szeleny:

1. A representative of Dow & Pinkham, the predecessor company to Morse, Payson & Noyes, checked off the policy limits on the first application for professional liability insurance in 1970.

2. In the subsequent twelve or thirteen years a representative of Morse, Payson & Noyes always checked off the policy limits on the application for liability insurance. Dr. Szelenyi then signed the application for the limits that he thought were being suggested by the agency.

3. Dr. Szelenyi's age, English language limitations, and lack of sophistication in liability insurance matters would incline him to look to his agent for advice on liability insurance matters or for the information needed to allow him to make a decision on such matters.

The first jury determined that by checking off the policy limits to be provided by the liability insurance, the agency placed itself in an ***advisory role*** to Dr. Szelenyi at the very outset of the relationship, or at least provided him with information on adequate liability coverage at the outset of the relationship. The jury could then reasonably infer that Dr. Szelenyi, in obtaining liability insurance through the insurance agency for approximately ***thirteen years***, actually looked to the agency for advice or information on the adequacy of his professional liability insurance, and so indicated this ***reliance*** to the agency by always signing the applications for the checked- off policy limits. Even if Dr. Szelenyi misconstrued the meaning of the checked-off policy limits in the subsequent insurance applications (the agency testified that the check-offs simply indicated the limits of the previous year's policy), that misunderstanding would not affect Dr. Szelenyi's ***expectations of the agency***, his reliance on it, and his indications of this reliance.

Based on this evidence, the court awarded damages to Szelenyi. In the current trial, the judge further analyzed the ***client-agent relationship***:

An insurance "agent" is sometimes thought of as representing the insurance company. It is entirely possible for an insurance agent to represent both the insurance company and the insured, who in this case would be Ernest Szelenyi. You may find that Morse, Payson & Noyes was representing both St. Paul Insurance Company and Ernest Szelenyi. If you find that Morse, Payson & Noyes was an agent for both Dr. Szelenyi and the insurance company, I instruct you that such a dual agency would not affect any duties owed by Morse, Payson to Dr. Szelenyi as a result of any ***agency agreement*** *between Dr. Szelenyi and Morse, Payson. Let me return now to that issue--the terms of the* ***agency agreement*** *between Dr. Szelenyi and Morse, Payson.*

The jury should understand that the ***terms of an agreement*** *between a principal and an agent do not have to be in writing. The jury should also understand that an agreement between a principal and an agent* ***does not*** *require a specific discussion between the principal and the agent which sets forth the terms of the agency relationship. Rather, the terms of the* ***agency agreement*** *may be* ***implied from the facts and circumstances of the relationship*** *between Dr. Szelenyi and Morse, Payson & Noyes. Such an implied agreement would be an actual agreement between Dr. Szelenyi and Morse, Payson & Noyes circumstantially proven from the facts and circumstances of the relationship between them.*

Please note what I have just said. An ***implied agency agreement*** *is an* ***actual*** *agreement between the parties. In deciding whether Morse, Payson & Noyes had a duty to advise Dr. Szelenyi on the adequacy of coverage under his professional liability insurance, or a duty to provide him with the necessary information to make an informed decision on the adequacy of his liability coverage, the jury must not consider whether Morse, Payson & Noyes should have assumed such duties in their dealings with Dr. Szelenyi without regard to any agreement to do so. Rather, the first task for the jury is to consider whether the facts and circumstances of the relationship between Dr. Szelenyi and Morse, Payson & Noyes establish, by a preponderance of the evidence, an implied, actual agreement between Dr. Szelenyi and Morse, Payson & Noyes which required the agency to perform the duty or duties asserted by Dr. Szelenyi.*

In considering this first issue--whether there is an implied, actual agreement between the parties imposing the duties asserted by Dr. Szelenyi, the jury may consider the following factors to the extent the jury deems them relevant:

1. The length of the relationship between the parties;

2. The age, sophistication and English language skills of Dr. Szelenyi;

3. Whether the agency ever held itself out to Dr. Szelenyi as an insurance specialist on the subject matter of professional liability insurance;

4. Whether there was some type of interaction between the parties on the adequacy of coverage, coupled with Dr. Szelenyi's reliance on the expertise of the insurance agent to his detriment;

5. Whether Dr. Szelenyi followed recommendations of the agency on the amount of coverage to buy;

6. Whether the agency provided information relating to the adequacy of coverage;

7. Policies and practices of the agency relating to the obligations of the agency to their clients, to the extent that those policies and practices were communicated in some way to Dr. Szelenyi.

8. Communications by Dr. Szelenyi to the agency concerning the actions he wished the agency to undertake on his behalf.

These factors, of course, are not intended to be exclusive. You may consider other factors suggested by the evidence that you deem relevant to the duty issue as I have defined that issue for you.

The judge went on to explain some issues of ***insurance law***:

1. An insurance agent must exercise such reasonable skill and ordinary diligence in meeting its duties to the principal as may fairly be expected from an agent in the profession acting under the same or similar circumstances in the locality.

2. In all transactions affecting the subject of the agency, the agent must act in utmost good faith, which means that the agent must act with an honest intention to carry out the terms of the ***agency agreement.***

3. The agent must make known to the principal all material facts within his knowledge which may affect the transaction between the parties and which relate to the duties assumed by the agent as a result of the agreement between the principal and the agent.

The jury was convinced and the agent's motion to reverse the original claim was ***denied***. The agent was liable for over $300,000 in damages.

Lost Rights

Agency agreements are very ***precise legal contracts***. You can help avoid conflicts with your carrier by understanding the "triggers" to potential claims and lost rights. Here are a few examples:

Aziz v.Atlantic Mutual (1998).

Mohammed Abdel Aziz ("Abdel Aziz") and Atlantic Mutual Life Insurance Co. ("Atlantic") entered into an agency agreement for a term of two years. The Agency Agreement permitted the Aziz Agency to produce insurance policies on behalf of Atlantic until September 1, 1995.

Agents Morris and Ruth Winograd offered to ***buy*** the Aziz Agency. Winograd proposed an agreement whereby he would run the Aziz Agency. Thereafter, the parties negotiated a ***management agreement*** which provided that Ruth Winograd would be the manager of the Aziz Agency. The Management Agreement was executed in October 1994. It made no reference to Morris Winograd or the Winograd Agency. Ruth Winograd and Abdel Aziz each testified that the Department of Insurance was not notified of the change in the Aziz Agency's management.

An employee of the Winograd Agency, testified that the Aziz Agency had no employees following the execution of the Management Agreement and that ***all the work*** of the Aziz Agency was being performed by employees of the Winograd Agency, under the supervision and direction of Morris Winograd. She testified that while the Winograd Agency was owned by Morris and Ruth Winograd, Morris Winograd was in charge of the operation. Ms. Venable also testified that she never told Atlantic about the change in management.

On January 9, 1995, Atlantic notified the Aziz Agency and the Commissioner that it was ***terminating*** the Agency Agreement effective April 9, 1995. The termination was upheld by the Commissioner on February 23, 1995. The Commissioner also permitted Atlantic to assign the Aziz Agency's book of business to another active agent of the company. The Aziz Agency sought review of the Commissioner's decision in the New Jersey Superior Court Appellate Division. In addition, prior to appealing the Commissioner's decision, the Aziz Agency and Ruth Winograd brought an action in the Superior Court of New Jersey.

Inter Alia?

Inter Alia is an important legal term that generally means "among other things", "for example" or "including". Legal drafters use it to precede a list of examples or samples covered by a more general descriptive statement.

An *Inter Alia* list is used to make absolutely sure that users of the document understand that the general description covers a certain element without, in any way, restricting the scope of the general element to include other things that were not singled out in the *inter alia* list.

Like most agency agreements a provision in the contract allows for the insurer to terminate an insurance producer ***for cause***. The termination in question was preceded by ***several requests*** by Atlantic ***for compliance*** with underwriting guidelines. Atlantic's

termination letter referred to these requests and the agency's ***continuing*** practice of submitting applications without the requisite underwriting information as justification for the termination.

Atlantic's additional claim is that the ***reassignment*** of renewal policies and premiums to another agency in contradiction to a provision in the agreement which provided that these renewals would remain the property of the Aziz Agency following termination of the policy.

The Aziz Agency and Ruth Winograd initiated their own action against Atlantic alleging, ***inter alia,*** breach of contract, tortious interference with prospective economic advantage and conversion. They sought to recover the value of the insurance policy expirations which they maintain Atlantic appropriated in ***contradiction*** to the aforementioned provision in the Agency Agreement.

Atlantic's counterclaim maintained that it was never advised about the Management Agreement or the fact that the Morris Winograd Agency was doing business as the Aziz Agency prior to its termination of the Agency Agreement.

Further, Atlantic argued that Aziz / Winograd ***lacked standing*** to bring this action because the assignment of the agency agreement is not permitted. Atlantic asserts that the Aziz Agency which is named as a plaintiff in this action is not in fact the Aziz Agency that applied for, nor is it in fact the same entity identified in the Agency Agreement which has a right to the book of business. Atlantic concedes that the Agency Agreement has no express prohibition against assignment by either party, but argues that the agreement was of a unique and personal nature such that it could ***not be freely assigned***.

Aziz and Winograd respond that they have standing to bring this action since they have a ***personal stake*** in the outcome. In addition, they emphasize that the Agency Agreement did not prohibit assignment. Plaintiffs also note that the Department of Insurance has taken the position that its own regulations are ***silent*** on the subject of assignment of an assigned producer's rights.

As a point of law, generally, a party to a contract may freely assign any and all of its beneficial rights in the absence of an express provision to the contrary. However, contracts which involve ***personal services, skill or confidence are not freely assignable.***

The ***special circumstance*** that helped the court decide in this case is the fact that Aziz was able to write business under the states PAP (Producer Assignment Program) . . . a fair plan that allowed consumers to buy personal auto coverage if they had been denied elsewhere. Prior to buying the Aziz agency, Morris Winogard was denied access to this program based on a poor performance history and unlawful business practices. The fact that Ruth Winogard was put in charge of the Aziz agency was a clear ***attempt to gain access*** to the PAP that Winogard had been denied previously.

The court sided with Atlantic and the agency agreement with Aziz / Winograd was terminated.

Blake v. Aetna (1998).

Richard Blake Agency ***sold*** his agency to Joseph Annunziata Associates, Inc (JAA) using all the required documents of sale, including Blake Agency and a security agreement. Of course, there was an unpaid portion of the purchase price which was secured by tangible and

intangible property, including a life insurance policy, several mortgages, the JAA office lease, and JAA stock.

Blake also contends that he acquired a ***security interest*** in the insurance accounts known as ***expirations*** (Blakes client list) that JAA obtained on behalf of the defendant Aetna Casualty.

Unfortunately, the ***ownership and use of the expirations*** that JAA obtained on behalf of Aetna were ***governed by*** the terms of an agency agreement, which expressly provided that if JAA did not promptly pay the premiums to Aetna, the ownership of the expirations would ***revert*** to Aetna. JAA subsequently defaulted in the payment of the premiums which prompted Aetna to terminate the agency agreement and transfer the expirations to a third agency. As a result of JAA's default, Blake tried seized certain assets that had been pledged as collateral but was unable to get transferred expirations; despite the filing of an expensive lawsuit that wound its way to the State Supreme Court.

Ford v. Lafeyette Life (1961).

This case is a good example of how precise agency agreements can be interpreted.

Two agents, operating under their partnership name as the Ford and Costello Agency, were appointed by an insurance company to be its "Regional Directors". They did what most RGAs do: appointing, training and supervising General Agents and Agents in their territory. Of course, ***bonus payments*** were provided for by the contract. One of the partners decided to ***withdraw*** from the partnership. Soon after, Lafeyette declined to make Ford's bonus payments claiming a ***change in the partnership*** was not acceptable since the agency agreement was not assignable. Ford, commenced this action.

Facts presented during the case include the Uniform Partnership Act . . . " a change in the relation of the partners caused by any partner ceasing to be associated" dissolves the partnership. From there, the thinking goes that ***dissolution brings to an end*** the ordinary business of the partnership including insurance agency agreements ***except***, in certain circumstances, where the agency contract has been assigned by the partnership to the surviving partner or partners and the insurance company may be said to have consented to the assignment. Unfortunately, in this case there was ***no assignment*** of the agency contract by the partnership. So, dissolution thereof ***terminated*** that contract. This kind of clause is clear and without dispute. It would have applied even if the two agents worked jointly, outside a partnership entity.

Hamilton v. Spencer etal (1996)

This case is a bit unusual in that, Agent Hamilton also happened to sit on the Board of Directors for the same insurance company he represented as an agent. Spencer was one of several on the Board who believed that Hamilton had attempted to ***move*** a Buchanan County Mutual policy to a competing company. He said that he believed that this was wrong for an agent who was also sitting on the board of directors and that taking policies away from the company harmed it.

Further the Board provided testimony to the fact that Hamilton admitted that he intended to continue selling other companies' property and casualty insurance

Hamilton was ***terminated as an agent*** as permitted by the agency agreement which read: *This Agreement supersedes all previous agreements, whether oral or written, between the Company and Agent, and may be terminated by either party at any time by giving thirty (30) days written notice to the other.*

This clause is pretty clear, however Hamilton felt that the Board went beyond simply terminating the relationship by ***conspiring to restrain*** Hamilton's trade or commerce, that the directors desired to deny him of his livelihood or to injure him financially, that the directors wanted to reap financial benefit by denying him a business relationship with Buchanan County Mutual

In support of their case the directors submitted affidavits and sworn testimony indicating that the directors had fired Hamilton and Downing for ***persuading*** Buchanan County Mutual policyholders to buy insurance from competing companies and that Hamilton and Downing had admitted "moving" some policies from Buchanan County Mutual to other companies.

The individuals who swore to the affidavit also said that the Board had not engaged in, nor were they aware of any conversations or discussions by any board members concerning any effort or intention to deprive Hamilton and Downing of their business or to divide their business among themselves or conspire between or among board members to restrain Hamilton's and Downing's trade and commerce; that they did not desire to deny Hamilton and Downing of their livelihood or to cause them financial injury or destruction; that they had no malintent concerning Hamilton and Downing; that termination of agency agreements with Hamilton and Downing was in the company's ***best interests***; and that the company had sent letters to policyholders advising them that Hamilton and Downing were no longer associated with the company and that their policies had been assigned to other agents. For a year after firing them, Buchanan County Mutual paid Hamilton and Downing commissions for policy renewals.

In his own deposition, Hamilton admitted that he knew of no one who had ever indicated having knowledge that the directors, that the directors said anything other than the truth, or that the directors had malice or ill will towards him.

Hamilton's claim that the directors acted out of self-interest, bad faith, and ill intent, rather than for Buchanan County Mutual's benefit was supported by their belief that their discharge resulted from the directors' desire to carve Buchanan County into exclusive sales territories. Indeed, at one time, the directors voted to divide the county's rural areas into "sales territories" in which only one agent could sell unless he or she granted written permission to others to do so. Hamilton asserted that this was an attempt to inhibit their ability to compete. However, the court promptly disagreed with this theory.

Hamilton and Downing also noted that the directors did not hire new agents to replace them. The directors did wait three months before hiring new agents, but the court felt this does not support an inference that the directors acted improperly or out of self-interest. Nor does the directors' sending notice to Buchanan County Mutual policyholders announcing that Hamilton and Downing were no longer company agents. The letters merely advised the policyholders that someone other than Hamilton would serve them in the future because Hamilton and Downing were no longer Buchanan County Mutual agents.

Hamilton also brought up a policyholder's letter notifying Buchanan County Mutual that she was canceling her policy. She explained in the letter that she was canceling the policy because her "present agent is not 'out of business' as was reported by one of the directors." They

suggest that this letter shows that the directors were ***falsely telling*** Buchanan County Mutual policyholders that they were "out of business." Buchanan County Mutual responded to the policyholder's letter by explaining that the director had assured the company that he did not tell the policyholder that Downing was "out of business" but told her that Downing was no longer a Buchanan County Mutual agent. This letter does not establish that the directors acted out of self-interest in terminating Hamilton's and Downing's agency agreements or that the directors interfered with their business relations.

Finally, Hamilton claimed that the directors' terminating their agency agreements was unjustified and wrongful and that the directors acted in concert to usurp Hamilton's and Downing's business relationship with Buchanan County Mutual and with their clients, to ***restrain them in their trade and ability to compete*** with respondents, and to improperly obtain clients and commissions which should have gone to them.

The court responded with the argument that in order for a ***civil conspiracy*** to take place, ***two people*** must commit an unlawful act. The evidence does not show that the directors conspired against Hamilton and Downing. The directors terminated Hamilton's agency agreements because of a concern that the appellants' were "moving" Buchanan County Mutual business to competing companies. Termination of the agency agreements was not unlawful because the agreements were ***terminable at will*** with or without cause with 30 days' written notice. The evidence does not show that any unlawful activity occurred which would support a civil conspiracy claim.

Hamilton lost his case but retained his renewal commissions for the prescribed time.

Costello v. Shelter Mutual Insurance (1985)

Costello was a direct insurance agent of Shelter. He had been associated with Shelter in the capacity of salaried agent, district sales manager, and district sales agent from 1972 to 1981. Even though Costello worked directly for the insurer he was considered an ***independent contractor***. As such, he had an agency contract terminable at will. Shelter terminated his agency as permitted by this agreement.

What caused the split? Costello's agency agreement provided he was an ***exclusive agent*** and could not represent other insurance companies without the express consent of Shelter Companies. At one time, Costello requested his wife, Beverly, be included on the agency agreements**.** His immediate supervisor advised Costello of longstanding corporate policy ***prohibiting a spouse*** from being an agent or signatory on agency agreements. (This policy was later changed.) Without the option to join her husband, Costello's wife passed her brokerage test and joined with another person to form Tri-County Agency, an independent insurance agency ***in competition*** with Shelter Companies in Warren County. As a broker, she solicited and sold insurance up until the time of the trial. Costello had no ownership or management interest in Tri-County Agency.

A bit later a group of Shelter Companies' agents formed an ***Agents' Association*** to voice concerns, negotiate and deal with Shelter Companies concerning problems and other matters regarding the agents and their relationship with Shelter Companies. Costello became vice-president and was an active spokesperson for the Agents' Association. On one occasion Costello and the president elect of Shelter engaged in a heated discussion regarding matters of concern to the Agents' Association, including the termination at will provision as will as commission issues.

Costello was informed that there was an ***unwritten*** policy agents' wives could not sell insurance for another company. If Costello's wife did not stop selling, his agency would be terminated. Costello's wife continued to sell insurance. Shelter then terminated its agent's agreement with Costello.

At trial, Costello presented evidence that:

(1) Costello was among the top agents of Shelter Companies and no one was dissatisfied with the manner in which he conducted his business;
(2) Costello was an active and vociferous spokesperson for the Agents' Association which Shelter Companies' new president Lehr strongly opposed. Lehr directed his anger towards Costello personally at a meeting when Costello expressed the Association's dissatisfaction with the contract right to terminate at will;
(3) Costello's immediate supervisor described Costello as evidencing disloyalty to Shelter Companies and threatened termination because he was vocal in his objections concerning the graduated commission scale and other company policies;
(4) Costello's wife had been a licensed agent for competing companies since April, 1980. Shelter Companies did not change its policy of not including a spouse on an agent's agreement until July 1, 1981. After Lehr's heated discussion with Costello as Agent spokesperson and shortly after Lehr became president, Costello was terminated;
(5) Extreme pressure was brought to bear on Costello to force his wife, who was not a party or signatory to the agency agreement, to change her activities;
(6) Similar pressure ***was not*** brought to bear on another female agent whose husband was a licensed agent and represented competing insurance companies;
(7) Shortly after Costello consulted an attorney he was abruptly terminated;
(8) Upon termination, Shelter Companies brought six high level management officials in to take over the business, and at the same time attempted to entice Costello's secretary away and take over his business telephone number.

The court disagreed and ***allowed the termination*** for two reasons:

- The competing agency of his spouse, and
- His activities in the Agents' Association.

The evidence regarding Costello's activity in the Agents' Association shows Shelter Companies were not happy with such activities. However, the heated argument between Lehr and Costello and the words of warning from his immediate supervisor were not sufficient to show a specific intent to injure Costello by firing him. The fact that Costello was terminated and suffered injury is insufficient.

Insurance is truly a competitive business!

Lorenzen v. United (2003).

Mark Steffen is an independent insurance agent and the president of the Lorenzen-Steffen Agency. On January 1, 1991, Lorenzen-Steffen signed an agency agreement with United Fire Insurance Company, giving the agency authority to solicit applications for the sale of United Fire insurance policies. On January 20, 1998, Steffen sent a letter to the chief executive officer of United Fire, Scott McIntyre, in which he wrote critically of United Fire's "loss carry forward system" in its profit sharing agreement. McIntyre responded in a letter, expressing concern that

Steffen's letter implied a "threat to conscientiously discriminate against United in the writing of business." A cordial meeting followed. However, in a subsequent meeting, he was informed that he would be terminated under ninety-day at-will notice provision in the agency agreement.

A short while later, United met with a another United Agent to discuss the retention of a large roofing contractor account of Lorenzens. The new agent called on the roofer and convinced him to ***move*** his account away from Lorenzen.

Lorenzen filed a claim alleging United Fire ***breached*** the terms of their agreement by contacting its competitors after the termination of the agreement, that United Fire intentionally interfered with its existing contractual relationship with the roofer, and that United Fire tortiously interfered with its prospective business relationships. The court agreed with Lorenzen and awarded him damages of $90,000+.

United Fire appealed this decision claiming there was ***no substantial evidence*** to support it. In a breach-of-contract claim, they said, the complaining party must prove: (1) the existence of a contract; (2) the terms and conditions of the contract; (3) that it has performed all the terms and conditions required under the contract; (4) the defendant's breach of the contract in some particular way; and (5) that plaintiff has suffered damages as a result of the breach.

The court looked deeper into the agency agreement which ***stated*** that Lorenzen "has the exclusive right to the use of the expirations and renewals of policies produced through his agency." It also states "this Agreement may be terminated by either party at any time by notice in writing." The contract thus allows either party to terminate the contract at will.

Lorenzen-Steffen did not dispute the at-will nature of the contract, nor does it claim there was any breach prior to termination. Rather, it maintains there was a breach of contract ***after*** termination because, according to its position, certain terms of the contract survive termination.

Additional language in the agency agreement stated that *the Agent has the exclusive right to the use of the expirations and renewals of policies produced through his agency, provided, however, (i) that the exclusive right to use said renewals and expirations will automatically pass to the Company if the Agent fails to punctually remit premiums to the Company in the manner hereinafter described, even if in the event of the failure to punctually remit, the Company does not terminate or suspend the Agency relationship, and (ii) in the event of termination of the Agency relationship, all premiums due the Company by the Agent are due and payable immediately. If said premiums are not then paid, the exclusive right to renewals and expirations relating to the business written through the Company by Agent, shall pass to the Company and the Agent shall have no claim therefor.*

In the event there is a reasonable dispute as to the existence or extent of the Agent's liability to the Company per items (i) and (ii) above, such dispute shall not prevent application of the ownership of the records and the ownership of the right of use and control of the expirations to be in the Agent's favor, provided the Agent promptly furnishes collateral security acceptable to the Company in an amount equal to that in dispute.

In addition, under the heading "Continuing Duties," the contract provides:

Following the termination of the Agreement, the Agent will still be required to fulfill his/her duties relating to the policies produced by the Agent. In addition, many of the Agent's other obligations under this Agreement will continue. If the Company chooses, the Company may

relieve you of some of all of those duties and obligations, and we will instruct you accordingly in writing.

The court noted there was no evidence Lorenzen "failed to punctually remit premiums" to United Fire. Thus according to the first paragraph above, the "exclusive right to use said renewals and expirations [does not] automatically pass to" United Fire. If the rights do not pass to United Fire, it must be assumed they are retained by Lorenzen. Further, there is no evidence that following termination Lorenzen failed to immediately pay all premiums. Pursuant to clause (ii) above, only when such premiums are not paid following termination does "the exclusive right to renewals and expirations relating to the business written through" United Fire pass to United Fire. Thus, the implication is Lorenzen retains the exclusive right following termination *unless* it fails to pay all premiums then due, which is not the case here.

The appeal court then concluded the contract provides that Lorenzen exclusive right to the use of expirations and renewals survived United Fire's termination of the contract. They further concluded that there was substantial evidence supporting the jury's finding that contractual right was ***breached*** when the company's new representative approached the roofer.

The appeal court did not find for Lorenzen on his claim United Fire's wrongful conduct interfered with its contractual business relationships.

What constitutes ***interference***?

1. A prospective contractual or business relationship;
2. The defendant knew of the prospective relationship;
3. The defendant intentionally and improperly interfered with the relationship;
4. The defendant's interference caused the relationship to fail to materialize; and
5. The amount of resulting damages.

The court believed that the evidence shows United Fire sought to maintain the Roofing Technology Inc., and Rock River Roofing accounts, both of which it had held for several years, by informing two competing insurance agencies of the two specific accounts and that it had severed ties with Lorenzen. The court concluded the financial motivation of United Fire to keep longstanding accounts did not constitute "aiming to financially injure or destroy".

Although United Fire's actions may have adversely impacted Lorenzen-Steffen's economic interests, such actions were undertaken to protect United Fire's own interests. The record does not support that United Fire's actions rose to the level necessary to constitute interference with prospective business relations. The district court thus erred in denying United Fire's motion for judgment notwithstanding the verdict on this ground.

What about Lorenzen's $90,000 damage award. The court indicated it could affirm the previous court award. A new trial would have to take place to determine if any damages could be found at all.

Crystal Springs v. Commercial Union Insurance (1989)

The Crystal Springs Insurance Agency, Inc. and its agent, Percy Burt Young were approached with the possibility of purchasing the General Insurance Agency, a local insurance agency that was ***failing***. The General Insurance Agency owed Commercial Union Insurance Company approximately $ 84,000. Instead of seizing the Commercial Union accounts held by the

General Insurance Agency, Commercial Union transferred the accounts to Crystal Springs and Young who agreed to pay Commercial Union $80,000 on monthly terms (a note).

Approximately one year after this arrangement was reached, Commercial Union ***terminated*** the agency relationship it had with Crystal Springs and Young. A ninety day, ***at will*** termination clause in the agency agreement made this possible. No reason was given other than a home office decision to ***reduce*** the number of agents and agencies with little or no production. Subsequently, Young quit paying the promissory note that had been executed to Commercial Union, leaving an outstanding unpaid balance of $47,000.

Commercial Union filed suit against Crystal Springs and Young demanding $47,000.00 in damages for the amount owed on the note. Crystal Springs and Young admitted the promissory note was unpaid but raised the issues of lack of consideration, inadequate consideration, and fraudulent inducement to sign the promissory note. He demanded $50,000 in damages for the alleged fraudulent inducement. The basis of the allegation of fraudulent inducement was the claim that Commercial Union knew at the time of the agreement with Crystal Springs and Young that Commercial Union would terminate the agency relationship after execution of the note. Commercial Union denies this.

Young had an uphill battle in his fraud allegation because the law states that ***fraud cannot be based*** upon statements which are promissory in their nature when made and which relate to future actions or contracts. Commercial Union argued that the promise, even if made, is unenforceable under the statute of frauds as it was not in writing and was directly contrary to the terms of the written agency agreement which gave either party the right to terminate the agency agreement at will on ninety days notice to the other party. This argument was so convincing the court originally awarded $47,000 judgment to Commercial Union.

On an appeal by Young, however, the court said if Young was able to prove that Commercial Union ***promised*** him that his agency agreement ***would continue*** for a long period of time and that Commercial Union did so with no intention of keeping the promise, he would be entitled to relief by way of damages. The best way and perhaps the only way for Young to prove that would be at a trial in which he could test the credibility of the persons whom he claims made that promise to him.

So, the decision of the first court was reversed and a new trial was ordered. It is likely the parties settled out of court since no further action is noted. This case clearly demonstrates the power of ***at will termination***.

Wilson v. American Family Mutual Insurance (2001)

Agency agreements may require far more of you than simply fair dealing with your insurance clients. In this case, an agency agreement between Wilson and American called for the following:

- *You agree to maintain a good reputation in your community and to direct your efforts toward advancing the interests and **business** of the Company to the best of your ability, to refrain from any practices competitive with or prejudicial to the Company and to abide by and comply with all applicable **insurance** laws and **regulations**.*
- *Except as provided below, this agreement may be terminated by either party with or without cause by giving written notice to the other and shall be deemed terminated as of the date*

specified in that notice. If both parties give notice, the earlier termination date shall control. This agreement shall automatically terminate upon your death or upon the date your license to act as an agent for the Company is suspended, revoked or canceled.

- *After two years from the effective date of this agreement or after the termination date of your Agency Advance Compensation Plan, whichever is later, the Company will give you notice in writing of any undesirable performance which could cause termination of this agreement if not corrected. The Company will not terminate this agreement for those reasons for a period of six months after that written notice. In no case shall notice of undesirable performance be required prior to termination if the performance in question involves a violation of Sec. 4.i. or any other dishonest, disloyal or unlawful conduct; nor shall any notice be required in the event the Company terminates substantially all agreements of this type throughout the Company or in a particular state or area.*

What went wrong? Wilson was terminated for sexually harassing women employees and contractors . . . once in 1993 and again in 1998. The victims made complaints to American.

Wilson argued that he did not receive ***proper*** notification of wrongdoing from American per the terms of the agency agreement. American, however argued that the agreement plainly states that it can be terminated ***at will with or without cause***. The court agreed that while "the contract merely places a six-month notice period into employment termination decisions it continues to provide for ***at-will employment***.

American further added that the conduct leading to the Wilson's termination in 1998 was of the ***same type*** that they had notified in 1993 was undesirable performance. Since Wilson had notice back in 1993 that they considered sexual harassment or misconduct undesirable performance, his contract became terminable at will any time after six months from that 1993 notice. No ***additional notice*** was required in 1998 to terminate the contract for the same type of undesirable performance, nor were they required to give Wilson a six-month opportunity in 1998 to "correct" his performance.

Furthermore, the nature of Wilson's conduct justified terminating the agreement without notice. Sexual harassment and misconduct ***violate*** sections of the contract ***because*** they constitute conduct that is not only prejudicial to the company but ***unlawful*** under both federal and state law.

The court agreed and allowed the termination to proceed.

Privacy

There is a lot of discussion these days about privacy. Mostly because the information business and the sharing of information has become complicated. Gone are the days where someone's personal file, financial or otherwise, is locked in a cabinet in a special secure room. New electronic distribution channels have created unprecedented access, often unwanted, to this information resulting in a profound potential for abuse. The following case is one such example.

Fraser v. Nationwide - 2001

This case demonstrates the length and complicity centering around an agent who criticizes the actions of his own carrier in public. You won't believe how the sides get whipped into a frenzy with accusations like wiretapping and review board shams. Ultimately, however, the validity of the agency agreement prevailed.

Facts of the Case

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.

The Agent's Agreement states that "the parties agree that the purpose of this Agreement will be best served by your acting as an independent contractor. Therefore, it is agreed that you are an independent contractor for all purposes."

Fraser was committed under the agreement to represent Nationwide ***exclusively*** in the sale and service of insurance. Such exclusive representation is defined in the Agreement to mean "that you will not solicit or write policies of insurance in companies other than those parties to this Agreement, either directly or indirectly, without written consent of these Companies."

The agreement further states that the agent or Nationwide have "the right to cancel this Agreement at any time" upon written notice. The provision on cancellation of the agreement includes a statement that "the Agent shall have ***access*** to the ***Agents Administrative Review Board***, and its procedures, as it may exist from time to time." The agreement provides for payment of earned deferred compensation upon "qualified cancellation" of the agreement. However, the agent ***forfeits*** his right to deferred compensation if, among other things, he accepts employment with a competitor of Nationwide within one year of cancellation and within a twenty-five mile radius of the agent's business location at the time of cancellation.

Agent Records

A dispute between you and a client and/or an insurer may require you to produce certain records and evidence. In your own defense, you can typically use any note or electronic record (fax, - e-mail, computer records, etc) as long as it is something generate in the ***ordinary course of business***. In other words, if it is your standard procedure to you use "post-it" notes in your client files, they will be admissible in court. The test? Do you use these methods for ***every client***?

Keep in mind, however, that most parties in a dispute may claim ***equal access*** to these same records. So, keep them legal and consistent. Also, never write derogatory comments about clients or the company in files. They could work against you in a trial or settlement!

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.

The Problems Start

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.

One of NIICA's goals is to preserve and defend the status of the Nationwide exclusive career agent as independent contractors. Members of NIICA sought increased state regulation of the insurance industry to protect their independence and maintain control over their work. For example, from 1996-1998, NIICA lobbied state legislators to obtain passage of "just cause" legislation that would insure that agent contracts could not be terminated without "just cause". They also sought remedies to prevent Nationwide from engaging in business practices that, in the agents' independent judgment, were illegal. The Pennsylvania View publicly criticized these practices.

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.

The Claim

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.

The Federal Wiretap Act civil liability to anyone who:

1) Intentionally accesses without authorization a facility through which an electronic communication service is provided; or

2) Intentionally exceeds an authorization to access that facility; and thereby obtains, alters, or prevents authorized access to a wire or electronic communication while it is in electronic storage in such system . . . "

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.

Fraser tried a third time under a claim for wrongful discharge, alleging retaliation for exercise of his First Amendment rights of expression, association and petition. Again, the courts disagreed since the contractual relationship between Fraser and Nationwide expressly stated that either party may terminate the contract at any time.

Finally, Fraser asserted a claim for Breach of the Implied Covenant of Good Faith and Fair Dealing. Specifically, he argued that defendants breached an implied covenant of good faith when Nationwide (1) exercised its right to cancel Fraser's Agent's Agreement; and (2) rendered the Review Board process, available to agents for review of a termination, a sham. Again, the court disagreed since a covenant of good faith and fair dealing is implied in every contract. However, it does not create a cause of action in every case. The Agent's Agreement signed by Fraser expressly states that the agreement may be terminated by either party for ***any reason***. Also, Fraser's employee handbook states that he will have "access" to a review board, which he did.

Agent Fraser retained a few commissions due him but lost his case ***and*** deferred compensation benefits.

Violation of Terms

Knowing the terms of your agency agreement in detail can save you a lot of trouble. Learn from the experience of these agents:

Blouch v. Zinn (1984).

Customer Blouch purchased numerous policies from agent Joel Zinn over the years. In many of these transactions, Zinn ***extended credit*** to Blouch when he was permitted to pay the premium after the effective date of the policy . . . ***sound familiar?***. On one occasion, Blouch submitted a written application for an Aetna life insurance policy to Zinn. Zinn mailed the application along with a report of Blouch's physical examination to the local Aetna office. Aetna provisionally approved the application and forwarded the policy to Zinn. Zinn's employee then mailed the policy to Blouch with an invoice attached . . . ***sound familiar?*** Unfortunately, nothing was explained about when the premium was due or that the policy was ineffective until it was paid. Zinn did phone Blouch and inform him that the policy was in the mail and to call if he had any questions. Zinn, however, ***did not*** question Blouch about the payment of the first premium nor inform Blouch that the policy was ineffective until the premium was paid.

Blouch died two weeks later and his wife requested the proceeds of the policy. Aetna refused payment claiming the first premium was ***never paid*** and that the policy never became effective. A lawsuit against Aetna and agent Zinn was commenced.

A lot of issues were presented at the trial, including the fact that Zinn has a ***history*** of extending credit -- a clear violation of his agency agreement. It was also pointed out that Aetna had a ***history*** of accepting applications without payment from Zinn and others, despite the agency agreement rule that no credit be established.

The court determined that Aetna was liable and was forced to pay Mrs. Blouch. Of course, Aetna turned around and sued agent Zinn for violation of his agency agreement and state law:

No insurance agent, solicitor, or broker, personally or by any other party, shall offer, promise, allow, give, sell off, or pay, directly or indirectly, any rebate of, or part of, the premium payable on the policy or on any policy or agent's commission thereon or any special advantage in date of policy or age of issue, or any paid employment contract for services of any kind, or any other valuable consideration or inducement.

The object of this legislation is to outlaw ***unfair treatment*** of prospective insurance clients of the same class. Apparantly there is previous legislation which holds that delivery of a life insurance policy on credit confers a special advantage in violation of this statute, Katchmer v. Prudential Insurance Co. of America (1937).

In addition, Zinn's agency agreement specifically provided that Zinn was ***not authorized*** to extend the time for paying any premiums, and that Zinn could not waive or alter the agreement. Furthermore, the application which Blouch submitted, and the policy which he received, expressly stated that the policy was ineffective until the initial premium was paid.

The jury determined that credit had been extended to Blouch for the initial premium. The same jury then determined that Aetna was ***not entitled*** to indemnification from Zinn, and therefore concluded that Aetna ***knew of*** Zinn's practice of extending credit to insureds and accepted and ratified such a practice.

So, even though Zinn exceeded the authority of his agency agreement, the fact that Aetna condoned it was cause to release Zinn from having to indemnify the cost of the policy paid to Blouch. Ok, so the agent got off in this case . . . but think of the legal fees and time lost in court.

At Will Termination

Like it or not, your agency agreement may give your insurer the unequivocal right to terminate you upon written notice.

Cavanaugh v. Nationwide (1976). Ronald Cavanaugh was an "agent" for defendant Nationwide for twenty-two years. For a period of sixteen years, he entered into an annually renewable Agency Agreement with Nationwide. Nationwide suddenly terminated his Agency Agreements causing Cavanaugh to file a lawsuit.

Cavanaugh's Agency Agreement provides, some interesting language:

1. *Independent Contractor. The parties agree that the purpose of this Agreement will be best served by your acting as an independent contractor. Therefore, it is agreed that you are an independent contractor for all purposes. As an independent contractor, you have the right to exercise independent judgment as to time, place, and manner of soliciting insurance, servicing policyholders, and otherwise carrying out the provisions of this Agreement. Insurance being a closely regulated business, it is understood that it will be necessary for us to provide you with certain manuals, forms, records, and such other materials and supplies as are necessary in the conduct of an insurance business. All such property furnished to you by the Companies or on behalf of the Companies shall remain the property of the Companies and be returned to them in good condition upon any termination of this Agreement. We may offer to you, from time to time, training, counsel, and guidance based*

upon our accumulated experience in the sale and servicing of business. However, it is understood that you may reject or accept such offers at your discretion.

9. *Termination. This Agreement shall continue from its effective date until the end of the current year and shall be automatically renewed thereafter from year to year unless sooner terminated.*

   This Agreement shall ***automatically terminate*** *upon the date your license to act as an agent for the Companies is revoked or cancelled, or upon your death, or normal retirement at age sixty-five. Further, due to the personal nature of our relationship you or the Companies have the right to terminate this Agreement at any time after written notice has been delivered to the other or mailed to the other's last known address.*

12. *Agent's Activities* ***After Termination****. (Applicable only to agents entering an independent contractor's agreement for the first time on and after July 1, 1969). You agree that if the contract is terminated within a period of five years from the date of your first contract as an agent with the Company, you will not, either directly or indirectly, by and for yourself or as an agent for another or through others as their agent, engage in or be licensed as an agent, solicitor, representative, or broker or in any way be connected with the fire, casualty, health, or life insurance business for a period of one year from the date of the voluntary or involuntary termination of this Agreement or, should we find it necessary by legal action to enjoin you from competing with us, one year after the date such injunction is obtained, in the following area: Within 25 Miles * * *. In any jurisdiction where a covenant similar to that appearing above is held to be invalid either by statute or by judicial decision, you agree upon termination of this Agreement you shall thereafter refrain from further solicitation or by servicing of policyholders of the Companies and from interfering in any way for a period of one year with existing policies and policyholders in the geographical area described above.*

    In the event that we are successful in any suit or proceeding brought or instituted by us to enforce any of the provisions of this Agreement or on account of any damages sustained by us by reason of the violation by you of the terms and/or provisions of this Agreement, you agree to pay to us such reasonable attorneys' fees as are permitted by statute and fixed by the court."

Despite Cavanaugh's plea that he had complied with all terms of the agency agreement; that he was being deprived of doing business unfairly; that his equity in a large "book of business" was being threatened by a 25-mile "non-compete" clause; that the termination reflected negatively on his reputation; and that Nationwide was arbitrary in this termination, the court ruled against him, thus allowing the termination to happen.

In its statements, the court emphasized that a ***written agency agreement*** is a ***legal, controlling document*** that must be enforced. This fact has nothing to do with whether or not an agent acted in good faith or performed his job in a reasonable, fair manner. A decision otherwise would mean that all written agreements mean nothing.

Cavanaugh's final plea to the court was in regards to the fact that an "at will" termination clause is unconscionable and a result of ***unequal bargaining power***. The court disagreed because the agent-insurer relationship here is clearly that of independent contractor status. Thus, no employer-employee status can be used to determine such a clause is unjust.

The agent lost his case and was liable for all court costs.

Lourdin, etal v. Aetna (1992).

Lourdin and several independent insurance agents had agency agreements with Aetna. At different times, Aetna canceled each agency relationship for ***unprofitability***. According to Aetna, the terminations were according to the terms of the agency agreement.

Aetna further informed each agent that ***no commissions*** would be paid on any existing policy renewals after the effective date of the terminations. Aetna further informed all of the agents' clients insured by Aetna that those policies would ***not be renewed*** because their agent no longer represented Aetna. Policyholders were advised to contact their respective agents in order to obtain coverage from another insurer.

The agents filed complaints with the Insurance Commissioner charging that these nonrenewals were improper under state law. Specifically, an insurance policy which has been in effect for two or more years must be renewed if the policy holder so desires, with certain enumerated exceptions, none of which are relevant to this case.

In response, the Insurance Commissioner required Aetna to inform these policyholders of their ***statutory right to renewal*** of their policies. Aetna complied by sending a letter advising them to contact their agent to discuss their insurance needs.

Where policyholders decided to keep their Aetna policies, Aetna made arrangements to ***convert*** these policyholders to a ***direct billing system***, as well as a system to directly file claims via a toll-free number. Aetna even allowed the terminated agents to continue to perform these services, so that they could maintain their business relationship with these clients, but it would not pay them any commissions on renewals or for servicing these policies.

So, while the policyholders were being taken care of, there was still the issue of the termination and renewals.

The right of an ***insurance agent to commissions*** on renewal premiums ***depends*** upon the contract existing between the agent and the insurer. The general rule is that unless the agent's contract makes allowance for the payment of commissions on renewal premiums paid by insureds after his termination, he will not be entitled to such commissions after his employment has been rightfully terminated.

What do the agency agreements in this case say about this?

Following termination of this Agreement, the commissions specified in the Commission Schedules will not apply to the renewal of an insurance contract which the Company is required by law to renew, ***unless*** *the Company failed to comply with any notice requirement which would have permitted non-renewal of the contract or unless such commissions are required by law to be paid.*

It appears the parties expressly agreed that ***commissions would not be paid*** on policies which Aetna was required by law to renew. Further, this particular state does not have a statute requiring the continued payment of renewal commissions after the termination of the

agency relationship. Therefore, Aetna was within its rights under the law and the contract in refusing to pay commissions under these circumstances.

The agent's also allege that Aetna breached an ***implied*** covenant of good faith and fair dealing by terminating their agency agreements without cause and by reducing their future commission on renewals to 0%. This claim is also without merit since the signed agency agreements ***allow*** for termination by either party upon ninety days notice.

Another complaint alleged that Aetna tried to ***convert*** their expirations to its own use by mailing notices to policyholders offering to bill and service them directly if they chose to renew their policies with Aetna. Here again, the courts sided with the Insurer because in this case Aetna ***never solicited business*** from the agents' clients. In fact, Aetna's letters to these policyholders urged them to contact their own agent to discuss their insurance needs. Moreover, Aetna was ***required by state law*** to mail such notices explaining the insureds' right to renewal. Aetna's actions in this regard, therefore, cannot be wrongful.

The agents further claimed that Aetna tortiously (in a devious manner) ***interfered*** with their business relationships with their clients. This was dismissed because Aetna cannot tortuously interfere with its own contracts with its insureds. The agents are ***third party beneficiaries*** to those contracts. Beyond that, there was no impermissible use of the agents' expirations.

The agents also claimed that they are entitled to recovery because they continued to service these accounts without being paid. This claim was also dismissed for reasons that ***to recover commissions***, one must have a ***reasonable expectation of payment***. In this case, the agents continued to service these accounts with the full knowledge that they would not be paid. In addition, the agency agreements stated that the agent could continue to service an existing policy after termination of the agency relationship. However, no commissions will be paid on policy renewals which Aetna was required by law to renew. The parties' agreement was considered plain and unambiguous.

Contract "Integration Clause"

A contract integration clause (or "entire agreement clause") might read something like this: *This Agreement is the entire and sole agreement of the parties hereto with respect to its subject matter. It may be modified or amended only by a written instrument. There have been no representations, warranties or promises outside of this agreement. This agreement shall take precedence over any other documents that may be in conflict with it.*

The purpose of such a clause is to preclude either party from later claiming that there were ***oral promises, representations or contract terms*** in addition to those stated in the written agreement. It proclaims to the courts that this written agreement supersedes any and all previous oral or written communications between the parties except those communications which were also included in the written contract. In effect, no party may rely on promises made during the contract negotiations but not included in the written contract.

Finally, the agents claimed they are entitled to civil damages, under RICO statutes, by virtue of the their belief that Aetna's direct communications with its policyholders was ***mail fraud***. This claim was also denied since ***no activity*** could be linked with "racketeering".

Following is another case where ambiguity in the agency agreement created a major conflict:

Hamilton v. Nationwide (1998).

Neil Hamilton took over one-half a Nationwide agency after the death of a previous owner. Initially, while receiving extensive training, Hamilton was considered an ***employee*** of Nationwide. Three years later, an ***agency agreement*** between the parties was initiated. Like many agreements it was ***terminable at will*** by either Nationwide or the agent. Hamilton, however, believed that he had attained career status and that his position with Nationwide was secure even though, at this point, he was considered an independent contractor.

Hamilton decided to incorporate the agency in 1992 receiving a Corporate Agency Agreement from Nationwide. Again, an at-will termination clause was included, as was a non-competition clause as well as an integration clause. If Hamilton chose to compete with Nationwide within one year of termination, and within a radius of twenty-five miles, he forfeited his right to Agency Security Compensation (ASC), which entitled him to certain benefits regardless of the reason for termination as long as the conditions for the benefits were met.

This is where things get interesting. You see, when Hamilton started with Nationwide, he was furnished with a copy of Nationwide's Agency Administration Handbook, which contained a provision entitled ***Contractual Stability*** as well as a provision entitled "Agent's Administrative Review Board."

At or about the same time, Nationwide initiated a Portfolio Management Plan. Specifically, the PMP evaluates an agent's performance based upon the ***loss-premium ratio*** of the policy holders in the agency. If the ratio for the most recent three year period is 90% or more, an agent is classified as "historically unprofitable" and, absent plan-level improvement of the three-year ration within the next two (2) years to less than 90%, the agent is terminated. In effect, the PMP ***blames*** an agent for writing a policy that produces a ***claim***. It was on the basis of his PMP performance that Hamilton was later terminated.

Hamilton, however claimed he did not receive a copy of the PMP until he was advised of his termination. Hamilton sued Nationwide claiming that termination under the PMP Plan was not for just cause. He argued the APMP was unfair, as it relied on the loss ratio of the agency, which was outside the control of the agent. He further claimed the program was ***not properly applied*** to him.

The court agreed that the contract was ambiguous and the non-compete clause too restrictive. Hamilton won on this count.

But, Nationwide appealed and tried to prove the contract was not ambiguous. After all, both parties agreed to the at-will termination language. Upon further testimony, the court learned that the Corporate Agency Agreement provides the following:

Cancellation. This Agreement shall be in force until canceled by either party. This Agreement shall automatically cancel upon the date the Agency's or its Principal's appointment or license to act as an agent for Nationwide is revoked or canceled, or upon death, disability or retirement of the Principal of the Agency. Further, the Agency or Nationwide have the right to cancel this Agreement at any time with or without cause, after written notice has been delivered to the

other or mailed to the other's last known address. It is understood that the Agency shall have access to the Agents Administrative Review Board, and its procedures, as may exist from time to time.

The Agreement ***also*** contained a provision, which reads:

Amendments or Modifications. Except as otherwise provided herein, this Agreement may be changed, altered, or modified only in writing signed by Agency and an officer of Nationwide.

Also, Nationwide's Agency Administration Handbook states the following about "Contract Stability":

Company-initiated cancellation of Independent Contractor Agent's Agreement . . . is primarily limited to:

A. Breach of Contract
B. Criminal Acts
C. Dishonesty or Fraud
D. Actions clearly contrary to the best interests of customers and the Company; specifically defined as failure of the agent to:

1. Promptly submit monies and applications.
2. Furnish complete and accurate information on applications.
3. Adherence to underwriting and administrative rules.
4. Deliver acceptable service to customers.

After much deliberation and the presentation of many more documents, the courts decided that even though the at-will provisions in the agency agreement were clear and unambiguous, the "Contract Stability" provision of the Company Handbook sent a ***mixed message***. Hamilton was able to pursue his case on the basis that he was terminated for lack of good cause.

Unfortunately, his case was overruled on the basis that the agency agreement contract was ***fully integrated***, and superseded any prior agreements between the parties.

Notification

Gatti v. Alliance (1998).

Gatti applied for property insurance through an the Alliance Group agency. An application was completed and a $300 deposit paid. Thereafter they were ***advised by the agent*** that there was coverage. This was confirmed a bit later by a ***binder notice*** from Alliance. About six months later Gatti sustained a loss when the roof of his building collapsed. However, the insurer (Merchants Insurance Group) denied the claim on the basis that it did not issue a policy for the property. Gatti sued Merchants for a damage claim and the Alliance Agency for negligence and malpractice.

The agency agreement between Alliance and Merchants gave Alliance the ***power and authority to*** "bind, issue and deliver such policies, certificates and endorsements as are authorized by the Company in the Company's Underwriting Manuals and supplementary written instruction pertaining thereto."

Under the agency agreement the agent had an ***obligation to report*** insurance bound under its authority as an agent of Merchants ***within five business days*** after insurance coverage is effected. There is testimony from actual agent, Jim Diem for Alliance, and a representative of Merchants that Alliance had binding authority under the agency agreement for coverage to Gatti effective January 10, 1998. Jim Diem also testified that he intended to bind coverage for plaintiffs in January 1998.

State insurance law establishes that . . . *an insurance binder is a temporary or interim policy until a formal policy is issued. A binder provides interim insurance, usually effective as of the date of application, which terminates when a policy is either issued or refused ... A binder is limited in time until an assessment of risk is completed by the carrier." (Springer v Allstate Life Ins. Co., 94 NY2d 645, 649 [2000].)*

Based on these laws, the court agreed that the binder issued by Alliance, under the authority of the agency agreement, was a temporary or interim policy of insurance from Merchants effective on January 10, 1998 (the day it was bound) and good until an assessment of risk is completed by the carrier and a formal policy is either issued or refused. The actual binder itself, also lends the conclusion that the client is ***bound until terminated***.

Seems like a clear-cut case . . . right? Well not so fast. It appears that in about 30 days from the date that Gatti was bound, the insurer sent a letter ***declining the application***, as it was incomplete, and returned the deposit check to Alliance. This letter also stated that if the application and deposit are not received back within two weeks, then the Merchants file will be closed and they will assume the policy is no longer needed.

The courts agreed that Merchants had a ***right*** to decline coverage based on an incomplete application. ,However the local state insurance law requires specific procedures for canceling a policy for a commercial line of insurance:

During the first sixty days a covered policy is initially in effect, no cancellation shall become effective until twenty days after written notice is mailed or delivered to the first-named insured at the mailing address shown in the policy and to such insured's authorized agent or broker.

It is interesting that this statute did not differentiate between an interim policy of insurance issued through a binder by an agent, and a formal policy issued and delivered. Of course, the ***spirit of the law*** was to provide a ***mechanism*** for an insured to be notified that his policy is being cancelled in order to plan for a new one.

Another issue in this case is that the agency agreement states that Merchants shall comply with all requirements prescribed by state statutes pertaining to individual risk cancellation, and that cancellation notices sent to the insured will also be sent simultaneously to the agent. Merchants position that they could not cancel a policy that was never issued and that they had no relationship with the plaintiffs was shot down.

Without evidence to show that they mailed a written notice of cancellation to Gatti the courts determined that Merchants, the insurer, was in violation of the agency agreement. Therefore, the interim policy remained in effect at the time of Gatti's' loss.

Supplemental Agreements

In many agent/insurer arrangements, agency agreements are supplemented by letters of understanding, letters of intent, cover letters, addendums or completely separate contracts. Agreements can even be ***implied*** where actions of the agent are ***specific and consistent***. Exactly how these outside documents affect the agent/insurer relationship vary with the case.

Dowell v Employers Modern Life

Dowell signed fairly typical agency agreements in 1990 containing a mutual no-cause, thirty-day written notice termination provision. They also expressly terminated and replaced all prior negotiations and agreements. Prior to signing, however, Dowell sought some assurances from Employers because the territory in question was untested. The President of Employers wrote a letter with the following verbage:

The purpose of this letter is to reaffirm to you that we are committed to the Managing General Agent system. No one is really sure what the future has in store, but I will give you my assurance as President of Employers Modern Life we will back you as Managing General Agent as long as it is mutually profitable, for each of us. It would not be to the advantage of the company to watch you build a region, based upon obtaining mutual production objectives and then change the direction of the company.

Also, the future may be such that you are not interested in maintaining a Managing General Agent contract. Should this occur, we would not want to stand in the way of progress. In summary, no one is sure what tomorrow will hold. As long as we have an open means of communication and are working towards helping our P/C agents produce life business, I can see no reason why we will not have a successful business relationship.

In 1995, the parties entered into Regional General Agent (RGA) Supplemental and Bonus Plan Agreements. By their own terms these agreements were incorporated into and made ***part of*** the original 1990 agency agreements.

Also, in 1997 new agency agreements were signed. These agreements still provided for a mutual no-cause, written termination, but ***extended*** the notice period to ninety days. Even though the 1997 agreements expressly terminated and replaced "all prior negotiations, agreements, and their “addenda”, the parties continued to operate as if the 1995 RGA Supplemental Agreements remained in force.

In 1998, EML reconsidered the cost effectiveness of the arrangement and delivered a ninety-day written notice it was terminating Dowell’s contract for the marketing of its life insurance plans.

Dowell sued EML on fraud and breach of contract theories and sought punitive damages. He contended that the 1990 letter written by Employers was an agreement to extend the normal agency agreement term.

Unfortunately, the court disagreed. The ruling indicated that even if the 1990 letters operated to control the plaintiff’s status separate and apart from the 1990 agency agreements**,** nothing on the face of the letters themselves would seem to constitute a promise for a perpetual arrangement or one that exceeded the roughly eight years during which the plaintiffs served as

RGAs. In the letters, EML expressed only its commitment to the Managing General Agency *system* and assured continuation of the arrangement with the plaintiffs only as long as it was *mutually* profitable. The letter very carefully avoided a promise of long-term commitment, twice articulating the uncertainty of the future, and affirming the plaintiffs' right to terminate the agreement.

In essence, the court concludes that the insurer has the right to terminate the RGA Supplemental Agreements by written notice with or without cause.

Dowell appealed the case based on the controlling nature of the 1990 letters, and the apparent integration between the letters and the RGA Supplemental Agreements. The courts again reaffirmed that the agency agreement called for **at will** termination. However, if the supplemental agreements had not incorporated the **agency agreements,** but were independent and separate agreements, it is probable that a perpetual agency could have been present. The jury found EML had not breached any of the contracts.

PIP Agency v. ITT Life (1972)

A general agency agreement was executed by the PIP Agency and ITT. About the same time, a former officer of the insurance company signed an undated ***letter of intent*** whereby his company was obligated to pay the agency further compensation in addition to commissions and expenses called for in the general agency agreement.

A formula in the letter of intent required that in "addition to the commissions and expense reimbursement allowance specified in your general agency contract, ITT would determine its own extra expenses in developing pension insurance business, excluding that developed by plaintiff and excluding and adding certain other items, and then defendant would pay PIP 75% of such a percentage as arrived at above and apply it to the first year premium income. Thus, any new business generated by the PIP agency and plaintiff's compensation would increase with that volume.

Normal commissions were paid in full. However, the ***excess compensation*** described in the letter of intent were refused. PIP filed a claim action.

During the case, the insurance company defense included:

- The letter of intent, as executed on behalf of defendant insurance company, was done so without authority, and
- That the letter of intent is illegal and unenforceable.

The court, was not sure that the letter of intent was done ***without authority***. However, the formula proposed in the letter amounted to a "bonus," "prize," or "reward" -- a strict violation of the State's Insurance Law that ***prohibits*** "increased or additional commissions or compensation of any kind whatsoever based upon the volume of any new business".

Department of Insurance regulations also stated that: "Life insurance is deeply affected with public interest. Consequently, the statute prescribes the maximum compensation payable to agents." "The Insurance Department continues to be concerned with precluding situations where expense reimbursement payments to general agents and soliciting agents are used to circumvent the statutory restrictions on the maximum compensation to agents. The

management of life insurance companies has a definite responsibility to see to it that agency expense reimbursements are made only for actual and legitimate expenses incurred on behalf of the company verifiable by bona fide vouchers from agents to whom actual payments for such expenses are made".

As a result of these code and law discoveries, the letter of intent was considered ***illegal, void and unenforceable*** by the agent.

Indemnification

As an agent, you have the duty to exercise ***reasonable care*** in all transactions. After all, you are a ***fiduciary*** of the insurer. And, as a fiduciary you are liable for your negligence that induces the insurer to assume legal and financial costs beyond the normal claims experience. One of the insurer's best protections is the ***indemnification clause*** in the agency agreement. Take some time and read it . . . you may be responsible to reimburse your insurer for more than you think. And, it may not be a two-way street. In Goebel v Suburban (1997), for example, a claim against an agent by his own insurer was determined by the court to be frivolous. Do you think the agent was entitled to indemnification from his insurer for legal fees and court costs? He was not. The reason is that the agency agreement between the agent and insurer specified that they agreed to be bound by ***common law***. The common law in this particular case however, did not grant the agent the right to be reimbursed by his insurance company for a frivolous claim!

Common Law

Common law has no statutory basis; judges establish common law through written opinions that are binding on future decisions of lower courts in the same jurisdiction. Broad areas of the law, most notably relating to property, contracts and torts are traditionally part of the common law. These areas of the law are mostly within the jurisdiction of the states and thus state courts are the primary source of common law. Thus, ***common law*** is used to fill in gaps. Common law changes over time, and at this time, each state has its own common law on many topics. The area of federal common law is primarily limited to federal issues that have not been addressed by a statute.

Let's look at some cases where indemnification created similar problems for agents.

American Spirit v Owens, 2001

The agency agreement between Owens and American Spirit is fairly typical in that it calls for ***full indemnification***, ***including legal expenses***, for any breach:

[Owens] shall indemnify and hold harmless [American Spirit] against any liabilities [American Spirit] may incur as a result of any act of [Owens] in violation of this Agreement or outside the scope of authority granted to [Owens] pursuant to this Agreement or any action of [Owens] which is in violation of any law or regulation, except to the extent [American Spirit] has caused, contributed to, or compounded such failure.

[Owens] shall also reimburse [American Spirit] for any legal or other expenses reasonably incurred by [American Spirit] in connection with investigating any such liabilities.

What went wrong? On August 19, 1994, Owens insured Douglas D. Tyler's home: $65,000 for the structure and $ 45,500 for the contents. Owens had visited the property and was aware that the house was in a dilapidated state. However, he relied upon Tyler's personal representation that the house was worth it because he was in the process of making major renovations to the house. (Life applicants make similar claims about their health; "I'm in good shape"; "no problems", etc.).

Tyler's property was later destroyed by fire and American Spirit denied Tyler's claims for loss of the structure and its contents under the policy obtained for him by Owens. American Spirit based this denial on its conclusions that Tyler had set the fire or caused it to be set and that he had made ***material misstatements on the application*** for insurance.

Tyler and his wife filed suit against American Spirit alleging breach of contract. In that case, the jury found that Tyler had been ***responsible*** for the fire and had made false statements on the application for insurance. However, the jury further found that Tyler's wife was a resident of the house as defined by the policy and that she was entitled to recover $28,500 for the losses she suffered as a result of the fire. Subsequently, on June 5, 1997, American Spirit and the Tylers entered into a settlement in which the Tylers received $18,000 in satisfaction of their claims.

American Spirit then filed a motion for judgment against Owens alleging that he had ***breached*** the agency agreement and seeking ***indemnification*** for the expenses it incurred – about $45,000.

The court ruled against Owens. They ruled that Owens had "committed a material breach of the Agency Agreement**"** and, thus, Owens would be required to indemnify American Spirit for the $18,000 paid to settle the Tylers' claims. The trial court further ruled that "American Spirit would be entitled to legal fees and expert fees incurred in the investigation of the matter but not for expenses incurred in the trial of the Tyler lawsuit – a total of almost $22,000.

Demecs v Fogel (1987).

John K. Fogel, was an insurance agent employed by John Hancock Mutual Life Insurance Company. Under an unusual agreement between John Hancock and Sentry Insurance, Fogel was authorized to write policies for Sentry Insurance covering property insurance, including automobile casualty and liability insurance. The party being insured was a Dale Georgia. Fogel ***partially completed*** a Sentry application, however, there was insufficient information to complete it. But, Fogel told Georgia that ***coverage was effective immediately***. Georgia later purchased another automobile, accompanied by another application which was marked "bound". Fogel again told Georgia that his automobile was covered by Sentry.

A short time later, Georgia was involved in an automobile accident with plaintiff, Christopher Demecs. Georgia notified Fogel who in turn notified Sentry. Only then did Fogel submit Georgia's application and premium to Sentry. Sentry received the application dated March 3, 1983, on April 14, 1983. Initially, Sentry denied Georgia's claim, but later paid it. Sentry then ***pursued*** agent Fogel for ***indemnification*** claiming that Fogel had breached the agency agreement by ***failing to submit*** the policy application to Sentry within four days of its completion as required, and by binding Sentry's policy with Georgia in excess of his actual authority to do so.

Sentry's case focused on state law which stated that . . . *An insurance agent is liable to its principal (insurer) for losses incurred as a direct and proximate cause of breaching the agency agreement.*

In this case, there were four arguable breaches:

(1) Fogel bound Sentry to insure Georgia even though he should have submitted the policy application on approval;
(2) Fogel did not mail the application to Sentry within four days of its completion as required;
(3) Although it was indicated on the application that insurance had previously been non-renewed, Fogel nonetheless bound Sentry; and
(4) Fogel bound Sentry to insure Georgia even though Georgia had been driving without insurance.

In addition, Sentry had a strong policy against insuring people who had been driving without insurance. A brochure typically sent to Sentry Insurance agents clearly states: "Drivers who currently own and operate a car without insurance may not be bound."

The application filled out by Fogel explicitly provided a line for the name of previous carrier. The line next to it stated. "If none, DO NOT BIND."

It was discovered that much Fogel's actions were due to ***inexperience***, Fogel bound Sentry to insure a ***previously uninsured motorist*** it would not have insured if it had had reasonable opportunity to process the application. Of course, if Fogel did not understand the terminology contained in the application, he should have inquired before extending coverage.

Why did Sentry pay this claim? Because Sentry believed that Fogel was acting under apparent authority, thus avoiding a ***bad faith claim***.

The court agreed with Sentry's position throughout this case and awarded a judgment against agent Foley in the amount of $88,000+!

Underwriters v. Kirklan (1986)

Homeowner Kirkland purchased homeowners insurance through agent Whitman who represented, agents Underwriters Insurance Company. Since Kirkland was unable to pay the full premium amount at the time of the purchase, Whitman arranged for her to ***finance the premium*** by making monthly payments of $18 to Capital Premium Finance Corporation.

After issuance of the policy, it was determined that Kirland's home was worth more than originally thought and Underwriters required Kirkland to purchase additional insurance. Accordingly, a second policy was issued by Whitman, with coverage on the dwelling in the amount of $44,000. Rather than send a check for the total premium amount, Whitman arranged for Kirkland to ***wait*** until she received a refund of the unearned premium on the first policy ($85.00) then use that amount as a down-payment on the second policy. Underwriters issued the new policy, effective and forwarded a copy of the policy to Whitman, along with an invoice for the premium amount of $170.

According to Whitman, she subsequently received a phone call from an employee of Underwriters informing her that they had changed their billing procedure and that premium checks should ***no longer*** be submitted with each application for new insurance but that agents

would be ***billed*** by Underwriters on a monthly basis. Based on her belief that she would be billed later, Whitman failed to forward any premiums to Underwriters on the second policy.

Underwriters ***denied*** having told Whitman not to send premiums; only that a new billing procedure was being introduced. Besides, they said, the second policy in question was classified as a rewrite as opposed to either a renewal or new business and, thus, the new billing procedure did not apply at all to the second policy.

Underwriters mailed Whitman a ***cancellation notice***, stating that the policy would be cancelled effective on a certain date, as well as a credit memo for the premium amount of $170. Kirkland was directly notified of the planned cancellation through her mortgage holder, FHA, which had been notified by Underwriters. Whitman also received cancellation notices on several other policies issued through their office. Whitman then contacted Underwriters, to inform them that none of the policies should be cancelled and to request that Underwriters send a list of policyholders in cancellation status so that Whitman could pay the premiums on the policies. Kirkland's name ***did not*** appear on the list provided by Underwriters because Kirkland's policy had already been cancelled and was thus not in cancellation status. Whitman paid the premiums for the policies on Underwriters' list but, since she assumed that Underwriters would bill her later, she did not send a check for Kirkland's policy. Later, Kirkland endorsed over to Whitman the $85 refund check from the first policy (which was credited to Kirkland's account with Whitman). After that, she continued to make monthly payments of $30 to Whitman until the premium was paid.

Kirkland's home was destroyed by fire and Underwriters denied coverage on the basis that the policy had been cancelled for nonpayment of premiums. Kirkland then brought suit against Whitman and Underwriters, claiming:

- That Whitman was negligent in failing to obtain and/or maintain the coverage requested by Kirkland, and . . .
- That in the event the policy was found to be in force, Underwriters failed to pay the proceeds following the fire.

Underwriters ***cross-claimed*** against Whitman, seeking contribution and/or ***indemnity*** in the event a policy was found to exist and alleging breach of the agency agreement it had with Whitman. Whitman counter-claimed against Underwriters, seeking contribution and/or indemnity.

Trial was held on all issues and the jury returned a verdict finding:

(1) That the policy was in effect at the time of the fire;
(2) That Whitman had not committed any negligence causing loss to Kirkland;
(3) That Whitman had not breached its agency agreement with Underwriters;
(4) That Whitman had committed negligence causing loss to Underwriters; and
(5) That Underwriters had committed negligence causing loss to Whitman. Kirkland was awarded $77,944 in damages PLUS attorneys fees, and costs of over $18,000!

At a new trial, Underwriters moved for an indemnification judgment against Whitman raising the argument that Underwriters should NOT be bound by Whitman's ***apparent authority*** since Kirkland received notice of cancellation from the principal, in effect placing her on notice that Whitman had no authority to reinstate the policy. Whitman even assured Kirkland that the

cancellation would be taken care of by Kirkland endorsing her $85 refund check over to the agency. Also, Underwriters claimed that Whitman breached the agency agreement by failing to forward premium payments collected from Kirkland. The agreement states that agents shall ***collect and forward premiums*** "unless specifically otherwise directed."

The court disagreed on these issues because although the evidence in the case clearly shows that Whitman did not forward the premiums collected from Kirkland, it also shows that the reason Whitman failed to do so was because she was "specifically otherwise directed" by a representative of Underwriters. There was likewise no evidence to support a finding that Whitman breached the agency agreement by extending credit to Kirkland.

So, the presence of an indemnification clause does not always assure that an insurer will collect from an agent. However, the legal fees and courts costs alone would make you sick. And, there is always the possibility the insurer will appeal and win in another court.

Burns v. Gulf Insurance (1998)

Burns purchased liability insurance on its automobile dealership from Gulf and Select through agent, Leroy Nash. Burns sued Nash for ***misrepresenting*** the nature of that insurance coverage and the losses that resulted from uncovered claims against Burns, and the trial court in that lawsuit granted judgment for Burns. Nash then got Burns to agree to take an ***assignment to any rights*** he may have to reimbursement from Gulf under their agency agreement instead of pursuing him personally.

Gulf argued that an assignment of this indemnification was illegal and the court originally agreed. On appeal, however, Burns and Nash, argued that Nash, may be entitled to indemnity based on the following terms of the agency agreement:

Company shall indemnify and hold harmless Agent against any claims or liabilities Agent may become obligated to pay to or in behalf of any insured based on actual or alleged error of Company in its processing or handling Direct Billed or any other business placed by Agent with Company, except to the extent Agent has caused, contributed to or compounded such error.

Burns further alleged that Nash became obligated to pay damages as a result of Gulf's "errors in the handling and processing of claims filed by Burns." This was proved in court when Nash testified that any misrepresentations he made to Burns were based on Gulf's representations to him that the policies in question would cover the claims Burns first sought.

The court agreed and ruled that Gulf's error in misrepresenting coverage amounted to an error in handling business by Gulf. However, the court was still unsure whether the assignment to Burns of any indemnity to Nash through the agency agreement was what the parties intended when the agency agreement was first drafted. Gulf further argued that the assignment of the indemnity claim from Nash to Burns was collusive and against public policy.

The assignment was allowed and over $250,000 of damages awarded.

Arbitration

Many agency agreements provide for arbitration to facilitate the speedy payment and settle disputes between agents and insurers without the resort to full litigation. In this case, however, arbitration was spelled out for certain things but not others causing a major conflict between the parties.

Surplus v. Home State County Mutual Insurance (1995)

Arizona Premium Finance Company, Inc. sued Home State for unearned premiums. In its original petition, Arizona alleged it had paid Home State certain premiums on insurance policies that it financed for various insureds. Arizona claimed that Home State failed to return unearned premiums after it notified Home State that it was canceling the policies.

Home State also filed an amended third party action and intervention against Surplus, their managing agent, seeking ***indemnification*** for any liability they incurred as a result of the Arizona lawsuit.

In its original answer, Surplus asserted Home State and Security's claims ***should be arbitrated*** because the managing general agency agreement contained a mandatory arbitration provision. Surplus also asserted several counterclaims against Security and asked the trial court to submit them to arbitration. Surplus' counterclaims included claims of fraud, DTPA violations, and insurance code violations as well as causes of action for breach of the managing general agency agreement. Surplus also filed a motion to ***compel arbitration*** requesting the trial court to order all of the claims between the parties to arbitration.

Arbitration Clauses and the Courts

Arbitration clauses have met with substantial hostility on the part of courts, frequently being held void because they oust the court of jurisdiction over the dispute and thereby prevent access to the judicial system and a jury trial in matters of contract law. Courts particularly dislike these clauses in view of their ***take it or leave*** format. However, courts do not seem to reflect the same hostility to agreements to arbitrate made ***after*** a dispute has arisen.

The existence of an arbitration agreement was ***not disputed*** in this case. The argument was whether the claims asserted fall within that agreement.

The arbitration agreement in the agency contract provides:

Any controversy or claim of either of the parties arising out of or relating to this Agreement, or the breach of any term, condition or obligation, other than the payment of premium amounts, may be submitted to non-binding mediation under the supervision of the American Arbitration Association or any other agency for alternative dispute resolution. In the event that mutual consent to mediation shall not be obtained within thirty (30) days of written notice from any party to the other concerning the existence of a claim or controversy, the application of this paragraph shall be null and void.

Any controversy or claim of either of the parties arising out of or relating to this Agreement, or the breach of the same which is not resolved by non-binding mediation, except any matter

relating to the payment of premium amounts, shall be settled by arbitration to be held in Dallas County, Dallas, Texas, in accordance with the rules of the American Arbitration Association, and judgment upon the award rendered by the arbitrators may be entered in any court having jurisdiction. Matters relating to payment of accounts may, at the option of the claiming party, be submitted either to arbitration or to any court of competent jurisdiction.

Due to the wording relating to payment of premiums, the court ***denied arbitration*** to some of the claims made against Surplus. On appeal, Surplus argued that although the arbitration agreement excludes matters relating to the payment of premium amounts, the trial court nevertheless erred in not submitting those matters to arbitration. The agreement gives the claiming party, in matters relating to the payment of accounts, the option to submit the controversy to arbitration or to any court of competent jurisdiction. Surplus argues that matters relating to premiums necessarily also relate to the payment of accounts.

The courts again disagreed on the strength that the arbitration agreement in this case provides that certain claims are to be litigated and others are to be arbitrated. It is not for the court to rewrite the parties' agreement.

Surplus came back by contending that once a contract is found to contain an arbitration clause, the arbitrators, not the courts, should determine what is included in the arbitration proceedings. The courts again disagreed stating that the law requires a trial court to not only determine the existence of an agreement, but also to determine whether a given controversy falls within the agreement.

The plain terms of the arbitration agreement ***excluded*** from the agreement "any matter relating to the payment of premium amounts." The court therefore had to determine which of the claims set forth in Home State and Security's amended third party action and intervention related to the payment of premium amounts and were thus excluded from the agreement to arbitrate.

In a final attempt, Surplus learned that Home State and Security claimed that Surplus created uncertainty by alleging their notice of termination of the agreement was in violation of State Insurance Code. In fact, the section of the insurance code they referenced did not apply to the managing general agency agreement at all. Thus, the claim falls within the general provision of the arbitration agreement which compels arbitration on all controversies or claims arising out of or relating to the agreement. In the end, the court ***allowed*** arbitration. But only after a lot of frustrating legal volleys and a lot of money spent by the agent.

Protecting Clients

When bad things happen on your watch it may be hard for you, as an ethical agent, to just stand by. Your cooperation is certainly warranted, however, if you try and settle the case, make promises about resolving the matter or give legal advice of any kind you may create additional, personal exposure and/or void your errors or omissions coverage.

Here is a case where the agent had his client's best interest at heart but the law disagreed . . .

Bushnell v. Mitchell (1958)

Agent Mitchell signed an agency agreement with Trans-Pacific Insurance Company. The agreement provided that the Company would pay Mitchell a percentage of the premiums

written and paid for. Mitchell agreed to pay the Company a return commission at the same rate on any return premiums, including premiums returned by reason of cancellation.

The agreement had some pretty typical terms"

- *All money paid by the policy holders to the Agent, or to anyone representing him, shall be held by and chargeable to the Agent as a fiduciary trust for and on behalf of the Company, and shall be paid over to the Company as hereinafter provided.*
- *The Agent agrees to pay to the Company all premiums accruing on insurance written under this agreement, whether or not collected by the Agent from the assured.'*

As of a certain date, a sum of $16,298.74 in premiums was collected and owed by Mitchell on various policies. Also retained by Mitchell were unearned commissions amounting to approximately $5,400. The amount of premiums and commissions owed under the agency agreement were never disputed in this case.

What went wrong? Well, about the same time the Insurer was liquidated by the State. The receiver or representative of the liquidation was Bushnell – the state's insurance commissioner. Bushnell, of course, wanted all the monies owed to bolster a proper liquidation of the Company. Mitchell, on the other hand, felt that this would be like pouring money down a black hole. He felt it was his obligation to ***retain*** the monies and use them to purchase new policies for his clients.

A lawsuit against Mitchell was launched to recover the premiums and commissions owed under the agency agreement. Bushnell argued that Mitchell, as ***agent*** of the liquidated corporation, was acting in a ***fiduciary*** of that company and all monies received by the defendant from policyholders for premiums on policies issued by the company were his responsibility. His failure to remit them, in accordance with the agency agreement was a ***breach of that trust*** -- the basis of this action.

Much of Mitchell's defense involved the interpretation of an agency agreement. He cited other cases where the agreement gave the agent certain time within which to make payment to the insurer, and provided that in case the policies were canceled, the amounts to be collected by the agents were the amount of earned premiums with no liability on the part of the agent. However, the this case, the agency agreement does not contain such a provision, nor was this a suit to recover for premiums not collected by the defendant. This is a suit to recover premiums actually ***collected*** by the agent and not remitted to his principal, and for commissions deducted and retained by the agent on unearned premiums.

The court observed that in previous cases, the agent occupied a dual position. Under the agency contracts, they were agents of the Company to receive premiums on policies written by their companies. And by the terms of the notes given on 'financed accounts' they were also agents of the policyholders on such accounts to replace their insurance in other companies. Moreover, they were agents of the policyholders on 'open accounts' to replace their insurance.

Mitchell, according to the court, ***did not*** occupy a ***dual position***. He could not ignore his duties to the company as clearly defined in the agency agreement. The court ordered him to return all premiums and commissions plus interest.

CHAPTER THREE
Legal Conduct for Agents

As you have read up to now, legal compliance is an important duty in any business . . . especially insurance . . . where the cost of a single mistake can devastate you or your client. Your legal conduct is a responsibility ***you cannot chose to ignore***. Let's summarize some duties and discover some methods to minimize conflicts.

Do You Cross The Line?

Few agents can say they have never "crossed the line". . . went out on a limb for a client . . . looked the other way or fudged just a little when selling or serving a client. These indiscretions, hopefully tiny and few in number, usually lead to nothing. But when something goes wrong an agent's biggest fear comes true. . . ***a malpractice lawsuit***. Cases you have read about in the front of this course are proof that you do not want to go there!

If you are worried about this happening to you, you won't be able to put this portion of the course down. If you think it can't happen, you should know that almost 15 percent of the agent population is sued each year, and maybe half of these claims are "frivolous", virtually ***beyond your control***. The longer you stay in the business and the more expertise you develop, the bigger the target you become. YES, the litigation explosion is coming to a neighborhood near you and it might just end up on your door-step.

The reason this threat is greater now than ever before is a matter of public record. Insurance companies are ***fighting back,*** evolving from an almost cavalier attitude in settling nearly every claim, to a wholesale frenzy for ***standing firm . . . taking plaintiffs to trial***. Of course, this has come at the great expense and frustration of every personal injury attorney who liked the old methods of settling a claim ***. . . before trial***, but hated the big battles and courtroom antics glorified on TV.

For the more lucrative cases, attorneys are pushing back. Others are looking for greener pastures . . . directions where there is less resistance. In the case of insurance conflicts, can you think of anyone these attorneys might pursue who might be easier to get at than a major insurance company? Someone without staff attorneys, little time to spare and a lacking a huge legal pocketbook. Are there individuals who might fold quicker than a big insurer and "belly-to-the-bar" to settle a claim to avoid a long and protracted trial? If you haven't guessed by now . . . ***its you, the working insurance agent!*** You could be the next victim of a clever attorney looking to cash-in on a quick settlement when something goes slightly astray with your client's coverage.

Even if you are lucky enough to avoid a claim for now, every time another agent is sued, it gets closer to you because our court system makes ***legal decisions based on precedents***. Litigation experts believe this system is destined to expand liability to higher and higher levels because each decision in the chain sets the stage for the next step of expansion. For example, the Southwest v Binsfield (1995***)*** case decision automatically created added

exposure in that it established that agents should make clients aware of widely accepted policy options that are available at a reasonable price, i.e., ***a legal precedent was established***. Agents who fail to comply, are potentially closer to a lawsuit than others. This, coupled with the willingness of judges and juries who sanction the expansion of legal theories in our courts, means that liability gets closer and closer to you for smaller and smaller violations. As a matter of fact, if there is one thing you learn from these pages it's that you can be held responsible for matters related to the fact that you are a licensed insurance agent and your client is not! You will also learn that the root of most agent conflicts lies in the inability to understand ***statutory and fiduciary duties***. When you know what is expected of you, proper ***legal and sales conduct*** can be followed and conflicts minimized.

Don't ever believe that because you haven't been sued you are in the clear. Thanks to our legal precedent system, seemingly innocent events of the past are potential big problems today. To survive it all you need to justify your actions in a legally acceptable manner, manage your errors and plan ways to avoid making them in the future, i.e., ***you must change the way you do business***. There are many suggestions and guidelines provided under these covers to help you develop office and sales procedures that may be critical if a lawsuit develops.

Finally, don't depend on this information to be a universal solution for avoiding litigation or handling your own defense, rather it is a big, bright ***WARNING BEACON***. ***Study it, learn from it, but get legal advice before taking any action to reduce or defend a possible insurance conflict.***

Agent Liability

The agent of the new millennium deals with stiff competition, fast-paced decisions and some very unpredictable insurance markets. To aggravate this condition, we live in an era where courts are very sympathetic to consumers. People feel entitled to seek complete and generous compensation for the smallest problems, even when they are contributors or the discovered source. Furthermore, the consumer of our time has lost all respect for the status of the professional, any professional. This includes doctors, lawyers, teachers, clergy, real estate brokers, stockbrokers and insurance agents. Few would think twice about suing any one of these professionals to receive satisfaction for an honest mistake, let alone one leading to a financial loss or injury. Understanding this, it is easy to see that the selling of insurance can lead to conflicts and legal disputes.

When an insurance agent and his client cannot resolve differences, agent liability can result, even when the agent is right. In fact, about 75 percent of all insurance malpractice claims are frivolous, and while an agent may never pay any damages from these claims the process of responding is very costly, BOTH in money and lost production.

Claims against you may surface as a result of events that occur ***before or after*** a policy is issued, and they may involve you and a client, your insurer or a third party who is an ***intended beneficiary***.

Cases can be built around issues of legal conduct (the subject of this chapter) as well as sales conduct. Throughout this book you have and will learn the "triggers" that launch insurance related lawsuits. They can be as basic as failure to secure the type or amount of coverage requested by the client to more complex and seemingly "blue sky" claims where clients demand recoupment of losses and damages simply because of a relationship that existed

between agent and client. Other claims span the gamut from client losses due to an insurance company failure to refusal to pay a claim.

Sometimes, an agent's liability is the result of simply being too busy to witness a signature or too rushed when entering a policy premium payment . . . ***small "blunders"***. Of course, a single incorrect digit or a blank you forgot to fill can make the difference between a policy "in force" and a cancellation or denial of claim -- a matter that is a guaranteed BIG DEAL to a client when an accident, death or problem occurs.

The selling of insurance carries definite risk. Agents need to accept it and manage it.

Agents who have never been sued are sometimes lulled into believing that the way they do business must be working. Unfortunately, this ignores the real possibility that the same events of the past, that weren't a problem, can now become a problem. It is a world of legal rights and little trust. The long-term client who you trusted, can change. Also, regulations change, industries change, economies change and no one can really keep up or control every aspect of their present business, let alone the future. Can you imagine, for example, the changes that will occur over the life span of a whole life policy between today and when it endows in fifty or sixty years? Will a state or federal regulation change the way automobile or health policy benefits are triggered? Will the IRS retroactively disallow tax benefits for a an annuity contract or single premium policy you sold three years ago?

No one knows the answers to all these questions, but it should be clear by now that as an insurance agent you are prone to errors, some beyond your control. As a business person you need to accept the fact that your business carries risk. Then, you need to find ways to manage and plan for these risks to minimize the fallout when a claim occurs. You will notice we said "***when***" a claim occurs not "***if***" a claim occurs. We say this because statistics prove that anyone who stays in the business long enough WILL suffer the wrath of a client or insurance company claim.

You can try to avoid conflicts, make friends with your clients, buy errors and omissions insurance, incorporate and practice other means of asset protection, but you will always be at risk for the one problem that seems to "fall through the cracks" and rear its ugly head at your doorstep. You have to plan for that day NOW. In the last portion of this book, we suggest several steps to help you reduce and manage this exposure.

Now, let's look at the deciding issues that establish your legal conduct and create agent liability.

Agent Duties and Status

The most critical questions in determining agent liability is the extent to which accepted legal standards, state licensing and agency status obligates the agent. This process involves the investigation of many areas, including: Basic Agent Duties, The Law of Agency, Producer's Status (relationship to the client/insurer) and the classification of the producer as Agent/Broker or Agent/Professional.

Basic Agent Duties

The agent/broker generally assumes duties normally found in any agency relationship. One of the most important documents controlling duties is the ***agency agreement***. Agents who continually refer to their agency agreement shall have a better chance of remaining within the ***scope of their agency,*** thereby limiting liability. Caution is always advised, however, in light of cases where terminology in the agency agreement appeared to limit agent exposure only to be overruled by common law (Goebel v Suburban – 1997).

With respect to client activities the primary obligation is to ***select a company and coverage and bind the coverage*** (if the agent has binding authority, i.e., property/casualty agents). However, since clients typically ***request*** coverage, the basic duty may expand to include the agent deciding whether the requested coverage is ***available*** and whether the insured ***qualifies*** for it (Harnett, Responsibilities of Insurance Agents - 1990).

Agents are not required to obtain "complete" insurance protection for clients but may need to explain widely available options, gaps in coverage and in some cases monitor policies after the sale.

The mere existence of an agency relationship, or the simple selling of insurance, imposes no duty on the agent/broker to ***advise*** the insured on specific insurance matters (Jones v Grewe - 1987). Duty also DOES NOT require the broker/agent to secure ***complete*** insurance protection against any conceivable loss the insured might incur, but there may be a duty to explain policy options that are ***widely available at a reasonable cost*** (Southwest Auto Painting v Binsfield - 1995). Also, there is reason to believe that the agent has a duty to use ***reasonable skill*** in asking certain questions during the application process to determine types of coverage needed (Smith v Dodgeville Mutual Insurance – 1997). Or by failing to determine the nature and extent of the coverage requested as in Butcher v Truck Insurance Exchange - 2000.

An agent's duty to provide correct coverage is not triggered by a client's request for "full coverage" because that request is NOT a specific inquiry about a specific type of coverage (Small v King - 1996). In other words, just because a client asks for full coverage an agent may not be liable to provide it. However, if a client requests a ***specific type of coverage***, the agent is responsible to see if it is available and determine if the client qualifies.

Knowing the specifics between different policies in an agent's own product line is a legal responsibility that can't be ignored.

A local agent owes his client the greatest possible duty (Hartford v Walker County Agency - 1991) since he is the one the insured looks to and relies upon. Further, an insured is entitled to rely on an agent/broker's advice on the content and meaning of policy provisions. In Perelman v Fisher – 1998, the insured sued an agent for not informing him about the lack of

cost of living benefits even though the agent advised the insured to review the policy which clearly did not provide it. Or, how about Nast v State Farm - 2002 where an agent's misrepresentation about the client's eligibility for a policy caused them not to buy it. A later loss proved they were eligible and needed it. Consider also, Stivers v National American Insurance - 1957, where it is suggested that client reliance may sometimes be unjustified, as when the advice given by the agent "is in patent conflict with the terms of the policy". The law is also not without conflict, take Cooper v Berkshire Life - 2002 where the insured could not ignore conflicting or qualifying language in the policy or illustration and thereby close his eyes to avoid the truth.

It is a clear legal responsibility of agents to understand the ***difference*** between products that he is attempting to sell (Benton v Paul Revere Life - 1994). Whether an agent has an affirmative duty to inform a client of possible ***gaps in coverage*** depends on the relationship of the parties, specific requests of the client and the professional judgement of the agent Born v Medico Life Insurance Co - 1988).

Once a policy is issued, traditionally theories of legal conduct provide that an agent does not have the duty to ferret out, at regular intervals, information which brings the policyholder within provisions of a policy (Gabrielson v Warnemunde - 1988) and (Sintros v Hamon - 2002). In essence, it seems the courts have been more concerned about general agent duties to inform clients of appropriate coverage ***at the time of sale***. Recent departures from this opinion include a case where an agent was found liable for failing to determine that the insurance policy was no longer needed by the client (Grace v Interstate Life - 1996). In another example, an agent assured his client that the limits of the policy continued to meet his needs when they actually fell short (Free v Republic Insurance - 1992), i.e., agent duties may also include informing clients their coverage is appropriate ***after the sale***. Although each case stands on its own, the underlying determinant of "after sale" duty may be the "special relationship" that exists between client and agent, e.g., an agent handling the client's business for an extended period of time may assume a higher standard of care.

These are the basic agent responsibilities. Agents are not precluded from assuming additional responsibility, which they normally do in most client transactions. For example, in Mate v Wolervine Mutual – 1998, it was determined that an agent had a ***special relationship*** with an insured, demonstrated by years of experience and notes in the agent file, that created additional ***duty of care*** to know about the insurance needs of members of the family. In Cooper v Berkshire - 2002, agents held themselves out as highly-skilled insurance experts, possessing the ***special knowledge and expertise*** needed to interpret and understand the complex and sophisticated funding methods and mechanics of the disappearing premium policies. When the policy did not perform, they became entangled in a web of legal charges including fraud, concealment, negligence and breach of contract.

When a lawsuit arises, however, it is the client's burden to show that ***greater duty*** is the result of an express or implied agreement between agent and client (Jones v Grewe - 1987) where the agent has taken more responsibility; unless, of course, the agent is the ***proximate cause of the a loss*** (Valley v Valley Forge - 2002). In most instances, the facts of the particular case determine whether the court finds a greater duty has been assumed. In the Fitzpatrick v Hayes – 1997 case, no special duty to procure "umbrella coverage" was determined where the agent's brochure simply promoted a ***family insurance checkup***. A special duty might have been imposed if the agent held himself out to be an expert in umbrella coverage.

The Law of Agency

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

An ***agency relationship*** begins when agents are granted authority to operate by expressed, implied or apparent agreement. This can be ***created by contract or agreement*** or it can take the form of casual mutual consent. What is interesting about the business of insurance is that most agents start out as an agent for the client, when coverage is requested, and then become an agent for the company, when business is placed. As you will see later, the exact status you occupy when a problem occurs affects your liability exposure.

A person who markets insurance is typically referred to as a ***producer***. The insurance market and many state laws describe different kinds of producers -- ***general agents, local agents, brokers, surplus or excess-line brokers or agents and solicitors***. Following is a brief description of these categories:

General Agents

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

Local Agents

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

Brokers

Theoretically, brokers are agents of insurance buyers and not of insurers. Their job is to seek the best possible coverage for clients. This is can be accomplished in a direct manner with the broker acting as salesperson or through a network of agent contacts. Premiums paid by clients include the cost of commission paid to the broker by the insurance company, so the client indirectly pays the commissions of both the broker and agent. In the liability/casualty area, some brokers maintain a loss-control staff to help counsel clients on safety and prevention matters thereby aiding clients to secure a lower premium. In a sense, these brokerage firms act as insurance and risk managers.

Surplus Brokers / Agents

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

Solicitors

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

Marketing Organization & Clusters

A off chute form of producer status occurs when agents join ***marketing organizations or clusters***. Neither is a legal entity, but both can represent exposure to the agent if operated in a certain way. Most marketing groups and clusters are a simple banding of individual agents operating as sole proprietors for the obvious advantages that come with numbers (better contracts, group perks, access to information, etc. In this instance, member agents have no responsibility for one another or the entity itself. However, these groups are potentially more dangerous arrangements if the member agents have formed a general partnership to operate as a group. Here, the acts of one agent can hold ALL others responsible.

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

When disputes occur and agency is not clear, the courts generally lean to the assumption that an "agency relationship" exists to establish links to the "deep pockets" of the insurer.

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

So, the insurer is most often legally responsible for the acts of the agent and are regularly sued by third parties (clients of the agent) who feel they have been wronged. Of course, when a policy owner sues his insurance company, agents are often named for various breaches of duty between client and agent. Agent liability may also exist where insurance companies sue their own agents. Insurance companies and errors and omission carriers alike exercise their right to sue an agent under various legal theories, typically for indemnity of any judgement losses they may have incurred through a policy owner claim

Insurance Producer Status

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

When a dispute occurs and a producer's status cannot easily be determined the courts usually rule in the direction of ***agency relationship***. This bias is commonplace for two reasons. 1) It is easy to establish that an agent is representing his insurance company since there is typically a preexisting, written ***agency contract*** between the parties (the agent and the insurer). This relationship is distinguished from a ***principal-agent relationship*** where the client requests that the agent accomplish a ***specific*** result such as "Buy $150,000 of coverage from XYZ Company". 2) Holding a producer to be a true principal could block many claims a client might have against the "deep pockets" of the insurance company (Canal Insurance v Harrison - 1988). If the insurance company was not made part of the claim, the client's only recourse would be the resources of the agent which are likely to be a lot less than the insurer.

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

Agents who advise clients they are "covered" with knowledge that the intended insurer has not yet agreed to coverage are liable for client losses, i.e, the agent acts as insurer until coverage is accepted.

A huge problem for agents occurs when they ***act as principals***, when, in fact they are not, or when they have neglected to identify the principal, i.e., an ***undisclosed principal***. An agent who advises a client that he is ***covered***, with knowledge that the intended insurance company has not yet agreed to accept such coverage ***acts as the insurance company until coverage is accepted***, i.e., the client has FULL RECOURSE against the agent for any uncovered loss. If it can be proven that it was reasonable for the client to assume that the agent ***actually*** had real authority to act for the principal, the client can hold the insurer to the contract, even when one did not exist (Stock v Reliance Insurance Company - 1968). The client who incurs coverage shortfalls is in a much better position to recover from the agent where a principal (insurance company) is NOT disclosed.

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

terminate agency and stand as proof of evidence that an agent is representing the client/principal or “out of the loop”.

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

Producer status problems also occur when ***unlicensed employees*** of the agent are found to be doing the work of a licensee. A small mistake here can become a big deal (Williams Insurance Agency v Dee-Bee Contracting Co -1984). You can be held responsible for any claim or shortfall and it will likely void your errors and omission coverage. Insurance department sanctions, fines and possible revocation of license could also follow.

Agent vs. Broker

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

An ***agent*** is legally defined as "a person authorized by and on behalf of an insurer, to transact insurance". Agents must be licensed by the state and typically require a ***notice of appointment*** be executed. This document appoints the licensed applicant as an agent of that insurer in that state. Thus, an insurance agent is the agent of the insurer, NOT the insured (client). Of course, an insurance agent may be the appointed agent of more than one insurer.

An insurance ***broker*** is "a person who, for compensation on behalf of another person, transacts insurance, ***other than life*** with, but not on behalf of, an insurer". Brokers must be licensed through most states and are not prohibited from holding an insurance agents license as well. A broker who is also a licensed agent is deemed to be acting as the insurer's agent in the transaction of insurance placed with any insurer who has a valid notice of appointment on file.

In Kioutas v Life Insurance Co of Virginia – 1998, the agent was deemed to be a “broker” representing the insured to obtain the most suitable and affordable life insurance from among various insurers. Specific rules that determined this status included:

- Who set the agent in motion (who called the agent);
- Who controlled the agent’s actions;
- Who paid the agent; and
- Whose interest did the agent represent.

Basically, an insurance broker is an independent business or business person that procures insurance coverage for clients. Brokers generally receive commissions from the insurer once coverage is actually placed, and except when collecting premiums or delivering the policy, is the agent of the insured for all matters connected with obtaining insurance coverage, including negotiation and placement of the insurance (Maloney v Rhode Island Insurance Company). Typically, brokers are insurance professionals who maintain relationships with several insurers but are not appointed agents of any of them.

The ***purpose*** of determining whether the insurance producer was ***acting as a broker or as the insurer's agent*** when an insurance contract was placed helps establish the theories of liability that the client may plead and what defenses the agent or his insurer may raise. In many court cases, it is not clear whether the producer was acting as a broker or an agent. So, attorneys typically plead their case under the banner of each status thereby plucking the feathers of the agent ***and*** the "deep pockets" of the insurance company at the same time. Agents should be prepared to prove or disprove legal status at any given time.

Under basic liability theory, a client and his attorney may find it quite difficult to seek recovery from a producer acting ONLY as an agent. ***Traditional agency law*** in most states concludes that the ***insurance agent, acting as agent of the insurer***, owes duties primarily to the insurer. Of course, this assumes that the agent performed in the ordinary course of his or her duties as agreed between the agent and insurer per terms of the ***agency contract***.

Where an agent is acting properly, a person wronged by an agent's negligence has a cause of action against the ***principal or insurance company***, although this does NOT preclude clients from naming the producing agent also. Another general ***rule of agency law*** states that if an insurance agent acts as the agent of a disclosed principal, the principal -- NOT THE AGENT -- is liable to the client (Lippert v Bailey - 1966).

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

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

Agent vs. Professional

Despite rules which seem to offer reasonable protection of the agent producer, it should be made clear that ***agent wrongdoings*** outside the ***agency contract*** and other torts, WILL subject the agent to additional liability exposure, and it is easier than you think to step outside your agency agreement. A few pages back, we described a "dual agency" as the situation where the agent first represents the client as agent, then switches to agent of the company when business is placed. Now consider that ***dual agency***, and the added liability it creates,

also occurs when an agent assumes non-agency duties by agreement or simply by professing to have special expertise . A slogan on a business card, letterhead or company brochure may have sufficient information to establish you as an agent and a ***expert*** in the eyes of the law. When dual agencies such as these exist, the agent may be held liable for a breach of fiduciary duties owed directly to clients (Sobotor v Prudential Property & Casualty - 1984), (Montano v Allstate Indem - 2000) and, perhaps, contract and statute duties to the insurer. (Kurtz, Richards, Wilson & Co v Insurance Com Marketing Corp - 1993). Further, a determination that an agent is deemed a ***professional*** in the eyes of the law can extend liability ***beyond the normal statute of limitation*** period (Nowacki v Estate of Closson - 2001).

It is clear that activities ***beyond the scope of an agency contract*** can be dangerous to your financial health. If you go there you need to proceed cautiously. This is NOT an indictment of any agent who seeks to improve his practice by becoming a true insurance professional, complete with degrees and designations. The existence of these honors, by themselves, is not the problem nor a target. As a matter of fact, some feel that the presence of these awards may inhibit a client's willingness to file a claim. Rather, it is the agent who, regardless of his degrees or credentials, professes to be an expert but ***fails to deliver***.

Agents can be held liable for lack of reasonable follow-through in obtaining coverage or simply by their silence when coverage is not available.

In essence, we are talking about ***failed promises***. Agent wrongdoings in this area represent the majority of ALL insurance conflicts. For example in Fitzpatrick v Hayes – 1998, an agent merely promoted a ***family insurance checkup***. He did not promise special knowledge and was found innocent when an insured claimed he had a duty to obtain additional coverage. Compare this to the Blumberg v Paul Revere Life – 1998 case where an agent was found liable where he marketed ***guaranteed disability insurance,*** regardless of previous medical history, to an association. The agent intended this coverage to apply to existing members of the association but was held to personally cover any new members as well.

If you are somewhat confused about this agent / professional controversy you are not alone. There are many agents of professional status, such as CLUs, CPCUs, CICs, AAIs, ARMs and more, who practice ***due care*** for all the right reasons. Most stay clear of conflict by managing it. There may also be an entire army of extremely qualified agents who stay clear of professional designations for fear that the added exposure can't be managed. Perhaps there is room toward the middle. A position we call ***responsible agent***. These individuals also practice due care, yet operate strictly within the bounds of agency. They accurately describe policy options that are widely available, but "pass" on outside inquiries, not because they don't know, rather the request goes beyond the scope of their authority. They do not profess to be experts but know their product better than anyone. Their goal is simply to be the most responsible agent possible.

An agent who professes special expertise establishes "dual agency" and assumes additional liability exposure to both his client and insurer.

Contract Disputes

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

1) The existence of an insurance contract or principal-agent agreement or an implied agreement, and
2) The breach of contract or nonfulfillment.

A violation of contract terms is fairly clear cut. ***Primary breach of contract****,* however, can surface under any of the following headings:

Failure to Act/Procure Coverage

This is one of the most important areas of agent/broker liability because an estimated 60 percent of all claims result from agent malpractice in failing to procure coverage. In a typical transaction, a broker or agent agrees to procure a certain type of coverage for an insured. It is well established that the broker has a duty to exercise ***reasonable care*** in procuring that coverage. Consider the following cases: (Jones v Grewe - 1987) -- a failure to actually procure coverage; (Keller Lorenze Company v Insurance Associates Corp - 1977); -- a failure to perform some function related to the insurance coverage or a failure to see that policy was actually provided (Port Clyde Foods v Holiday Syrups - 1982); or, failure to forward premiums to prevent lapse (Spiegal v Metropolitan Insurance). In general, when an agent negligently ***fails to obtain coverage*** for a client, he steps in the shoes of the insurance company and becomes liable for loss damage or the limits of the policy until insurance is found (Robinson v J. Smith Lanier Co - 1996) and (Blumberg v Paul Revere Life – 1998). Liability may also be held to result from an agreement to procure a desired coverage at the lowest obtainable premium rate (Hamacher v Tumy - 1960).

Failure to procure coverage may also be used in cases where the agent has prior knowledge of the insured's condition and failed to disclose it on the application (Soho Generation v Tri City Brokers – 1998), (El-Hakim v American General Life - 1999).

Failure To Notify Lack of Coverage

Agents/brokers can also be liable for silence or inaction, as in an agent's failure to reasonably notify the applicant that the he was ***unable*** obtain insurance (Bell v O'Leary - 1984). The key here is "how long" a delay is normal before informing the client. The courts have not established any parameters other than that what is ***reasonable***. In one case this meant 2 days, in another four weeks. The best advice is keep clients fully and continually informed. This was proved in the Alaniz v Simpson (1998) case where an agent faxed a letter to an applicant that he was uninsured several hours before an accident. The victim of the accident (a third party) was unsuccessful in his attempts to blame agent for negligently misleading the applicant to believe he was insured.

Failure To Place Coverage At Best AvailableTerms

As part of the duty to exercise good faith, reasonable skill, and ordinary due diligence in procuring insurance, a ***broker*** has a higher duty than agents to be informed of the different insurers and policy terms and to place coverage at the best available terms. If other brokers working in the same market knew that better terms were readily available, the broker who failed to obtain these terms for the client could be liable for the client's loss (Colpe Inv. Co v Seeley & Co - 1933). This case dealt primarily with the fact that the broker failed to obtain "coinsurance" clauses that were ***commonly available*** and carried a lower premium. This must be distinguished from cases proving that the broker does NOT have an absolute duty to obtain the lowest possible rate (Tunison v Tillman Ins. Agency - 1987).

Failure To Renew / Notify

If an agent has a ***renewal history*** with a client of automatically and voluntarily renewing or reminding them to renew a policy, he can assume exposure for the “one and only” time he forgot (Siemorama v Davis Manufacturing Co - 1988). With the trend toward “direct billing” of clients by insurers, agents are not as close in contact as before. However, agents may still have renewal responsibility if the client depended on this service in the past.

In another recent case Everly v Gregary – 1999, the agent neglected to notify the insurer of a claim due to some strange titling of the property. The insurance company was still made to pay but the agent was responsible for a judgement in excess of the policy limits.

Policy Promises & Provisions

Agents should ALWAYS review client policies and retain "specimen policies" on file to answer prospect/client questions and compare with policies received. In most states, agents are legally bound to accurately describe the provisions of policies they procure for their clients (Westrick v State Farm Insurance - 1982) and point out the difference between different products he is selling (Benton v Paul Revere Life - 1994).

Many lawsuits have been pursued on misunderstood ***policy time limits*** that restricted the clients ability to perform or file a claim. Agents can easily become a focus of these disputes. Another misinterpretation might be: What is an "accident" defined to be? An insurer may deny a claim for lack of requirements establishing an "accident". Or, what is "reasonable medical treatment"? Some agents might be taught NOT to volunteer information on an issue such as this. But, insurers and agents have a ***fiduciary duty*** to their insureds to ***disclose*** full and complete information. Failure to do so may result in a claim of fraud (Ramirez v USAA Casualty Insurance Co - 1991). Overall, an agent can reduce his exposure by knowing that his policy contains clear and unambiguous descriptions (Dahlke v John Zimmer Agency – 1997).

Agents are legally bound and responsible to accurately describe the provisions of policies they sell.

Agents can be held personally responsible for any promise that exceeds the limits of the policy

Agent Promises

From time to time, agents make promises that ***exceed*** what the actual policy promises. Obvious violations would be intentional or unintentional misquoting of policy limits, specified coverages and exclusions. Agent liability also existed in a case where a producer promised to arrange ***complete insurance protection*** for a business or where an agent promised, but never did, to evaluate an appraisal of an individual's property or to determine its "insurable value" in order insure a certain percentage of that value. In Blumber v Paul revere Life – 1998, the agent went so far as to market ***guaranteed disability insurance*** to a company regardless of previous medical history. He was made liable for covering new employees.

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

Advertising Promises

Advertising violations are among the most costly mistakes. Regulators have been known to levy stiff fines of $1,000 or more ***per violation***. In other words, 1,000 non-compliant flyers distributed in the mail or otherwise could amount to a fine of ***$1 million or more*** ($1,000 X 1,000 flyers). By contract, agents are required to secure company approval of all advertising. Few agents, however, would think twice about scrutinizing company provided ads. However, it is suggested that agents carefully review advertising provided by the insurer to make sure it honestly reflects the promises of the policy. For example in Cunningham v PFL Life – 1999, information from the insurance company and agent touted life insurance policies as ***investment vehicles***. The insurance company was ultimately held liable for claims for failure to train and supervise its agents. Most violations of this type would probably not be actionable against the agent, but may name the agent nonetheless or may establish some form of "alleged" agreement that binds the agent / insurer.

What Policies Say vs What They Mean

No matter how clear the language, all policies will contain areas of ambiguity. The universal rule of ***policy ambiguity***, generally upheld by most state courts, goes something like this: If the policy could imply to a reasonable or average policy holder that coverage is in force, yet that exact language does not exist in the policy, then coverage

At minimum, policy holders should expect their policies to be fair and "say what they mean". Policy ambiguity is typically decided in favor of the client.

DOES extend to the policy holder. Agents may easily be involved in claims resulting from contract ambiguity.

Client Understanding and Reading of Policies

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

Today, policies are indeed more user friendly ***and*** the courts are still sympathetic to consumer confusion about their policies. Now, policy conflicts are determined by whether it was ***reasonable*** for a certain client to have read his policy and/or understand its meaning. The decision can be based on how simple or complex the policy is written or the client's level of sophistication (Karem v St Paul - 1973), (Greenfield v Insurance inc - 1971), (Perelman v Fisher – 1998) or (Dahlke v John Zimmer Agency – 1997). Each case stands on its own.

Minimum Standards

Courts have upheld that even though a policy does not promise to expressly act in good faith and fair dealings, it is the minimum that policy holders can expect. Agents owe a duty of good faith and fair dealings to their clients ***and*** their insurer (American Indemnity v Baumgart - 1982).

Agent Torts

In an action against an agent or broker, the plaintiff's (client's) attorney rarely distinguishes between contract and tort wrongdoings. BOTH are routinely pleaded. In the case of tort action, agents can be pursued on two fronts 1) Applicable professional standards and 2) The broker/agent's acts or omissions that do not meet these standards. Who decides what these standards are? In most court cases, the plaintiff's attorney will arrange for "expert testimony" by an agent or broker working in the same field. The fundamental issue is whether the accused broker's professional judgment and methods were appropriately exercised in line with acceptable standards. Following are some important areas of agent wrongdoing (torts) considered be outside acceptable standards:

Negligence & Misrepresentation

Agents and brokers can be liable for failure to procure the ***requested coverage*** (Mayo v American Fire & Casualty - 1972). Wrongdoing also occurred where an agent promised to procure ***complete*** business premises liability coverage and represented that a policy he procured afforded the desired protection when, in fact, it omitted coverage for a freight elevator occasionally used to transport people (Riddle-Duckworth inc v Sullivan - 1969). In Hardt v Brink, the agent was negligent in failing to ***advise*** fire insurance coverage on a leasehold made known to him by the client in advance. Another agent negligently obtained non-owner motor vehicle liability coverage for a client knowing it would NOT provide the coverage desired

(Rider v Lynch - 1964). In Walker v Pacific Indemnity Co - 1960, the agent negligently obtained a policy with smaller limits of coverage than had been agreed upon. In yet another case, the agent notified the client that the original insurer was insolvent and that a replacement policy would be needed. The broker replaced this policy with a new policy having LESS coverage. The broker was held personally liable for $150,000 because of the gap between the insured's primary and excess coverage (Reserve Ins Co v Pisciotta - 1982). Liability was also upheld in the case where a lending institution, which was licensed to sell credit life insurance, failed to offer it to a client who later died (Keene Investment Corp v Martin - 1963). Finally, in Anderson v Knox - 1961, an agent represented that $150,000 of life insurance, where premiums were ***so high*** that they had to be bank financed, was a suitable plan for an individual earning less than $10,000 per year knowing that it was not suitable. Another case of misrepresentation involved an application of life insurance with ***critical blanks*** (missing information). The deceased's widow held that the agent told her husband that the missing information did not need to be disclosed on the application (Ward v Durham Life Insurance Company - 1989).

Bad Faith

The insurance agent runs a great risk of ***personal liability*** in the event that he is less than fair or reasonable when dealing with either a client or claimant. Bad faith actions and violations of various statutes, such as the Unfair Claims Practice Act, are considered a breach of the implied duty agents have deal with clients in complete good faith. Agent liability may accrue due to unfair conduct by agents or allegations of fraud, deceit, misrepresentation or the statutes dealing with unfair settlement practices (where the agent is acting as a claims representative for the insurance company or in his individual capacity, independent of the agency).

Agents must remember that the number one reason that people purchase insurance policies through agents is ***service***. When an insured makes a request to procure coverage or turns in a claim, he is not bargaining for promises, but rather ***action***. Additionally, the insured is under the assumption that, due to his prudence in securing insurance in the first place, he will have peace of mind in knowing that he is being protected by the insurance company. Any breaches of this ***reasonable expectation*** will usually subject the insurance company and the agent to the exposure of insurance bad faith practices and a breach of the fiduciary duties owed to the insured. Licenses have been revoked for misrepresenting benefits of policies and entering false medical information on an application (Hihreiter v Garrison - 1947) or in the making of false and fraudulent representations about the total cash that would be available from a policy (Steadman v McConnnell - 1957).

In certain insurance arenas, bad faith issues surface under ***claim avoidance***. Some agents play judge and jury with client claims by advising them to NOT submit a claim since it would be cheaper to repair the vehicle or property or pay his own medical bills rather than incur potential insurance rate increases or even cancellation. Such conduct will expose agents to a ***breach of his fiduciary duty*** to the insured as well as a breach of the implied-in-law covenant of good faith and fair dealings. It may also be a breach of the unfair claims practices act in some states. This kind of agent deception even justifies potential punitive damages (Independent Life & Accident Ins Co v Peavy - 1988).

Client / Agent Relationships

The insurance agent/broker is increasingly regarded as a ***professional*** whom clients turn to for advice and guidance in insurance matters. In some states, the insured's pattern of reliance on the broker's advice has been the basis for a ***higher standard of duty*** (Hardt v Brink - 1961) and (United Farm Bureau Mutual Insurance v Cook - 1984). Relationship liability generally occurs on two fronts 1) Contributory and 2) Agents as Fiduciary.

Contributory Liability

When an agent holds himself out to be an ***expert***, a ***specialist***" or a ***professional***, he is creating ***contributory liability*** and may be held to higher than normal standards or standards beyond the disciplines of insurance. The earning of credentials or designations further compounds the agent's exposure, since he is considered, in the eyes of the law, to be subject to a higher standard of knowledge and responsibility. Yet, faced with stiffer competition, agents are somewhat compelled to upgrade their image by creating marketing "niche" expertise with titles, credentials and job descriptions like: financial planner, estate planner, retirement planner, "one-stop" insurance agency, loss control consultant, etc. Contributory liability relationships have also been cast simply because an agent has ***ALWAYS*** handled a clients business over the years, so much so, that clients have ***blindly depended on their advice***. The result of these "titles" and "agent trust" is a higher level of culpability. In fact, plaintiff attorneys have and continue to develop ***legal strategies*** that establish contributory liability of agents by multiple approaches, including:

Detrimental Reliance: Where the insured reasonably believes he is covered by virtue of representations by an insurance agent or broker, the failure of the broker to produce the coverage or else warn the client at once that coverage could not be obtained constitutes a failure to exercise the requisite skill or diligence required of a broker. One of the key elements in a ***detrimental reliance claim*** is whether or not the reliance placed on the agent caused the insured to miss the opportunity to obtain alternative coverage.

Lack of Client Knowledge: The insurance purchaser usually is not versed in the intricacies of the insurance business. Prospective insureds seek the assistance of the insurance "specialist" and come to rely on his knowledge. In some cases, the reliance on the agent is total and complete. When the agent procures coverage that turns out to be defective in some way or fails to make arrangements, the applicant should have a cause of action against the agent. This takes on more meaning today as agents and brokers have increasingly promoted their “professional expertise” in serving the public's insurance needs Sobotor v Prudential (1984).

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

Dual Agency: In many insurance transactions, the agent can generally be shown to have acted as a "dual agent" -- representing BOTH the insurer and client. As such, he owes a duty

to exercise due care and reasonable diligence in the pursuit of the client's insurance business regardless of the insurer chosen or represented by the agent.

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

Client / Agent Interaction: There is a lot of discussion about building solid relationships with clients. Considerable study has been done on customer satisfaction and the close association that develops with agents who are responsive to customer questions, explain policies well and are able "get it right" the first time. Some feel that the close ties often stop a lawsuit in its track . . . after all, they say, who wants to sue a friend!

Agents as Fiduciaries

New legal theories are continually attempting to establish an agent selling an insurance contract as a ***principal fiduciary*** and therefore a ***probable deep pocket***. A fiduciary is defined as someone who is held in trust or complete confidence. Compared to an agent's contractual duty, which requires negligence or tort action, fiduciary duty is intrinsic to his business. In other words, an agent's liability as a fiduciary simply comes with the territory . . . ***it's part of selling insurance***. In recent years, cases of fiduciary duty are more prevalent. The most obvious fiduciary responsibility of agents is to protect and safeguard client monies (Glenn v Leaman - 1983).

Other fiduciary related liabilities relate to an agent's duty of care. These cases even rear-up in a ***one-time business transaction***, i.e., you don't have to be a longstanding advisor to be liable. More often than not, the issue of fiduciary exposure surfaces where an agent proposes a ***full coverage*** policy but failed to describe a certain provision or exclusion that existed in the written policy (Eddy v Sharp - 1988). In addition, fiduciary problems are launched by special agent relationships where the insurance contract is established as a collateral issue of some greater purpose such as an insurance agent claim to have ***special expertise*** where the client is unsophisticated (Sobotor v Prudential Insurance -1984) / Kurtz v Insurance Communicators -1993 / Cunningham v PFL Life – 1999), or when an agent promises to provide "complete coverage" (Magnavox Co of Tennessee v Boles & Hite - 1979) The exposure also seems exist where the agent is the "exclusive" insurance provider for clients or in cases where the client, over time has come to be totally dependent on insurance decisions made by the producer. (Glenn v Leaman & Reynolds - 1983).

Another area of fiduciary responsibility concerns disputes dealing with Employment Retirement Income Security Act (ERISA) qualified funds. Many life agents help clients establish and fund retirement plans using insurance products. Under ERISA, a plan must designate a fiduciary to administer its operation. An ***ERISA fiduciary*** has been interpreted to be ***any person exercising managerial control over the plan or its assets, regardless of their formal titles***. In recent years, the U.S. Labor Department, the federal agency that administers ERISA, has become more aggressive in reviewing insurance funded plans and the link to agents as fiduciaries. It is even proposed that agents and brokers be labeled ERISA fiduciaries simply by how they advertise and market their retirement plan services.

In the past, it was typically the owner of the business, the board of directors or a specifically assigned fund manager that was considered the principal fiduciary. ERISA imposes a variety of duties on fiduciaries of life, health and retirement benefit plans, including a duty to act for the exclusive benefit of plan participants and beneficiaries. The act also establishes prohibited transaction rules governing plan fiduciaries that would disallow, for example, a fiduciary receiving personal benefit from a third party dealing with the plan. Does this mean that a commissioned agent who helps establish a retirement plan and recommends products to fund the plan violates these rules? The answer lies in whether the agent is actually deemed a fiduciary. *If the agent arranges to receive a fee for consulting on the pension plan, he is clearly a fiduciary*. *If the agent has an ongoing relationship with trustees of a plan who regularly accept the agent's proposals without advice from other consultants, he can be classed as a fiduciary of the plan.* On the other hand, where the agent is only acting in the capacity of an agent, offering a choice of products from which choose, and as a member of a team of plan consultants, he is less likely to be classed as a fiduciary.

To summarize, ERISA fiduciary status may be established where the trustees of a retirement plan ***relied heavily*** on the agent's advice in the purchase of insurance contracts. In Brink v Dalesio - 1981, the agent was found liable for unsound insurance purchases because the plan trustees relied on his advice. In Reich v Lancaster - 1993, the agent was again found liable as a fiduciary when insurance transactions absorbed the majority of the fund's assets. In addition, the agent failed to disclose his compensation or relationship with the insurer. Since the fund trustees were inexperienced in insurance matters and accepted every recommendation offered by the agent he was considered a fiduciary. In Kerns v Benefit Trust Life, an agent, as a courtesy, notified employees that their group term life coverage had lapsed shortly before their employer's death. But, he failed to forward the insurance company's routine offer to reinstate coverage and was found responsible.

An agent is a fiduciary of the insurer and has a duty to exercise reasonable care, skill and diligence.

In yet another case, a Louisiana district court held that an insurance agent ***was a fiduciary*** a profit sharing plan, even though he only ***sold*** a whole life policy in the plan's name. The policies later proved unsatisfactory from an investment and tax perspective. In support of their decision, the court stated that the ***primary purpose*** of a qualified retirement plan is to provide retirement benefits. The plan can provide life insurance death benefits only if those benefits are incidental to the retirement benefits. "Incidental", under IRS guidelines, would allow for premium payments LESS THAN 50% of the aggregate employer contributions to the plan. In the Louisiana Case (Schoegal v Boswell), the plan had purchased life insurance on a plan participant IN EXCESS of 50%. Since the ERISA rule on incidental benefits had been violated and the life insurance agent had violated the rule, he was declared a fiduciary and seemingly responsible for the taxes, penalties and possible disqualification of the plan. In further implicating the agent, the court pointed to Boswell's (the agent's) strong relationship with the custodian bank, management of the company, its employees and the plan administrator, deciding that he was *"...**clearly more than a mere salesman**"*. In the court's view, he had sufficient discretionary authority and control to be a plan fiduciary. Fortunately, the court's ruling has recently been appealed and reversed on the basis that agent Boswell lacked the necessary authority and control over the plan investments and because there was no underlying agreement that his advice would serve as the primary basis for investment decisions for the pension plan. While this is a favorable decision for

agents, it demonstrates the extremes and aggressive legal action to which agents are vulnerable, *particularly if the insurance transaction does NOT produce the anticipated or desired results for plan participants.*

New fiduciary conflicts may also develop in the area of ***Medicaid Planning***. Agents who routinely counsel clients on methods of transferring assets so as qualify for Medicaid benefits may be subject to fines and penalties under H.R. 3101 The Health Insurance Portability & Accountability Act of 1996 (Kassenbaum-Kennedy). Under this bill, if the transfer of assets results in a "period of ineligibility" BOTH clients and agents could be subject to misdemeanor fines of between $10,000 and $25,000 ***per violation*** and/or one five years in prison. Many agents recommend that clients purchase annuities, previously "exempt" in calculating assets, to qualify for Medicaid. Under these new rules, if the payout of the annuity contract does not match the payout schedules established by the Department of Health, (most don't) a disqualification of asset transfer and ineligibility period can be established. Look for future court cases here.

Insurer Claims Against Agents

When most agents ponder professional liability, they think client lawsuits. But agents and brokers also face exposure from the insurers they represent. When agents are sued by their insurer it is most likely for a violation of the law of agency. Most agents are familiar with the term fiduciary duty. Between agent and principal, (the insurer), ***fiduciary duty*** of the agent prevents him from competing with the principal concerning the subject matter of the agency or from making a "secret profit" other than what is stipulated or agreed as commissions. Fiduciary responsibility is especially pronounced when the agent writes insurance for himself (Southland Lloyd's Insurance v Tomberlain - 1996). Beyond fiduciary matters, agents are bound to his insurer by other ***statutory duties***. They include Duty of Care and Skill, *using standard care and skill*; Duty of Good Conduct *or acting so as not to bring disrepute 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 *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 and represent legal exposure for the agent. Following are some examples:

Basic Agency Violations

When an agency agreement exists between agent and insurer, the agent/broker has a duty to exercise ***reasonable care***. The agent is considered a fiduciary of the insurer. He or she must exercise ***skill and diligence*** and is liable for negligence that induces the insurer to assume coverage on which it suffers a loss. Brokers who have agency agreements with insurers have been found liable to the insurer for clerical mistakes -- incorrect policy dates, erroneous limits of liability and omissions of endorsements. A recent case, Goebel v Suburban – 1997, points to the what can go wrong even though an agency agreement is spelled out in writing. Here, a conflict regarding a clause in the agency agreement led the agent to believe one thing, yet it was ruled out by another clause in the agreement which stated that the agent and insurance company agreed to abide by common law. The common law, in this instance, did not grant the agent the right to be reimbursed by his insurance company for a frivolous claim.

Misappropriating Premiums

As representatives of the insurer, agents and brokers owe a ***fiduciary responsibility*** to the insurer to remit premiums collected from clients promptly or hold them in a trust account. In Maloney v Rhode Island Insurance Company - 1953, the agent converted premiums to his own use, facing liability to the insurer and possible criminal charges for embezzlement.

Failure To Disclose Risk Factors

An agent has a duty of ***good faith and loyalty*** to his insurer and may be liable for negligently inducing the insurer to issue coverage on which it suffers a loss. In Clausen v Industrial Indemnity - 1966, it was successfully argued that an insurer may obtain indemnity from a broker, if the broker knows or should know that an insurer is relying on the broker to supply information about the client; the information furnished is incomplete or incorrect; the incomplete or incorrect information is material to the decision to accept or decline the risk; and the insurer is forced to pay a loss under a policy that the insurer would NOT have issued if complete and accurate information had been provided by the broker. In a similar case (New Hampshire Insurance Co v Sauer - 1978), the insurer sued its agent, alleging negligence for failing to notify the insurer of the exact nature of the insured's business when applying for business interruption coverage. The jury attributed 70 percent of the loss to the insurer and 30 percent to the agent's negligence. In yet other cases the insured sued the agent for failure to ask if the insured had been cancelled (Smith v Dodgeville – 1997)**;** or failed to indicate a known pre-existing heart condition (Life Investors v Young – 1999); or failed to accurately disclose a client's prior loss history (Soho Generation v Tri City Brokers – 1998).

Agents are liable to their company for violations such as clerical mistakes, mishandling premiums, withholding information, twisting information, failure to perform, exceeding authority, fraudulent schemes and unfair trade practices.

Failure To Cancel or Notify of Cancellation

Agents do not normally have an obligation to the insurer with respect to canceling an insured's coverage. For example, if the policy is billed directly, the insurer usually notifies the insured directly of the insurer's intent to cancel and, thereafter, of the actual cancellation. The broker/agent is typically "out of the loop". However, a broker who has undertaken responsibilities in canceling coverage (Gulf Insurance v The Kolob Corporation - 1968) through agreement with the insured, owes the insurer a duty to follow the insurer's instructions promptly and correctly.

In Mitton v Granite State Fire Insurance Company - 1952, an agent was accepted as the insurer's general agent for purposes of signing policies, issuing endorsements, etc. As the insurer's agent, the broker was instructed by the insurer obtain a flood and landslide endorsement from an insured. If the insured refused to accept such an endorsement, the

agent was to notify the insurer who would cancel the policy. The broker failed to do either and was held liable to the insurer for the insured's flood damage.

Authority To Bind

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

Legally, the agent possesses the powers that have been conferred by the company or those powers that a third party has a right to assume he possesses under the circumstances of the case. In Troost v Estate of DeBoer - 1984 the agent exceeded his binding authority yet his acts and representations were relied upon by the insured. The agent was held liable for the insurers' losses.

Premium Financing Activities

Frequently, brokers play a role in helping clients finance their insurance premiums by bringing the insured and the financing entity together. There have been cases where the financing company has been the victim of fraudulent schemes misleading them into issuing loans to nonexistent insureds. In an effort to recover its losses, the financing entity may look to the insurer on grounds that the broker was acting on the insurer's behalf in arranging the financing, even though the insurer may not have given the agent explicit authority engage in premium financing activities. In New England Acceptance v American Manufacturers Mutual Insurance Company - 1976, an insurer was held liable for its agents actions in such a financing scheme because it was "implied" that the agent had been authorized to conduct premium financing. In a similar case, Cupac v Mid-West Insurance Agency - 1985, the court held that the insurer had ***not authorized*** its agent to engage in premium financing activities because nothing in the agency agreement referred such activity. The agent was held liable. Various states have split on the decision that the business of premium financing is an integral part of the business of insurance.

Unfair Practices

Insurers may also lash out against agents under the National Association of Insurance Commissioners "**Unfair Trade Practices Law**" which many states have enacted. The thrust of this code is contained below.

"Persons (defined to include insurance companies and insurance agents) are prohibited in engaging in "unfair methods" of competition and deceptive acts and practices." Including, "making, publishing, disseminating, or circulating, directly or indirectly, or aiding, abetting, or encouraging the making, publishing, disseminating, or circulating of any oral or written statement or any pamphlet, circular, article, or literature which is false, or maliciously critical of or derogatory to the financial condition of an insurer, and which is calculated to injure any person engaged in the business of insurance."

Under this act, it is conceivable that an insurer could commence litigation naming an agent where the company's insolvency was related agent "derogatory" actions. Consider a case similar to Mutual Benefit Life, where agents were actively involved in the disintermediation or withdrawal of "blocks" of client policies after rating drops occurred. Ultimately, this "run on the bank" was deemed the single greatest issue contributing to the companies liquidation. Were agents exercising "due care" for clients or breaching their legal and "unfair practice" duties to their contracting company?

Liability by Insurance Company Failures

To date, few courts have held that insurance brokers or agents are liable for the losses that policy owners might suffer from an insurer insolvency. Be assured, however, agents continue to be sued and pursued for malpractice in this area, and there are countless legal theories being proposed to force accountability. The basis for most tort actions where an insolvent insurance company is involved lie in certain cases and written code sections. At first glance, these regulations imply that agents are not responsible for involving a client with an insolvent company or a carrier that eventually is state liquidated. Here is how the law of liability is interpreted in most states:

"The general rule in the United States is that an insurance agent or broker is not a guarantor of the financial condition or solvency of the insurer from which he obtains coverage for a client." (Harnett, Responsibilities of Insurance Agents and Brokers - 1990).

In an actual case against a California agent, Wilson v All Service Insurance Corp (1979) similar results accrued:

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

Before an agent rejoices in knowing that laws of this nature are on the books, he must realize that regardless of this implied protection, court cases continue to be tried and a trend is developing that places greater legal responsibility on agents concerning insurer insolvency. In Wilson v All Service Insurance, for example, the client commenced a lawsuit in 1975 and even though the agent prevailed, the decision was not rendered until 1979 -- that's four years of attorney and court fees! So aggressive was the client that two different appeals the State Supreme Court were attempted involving more defense fees. One must also ask . . . If agent liability laws and codes represent a "safe harbor" and if agents are "untouchable", why do professional liability policies ***REFUSE to***

Agents who induce clients to buy or move to an insurer, which then becomes insolvent, may assume liability if the agent made false promises or misstatements about the insurer's financial condition.

defend and REFUSE to indemnify agents where an insurer insolvency arises?

The legal caveat that "muddies the waters", relevant to agents and insurer failures, is the results of a 1971 lawsuit -- Williams-Berryman Insurance v Morphis, (Ark. 1971) 461 S.W.2d 577, 580. It proclaims the following:

"*The agent or broker is required to exercise reasonable care, skill and judgment in procuring insurance, and a failure in this regard may render him or her liable for losses covered by the policy but not paid due to the insolvency of the insurer*." What is "reasonable care"? In Wilson v. All Service (above), the fact that the carrier was an admitted company proved to be adequate care. In Higginbotham & Associates v Green - 1987, however, the courts further clarified:

"If, for some reason, it is shown that the agent or broker knew, or should have known, that the insurer was insolvent at the time of placement, he or she may be liable for the loss caused by insolvency." A prime example is Moss v Appell – 1998. An agent knew or should have known of pending problems with an insurance company when he received a letter from the company indicating the need to find capital to bolster reserves.

In all these cases, the agents won, or prevailed on appeal. The reader should be aware, however, that in addition to the expense of lengthy trial a pattern is established. To summarize, the burden of ***agent liability involving financially distressed insurance companies is greater today for two reasons:***

1) More liquidations are in process, and
2) The courts want agents to be more responsible for their actions.

In addition to these known precedents and cases, agents are continually subjected to harassment suits from disgruntled clients and others that are settled out of court. Because these settlements are not published, it is impossible to know the depth and breadth of the problem. Most agents, however, know someone or has had some personal experience, realize they occur frequently. One such case involved an Oregon couple who invested their $26,000 retirement fund in an annuity with Pacific Standard Life in 1987. About three years later, they attended a financial planning seminar where they learned that their insurance company had been taken over by the California State Insurance Department due to losses in "junk bond" holdings. The couple immediately demanded a surrender of their policy. Of course, they were blocked from withdrawing their money by the conservators and the six-month payment delay provision in their policy. Seven months later they received a check for about 70 percent of their annuity value. The agent was threatened with legal recourse to pay the deficiency. After weighing the possibility of a lengthy court case and to keep an action from going public, the agent agreed to pay. From the above court recitals, this agent clearly had no exposure. The least path of resistance, however, was to pay the client and move on. Fortunately, the dollars involved were controllable. But what of the situation where multiple clients are seeking reimbursement or the numbers are significant? The answer is not easy to predict, but the solution involves a multi-faceted approach to managing exposure while still providing service.

Misrepresentation & Insurer Failures

Insurer insolvency cases against agents may be based on ***misrepresentations*** by agents. Where agents have made expressed warranties or specifically agreed to supply a solvent carrier or one with stated or minimum amounts of capital are the most obvious areas where liability abounds. An even worse situation occurs where an agent knowingly distorts actual capital or asset statistics of an insurer to make it more appealing. A similar violation occurs where an agent represents that he made a ***detailed investigation*** of the insurer when, in fact, he did not.

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

In yet another legal strategy, agents may be culpable by his statements of confidence. Saying things like, ***"trust me" or "I guarantee it"*** could be construed as a ***warranty*** by the agent. Since most agents find it impractical to "clear" every representation with compliance departments, many oral declarations are made in the course of a sale or in the counseling clients. Technically, a guaranty should be in writing, but this would not stop an attorney from pursuing a talkative agent who made similar representations to more than one client. A common example is in the area of ***safety regulations***. The following are terms probably used everyday by agents and though they stop short of creating an absolute financial guarantee for policy owners, they infer financial stability and give the purchaser a measure of confidence that the company behind the product is financially secure. An agent who cites these utterances is likely to be responsible for their truth:

Claims of Regulation by the State Insurance Department

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

Claims of Minimum Capital and Surplus Requirements

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

Claims of Minimum Reserve Requirements

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

Claims of Annual Statements

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

Claims of Periodic Examinations

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

Claims of Statutory Accounting

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

Claims of Investment Restrictions

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

Guaranty Fund Claims

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

Virtually every state has enacted what are commonly know as "guaranty fund" laws for the added protection of the policy owners of insolvent insurers. These laws generally provide that other insurers doing business in that state will contribute funds to alleviate any deficiency of assets in the insolvent insurer. The provisions of the laws generally cover all policy owners, wherever located, of insurers domiciled in such states and all residents of such states who are policy owners of insurers who are not domiciled in such states, but who are authorized to do business there. The law in some states, however, limits protection on several fronts: There are coverage limits or caps ranging from $50,000 to $1 million per claim; some completely eliminate claims or place severe restrictions on certain policies including life, variable life blends, disability, mortgage guaranty, ocean marine, surplus lines, HMOs, PPOs and other non-traditional markets. Learn more about guaranty funds in Chapter 3.

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

Agent Relationships & Insurer Failures

Often, agents develop special relationships with clients that can result in additional liability exposure. This can occur when an agent has handled ***all the insured's business*** or when a client has come to completely ***depend on the agent*** for all his insurance decisions and the agent knows it. In these cases, there may be legal authority to proceed against the agent where losses are due to an insolvency. Even when faced with limited success, policy holders and their attorneys have pursued agents asserting a "personal" claim -- that is, the culpable conduct of a ***third party*** (the agent) was personal to the policy holders, who relied upon that wrongful conduct. Also, never let it be said that policy holders cannot sue an agent for any reason. This "right" has been upheld under Matter of Integrity Insurance Co., 573 A.2d 928 (1990).
One justification for placing ***tort responsibility*** on the agent is the conclusion that :

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

Cal Ins Code, 780-790.1 (Dearing 1991), N.Y. Ins Laws, 2401-2409 (1990), Mass Ann Laws ch 175, 2B (1990).

In essence, the courts are sympathetic concerning an insured's need for complete protection. This stems from the ***special circumstances*** that surround an insurance contract:

- The insured and insurer are ***not equal partners*** since the insured cannot protect itself by contract.
- The insured cannot bargain or require a provision of the policy to protect or indemnify for a potential insolvency.
- The insured can only seek other insurance with a more stable company. And, even when an insured is informed about the financial condition of an insurer, the courts feel that they would lack the knowledge and experience necessary to evaluate financial statements, reports and solvency terms like surplus, reserves, etc.
- Finally, an insured cannot mitigate or control his damages since insurance cannot be purchased after a loss, i.e., the insured could have already paid for a benefit he cannot receive if an insolvency occurs.

Recent legal research, which will be cited in claims against agents, presents a clear and loud indictment of agent and broker responsibility (A Proposal for Tort Remedy For Insureds of Insolvent Insurers Against Brokers, Ohio State Law Journal, vol 52, 4 (1991):

"When one considers all of the factors of tort recognition, including the social policy aspects, the argument for the establishment of a tort duty on the part of the collateral parties (agents, brokers, reinsurers, etc) to the insurance relationship is compelling. Placing a duty on the collateral parties to investigate and monitor reasonably the solvency of insurers with which

they deal yields a much more socially advantageous result. This duty logically extends the duty already existing for brokers to exercise care in the placement of insurance with solvent insurers. The proposed duty, however, requires affirmative investigation and monitoring. This investigation and monitoring should, at least, include an evaluation of National Association of Insurance Commissioners' data, Insurance Regulatory Information System data, ratings service data, and any other public information and general information circulating within the industry. Thus, the duty requires a more thorough investigation than present law apparently requires brokers to make. In addition, the duty continues past the placement of the insurance or the commencement of the insurance relationship."

"The duties of these public parties is a high duty that encompasses nonfeasance (Pennsylvania v. Roy, 102 U.S. 451, 456). Imposing a duty on collateral parties (agents, brokers, reinsurers, etc) to conduct a reasonable investigation and monitoring of the solvency of insurers, and imposing liability for a failure to abide by that duty accords with prior treatment of public entities."

Congress has also chimed in by suggesting that:

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

CHAPTER FOUR
Managing Conflict

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 the previous chapter on Legal Conduct). 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". Think about developing a website if only to post public policies like this in case you forget to handle them in writing. Refer to the website on all your ads and stationary.

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:

Know Your Agent Responsibilities

We discussed your legal responsibilities in the last chapter. However, we would like to summarize them again. This information bears repeating!

The Agent & Client Duties

As we pointed out in Legal Conduct, 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". ***Agent 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.

Correspondence

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

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 client. Standard procedures can be critical in establishing your notes and records as usable evidence in a trial. Further, it can be suggested that an agent who is careful to follow set procedures is usually found to be more credible in his own defense. Both are important reasons to document procedures in an ***operations manual***. Some errors and omission insurers are requiring agents to have and see their operations manual before coverage can commence. You should also be aware that in an insurance dispute, the existence of such a manual may be uncovered. From a defense standpoint, the manual and your adherence to it may prove that you are a diligent agent. From a plaintiff's vantage, non-compliance of policy procedures that you establish may work against you.

Your operations manual should cover procedures for dealing with client applications, claims, policies and certificates, insurance companies and any special services you plan to offer. The following is a basic outline of information that could be included in your manual. Because agencies and insurances differ widely, you will want to add issues that are specific to your business before implementing any procedures.

- Client needs and requests should always be noted in the file. Many agents routinely take 5 minutes after a client interview or phone call to document the needs and requests of the client in the file. Even if you have to shut the door and set the answering machine, this is important. Chapter 2 discusses many routine questions concerning agent due care and client needs.
- Always be consistent. If you ask one client to accept or deny a specific endorsement or make sure that you ask the same question of others.
- Note the date or nature of all correspondence that notifies a client that his application has been accepted or denied. Equally important is logging notification of clients or potential clients that coverage is NOT available.
- Create a "hot list" or "follow-up" file for ALL transactions that require additional review. A contact management or database system is excellent for noting the need to review the client file within 10 days, 20 days or on a specific date to check a renewal, ordered endorsement, etc.
- Your operations manual should also layout office procedures to be followed for handling and logging phone messages, faxes (copy thermal paper before putting in file), e-mail, photographs,, microfilm, proof of mailing receipts as well as how long and where storage and "deep storage" of records will be kept. Standard procedures using window envelopes (advisable) for all notifications should also be established.
- As mentioned above, all oral agreements and binders should be reduced to writing and dated in the file.
- Policies received should be checked against "specimen policies" to be sure it is the same contract and against the client application to be sure it meets client needs
- Endorsements should be processed as soon as possible. Make notes that show the policy has been endorsed and create a follow-up system that compares any endorsement papers mailed with the endorsement received from the insurance company.
- Cancellation procedures should comply with state regulations and policy provisions. Notices to client should be tracked and posted in the client file. Also, be sure that the client does NOT continue receiving a bill after cancellation.
- Renewals should be sent within a specified time before expiration of the policy (usually 60-90 days). Experts agree that if you can't reach the client you should order the renewal anyway. Posting and tracking any notices to file is very important.
- Expirations should comply with state and policy provisions. Always notify client of any expiration.
- 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.

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