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Chapter One

Conduct and Suitability

In the insurance industry, it is the client who makes the choice about not only whom or what to insure, but also the amount of coverage to buy. The agent then becomes advisor, suggesting policies that best mitigate the client’s risk(s). Most clients tend to purchase policies in a bid to reduce potential risk, so it is the agent who must recommend a policy that suits their needs.

During this process of evaluating needs and recommending insurance, practicing due diligence and the utmost of care cannot be stressed enough—in fact, this is what actually defines the value of service an agent provides.

An agent can use several methods to identify client needs. While these techniques are often ways to place clients into particular segments, they do not offer much insight into other social or emotional factors that are equally vital in understanding a client.

Suitability: The Legal View

While there is no legal onus on agents to make certain that a consumer has procured complete insurance coverage for every need, the agent may be legally culpable if he or she has not explained all insurance options available—and the costs involved. The law also places on the agent the onus of asking questions and gathering required information to determine the most appropriate insurance for a particular client. Failure to recommend appropriate coverage can be cause for a lawsuit...

Liability in suitability lawsuits is often determined by relationship and purpose. A legal personal relationship is established the first time a client consults an insurance agent. Any information provided during these consultations that help the agent determine appropriate coverage is covered by the legal relationship. The law views the relationship between insurance agent and client as akin to that of an attorney and client when it comes to the dealings concerned with the client's policy. It is expected that the agent-client relationship be governed by similar loyalty and confidentiality.

Any alleged negligence by agents in providing consultation specific to a client's particular needs can result in a personal tort. As an example, in Forgione v. State Farm Insurance (1995), it was found that the clients had specifically consulted the agents about potential gaps in the insurance purchased. In a $600,000 claim, the complainants alleged that their agents had not exercised the due diligence expected of them in recommending and purchasing coverage that best suited the client’s needs, therefore rendering the policy unsuitable.
Agent Leland Anderson specialized in bank-financed insurance in which premiums were provided by borrowing certain amounts from banks, along with an assignment of old and new insurance policies. Mr. Anderson offered Mr. Knox a bank-financed life insurance plan, theorizing that Knox would need to pay the bank loan interest only.

This theory stemmed from the fact that Knox’s interest payments were to be tax-deductible and the annual net amount he would pay would be the loan interest minus the taxes he would save by virtue of the deduction of interest on his income tax returns. Knox’s net cost would ultimately depend on his tax bracket at the time of taxation. Basically, the savings he would realize on the deduction of the interest paid was the main feature of the bank financed life insurance plan.

The court ascertained that while such bank finance plans would be appropriate for someone in a high income-tax bracket and with the capability to liquidate debt from alternative sources, Mr. Knox was not such a person. In fact, Knox’s annual salary was $8,100 per year, his investment income was $1,600 per year, and the premiums for the bank-financed plans were more than $7,000 per year! With a job as superintendent in a sugar plantation, he had benefits of free housing and company car but, according to the court, Knox belonged in the 26 percent tax bracket.

During the course of the court case, Knox expressed the faith he had in Anderson because the agent came highly recommended by a successful businessman. Knox also claimed that, based on Anderson’s reputation, he assumed Anderson would recommend a suitable insurance plan. Knox told the court he had asked Anderson if he could reduce or drop the bank-finance insurance plan after starting it in the event it became burdensome. He said Anderson had assured him this was an option, but neglected to mention the range of Knox’s loss if he exercised it.

An expert witness testified that the plan Anderson recommend was unsuitable as both an investment plan and a retirement plan because it provided Mr. Knox with neither retirement benefits nor investment savings. The expert witness further stated that Anderson had not properly understood the requirements of Mr. Knox, he had not matched Mr. Knox’s financial ability to the insurance plan, and he'd made a simple representation of the plan without exploring and explaining the consequences of the use of bank financed loan plans.

The expert witness stated his belief that Anderson, as a responsible agent and apart from offering insurance plans, had an obligation to prevent his clients from making a bad choice. Thus, Mr. Knox was left with the burden of paying for an insurance plan that risked his assets rather than reducing the level of uncertainties in his life.

Mr. Knox won compensatory damages for mental anguish and distress because the agent did not match his needs to a suitable plan of insurance that would best protect his interests.
Importance of Suitability Conduct

What meaning, then, does suitability conduct hold for an insurance agent? It calls for all agents to go beyond matter-of-fact transactions where the customer is a mere number.

Being an effective insurance agent requires that agents make it their business to match clients to the policies that most closely meet their needs. This “matching” requires agents to go beyond the call of duty and really know their clients.

When a consumer consults an agent for advice on the best policy available, the agent will be required to sell the client the policy that is best for his or her particular circumstances. A client profile needs to be prepared to take into account needs, financial strengths and weaknesses, and other liabilities. The profile should also anticipate any risks that might crop up in the future. The needs of a 30 year-old will always be different from those of a couple close to retirement. In order for agents to ensure that treat clients appropriately, it is a good idea to draw up a checklist of questions that might include

• Have I understood what you are looking for?
• Do you have any questions about this policy?
• Does the policy and its premium fit into your overall plans for the future?
• Are you uncomfortable about an aspect of this purchase?

An agent should use client profiles to gather as much relevant information as possible. Such information will include personal details, medical history, housing costs and obligations, risks, pending litigation etc. Agents should know their clients—and the clients’ needs. In addition, agents should know the policies they sell and should confirm that clients understand what their policies entail. Agents should always give their clients space and time to think about their options and alternatives. Clients should be involved in the process of selecting a policy—the suitability conduct is all about a correct analysis of exchanged information that helps the agent match the client to the right policy.

Review Questions/Chapter 1

1. In the insurance industry, who makes the choice about whom or what to insure?
   a] The insurance company
   b] The client
   c] State regulators
   d] The NAIC
Chapter Two

Analyzing Risks

It is imperative for all concerned to not only analyze risk but also to manage it to avert financial catastrophes. Consumers work with agents to mitigate their risks—even if they don’t consciously realize it. Identifying risks, and then finding the most suitable insurance coverage for a client, is the agent’s job. At the same time, it is equally imperative for agents to inform clients there is no such thing as total coverage and that, at certain times and in certain situations, an agent cannot even provide coverage.

Recognizing Client Risks

The risk identification process begins with the client providing details in questionnaires and insurance application forms. The information provided is then analyzed to understand the applicant’s needs, identify the client’s risks, and match those risks to the appropriate type and amount of insurance coverage. Risks that a client faces can be gauged from occupation, age, place of residence, responsibilities, activities, and hobbies. The number of family members, family obligations, owned property, and other physical assets are some more determinants of risk.

Agents need to use questionnaires and forms designed to unearth the many potential risks the client faces. Discerning agents need to familiarize themselves with policy applications, supplements, and related forms. Agents also need to encourage clients to submit accurate information so the insurance company can accurately assess risks—agents should inform clients about the consequences of misrepresentation. Both agents and clients must avoid providing incorrect information—insurance can be reduced, denied, or rendered void on the basis of a misrepresentation. Insurance applications help agents glimpse their clients’ major concerns and potential fears, which might otherwise remain unspoken in an interview.

A risk once identified needs to be managed. The client and agent decide to manage risks by:

• Avoidance – The client can refrain from participating in particular activities, or choose not to own particular property, that might result in a loss. For example, if the client is concerned with auto accidents, he can refrain from driving or not purchase an automobile. Avoidance is not always realistic.
• Reduction – The client can take steps to reduce any loss that may occur. For example, he or she can wear a seat belt when driving a car or the client can install a smoke detector in his home.
• Retention – The client can accept that a loss may result from participating in a particular
activity, or purchasing property, but decide to assume responsibility for that loss himself. A policy deductible is a form of retention because an individual assumes responsibility for a portion of the loss along with the insurance company.

• Transfer – The client can take steps to transfer the financial consequences of loss to another party. For example, legal contracts transfer risk; hold harmless agreements and insurance policies are two common ways to transfer risk via contract.

Agents must explain to clients what each risk management strategy entails and how clients can best manage the risks they face. The decision to retain, transfer, reduce, or avoid the risk depends on the client, the risks themselves, and the method with which the client is most comfortable. Insurance is only one way of managing risk and agents are required, legally and ethically, to explain all forms of risk management and to document any recommendations made.

Review Questions/Chapter 2

1. What process begins with the client providing details in questionnaires and application forms?
   a] Policy issuance
   b] Claims settlement
   c] Risk identification
   d] Policy declination
Chapter Three

Analyzing Needs

Suitability is not only based on risks, but also on needs. Thomas J. Wolff, before becoming an insurance industry legend, was a struggling insurance agent. He believed there was a need to go beyond artful selling and analyze needs of the customers.

During the 1960s, he took the concept of Needs Analysis and refined it to teach other insurance agents how to analyze the capital and financial needs of prospective clients. Needs Analysis is a way to help customers plan an insurance program for their future. Needs analysis can also assist an agent to sell the appropriate insurance coverages.

The basic principle of the Needs Analysis process is to complete a thorough evaluation of a client’s needs and map out an insurance plan that responds to those needs. For a needs analysis to be most effective, an agent should use it from beginning to the end of the sales process. The agent collects information, examines the needs and finances of a client, and alerts the client to any problem areas that might exist. Together, the agent and client seek a solution that addresses the client’s actual needs and takes into consideration the client’s actual financial position.

Needs-based analysis requires:

- Analyzing the client’s needs in detail;
- Requiring the client to express his or her opinions;
- Pinpointing the actual needs and goals of the client;
- Incorporating the client’s ideas into the insurance program; and
- Suggesting solutions based on a logical understanding of the needs and goals.

Needs Based Analysis: An Holistic System

The course of needs-based selling makes it a comprehensive system. During the process of seeking an appointment, conducting the interview, collecting relevant information, involving the prospective client in the analysis and decision-making, and jointly exploring the various insurance plans that offer the best solution, a relationship builds. The relationship is usually one of trust and mutual respect.

Needs based procedures require an accurate assessment of the client’s needs. This, in turn, requires a careful and professional fact-finding mission for the purpose of not only gathering
information about prospective clients but also to know the client. Whom would the client like to provide for in cases of death, disability, or other catastrophic events? What are the retirement needs, if any, the client wishes to address? What is the real (and personal) property the client seeks to insure against fire and other hazards? Questions such as these will generate very different responses from clients based on their ages, current interest rates, property values, total assets, inflation, and their own opinions and aims.

Needs analysis also helps agents and clients arrive at the proper amount of insurance coverage needed by the client. Not only does it ensure that a client buys insurance for the right reasons, it also ensures that an agent sells the insurance for the right reasons. It pre-empts the sale of insurance based on false promises, perfunctory calculations, and other less than admirable motivations. Selling needs-based insurance is what makes an insurance agent indispensable as an advisor and prevents the sale of insurance based on a desire for personal sales records or commission dollars. Overall, it promotes an ethical process of selling, and buying, insurance.

Needs based analysis is a holistic system because it helps agents ask the right questions and encourages clients to express their views and jointly assess whether they want to prioritize their financial security on the basis of:

- Accumulation of funds,
- Protection needs, and
- Retirement plans.

Because each client is unique, needs based analysis reveals that the concerns of a person born in 1956 are bound to be different from those of one born in 1966. While the former will be seeking a plan to meet his or her retirement needs, the latter will likely be more interested in creating funds for children’s college education and protecting himself or herself from unforeseen events such as premature death.

The younger the client, the more likely it is that he or she is underinsured. A needs based analysis will help explain the reason for protecting mortgages and rent, setting aside college education funds for children, and insuring against loss of property or life. Meanwhile, clients from the more senior bracket would have less need to protect themselves against death or plan for college education funds because they are at a stage when they have discharged their responsibilities and living a life of retirement.

**Needs Based Analysis Process**

As mentioned earlier, when using the needs based analysis in the insurance sales process, the agent can take no shortcuts—the process must be followed in totality from beginning to end.

**Step 1: Reach Out**

To begin with, the process requires the agent to seek a face-to-face meeting with a prospect by sending out a formal letter. The letter should include the agent’s name and work address, an introduction about how the agent received the prospective client’s name, and a request to contact the client over telephone for an appointment at a convenient time.
**Step 2: Seek a Meeting**

The next step is for the agent to approach the client for a meeting. The agent needs to seek the appointment within a week of sending out the letter. Note that this telephone call does not involve any an intention to sell any financial product or service. The aim is to keep the telephone call polite, yet involved. Begin by inquiring if the prospective client received the introduction letter and request a meeting at a time convenient to the client.

**Step 3: Set the Stage**

First impressions last, so the first interview is what an agent will use to set the stage for future action. The agent should use the initial interview to create a bond of trust by beginning with friendly overtures, offering a brief explanation of the services available, and asking the right questions. For example, the agent should ask questions about children once it has been ascertained that the prospect is married.

- The agent should use a questionnaire to collect factual data like name, date of birth, client’s occupation, spouse’s occupation, hobbies, activities (i.e. recreational, business, and volunteer), children’s’ names and ages, contact phone numbers and addresses, assets, liabilities, retirement plans, other insurance in place, etc.
- The agent should inquire about the main responsibilities and obligations the client faces. These may include mortgages, loans, other debts, dependent parents and other adults, etc. At this point, the questionnaire is an ideal tool for helping to gauge the client’s feelings, needs, concerns, and aims in terms of financial concerns for the present and future.
- The agent should examine details of the prospective client’s financial health—and that of his or her spouse and dependents. This section of the questionnaire aims at identifying yearly income, total life and disability income insurance in place, assets and liabilities, investments in money markets, real estate, mutual funds, stocks and bonds, 401(k)s, IRAs, pension plans, employee benefits, etc.
- The agent should assess the prospective client’s financial risk profile. Determining how high or low a financial risk the client is ready to take is an important responsibility the agent must undertake. Ascertaining the risk profile will help assess the prospective client’s readiness to shoulder moderate or substantial risks should insurance or financial plans be required to meet his or her needs.
- The agent should question the prospective client’s expectations of the future. Although little about the future is guaranteed, asking this question and securing the prospective client’s answer, helps establish a plan. The client may expect to receive a bonus, change career or a job, start or sell a business, buy a new home or vehicle, get married, send children to college, take care of elderly parents, etc.

The initial needs analysis assists agents establish the eligibility, or insurability, of prospective clients before initiating the selling process. It is also a means of establishing trust with the prospective client by gaining insights into what he or she thinks and feels. Although the sale of insurance and financial products is a business transaction, the initial needs analysis interview(s) and personal transactions that lay the foundation of a relationship based on trust, caring, and respect.
**Step 4: Review, Analyze, and Commit**

This review step allows the client to complete the questionnaire and the agent to review it. The goal, at this point, is to identify significant details: dissatisfaction with current premiums or insurance and financial products, lacks or gaps in protection, and issues of trust in current relationships.

After reviewing the needs analysis, the agent should be able to evaluate if the prospective client is eligible for assistance, if his or her needs can be met by any of the products in the agent’s portfolio, and if the relationship is a good match.

This initial review of the needs analysis should screen out ineligible prospects and allow the agent to explain how eligible prospects will benefit from the agent’s expertise. This is the moment the agent should explain how the client’s goals can be met and needs can be satisfied.

Alternately, if the agent is unable to provide the assistance, services, and/or products the prospect requires, the agent can involve a more experienced agent or offer a referral to an agent who may be able to assist. Being an ethical agent is about answering the needs of the client.

**Review Questions/Chapter 3**

1. Suitability is based on what two factors?
   a] Property and casualty
   b] Life and health
   c] Risks and needs
   d] Losses and claims

2. Needs-based analysis requires all of the following EXCEPT _____?
   a] Analyzing the client’s needs in detail
   b] Requiring the client to express his or her opinion
   c] Pinpointing the actual needs and goals of the client
   d] Paying claims promptly
Chapter Four

Synchronizing Needs and Products

Once the client’s needs have been analyzed and the risks identified, it is necessary to match the client's needs to the insurance solution that best addresses the risk. This calls for due diligence on part of the agent to avoid legal wrangles that may stem from a compromise of the customer's financial interests.

Insurance agents have been accused in the past of dubious dealings powered by greed, misleading information, and unethical behavior. These accusations were made worse by certain insurance company solvency issues. As a reaction, regulatory measures including agent reprimands, license revocations, insurer fines, and a variety of forms and disclosures resulted, thus making it harder for some agents and insurers to continue doing business as they had been doing. In addition, falling interest rates and stiff competition required a new breed of smart agents who were unafraid of hard work and were ready to commit to doing business under higher standards. Apart from maintaining conduct beyond reproach, a successful agent's understanding of insurance plans and financial products must be far above average.

At the core of today’s insurance industry is the focus on client needs. Never before has sales conduct been more important. Smart, successful agents stand out in the crowd because of the care they take to understand their clients’ needs and match them to the appropriate insurance plan or product.

Failing to take due care is considered negligence; agents who behave negligently not only damage their own reputations, they harm their clients. In the eyes of the law, personal relationship is formed from the moment a client consults an agent—the agent is duty bound to provide proper, professional advice. Suitable sales conduct is required of all agents, as is examining the ways to practice due care when analyzing all types of risks clients face.

Life Insurance Risks

Risks are part of everyone's life. However, individual risks vary based on a plethora of reasons. Because of this diversity, the amount and type of insurance coverage required by each individual varies, as well. Due diligence requires the agent to evaluate and discuss all available kinds of life insurance plans with the client. Due care requires the agent to be alert to differences in attributes between term life insurance, annual renewable term, and decreasing term—as well as to those between term and permanent insurance. An agent needs to understand if a single
premium life policy would best suit the client's risk need as opposed to variable life policy. It is crucial that agents evaluate each life insurance product against the risk needs of their clients; agents should also discuss the needs in detail and gives advice about the most appropriate solution. An agent might even be required to counsel the client against buying life insurance rather than recommend a policy that involves a premium the client cannot afford.

In order to carefully calculate the life insurance coverage amount required by a client, an agent could conduct a capital needs analysis. The Capital Needs Analysis method helps an agent to maintain suitable sales conduct while also assessing a client’s needs according to not only age, occupation, and earned income but also the client’s capital needs. Using a capital needs worksheet, an agent can analyze:

- **Family Income** – The most common aim of life insurance is to provide funds for the surviving family in case of the breadwinner's death. At least 75% of the earned income of the breadwinner is usually considered necessary for the surviving family to maintain a comfortable lifestyle. By examining the family's capital needs, an agent can ascertain the correct life insurance plan to create the capital necessary to address the family's income gap.

- **Debt and Repayment** – Analyzing a client’s debts helps an agent gauge the lump sum capital needed to make debt and loan payments. Be it home mortgages or business debts, decisions can be contemplated to pay off debt within a specified period of time with a fund created from life insurance proceeds.

- **Miscellaneous Capital Requirements** – A client might have capital needs to provide for children's college expenses or a reserve fund for emergencies.

- **Estate Settlements** – Capital needs to cover burial and funeral taxes, estate taxes, and uninsured medical expenses must be accounted for to determine the appropriate face amount of life insurance coverage needed. These amounts will vary based on the client’s tax bracket, state of residence, etc.

- **Available Assets** – Capital needs analysis also takes into account the assets currently at the client's disposal in terms of savings accounts, real estate, and other investments. Valuing the available assets helps the agent determine the amount of life insurance to be purchased or if pension funds are needed.

The analysis of the preceding factors enables the agent to arrive at the client's net capital requirement to be addressed by life insurance. The agent examines the capital needs and the income currently available to pay premium to determine the type and face amount of life insurance to be purchased.

Care needs to be taken to prevent the client from purchasing too little, or too much, life insurance. Should the client be unwilling or unable to pay the premiums generated by the agent’s recommendations based on the capital needs analysis, the agent may want to suggest lower face amounts of coverage. In such circumstances, the agent should document both the original recommendation, including the illustration and pricing, and the client’s written authorization for a lower face amount of coverage.

An agent should take care to explain how a client should remove life insurance proceeds from his or her taxable estate via an insurance trust or transfer of ownership. The agent should explain
that while the client may avoid federal taxation by transferring ownership of an insurance policy to another person, once ownership has been transferred, the client loses all rights to the policy—i.e. the client no longer controls the premium payments, the naming of beneficiaries, etc. Hence, the client should be alerted to issues such as divorce and competency when planning to name the new owner. Due care requires the agent to refer the client to an experienced estate planning attorney if estate tax concerns exist.

Overall, agents should pay attention to all details affecting a capital needs analysis and obtain answers to a list of pertinent questions regarding life insurance:

- Does the client already have death benefit plans such as survivor's income or association group life plans?
- Who, other than the client, is being insured?
- Is there life insurance available that covers a married couple together for common or shared misfortunes?
- Do the death benefits match the client needs?
- Does the client need coverage for business or personal debts or dependents requiring special care?
- Will it benefit the client to have a waiver of premium rider on the policy?
- Will accidental death benefits help the client if the client opts for a lower premium—and less coverage?
- To what age is the coverage guaranteed renewable?
- Is it in the client’s best interests to replace existing policies and is the client healthy enough to justify such a change?
- Does the policy offer dividends and, if so, how is the client making use of them?

**Disability Risks**

Definitions of disability vary. For example, the legal definition of disability as set forth in the Americans with Disabilities Act of 1990 (ADA) states, “The term ‘disability’ means, with respect to an individual—(a) a physical or mental impairment that substantially limits one or more of the major life activities of such an individual; (b) a record of such impairment; or (c) being regarded as having such an impairment.”

In the insurance industry, the definition of disability is spelled out in a disability income policy and usually includes one of the following—which results from a medical condition:

- The inability to work at the material and substantial duties of your occupation or
- The inability to work at any occupation.

A disability generates a loss of income, either temporary or permanent, and is caused by an accident or an illness. An agent is likely to have many clients fear the risk of being disabled and seek to provide themselves and their families with a financial safety net to guard against debilitating accidents and illness.

Apart from examining the client's current employment, due diligence requires the agent to ascertain the after-tax income of the client while keeping in mind that some expenses might actually be reduced if the client is disabled. Certain disabilities may render the client
homebound, thus reducing transportation and other costs. The agent should also take into account Social Security benefits that might contribute funds, along with income from investments, employer disability protection plans, and other available sources of income should the client become disabled.

Once an agent identifies the disability income needs, the agent should explain some facts to a client:

- The maximum monthly amount of disability coverage available depends upon the monthly income the client earns and the amount of any disability income coverage already in force;
- A waiting period exists before the payment of benefits begins, such as 30, 60, 90, or 180 days;
- The benefit period, or length of time that payments are paid, varies and can be as short as 12 months or as long as the client’s lifetime;
- The amount of monthly benefits paid may vary based on the type of disability; and
- Policies have different features, such as the definition of disability, the renewability of the contract, etc.; and
- Policies allow for the addition of certain riders, such as Social Security Rider, Cost of Living Benefit, Future Increase Option, Hospital Confinement Rider, Waiver of Premium Rider, Accidental Death & Dismemberment Rider, Rehabilitation Benefit, etc.

An agent should advise the client about the gaps in coverage that might exist and help create a contingency plan to offer alternative protection against disability. To assess coverage for disability risks, an agent would need to run through the due care disability queries:

- What amount of monthly income does the client need to ensure protection against a disability and a loss of earned income?
- Does the client need a supplemental individual policy or does the client have income to buy disability protection?
- What are the timeframes of the protection the client is seeking?
- Can the disability coverage be cancelled or non-renewed?
- Does the client already have disability income coverage as part of an employee benefits package?
- Would having multiple disability plans be useful? If so, how is disability defined in each of the plans and how are benefits coordinated?
- Does the policy provide for coverage for work-related disabilities?
- Would a waiver of premium rider benefit the client?

Health Risks

The most sought-after type of insurance is coverage for health issues. Because of the unpredictable nature of health risks and complications engendered by the health care system and federal directives, it is also one of the most costly types of insurance to purchase. Once upon a time, group health insurance afforded the most comprehensive health coverage—but that is not necessarily the case today. Due diligence requires the agent to seek medical coverage for clients not only through the purchase of an individual or group health policy but to seek available
coverage under Medicare and workers’ compensation insurance. To assess the amount of health insurance coverage a client needs, an agent must analyze:

- **Eligibility issues:** Does the client want to cover the entire family? If yes, then the agent needs to discuss health issues of all family members to be covered, including their ages and any special physical needs or disabilities. Other items to be discussed might include provisions for changes in case of divorce, children becoming ineligible for coverage due to age or marriage, etc.
- **Maximum Coverage Amount:** The agent should discuss the lifetime and annual coverage limits each family member and for the entire family.
- **Deductibles:** The agent should determine the maximum amount of money the client can assume via deductibles. Deductibles are applied per individual and per family; certain types of treatments, medicines, and accidents or illnesses may carry their own deductibles.
- **Co-Payments:** The client may have to share the cost of medical expenses with the insurance company; for example, after paying the deductible, the client may have to pay 20% of covered expenses until a certain amount of benefits have been paid. The agent should ascertain what co-payment amount the client can afford.
- **Conditions and Limits:** Some policies may limit coverage for certain conditions, such as out-patient treatment for drug or alcohol use, or they may limit out-patient charges to $25,000 per calendar year.
- **Exclusions:** All policies exclude certain conditions and services. Typical exclusions include those covered by worker's compensation and cosmetic surgery. Exclusions are particular to each policy and should be carefully reviewed by the agent so the client understands what types of treatment and conditions are excluded from coverage.
- **Renewability and Rates:** An agent should inform the client if the insurer is at liberty to increase premiums and, if so, at what intervals.
- **Dates and Notifications:** The agent should notify the client about requirements and forms concerning claims, including any pre-certification requirements and time frames for reporting.

Due diligence requires an agent (especially if he or she is handling different product lines) to know what impact a health insurance plan may have on a client's entire financial plan. If a client is financially strained and has no health insurance, an agent usually should not sell a whole life insurance policy—rather the agent should arrange for the client a combination of a basic health plan to cover medical emergencies along with a term life insurance policy. There should be adequate coverage to address any unexpected medical concern that might befall the client and his or her family. An agent should use the following due diligence health insurance questions to assess coverage types and amounts:

- Does the client already have health insurance such as a group plan, individual plan, Medicare, Medicaid, etc.?
- Does the client already have medical benefits that can finance hospital charges and/or major medical costs?
- Does the client suffer from a medical condition that might make him or her ineligible for coverage?
- Are members of the client's family insured by their own group plans, individual plans, Medicare, Medicaid, etc.?
• Are members of the client’s family eligible for any coverage issued to the client or that might be recommended?
• Does it make sense to end any existing medical expense premiums?
• Is the recommended health insurance plan guaranteed renewable? Does it have any rate guarantees?
• What are the provisions for the client's dependents if they become eligible for coverage under their own plans?
• In event of the client's death, what benefits are provided to the client’s dependents?

**Long-Term Care Risks**

Long-term care is the assistance needed by person who is chronically ill or disabled and who cannot care for him or herself. **Long-term care insurance policies provide coverage for long-term care if a person cannot perform two or more activities of daily living (ADLs) for 90 days or more and if the person requires supervision.** Covered care ranges from assistance bathing, shopping, and dressing to professional nursing care.

Long-term care coverage has expanded from the original coverage that provided yearly coverage for incurred expenses resulting from necessary medical care, therapy, rehabilitation, or personal care in settings other than a hospital. Today, long-term care services include:

• Volunteers who shop, mow lawns, clean the house, and perform other similar chores;
• Organizations delivering hot meals at home, or offering services like story reading;
• Social activities arranged by senior care centers;
• Daytime activities provided by adult care centers;
• Nurses, physiotherapists, and nutritional counselors provided by in-home services;
• Professional physical, occupational, and speech therapy provided by rehabilitation programs;
• Services designed to assist primary caregivers;
• Housing communities for the elderly that provide residence units and social services;
• Assisted living centers that, apart from helping the infirm with daily chores like bathing, also provide medical attention;
• Intensive nursing care centers that give 24-hour care; and
• Sub-acute and acute care centers that provide skilled care for short periods of time and for prescribed periods of care.

Long-term care insurance coverage is constantly changing and the variety of policies, insurance limits, new legislation, medical improvements, and customer demands, require agents to analyze long-term care risks in the context of constant changes. Some policies may extend benefits to adult day care facilities only. Other policies may cover home care, but not certain services without which the person may require institutional care.

Agents should also examine how policies describe Activities of Daily Living (ADLs). For example, an eating disability could be listed as an activity for which supervision is required and not just the inability to eat by oneself. Agents should be familiar with how policies define activities such as “Hands on” or “Standby” assistance. IRS Notice 97-31 clarifies that “Hands
on” refers to actual physical help required by another person to perform certain ADLs while “Standby” refers to simply the presence of another person to stand by and prevent harm.

Some long-term care policies may cover incidental costs rather than reimburse actual costs. Policies with non-forfeiture and paid-up features might suit a couple with a steady income because it might help them benefit from a paid-up policy during retirement. Agents need to alert clients to insurers who cap benefit account increases to twice, or even three times, the base amount of benefits. Agents should also inform clients about the need to have inflation protection to deal with the rising costs of both long-term care and medical insurance. A policy with automatic protection might be cheaper in the long-run than a policy purchased without an inflation protection rider.

Due diligence demands that agents analyze a long-term care policy and its relationship to long-term care services available to the client. The following questions will help an agent make the appropriate recommendation of long-term care coverage to a client:

- What is the amount of money needed to pay for care in local nursing homes?
- Is the policy an indemnity plan covering incidental costs or a reimbursement plan?
- Does the coverage include daily benefits for assisted living, home care, or both?
- Does the policy allow the benefit amount to be increased and, if it does, are underwriting requirements necessary for the increase?
- Does the policy allow the benefit amount to be decreased if the policy premium becomes too costly for the client at some point in the future?
- Can a client and spouse purchase long-term care benefits jointly and receive a discount?
- Does the policy allow for a survivorship benefit?
- Will the policy benefits apply if the primary caregiver is not a professional; for example, a family member or friend?
- Does the home care coverage increase the premium and, if so, by what amount?
- Will the premiums remain level and not exceed five per cent of the client’s income?
- What are the limited paid-up features and will they work for a client who is financially constrained?
- Are the benefits expressed in days or years?
- Does the policy provide for benefits that pay for an entire day’s care at the home health care or the adult day care?
- Does the policy provide for an automatic increase in nursing home or home health care benefits?
- Are benefit increases based on the Consumer Price Index or the Medical Price Index?
- Does the policy have a cap on any benefits increase amount?
- Does the policy offer any kind of protection from inflation? Does the policy allow for the purchase of an inflation protection rider at a future date?
- Would it be more cost-effective for the client to increase benefit amounts rather than buy inflation protection?
- Does the policy list bathing and dressing as activities of daily living?
- Is the policy language clear about the specific activities of daily living that are covered?
- Does the policy evaluate physical activities in conformity with the IRS Notice 97-31 clarification of “standby” and “hands-on?”
• Does the policy recognize medical necessity to enable a client who suffers from a medical ailment but can perform daily activities?
• What are the special underwriting requirements of the policy?
• What are the lifestyle underwriting clauses on the basis of which coverage may be rejected?
• Does the policy mandate the installation of special equipment before benefits are provided to a client?
• Does the policy provide coverage for the installation of stair lifts, grab bars, and other home care alterations?
• What are the policy benefits in the context of cognitive impairment?
• Does the policy measure cognitive impairment differently from physical ability and would it exclude a client who can perform ADLs but have no memory of why or how they perform an activity?
• Does the policy allow for non-forfeiture options or return of premium?
• What is the schedule for any return of premiums?
• Do the non-forfeiture options return premiums or do they pay benefits?
• Does the policy have the provision for cognitive reinstatement in the case of the client’s mental impairment causes a failure to make required premiums payments?
• What other unique policy features might benefit the client?

Annuity Risks
Agents should have a very clear understanding of who makes a perfect candidate for investing in an annuity. Usually, the ideal annuity client is in the 15 percent tax bracket and seeks a long-term investment. Other candidates for an annuity purchase include those in moderate or high income tax brackets who want to safely invest their current incomes in exchange for long-term retirement benefits.

The proper sales conduct while recommending an annuity purchase requires an agent to gauge what role annuities might play in the client's financial plan. The needs analysis should examine growth versus income needs, liquidity, and risk tolerance—both for the present and in the future. Agents should also possess a thorough understanding of the various types of annuities available in the marketplace. This knowledge enables them to match the annuity to the investor.

Once an agent ascertains that a client is financially equipped to make annuity investment, due diligence requires him or her to evaluate and discuss the following options:
• Immediate or Deferred Annuity: The client’s needs for immediate income, or income at a future time, will determine whether an immediate or deferred annuity is purchased. Quite often, purchasing both an immediate and a deferred annuity will prove valuable because of liquidity needs and tax planning.
• Single or Flexible Premium Annuity: To invest in a single premium annuity, the client will have a lump sum at his or her disposal. Otherwise, flexible or regular payments will be deposited into the annuity to accumulate the required funds.
• Fixed or Variable Rate: These annuities require a client to lock-in yields or aim for growth. The CD-type annuity investor would likely opt for the fixed rate annuity, while investors ready to assume some risk would opt for the variable rate annuity. Whatever
the case, due diligence requires an agent to explain how variable plans involve a possible loss of principal. Agents should also advise clients to monitor principal returns and the yield that accompanies fixed or variable rates of interest.

• Yield or Guarantees: Keeping in mind the principle that if the guarantee is strong, the yield is low, agents need to inform clients that high first-year bonuses might generate higher yields but they may also disappear at a later date. Agents should suggest contract options that offer a lower yield for a specific locked-in period to generate a more predictable yield. Due diligence requires agents to clarify the method the insurer uses to adjust the yield. For some clients, contracts with guaranteed yields may be more appropriate than contracts with an adjusted yield. Also, knowledge about whether a yield is banded, or separately adjusted for specific blocks of investors, should be shared with the client.

• Yield or Liquidity: In cases where agents have clients who want liquid assets at their disposal, agents should suggest lower yields. An agent can go so far as to suggest investments to provide for special needs like payments for illness or nursing home care. While some contracts contain penalty-free withdrawals under certain circumstances, an agent should clearly explain the surrender charges, or penalties, of the contract.

• Maturity Options: An agent should inform the client about when annuity contracts mature because this information will likely impact the client's tax plan and long-term investment plan. For example, a client who invests in a long-term deferral plan through the age of 95, should not purchase a contract that requires annuitization at age 75. Due diligence also demands that an agent inform the client of taxes imposed on the annuity that is maturing.

• Withdrawals and Penalties: An agent should inform the client that if some or all of the annuity values are withdrawn before the annuitant reaches age 59 ½, an IRS penalty of ten percent will be imposed on the premature withdrawals. It is only in case of the annuitant’s death or a severe disability that this penalty can be avoided.

• Death Benefits: Should the agent be counseling a client in estate planning, explaining death benefits is required. While most of the fixed rate annuity contracts do assure a return of principal as well as any accumulation value, agents need to discuss surrender penalties and how they can be handled. An agent should also understand what the death benefit guarantee is based on—is it just the contract value on the day the client dies or is it something else?

• Taxes: An agent should clearly explain to a client that an annuity involves tax deferral and that it entails the payment of taxes when money is withdrawn from the account. The client is required to pay taxes on the amount that has accumulated. The tax is calculated as the difference between the amount invested and the annuity’s contract value, multiplied by the client's tax bracket. An agent should discuss settlement options when addressing taxes, since taxes are due only on amounts that are withdrawn and not on amounts remaining in the contract.

• State Guaranty Funds: The agent should understand how the state’s guaranty fund works and should inform the client of the limits that apply. An agent should make every effort to protect the full annuity amount in case of insurer failure. Discussing the state guaranty fund also serves to exhibit both due diligence and the client’s interest in diversifying annuities among several insurers—if that protection is afforded by the state’s fund.
• Titling Issues: Due diligence requires agents to disclose details regarding titling contracts, especially if the agent is not providing tax and estate planning. It is advisable for an agent to refer clients to an experienced attorney and tax expert before making an annuity purchase. It is vital for a prospective client to understand that the annuitant's death will generate a death benefit that will be taxed. If the beneficiary is a person other than the annuitant’s spouse, the beneficiary will have to either pay the lump sum tax or annuitize for at least a five-year period.

It makes sense for insurance agents to adopt social conduct beyond reproach—especially when involved in annuity sales. The following list of diligent inquiries during the process of determining whether an annuity sale is recommended serves as a roadmap to analyze annuity risks and determine the correct coverage:

- What is the client aiming for, growth or income?
- What kind of income does the client want to create, retirement or current income? How soon will the client want to begin taking income payments?
- What is the level of risk the client can assume and how much loss can the client bear?
- Can the client withstand an interruption of income?
- What kind of liquidity is the client seeking?
- What tax bracket does the client belong to?
- How old is the client and would when does the client plan to begin withdrawing from the annuity?
- Is the client seeking total protection of principal or is the client willing to risk investing in variable contracts?
- What is more crucial to the client, preservation of principal or inflation effects on the fixed yield?
- What will the needs of the client’s spouse or other dependants be when the client dies?

**Business Risks**

An agent needs to practice due care and diligence with both individual clients and business clients. The needs of business clients tend to focus on people: the people who run a particular business and their employees. Concerns such as workplace accidents, disabilities, and even death might impact the revenue generation and long-term success of the business.

For an agent selling insurance coverage to a business, due care necessitates that agents analyze the likelihood of reduced revenues, along with increased expenses, due to the illness or death of key employees, partners, and owners. The agent should assess the extent of risk protection that depends on the affected person, and which might affect the company's legal and business structure.

The sales conduct of agents selling business insurance depends on the risks in the following types of business ownership:

- Risks in Sole Proprietorships: The business and personal debts and risks of a sole proprietor are one and the same. It is often difficult to define a clear difference between the personal and business liabilities of sole proprietorships. Basically, the agent needs to assess the risks that might be incurred by the survivors of the proprietor who will become
responsible for the care and running of the business in the event of the proprietor’s death. The pre-loss arrangements should determine whether the survivor(s) can keep the business, or circumstances require its sale or liquidation.

- **Partnerships Risks:** In cases involving partnerships, disabilities or deaths of one or more partners directly impact the other partners—and the business. In addition to risking financial difficulty, the roles of the dead or disabled partner’s inheritors will have significant impact on the business. Due care on the part of an agent requires exploring the possible results of the dissolution of a partnership. For example:
  - How is the business to be reorganized?
  - How might revenues and expenses be affected?
  - Are contingencies in place for dealing with business debts?
  - What are the plans of the survivors?

If the survivors want to exit the business, an agent needs to review any buy-sell agreement to confirm that insurance in place—or to be issued—satisfies the purchase of the dead partner’s share of the business.

- **Risks in Corporations:** In corporations, stockholders experience risks that might include consequences arising from the death or critical disability of a major stockholder or employee. Such an event might be responsible for reduced revenues, financial strain, and issues of how other members in the corporation might purchase the disabled or deceased stockholder’s share of the business. Due care requires agents to explore how this purchase might be made as well as what types of insurance coverage would best provide protection for the corporation and its stockholders.

For an agent providing business insurance, reviewing business liabilities and understanding tax planning is important. It is crucial for every agent to gauge the impact of income tax on the transfer of assets. The following is a list of questions can ask to determine applicable factors:

- In the case of a business partnership, who will gain control of the business in the event of the death or disability of one or more of the partners?
- If the need to sell the business arises, is there a demand for a business of the type in question?
- How much money is at the disposal of the business’s heirs and is that amount adequate?
- Will liquidity issues and taxes on the business’s value impact the estate of the deceased business owner or partner?
- Can surviving business owners and partners sustain the business if a key employee, partner, or owner dies?
- What plan will the business adopt to maintain working capital in the event of the disability or death of a key employee, partner, or owner?
- Would the transfer of the business to a different owner cause a reduction in its value?
- What provisions have been made should one of the partners or owners decide to retire or sell his or her share of the business?

**Liability Risks**

The main goal of risk management is to transfer risk. For insurance agents, it is essential to understand the liabilities they will shoulder should any client allege failure on the part of an agent to show due care and diligence. Keeping in mind his or her liability, an agent must know that an oral binder occurs the moment a client is promised coverage. Agents should take care to
have the terms of coverage documented in a written binder immediately after verbally binding coverage to avoid the possibility of disputes.

Insurance laws about redlining vary from state to state, however, an agent needs to comprehend the laws of the state(s) in which he or she is licensed concerning a consumer’s right to apply for coverage—even if the consumer is economically challenged or located in a minority community. Agents are required to make professional and ethical decisions about the declination of coverage rather than resorting to redlining applicants for any reason.

Similarly, due care needs to be taken with regard to indemnity contracts such as property and casualty insurance policies because these contracts provide compensation for loss and damage. Agents need to practice due care when defining and identifying perils and hazards; coverage should be recommended based on the types of loss that might result based on a client’s unique exposures. Due care requires that the agent be able to identify moral and morale hazards as well as common property and casualty exposures and hazards.

Keeping in mind liability issues, agents should carefully explain the terms and conditions of insurance contracts to clearly spell out covered perils and hazards—as well as policy limitations and exclusions. Agents need to review specimen contracts with clients and educate them so that all available coverages, limits, endorsements, and exclusions are fully understood by the client before making coverage selections.

Agents should also take into account the client’s existing insurance to avoid either duplication of coverage or coverage gaps. Some of the main points for every agent to concentrate on while educating a client revolve around the issues of risk, valuation, and loss of control:

- Understanding Risk: An agent must gauge a consumer's perception of risk because the consumer’s understanding determines his or her lifestyle and decisions. The attention paid to protecting risks by most consumers is, surprisingly, minimal. For example, the risks involved in building a house in flood plain or wildfire areas are often ignored or overlooked by consumers. Many such consumers fully expect insurance to be issued on the same terms as if no such risks existed.

- Understanding Valuation: Surveys reveal that more than half the houses in the United States will be underinsured in the event a total loss is suffered. Agents should practice due care when helping clients evaluate property replacement values. Replacement values should reflect the current value of the property to be insured and should not be based on the consumer’s or client’s desire to pay a specific premium. Replacement value calculations should be based on the basis that the insured policy will provide coverage for property of the same type and material as that insured, at current prices, and without deduction for depreciation. When an agent writes coverage on the basis of inadequate valuation, a number of negative consequences can result:
  - The client will be underinsured at the time of loss;
  - The agent and insurance company risk litigation filed by the insured; or
  - The agent and/or the client risk allegations of misrepresentation or concealment.

- Loss control addresses the processes and procedures used by a client to reduce risk. Loss control measures help to make businesses, people, and property safe. Insurance companies either provide loss control services themselves or outsource loss control
services to other firms who charge a fee. The choice a company makes is based on its perceptions of the pros and cons of offering loss control services. While an agent or insurance company providing loss control advice might benefit in terms of increasing client credibility, client retention, new client acquisition, the E & O exposure created by providing such advice also exists.

It helps agents avoid E & O exposures if they run through due diligence inquiries:

- What is a consumer’s interest in obtaining insurance coverage?
- How do recommended policies define perils and exclusions and are the consumer’s exposures being covered by the defined perils?
- Is the consumer’s property, person, or business covered in the most appropriate way possible by the recommended policies?
- Do the recommended policies cover the kinds of loss the consumer seeks to insure?
- Do the policy terms of the recommended policies match the time period coverage is required by the consumer?
- How long will it take for the policies to be issued and for coverage to take effect?
- What are the hazards (physical, moral, or morale) that might preclude coverage from being issued?
- What will the consumer’s duties after a loss or occurrence be?
- On what basis does the insurer plan to settle losses and is that settlement basis acceptable to the consumer?
- Is the consumer clear about the time limits available, and pertinent requirements, during which he or she can claim insurance coverage?

**Homeowners Risks**

While selecting a homeowner policy for recommendation to a consumer, agents need to match the précised type of coverage afforded to the client's need. Requirements of due diligence make it imperative for agents to review the home, its occupancy, its construction, its location, other buildings and structures on the premises, and its residents. Also important for the agent to note are issues liability and loss of use. Agents should be aware about the limits of the consumer’s needs for coverage along with any special needs or circumstances that might exist. When insuring a home, agents need to bear in mind the following issues before recommending a policy:

- Value issues: Agents have to not only ascertain the actual replacement value of the dwelling, they have to ascertain the value of any outbuildings and other structures. In addition, agents should explain to the clients any personal property limits contained in the policy and recommend appropriate endorsements and/or other types of coverage that might be required based the types and values of personal property owned by the consumer. Agents should make it clear that certain laws may exist that regulate repair and reconstruction after damage has occurred and that increased costs to comply with such laws and ordinances might be limited or excluded from coverage. Agents should recommend that consumers provide personal property inventories to assure that limits provided by policies are sufficient to protect the consumer’s belongings. Agents should strive to help consumers establish values and be sure to protect other parties that might have insurable interest in insured property, such as mortgagees and loss payees.
• Eligibility issues: Agents should clearly explain the conditions under which insurance companies issue coverage. This helps ensure that future claims are not declined. Details about occupancy—will the dwelling be owner or tenant occupied; are business activities conducted on the premises?—must be disclosed for eligibility purposes. The consumer must be informed about how issues like proceeding with alterations or building additions without a proper permit may impact coverage. It is prudent for agents to inform consumers that they must provide the insurance company with a proof of loss (inventory of property that is damaged, destroyed, or lost) and to make the damaged property available for inspection if a loss should occur.

• Deductibles issues: Agents should inform consumers about available deductibles and how they affect the policy premium. Higher deductibles usually result in lower premiums; however, at loss time, the consumer will bear a larger share of the loss if the policy carries a higher deductible than the one contained in the previous policy.

• Exclusions issues: Due diligence requires agents to discuss the exclusions listed any policy they recommend. Typical homeowner exclusions include flood, earthquake, sewer backup and water damage, power interruption, war, the freezing of pipes—under certain circumstances, wet and dry rot, pest infestations, rust and mold, etc. Any vacancy provision should also be disclosed as it may eliminate or reduce coverage for all losses or those caused by specifically listed perils.

• Liability issues: Before ascertaining liability limits, agents need to determine the consumer’s total exposure. Due diligence in asking appropriate questions to establish the consumer’s net worth, and how much of it the consumer is willing to risk, is imperative. In most cases, umbrella liability should be offered to the consumer. As with property coverages, liability exclusions listed in the policy should be spelled out to the client and often include business liability, intentional injury, etc.

Auto Risks
Agents selling auto insurance are familiar with the fact that auto insurance policies offer a variety of coverage types, including personal liability, uninsured and underinsured motorists coverage, medical payments, and physical damage coverage. Depending upon the type of coverage offered, single limits or split limits are offered.

For example, medical payments coverage is usually offered at a single limit, such as $1,000 per person or $5,000 per person. Liability and uninsured/underinsured motorist coverage may be offered at either split or single limits. With split limits, coverage applies per person and per accident. When purchasing split limits of 100/300/100 for liability coverage, for example, a policyholder has coverage as follows:
• Up to $100,000 of coverage, per person, for bodily injury losses;
• Up to $300,000 of coverage, per accident, for bodily injury losses; and
• Up to $100,000 of coverage, per accident, for property damage losses.

A consumer may also purchase a single limit of coverage for liability, such as $300,000 or $500,000; this limit would apply to all covered bodily injuries and property damage resulting from a single loss.

Some of the due care concerns for agents with respect to auto insurance include:
• Rating Information: Agents should clearly ask who the owners of insured vehicles are, who the licensed resident relatives are, and who the regular operators of covered vehicles are. In addition, information such as vehicle use (business, commuting, or personal for personal auto policies and service, retail, or commercial for business auto policies), garaging address (where the vehicle stays overnight), annual mileage, driving history of all drivers, and existence of prior insurance should be requested. Auto insurance discounts vary by state, and questions concerning eligibility for pertinent discounts should also be asked.

• Limits and Coverages: Agents need to determine the value of a consumer’s assets to help determine the appropriate coverages and limits for their protection. State laws stipulate minimum required limits and coverages for their residents and agents should be familiar with all statutory requirements. States require motor vehicles driving on public roads to have minimum limits of liability insurance for both bodily injury and property damage. The purchase of a bond or other type of self-insurance often satisfies this financial responsibility requirement. Some states also require minimum limits of liability for uninsured motorist coverage, underinsured motorist coverage, and personal injury protection or medical payments coverage. While physical damage coverage (collision and comprehensive) is not required by state law, most lenders require clients who have secured auto loans to purchase collision and comprehensive coverages with deductibles ranging from $500 to $1,000. Agents should also be sure to offer optional coverages such as Towing, Rental Reimbursement, Hired Car, Non-ownership liability, and any other coverage that is specific to the writing insurance company.

• Conditions: The auto insurance policy will contain conditions agents must disclose to consumers. For example, the named insured is usually required to report an accident within a specific time frame and to take certain steps to prevent further damage to the vehicle. Policyholders are also required to give proof of loss and notify law enforcement authorities if involved in a hit-and-run or if the insured vehicle is stolen or vandalized.

• Endorsements: Agents need to explain available policy endorsements. Most states and insurance companies offer endorsements that provide insurance to fill coverage gaps, such as for certain non-owned vehicles (company cars, those furnished to or available for the regular use of the insured or household members), use as a public or livery conveyance, auto loan/lease, etc. Due diligence on the part of the agent to both offer such endorsements, and secure the client’s written rejection of endorsements not desired, is recommended.

• Exclusions: All auto insurance policies contain exclusions about which an agent must inform the consumer. Typical exclusions include losses that occur when the party driving the insured vehicle did not have a belief of entitlement to drive the vehicle, when the vehicle is being used as a public or livery conveyance, and intentional loss or injury. If a consumer knows that certain exclusions exist, it enables the consumer to avoid particular activities and vehicle use. For example, it is crucial that a policyholder understand that the policy territory does not include Mexico and does include Canada.

Commercial and Professional Risks
For agents selling business insurance, recognizing certain professional liability exposures—in addition to other business and general liability exposures—is essential. In addition to property, general liability, and auto exposures, commercial and professional risks include many other types
of exposures. The following list represents some of the more typical exposures; it is not exhaustive:

- Professional liability of directors and officers of corporations and non-profit organizations;
- Professional liability of medical providers (doctors, nurses, social workers, etc.) and business professionals (insurance agents, attorneys, architects, etc.);
-Workers’ compensation;
- Employee benefits;
- Employment-related practices;
- Pollution;
- Equipment breakdown;
- Bailee liability; and
- Needs for excess and/or umbrella liability.

Some of the due care concerns for agents regarding commercial and professional risks are:

- **Rating Information:** Agents should be especially careful to all information requested on commercial and professional insurance applications and supplemental questionnaires. Information of particular note include all named insureds and parties with insurable interest in the property, business, or professional being insured and the legal status of the entity being insured. Agents need to explain the importance of the First Named Insured and the responsibilities of, and benefits to, this individual. Agents should also advise clients that coverage is afforded under a commercial or professional policy based on the legal status of the named insured. For example, the spouses of corporate officers are not considered an “insured” when the named insured is a corporation; however, the spouse of a sole-proprietor is considered an “insured.” (Note: an “insured” in a business policy is covered only when conducting the business of the named insured.)

- **Coverages and Limits:** Commercial and professional insurance policies offer particular coverages based on the business industry and/or the particular activities of the business or professional. Agents should be especially diligent when eliciting information about the activities of the proposed insured and the assets at risk. In most cases, agents should also recommend commercial umbrella protection for businesses and professionals.

- **Eligibility:** As with other types of insurance, eligibility requirements exist in commercial and professional insurance and are often more stringent and restrictive than those for other types of insurance do. Agents need to ensure that proposed insured understand all eligibility requirements and potential policy limitations that might exclude coverage in the event of a loss.

- **Endorsements:** Proper sales conduct necessitates agents to provide prospective insureds with lists containing available optional coverages and endorsements, along with exclusionary endorsements. Reviewing such a list prior to purchasing coverage enables a business or professional to make the most informed decisions.

- **Exclusions:** Due care demands that clients are informed about all policy exclusions and limitations. Because policy exclusions and limitations in commercial and professional policies are unique to the business industry and particular named insured, and not standard as those found in personal and life lines of insurance coverage are, it is especially important for agents to be sure their business and professional clients understand not only policy exclusions and limitations, but what consequences they entail.
Review Questions/Chapter 4

1. What is at the core today’s insurance industry?
   a] The focus on client needs
   b] The Internet
   c] The Fair Credit Reporting Act
   d] Premium payments

2. A disability generates a loss of income and is caused by which of the following?
   a] An accident or an illness
   b] A broken leg
   c] A heart attack
   d] Food poisoning

3. In long-term care insurance, what does the acronym ADL represent?
   a] Answers in daily life
   b] Activities of daily living
   c] Accidents, disabilities, and long-term care
   d] Accidents in daily life

4. In auto insurance, what are the two types of liability limits that are offered?
   a] High and low limits
   b] Expensive and inexpensive limits
   c] Single and split limits
   d] Collision and comprehensive
Chapter Five

Insurance Needs – The Next Level

The basics of client suitability lay out a framework for agents to understand that the main goal is to identify the risks and needs of the prospective client and match them to the solution that best addresses both the needs and the risks. The basics, however, are not enough. The need of the hour is to take the basics to the next level with cutting-edge strategies.

Solution-Based Planning

An agent knows that a client with needs is looking for a solution. The task for the agent is a painstakingly detailed review of products features, options, coverages, and exclusions until agent finds the policy that is the perfect solution for the client.

Does the prospective client have to be forced into accepting the solution the agent picks as the best one? No. Instead, the selection of a solution involves discussions with the client because it is imperative that the client believes the solution is the one he or she seeks. The agent needs to make the extra effort to affirm that the client:

• Understands how the plan solves his or her problems and needs;
• Has adequate information to decide about committing to the solution;
• Is provided with additional answers about how the solution fits his or her needs; and
• Is comfortable with the way the solution impacts tax plans, finances, and lifestyle.

Overall, the agent needs to address the prospective client’s doubts, concerns, and questions. Not only should the agent provide the client with positive responses, but the agent should also caution the client about choices that might not be in the client’s best interests. Agents should encourage feedback from clients to ascertain that, as counselors, they have, indeed, offered solution-based advice.

Researching Needs

It cannot be stressed enough that the necessity exists to research the consumer's actual needs. Agents are required to research more than the information contained on the insurance applications. In-depth interviews and fact finders should be conducted to elicit all information pertinent to the risk being insured.

Due to the paucity of time, some consumers may not be able or willing to allot the amount of time necessary to interviews and fact finders. When agents find themselves working with such consumers, they should supplement the research process with strategies like generational
marketing, psychographics, and market segmentation. The aim is to understand clients in the relative context of who they are, what kinds of lives they lead, and what expectations they have.

The requirement to determine insurance needs using new processes exists because each client is looking for a separate and unique kind of service. No single insurance consumer is the same as another. An agent might find one client needs more assurances through regular contact via telephone, e-mail, and face-to-face meetings, while another client might want all communication conducted during the process of the initial interview. When agents research a client’s needs, they will get a look into the world of the prospective client, the markets he or she deals in, and the risks that are faced. This process gives agents insight into what the client needs and how to best address those needs. Based on the information agents gather during their research process, new trends and expansion of the client group becomes easier.

If an agent’s research is intensive and based on disciplined strategy, it satisfies clients, attracts new clients, assures that clients secure the most appropriate coverage, and provides agents with a steady income. Structured research on client needs helps an agent to:

- Plan strategically about where to invest in the context of consumer trends;
- Understand how new products and new services address certain specific lifestyle needs;
- Redesign services and products to serve the need of changing consumer lifestyles;
- Position the advantages of products and services against those of competitors;
- Target new products for new consumer groups;
- Communicate strategically with appropriate marketing messages to the target consumer group;
- Identify channels of communication to connect to consumers;
- Understand how consumers spend and save;
- Understand customer perception of loyalty to brands to encourage brand loyalty; and
- Gauge the future of the market and consumer trends to gain a competitive advantage.

**Needs of Emerging Consumers**

People seeking insurance today are very different, and possibly more complex, than they have ever been. Today’s consumers display a marked departure from people of after World War II. It is impossible to walk through a neighborhood expecting everyone to have the same house, the same manicured lawn, and to be bound by the same American dream. In fact, the neighborhood is no longer American. It is the world of the global citizen with different values, different drives, different dreams, different lifestyles, and very different insurance needs. Agents need to explore the emerging modern consumer and how different the actual needs of each consumer are. Agents must be acquainted with the insurance motivation of these consumers to develop a rapport with, and retain, this new client group.

**Needs of Clusters and Cohorts**

Clusters and cohort groups are people who are united by a shared life experience. They might belong to the same generation, enjoy the same music, or share the same political affiliation. Due to their shared experiences, a cluster evolves into a cohort. As a cohort, the group shares similar trajectories of life and social values. As members of a cohort group, they sort and evaluate each life experience similarly. For example, buying a home or car, planning for a child’s college
education, tax planning, saving for retirement, etc. For agents, it is imperative to understand how such clusters and cohorts view savings, investments, and the risks they face.

By analyzing different clusters and cohort groups, agents gain insight about how different the needs of each cluster and cohort group are. While one cluster of clients might seek safety in whole life insurance policies, another cluster might be ready to diversify into term or variable life insurance policies. The study of cluster and cohort needs prepares agents to step inside a group that has a certain degree of homogeneity. As agents build credibility with one client, that credibility often leads to referrals to other clients within that cluster or cohort group.

**Needs of Groups**

While clusters and cohorts might share similar views, within the group there may be different insurance needs that are based on differences of generation. For example, the son may not buy the same retirement plan his father bought at his age. An agent should guard against making the mistake of assuming that belonging to a group will make for identical insurance needs. It is vital for agents to distinguish the needs of each client within the group on the basis of age and life experience.

A product that satisfied a Baby Boomer when he was 35 might not satisfy the need of a 35-year-old Generation Xer. However, Generation Xers still are drawn toward the values of the Senior generation that trusted in hard work and could hardly be described as flamboyant. An agent thinking out of the box will need to reposition himself or herself among the various groups to sell insurance solutions that serve the best purpose of each individual client.

This kind of repositioning requires agents to find a shared platform within each group to which service is being provided. These are not the days to conduct business on face value. To take insurance needs to the next level, an agent aim at repositioning by actually getting to know the client aims aspirations, investment habits and the all-vital needs.

**Knowing Clients**

<table>
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<tr>
<th>The categorization of people based on generation has given us the following groups:</th>
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<tbody>
<tr>
<td>• Seniors;</td>
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<tr>
<td>• Baby Boomers;</td>
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<tr>
<td>• Generation Xers; and</td>
</tr>
<tr>
<td>• Nexters.</td>
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Profiling each generation category helps agents understand, in a general sense, each group’s work ethic, lifestyle, opinion about financial products and services, and, most importantly, how to uncover its insurance needs. An understanding of each generational group helps agents to devise methods of interacting successfully with members of each group, to gain their trust, and to find appropriate solutions to their needs.

**Seniors**

The Seniors group consists of those born before 1946. Seniors worked hard and withstood war and economic changes. Most of the males in this generation joined the army and received
benefits from the federal government. Also important to note about this group is the fact that all consecutive presidents from John Kennedy through George Bush, Senior hailed from this generation. The events at Pearl Harbor and the prowess of Babe Ruth are topics of informed discussion among Seniors. The underlying ethic and vision of Seniors is to rebuild society. This group is selfless and members seldom hesitate to sacrifice their desires for the betterment of the next generation. Their motto definitely is, “Duty before Pleasure.”

One can credit Seniors with giving the following generations a stable foundation that encouraged growth. Seniors had clear goals and worked hard toward achieving those goals. Hard work was the core of all their efforts and they held high ideals. Their efforts were rewarded with government formulated programs such as the Servicemen's Readjustment Act of 1944, more commonly known as the G.I. Bill, that made it possible to buy homes and have access to education. Their jobs were more secure and they believed in the American dream. Seniors tend to be loyal to certain brands and that trust is hard to shake.

Low interest rates and uncomplicated financial plans helped Seniors pay for their homes, buy stable health insurance plans, create retirement funds, and retire early.

Agents should understand that Seniors might be old but they are neither ignorant nor uneducated. They are a smart, wealthy group that may seem like conformists on the surface. Agents should view this generation as active, happy, young at heart, and possessing a dislike for anything and anyone that might suggest they are old and outdated. This group is loyal to branded companies and its business dealings are conducted in a uniform, logical manner. Seniors are disciplined and detailed and expect the best quality in their products and service providers.

Agents working with Seniors should accept them as knowledgeable. It would be wise for agents attempting to sell insurance to any member of this group to begin an interview with a history about the insurance company and to show how any recommended product is being offered by a brand that can be trusted. Agents should pay special attention to being punctual, prepared, and ready with answers to questions about any products being considered. E-mail is not the ideal method of maintaining communication with people in this group; a face-to-face approach is far more likely to be well received.

Numbering approximately 52 million members, this group might be a conservative set of people, but they are focused on details and order.

**Baby Boomers**

The Baby Boomer group is made up of those born between 1946 and 1964. This is a group of people who were born under the spotlight and see themselves as being special. Having been born in an optimistic and forward-thinking phase of United States history, Baby Boomers are enthusiastic, well-educated, and economically comfortable. The burgeoning self-confidence of Baby Boomers made them see themselves as born to rule; many members of this group have a disregard for punishment and don’t take well to criticism. Baby Boomers are focused on personal freedom and are not ashamed to put their needs ahead of the needs of others. Baby Boomers share the vision, skills, social, and economic values geared toward economic growth. They are people who believe in experimenting and implementing new ideas.
Believing that the bubble could not burst, events like the Vietnam War and Watergate affected the rosy vision of Baby Boomers. The economic downturn of the 1970s created much doubt in this group until the economy changed in the following decade. To be rich was a shared goal of Boomers and many like to display their wealth. When President Reagan enabled Baby Boomers to have more cash via economic and tax policies, Boomers went shopping.

They virtually invented the term *conspicuous consumption*. Baby Boomers not only sought out designer wear and customization, they want discounts and outlet malls. To encourage their spending, television shopping networks were born. However, the 1987 stock market situation left many Boomers saddled with debt and changed their shopping habits. They suffered from an incredible degree of self-created stress and bad health due to indulgent lifestyles.

In the present day and age, while still being buccaneers, the Baby Boomers realize the need to save and plan for retirement. Agents who work with members of this group need to know that Baby Boomers welcome risks and are ready to experiment. However, considering the level of their stress, agents should also know that this group—which contains approximately 80 million members—consists of people who like to look for products and services that simplify and stabilize their lives.

**Generation X**

The Generation X group consists of those born between 1965 and 1980. This is a group of people who revere their independence and are rooted in their desire to have a home and roots. Diversity characterizes this group in both age and ethnicity and lacks the homogeneity that characterizes the Seniors and the Baby Boomers.

Considering the heritage Baby Boomers handed them, Generation Xers have a need to fix what they see as the failings of the prior generation. Generation Xers are bound by the will to survive: they have survived divorces, homelessness, disputes over gas lines, the Iran-USA turmoil, threats and effects of both nuclear and corporate meltdowns, and the punctured ozone layer. Generation Xers have not had role models of the caliber of the Seniors and Baby Boomers; while they do know the importance of hard work, they also know the importance of being resourceful.

Generation Xers tend to be a slightly cynical and detached. They don’t think highly of working for others and will seldom miss an opportunity to display their entrepreneurial skills. They believe in self-help and they are not as trusting as the previous generations. The computer and the Internet is the greatest ally of Generation Xers. They might read less due to their preference for short, concise e-mails, but they network extensively.

For agent who works with Generation Xers, cyberspace is a great place to market to, and network with, them. They are less formal than the generations before them and do not have much regard for authority. To create a rapport with this group, agents need to walk their talk. Generation Xers do not listen to agents waxing eloquent sales jargon. They want to know facts and *what’s in it for me*. By virtue of being addicted to the Internet, Generation Xers may be removed from reality agents can gently encourage them to pay attention to areas they may be overlooking.
The goal of most Generation Xers is to excel in their enterprises and be innovative. At the same time, they are very concerned with providing a stable household income. Generation Xers do not like to risk the way Baby Boomers do. The Generation X group contains approximately 44 million members; it is a group of people who are technologically advanced and may be big players in the markets.

Nexters
The Generation Next (Nexters) group consists of those born after 1981. A realistic group of people with a fair share of optimism, they are not just technologically advanced like the Generation Xers, they are also imbued with the Senior’s spirit.

Nexters are ready to work hard, ready to dream, and--like the Boomers--want the very best of everything. A stable and independent group of people, individual Nexters are goal-oriented and have a vast degree of resilience. They have access to the best education and are conservative in the sense that they like to preserve and protect what they have.

The Generation Next group contains approximately 80 million members and represents the ideal client base for an insurance agent.

Meeting Needs of the Generations
Once an agent has completed research on the values and opinions influencing the lifestyle and financial choices of a generation, the agent must identify the needs of individual consumers. Agents should attempt to understand the consumer’s past experiences and relate them to current times. This process calls for a certain degree of empathy and an agent will need to display empathy to create a bond with the client.

Effective communication becomes key. A smart agent will be politely formal with a Senior but casual and relaxed with a Generation Xer. Similarly, a perceptive agent will know better than to suggest a Senior visit a website to learn about a particular product or hand a five-page document to a Generation Xer to read. The most important thing to bear in mind when selling insurance to different generations is that individuals from different generations must be approached in different ways. The common thread of working with all generations, however, is to know that they all expect excellent service from their insurance agents. Agents can provide the most professional service by knowing the individual client and his or her generational needs.

Insuring Seniors
When working with Seniors it is important for an agent to acknowledge their experience. Agents should not appear condescending or patronizing. Seniors want to be respected and valued for their contributions rather than be guided and led. Agents may meet Seniors at seminars hosted by experts or through referrals. Agents should speak clearly and politely, refrain from slang, and spend more time listening than talking. Seniors want to be heard. Any product literature, such as brochures and illustrations, should be easy to read and succinct. Agents should understand that experimental or new and innovative insurance products might not be well received by Seniors. They should also consider that Seniors do not readily show emotion and enthusiasm but may ask a number of questions.
With Seniors, it is best for agents to keep the following details in mind:

- Begin with a personal introduction and that of the insurance company;
- Add a personal touch with handwritten letters and avoid electronic messages;
- Establish expertise and knowledge to garner their respect;
- Provide thorough explanations and give seniors time to respond and make their decisions;
- Seniors are more likely to spend money on other people, such as children and grandchildren, than they are to spend money on themselves;
- Confirm, follow up, and follow through;
- Present organized, detailed, and well-researched information; and
- Refrain from directly referring to age or disabilities arising from old age.

**Insuring Baby Boomers**

This self-confident generation is proud to be viewed as dynamic and knowledgeable. Agents should know that although Baby Boomers do not like to hear the entire history of how an insurance company was founded, they do like to know that an insurance company can provide them with leading products and services that other companies cannot, or do not, offer. Baby Boomers like to be part of unique transactions and exchanges. A Baby Boomer is likely to focus on what lies in the future and will welcome advice about how to address retirement needs.

When trying to insure the needs of Baby Boomers, agents should:

- Be warm, polite, and respectful and make it clear that their experience counts;
- Present testimonials and documented expert opinions;
- Ask a lot of engaging questions;
- Avoid interrupting;
- Provide efficiently organized details and materials;
- Provide information through books, self-help texts, and audios; and
- Offer safe ways to plan for retirement.

**Insuring Generation Xers**

This generation wants that little bit extra in their life but doesn’t want it come with too many rules. Generation Xers want clear, to-the-point information. For agents working with this group, it is better to be relaxed, casual, and entertaining. Generation Xers will admire agents more for their people skills than their insurance designations. Agents can establish contact with members of this group via e-mail and can refer them to an agent or insurance company website. Agents should give Generation Xers solutions that provide new opportunities to make their lives better. Members of this group may not be seeking retirement solutions.

When working with Generation Xers, agents should:

- Be sincere and focus on earning trust, as this generation is known to be low on the trust quotient and high on skepticism;
- Be honest and technically competent;
- Offer a product or service that protects the client from certain risks while also making the transaction or purchase easier;
- Refrain from preaching, touting experience, and statistics;
- Refrain from giving exhaustive literature and detailed brochures;
• Offer websites, and interactive CDs; and
• Provide plenty of time for decision-making.

**Anticipating Needs**

Change is often viewed as the only constant. Life is always changing, as are insurance needs. No matter how responsible agents are, they cannot predict the future or provide foolproof or total coverage for each need of every client. Despite the confusion and uncertainty in life, agents are expected to anticipate current and future needs and to provide insurance coverage for them. Agents need to anticipate client needs in this ever-changing world.

The task at hand is to acquire skills and be aware of threats and opportunities. Agents’ career growth depends on the aptitude to anticipate future problems and events. The future and the capacity to know and understand customer needs are linked. The future brings change that affect client needs. Wise agents need cultivate the ability to adapt.

Future changes impact the insurance world and an agent’s business. Although an agent may not predict or foresee future changes, he or she can make educated guesses about what will happen based on the current state of affairs and past experience. For example, by analyzing the growing gap between the wealthy and the poor, one can deduce that in the future, the number of people who do not have as much buying capacity as they used to will grow. Agents can then plan to review their products to match consumers’ lack of buying strength while still covering their needs. Income losses, market fluctuations, inflation, and unemployment are all issues that the perceptive agent anticipates, understands, and adapts to while tailoring insurance products to meet the needs of clients.

Agents must monitor emerging trends and be alert to events that may occur. For example, healthy eating is not as common as it used to be since the advent of fast food restaurants. Considering the level of unhealthy eating and obesity in the U.S., it is likely that a certain segment of the population will require special medical attention and alternatives. This would require coverage and then agent should be there to anticipate this need for coverage and find that best fit solution. In addition, the rate at which technology is pacing ahead, an agent would have to not only be technological skilled to use insurance software applications, but also know how to leverage the Internet to offer his or her products and services. However, there would be seniors, who do not want to be bothered by computerized services, and once again, the agent should adapt and be ready to do the traditional paperwork.

The smart agent of today would keep an eye on the following issues, to gauge and anticipate changing insurance needs of the future:

**Demographics**

• The longevity of the average person has lengthened. As a result, there are likely to be more citizens over the age of 60 in the future. This group is much wealthier than the younger generations can aspire to be. This demographic indicates the need for more products to target older clients who have needs for pensions, medical insurance, and long-term care insurance.
• More women are in the workforce today than ever before. They have independent incomes, are more educated, and have sophisticated needs. Agents need to look for products designed specifically for women and their evolving needs.

• The definition of family has transformed and now includes single parents with children and domestic partners living together with or without children. Insurance products for the traditional family must change to meet the needs of both traditional and non-traditional families.

• The diversity of ethnic groups, along with their growth, indicates that some “minority” ethnic groups will not remain minorities in the future. The process of embracing ethnicity will involve change in neighborhoods, education, consumer products, language, and other areas. This demographic calls for the services of skilled insurance agents who are fluent in different languages, familiar with different cultures, and open to offering services to people from all walks of life. It also calls for new products that cater to an ethnically diverse and wealthy population.

• Ethnic and cultural groups seem to show more affinity to brands than other groups. Agents must work to establish and retain brand loyalty, as the groups of people who are likely to become loyal clients are growing.

• With certain cultures settling in concentrated geographical areas—creating neighborhoods, towns, and cities of their own—cultural beliefs and preferences are likely to influence the purchase of products and services, including insurance. Agents wanting to do business with different cultural groups should educate themselves about the unique qualities of different cultures and incorporate that knowledge into the running of their businesses.

• Ethnicity and culture have melted away the homogeneity of our society and the insurance industry must rework its products and financial services to be more adaptable and customizable to different groups. Agents, regardless of what groups they choose to work with, need to become culturally sensitive.

• Second generation immigrants tend to adopt the American way of life more readily than their parents. As a result, their needs are much more different from those of other groups and revolve around a unique combination of both words, with the trend of becoming more American.

• As the income gap widens between different socio-economic groups, middle-class Americans will likely have access to fewer jobs in the future, despite their education. This leaves the middle class with less money in hand and a greater need to seek supplemental income and protect exposures. Products targeting the poor need to be developed, as well.

• Entrepreneurs are younger than ever and include more women than in previous times. While this new breed of client needs specific products, they may not be able to afford all the protection they need.

**Technology Turns**

The Internet has transformed consumers and the way they make purchases. People are now able to make instant buying decisions and then hop online and make the purchases. Buying insurance online is becoming more and more popular and smart agents will broaden their areas of expertise and offer more service to become indispensable to clients.
Just as buying insurance online is becoming easier, information about products—both pro and con—is more easily available on the Internet. Because of the easy availability of all kinds of information, both accurate and inaccurate, it has never been more important for agents to know and understand not only their products, but also those of the competition.

Although the ease of obtaining information and making purchases online is an advantage to consumers, it creates one enormous disadvantage: the elimination of face-to-face contact and accessibility. To counter the impersonal world of the Internet, agents need to perfect their relationship building skills.

**Economic Equations**

The authority of the government over consumer finances may give way to the dominance of the private sector. In addition, with the government’s limited social spending, people will become more independent and financially self-reliant. Trends point to self-health care and controlled purchasing patterns. This factor indicates that changes will be required in coverages for medical and other risks.

Heightened competition should ensure that prices would be controlled. An agent’s success, however, will depend on how his or her products and services are positioned to stand out from those of the competition.

The manufacturing sector in the United States will be changed by technology and become more dependent on knowledge than labor. The products that provide insurance coverage to manufacturing concerns will have to adapt to these changes. Agents working with manufacturing businesses will need to increase their knowledge about the new technologies and processes.

The size of a business, in terms of gross revenues, should not be a major factor. Although many consumers prefer purchasing from larger companies that offer brand recognition, the values of networking and personalization will continue to allow smaller organizations their share of access to consumers. Many consumers prefer buying from smaller, local, and regional firms rather than restricting all their trade to larger companies.

Outsourcing, in the future, will be the ticket for businesses and even government agencies when buying services and goods from external sources. This will greatly improve service, as entrepreneurs will step up to win and retain customers. Insurance companies will have to adapt their products to fit outsourcing needs as well as to gear their support of home, virtual, and remote offices.

The scaling back of employment will likely result in more middle-class Americans losing work and becoming temporary workers. This will require different kinds of insurance coverage.

**Work Ways**

Baby Boomers are opting out of the workplace and white-collar workers are accepting premature retirement. Minimalism and simplicity is replacing affluence, so agents need to offer excellent products that cater to basic needs.
Technology is dominating the workplace. Professional, sales, and interpersonal skills must be honed. Agents must also be prepared to embrace electronic and teleconferencing communication rather than wait for consumers to grant face-to-face interviews.

**Lifestyles**

As there will more people over age 60 in society as we move forward, health will be a focus as age related ailments like osteoporosis, arthritis, heart disease, and Alzheimer's will increase. Health insurance coverage will need to relate more to covering such issues.

Dissatisfaction with care provided by hospitals and other medical facilities might encourage consumers seeking treatment to seek out alternative methods of healing, which are growing in popularity. Health insurance coverage may have to address these alternative methods as more consumers refuse to take medical risks such as undergoing surgery or taking medication.

Due to employment opportunities and longer life spans, women opt to have children later in life. This lifestyle choice often leads to the increased need for fertility treatments that often result in miscarriages, multiple births, and other complications. If this trend continues, health insurance plans will need to adjust to respond to them.

The increased availability of higher education and information on the Internet, combined with overall self-confidence, makes consumers ready to protect their rights when they feel a provider of goods or services has compromised on quality. This intolerance has pushed for advances that ensure people get more for less, and efficient handling of customer satisfaction. The incidence of litigation has increased because of consumers’ demand for higher levels of quality in products and services.

Considering the fact that our population contains more seniors than ever before, the number of deaths will increase. Insurance coverage for medical attention, funeral services, and estate planning will be on the rise.

Hospitals are likely to come under more scrutiny due to infected equipment, contagious bacteria, etc. as these occurrences affect patients who would otherwise not have contracted infection. This type of issue will impact health care costs and costs related to litigation that results. As hospitals come under the microscope, scrutiny will create the desire for the availability of home care, as consumers will likely prefer to heal at home where they’ll run fewer risks of infection and malpractice. Children may emerge as the main caregivers for parents, which will require more changes in long-term care coverage.

People are becoming more and more comfortable with casual forms of clothing and address. This will impact the fashion industry and encourage it to create comfortable clothes and will likely reduce the formal atmosphere at many business and professional offices. These changes will impact agents; although society’s emphasis may trend toward casual, agent demeanor will still require professionalism.
Legal Loopholes

Civil rights claims are on the rise. The insurance industry, and agents, is seeing an increase in suits related to the Americans with Disabilities Act (ADA). Agents must be careful to examine policy definitions and requirements of physical and other disabilities. In one legal case, a client claimed unlawful ADA discrimination because an insurance plan offered different settlements for physical and mental disabilities. (Parker vs. Metropolitan Life)

Agents should also explore the exclusions and limitations pertaining to AIDS and HIV. The courts, in one case, stated that while the limitation was mentioned in the policy, it was not highlighted, per state requirements. Policy formats and disclosures must be clear and meet the requirements of state and federal regulations. (Gonzales vs. American Life)

Agents are advised to offer precise and comprehensive information on insurance applications. In one legal case, a radiologist’s disability claim was rejected because he could still work as a radiologist despite spinal and neck problems. The issue at hand revolved around the fact that he specialized in vascular interventional radiology and could not work in this specialized field after his disability. Because the agent had described the client’s occupation simply as radiologist, and the client had signed the application, he was not considered disabled. (Oglesby vs. Penn Mutual Life)

Policy clauses and provisions need to be spelled out to clients. In one case, a client was denied coverage because his back injuries, instead of being totally physical, seemed to be partially psychological in origin. Courts sided with the client, because the disability satisfied the policy definition of “total disability,” and the psychological aspect was not pertinent. (Rizk vs. Dun & Bradstreet / Met Life)

In a sick building case, although a client’s doctor gave the diagnosis that her disability was caused by exposure to toxins and chemicals in the workplace, the insurance company conducted tests to verify that the workplace contained no such toxins or chemicals. The courts determined the client’s disability was psychological and found in her favor. (Steinmann vs. May Department Stores)

Clear definitions of experimental treatment are needed in health plans. Many legal cases have been argued over what experimental treatment actually is, most notably concerning breast cancer or AIDS induced liver transplants. Disagreements arose over policy terms or because an exclusion regarding experimental treatment was not highlighted or contained ambiguous language.

Cases dealing with the misunderstanding of policy language are rampant and agents must be alert to this fact. Many clients have filed cases saying that they did not really understand an issue, largely because the agent did not explain it properly. In one case, a client claimed that she did not understand English and was unable to read the application form. The fact that she did not tell the agent about a pre-existing condition was not held against her because the court felt it was more of misunderstanding of language; hence, she did not intend to deceive. (Parsaie vs. United Olympic Life Insurance)
The language used in policies to describe “accident” has been much misunderstood. Insurance companies consider suicides and attempted suicides to be intentional rather than accidental. Life insurance policies only pay death benefits for suicide after a certain period of time, called a contestable period. In health insurance policies, however, coverage may be excluded for suicide if the definition of “accident” clearly excludes suicide or if suicide/attempted suicide are explicitly excluded. In one case, a client prevailed against an insurance company that refused to pay health insurance benefits to an insured who attempted suicide and suffered permanent disabling injuries. Because the policy did not specifically exclude suicide, and the term accident was not defined, the court found in favor of the client. (Casey vs. Uddeholm Corp)

Ambiguity in policy language invites legal tussles. The Environmental Impairment Liability Insurance (EIL) aims to give pollution coverage for incidents that, by insurance definition, are not covered by the Comprehensive General Liability (CGL) policy. While EIL policies are actually claims-made policies, CGL policies are occurrence policies. Even though EIL coverage may be broader than CGL coverage in some areas, it may also much narrower in other areas. If a company to buy both types of coverage, would EIL insurance be the primary insurance with the excess covered by the CGL? Or would the situation be reversed? (Rhone-Poulenc vs. International Insurance)

In another legal case, a client did not find coverage under his policy for an issue of contamination caused by the negligent practices of an exterminator because the policy did not define contamination. (Conde vs. State Farm Fire & Casualty)

Legal cases occurring after natural disasters and lost business revenue may also be in the rise if business insurance policy definitions, and agent explanations, are not clear. In one such case, a client believed that if it were not for a devastating hurricane, he would have earned considerable profits. He lost the case because the court ruled that future profits were hypothetical and would amount to a windfall rather than actual revenue. (American Auto Insurance vs. Fisherman's Paradise)

**Uninsurable Risks**

The goal of professional and ethical insurance agents should be to sell insurance coverage that is the best form of protection for the needs and exposures of their clients. Consumers, obviously, do not buy insurance if it serves no purpose. There may, however, be circumstances where prospective clients seek coverage for a risk that is not insurable. The onus is on agents to help clients access forms of risk transfer other than insurance in such circumstances.

Clients may not have the time to analyze, monitor, and anticipate risks. It is often left to insurance agents to shoulder the responsibility of identifying and managing risks. A client’s assets must be protected; however, insurance policies contain limits, conditions, and exclusions. Some clients may be uninsurable, underinsured, or exposed to huge gaps in insurance coverage. Insurance may not be the only solution for some clients and agents have an obligation to direct clients down avenues that may assist them in the protection of all their exposures.

Agents must offer solutions outside insurance policies. Once such solution is asset protection planning. Some alternative solutions outside insurance include:
• A safety arrangement to use as a replacement strategy when premiums become too costly for the client to bear;
• Supplemental income coverage gaps such as penalties and uninsurable health conditions;
• Back-up plans for lapses, or expirations, in insurance coverage;
• Financial strategies in case of bankruptcy or other financial catastrophes;
• Supplemental estate plans to safeguard inheritances; and
• Protection plans for business and property owners to guard against unforeseen future environmental problems.

**Escalating Living Costs**
From current trends, it is obvious that cost of living will continue to increase. To minimize the financial pressure on clients, agents must include protection for inflation in insurance products. For example, health coverage should not be paid for by sacrificing children’s education. Smart agents help clients decide the amounts to be invested when covering various areas of risk while also keeping in mind future inflation increases.

When selling life insurance to clients, agents should anticipate the financial needs of dependants in the future. Similarly, any health insurance or long term care plan should anticipate the rising cost of medicine, long-term care, and professional care-giving services. Such contingencies of the future should be evaluated while keeping in mind the escalating costs of living, care, and services.

**Increasing Liabilities**
The risks of new forms of liabilities are on the rise. Agents do not know what form of claim will be submitted by a client. Any insurance coverage should be strengthened by additional plans that can protect the client from an ever-growing list of liabilities. The liability list could contain negligence, unfair trade practices, safety issues, contract disputes, and joint liabilities. The list is unending and it is not possible to provide insurance coverage for all the exposures a client might face. The liability could arise from excessive debts, business partnerships, government duties, code violations and, of course, tax liabilities.

This is a world where an exceedingly hot cup coffee may cause litigation that lasts for years. While it might not be possible to provide all-inclusive liability coverage for all clients, it is crucial that agents prepare clients for unexpected liabilities.

**Costs of Defense**
Not only will clients need to plan for future liabilities, they will also have to prepare contingency plans to meet the expenses of defense. Insurance policies provide defense costs for covered losses. However, if a loss is not covered, defense will not be provided by the insurance policy. In such circumstances, it is wise for clients to have contingency plans.

**Chasing Deep Pockets**
If a client is very wealthy, or possesses many assets, it is even more important for agents to recommend supplemental protection for emergencies. Deep Pockets are always easy targets for
those wanting to make easy money. Agents to clients with deep pockets must ensure that their insurance program is supported by protection plans that anticipate frivolous lawsuits.

**Leveraging Asset Protection**

As explained earlier in this course, a client may not be totally covered by insurance for a variety of reasons. Suitability conduct requires agents not only to anticipate risks but also to strategize with solutions outside traditional insurance coverage to ensure that these risks are covered. One of the additional measures that an agent might undertake is to adopt asset protection planning for the following several reasons.

**Safeguarding Clients**

Rather than acquiring a list of clients who have received claim penalties or been denied coverage because of limits, pre-existing conditions, or other issues, an agent is better off covering a client beyond the traditional scope of an insurance policy. Recommending plans that protect assets of clients may increase credibility among the client base.

Preparing a client for an unforeseen claim with asset protection saves the client from the stress and litigation of an inadequate insurance program and provides them with a backup plan. Referring a client to an asset protection attorney should be seen as a credible move toward safeguarding the client rather than simply increasing insurance sales.

**Creating Legal Shields**

Agents should use asset protection planning to put in place legal safeguards for the assets of clients. Although there are many legal strategies based on difference tenets of legal theory, the following would be helpful for agents to be aware of:

**Free Alienability**

The theory of free alienability of property stipulates that people have the privileges to sell or dispose of their property in the manner they see fit, so long as they have no credit or liability issues. A person can sell his or house, gift it to children, or transfer it to a trust. The sale or transfer must not be used to evade liabilities and taxes.

**Whole versus Sum**

The legal theory of whole versus sum rests on the tenet that the whole is worth much more than its parts. Asset protection planning uses this theory to take the entire assets of the client and break them into smaller blocks of assets. Compared to the entire asset, these smaller assets are difficult for a creditor to keep track of and thus, each single asset receives more protection. Creditors usually target single-titled blocks of assets rather than multiple-titled multiple blocks of assets, because it is more cost effective for them to do so. Asset protection planning not only protects these smaller assets, but also reduces the risk of any third party acquiring the assets.

**Selection of Laws**

People are usually free to choose the law that presides over a business transaction. This selection may leverage clients advantage to choose a law that favors, or protects in the context of language, political or economical jurisdiction, etc. Client may choose to institute a trust and have it governed by the laws of any state, not just the state of domicile.
Advantages of Encumbering
Asset protection planning advises a person to opt for encumbering property rather than owning it free and clear. This advice is based on the theory that encumbering property will lessen the interest of creditors. Owning assets free and clear also subjects an owner to increased losses.

Weakened Protection
Conventional insurance methods are no longer as efficient as they used to be. They are exposed at too many levels and are also weakened by insolvency, over-insurance, and exclusions.

Legal Entity Defenses
Agents can point clients in the direction of asset protection programs that create holding companies. These legal entities isolate liability and actually help to protect clients’ assets from exposure. Legal entity protection might not be absolute, but it does safeguard assets.

Asset Transfers
Asset protection planning helps clients avoid fraudulent transfers of assets. It is a naïve assumption to believe that transfer of property to a spouse or child will help avoid creditors. In fact, transferring assets to spouses and children has often proved to result in fraud. In addition, such transfers may be declared invalid under law. Assets transfers designed to safeguard need to be gifted with the intent of relinquishing control of the property.

Understanding Rights of the Creditor
When using asset protection programs to safeguard assets, agents should understand the roles of creditors and explain them to clients. Creditors have the right to seize a person’s asset or property in certain circumstances and under certain and different ownership entities.

Joint Tenancy
If a client is a debtor and joint owner of property, the creditor may end joint tenancy and assume the client’s tenancy along with other joint owners. Being joint tenants offers very little protection for assets because creditors can petition courts for the division of property. In the event property can’t be divided, the creditor may sell the asset. A creditor may acquire a joint tenancy by:
1. Selling only the debtor’s interest, or
2. Acquiring the debtor’s interest.

Tenancy in Common
When jointly owned property is owned as tenancy in common, a creditor may only sell the debtor’s interest. Once a creditor acquires the tenancy, the creditor may sell the common asset. A client should be advised to ensure that co-tenants are financially sound.

Community Property
A creditor can hold both husband and wife liable for debt if they own community property. If the debts were incurred before marriage, or after a divorce, then the concerned spouse has a separate obligation. The creditor may only sell the debtor’s interest but clients should note that a creditor’s access to marital property cannot be impacted by the way both spouses contract. No matter who pays the bills, each spouse is held liable even for the debts that are incurred later. To
avoid joint liability, a spouse must state in writing that all actions of the marriage partner have been taken inappropriately and without consent.

**Partnerships**

For a creditor to acquire the debt of an individual in a partnership, the partnership must first be dissolved. Then, payment of the partnership’s debts must be made. Only then may a creditor acquire the debtor’s interest. However, in a procedure known as a charging order that can be obtained from the court, creditors may attach the profits, as well as the surplus, of the debtor. It should be noted that acquisition of debt cannot make creditors partners and does protect other partners. In case the charging order does not solve debt issues, the courts may allow foreclosure of property. This means only the partner's interest in property would be up for sale--not partnership assets. Should a creditor choose to make the purchase, it will receive the partner’s profit only until the partnership is dissolved.

**Corporations**

Creditors may not engage in proceedings against the stockholders, directors, officers, or agents and employees of a corporation. They may only target the assets of the corporation. However, a creditor may target stockholders, directors, officers, agents, and employees of a corporation in the following circumstances:

- When an individual has made personal guarantees of corporate obligations;
- When individuals are accused of negligence;
- When individuals have withheld taxes;
- When individuals have committed wrongful acts; and

**Limited Liability Companies**

Although members of LLCs are held personally accountable for debt liability, creditors hold all members liable in the context of their investments.

**Trusts**

The general consensus maintains that, in case of trusts, a creditor may attach the beneficiary's interest or sell the beneficiary’s interest. The grounds on which a creditor may access trust assets are if the trust is based on fraudulent funding, if the settler seems to have more control and interest than necessary of trust assets, and if the trust is a sham.

**Planning Exemptions**

Agents can inform clients that legal safety nets may be deployed to keep certain assets from the purview of creditors. This would require exemption planning. Also important to note is that exemption planning can be waived if the client neither files nor makes a claim. Asset protection planning can help plan exemptions with the following:

**Civil Codes**

Clients need to be alerted by experts about civil codes that give exemption protection from a creditor. These might include things like spousal support or child support payments.
**Homesteads**

One way of protecting assets is for clients and their spouses to declare and record their residences as homesteads. This process requires the homestead to be the primary residence of the debtor, which is why a houseboat cannot be recorded as a homestead. The minimum amount of a homestead exemption varies by state and this amount may be increased in some jurisdictions if the homestead is a primary residence for older, disabled, or economically challenged people.

**Personal Property**

Some personal and business items may be subject to exemption from creditors and may include items such as jewelry, appliances, health aids, clothing, vehicles, cemetery plots, and business tools required to earn a living.

**Annuities and Life Insurance**

Both annuities and life insurances often qualify for exemptions, even without filing. It should be noted that although a creditor may not coerce a debtor to exchange these policies, the debtor might be compelled to borrow against their cash values. The exemption amounts vary by state and by the marital status of the debtor. The proceeds earned from policies are also exempt, if they are proven to be needed to financially support the debtor.

**Health Insurance**

Benefits that a client earns from either disability policies or health insurance policies are eligible for exemption without filing. It should be noted that these exemptions are not valid if the disability benefits or health care services are provided by the creditor.

**Retirement Plans**

Retirement plans, whether private or public, are usually protected from creditors unless the contribution limit has been exceeded and there is a need for both spousal and child support.

**Damage Awards**

Wrongful death and personal injury awards are usually eligible for exemptions if they are shown to provide needed financial support to the debtor.

**Bankruptcy**

A debtor may file a bankruptcy to protect assets and gain exemption from creditors. However, certain federal and state laws apply. Some bankruptcy filings are:

- **Chapter 13**: Allows a debtor under court protection to develop a plan to repay debts over three years; extendable to an additional two years.
- **Chapter 11**: The same as Chapter 13 but applies to businesses.
- **Chapter 7**: Allows assets to be liquidated to pay the creditor.

**Miscellaneous Exemptions**

A client may be eligible for exemptions on paid earnings, unemployment benefits, college financial aid, veteran's benefits, and workers' compensation payments.
**Medicaid Benefits**

Aimed at seniors, plans exist to reap Medicaid benefits by adopting exemption planning. The goal is to divest oneself of countable assets and income to qualify for Medicaid. In the absence of utilizing this plan, many seniors may not be able to afford the escalating costs of health and long-term care. Known as spend down, the process reduces the client’s assets that are countable (for example, certain amount of cash, stocks, mutual funds, CDs, treasury notes, and money market accounts). This list varies by state.

Clients are permitted to keep liquid assets of up to $2,000, along with non-countable assets considered exempt such as the primary residence, car, wedding ring, household furniture, surrendered cash, and cemetery plots, etc. While similar divestment is not required of the client’s spouse, there is a limit to what may be retained by the spouse—, which, in turn, might generate a reduced quality of life.

The amount to be retained is calculated by totaling all assets of the married couple and, if one-half of the total assets do not exceed the state-prescribed amount, the spouse is able to retain those assets. The remaining assets are divested to pay for medical bills and then Medicaid benefits commence.

There are, of course, eligibility rules for Medicaid. The basic rules are that a person should be spending his or her entire income on medical and nursing care. There are also income restrictions because Medicaid was intended for financially members of society.

**Offshore Protection**

Asset protection in its most aggressive form resorts to offshore protection. The process involves moving assets to countries that do not recognize U.S. court dictums and provide ample protection to a client’s assets. It is a huge effort for creditors to access offshore assets and the costs involved to institute litigation in other countries, with local attorneys, witnesses, etc. is quite a deterrent. Some of the ways clients can protect their assets offshore include:

- **Creating foreign trusts:** The idea is to form a trust in a locale that favors debtors and is ready to give legal protection within its local jurisdiction. To make the trust irrevocable, a duress clause needs to be added. This thwarts both lawsuit and seizure of assets. If a creditor manages to access the trust, it can be moved to another jurisdiction.
- **Creating offshore corporations:** Creating a corporation is another tactic to protect assets. This is much more protected and confidential because it makes use of nominated officers, directors, and bearer shares. While the corporation has title to the bank and brokerage accounts, along with other investments, the bearer shares are in the control of an offshore trust. Usually offshore corporations and the trust would be in different jurisdictions for greater protection.
- **Creating offshore accounts:** Opening banks in favorable jurisdictions with confidential bank laws and ultra modern communication methods that facilitate quick transfers may also protect a client’s asset.

Offshore protection may be the most effectual way of protecting assets and may also be the most expensive. It is usually the strategy of the wealthiest of clients.
Leveraging Multi-Entity Protection
Experts in asset protection planning understand the need to use cost-effective and legal methods to safeguard a client’s assets. The multi-entity method is moving toward becoming an affordable and efficient option. To protect a client’s assets, the multi-entity planner devises a combination of entity methods to keep the assets safe beyond an insurance plan. The aim of the multi-entity protection plan is to:

- Safeguard assets from liabilities;
- Lower an estate’s taxable value;
- Reduce income tax liabilities; and
- Enable charities but keep the legacy as is.

Entity Structures
These plans can utilize from two to four of the following in combination to maximize asset protection and supplement insurance coverage.

Revolvable Living Trust
Asset protection experts require a legal document for each person or family named in the Revolvable Living Trust. It is not common knowledge that in case a client has a will and no planning documents, a probate court acquires control of all the client’s assets upon his or her death. The client’s heirs would have to petition the Probate Court to have the deceased’s assets transferred and would incur legal fees—because there were no trust documents in place.

Responsible agents and asset planners will suggest that the first thing clients need to do protect their estates is to draft a Revolvable Living Trust.

Corporations
The corporation is a basic structure for American businesses. A corporation is an entity that files Articles of Incorporation according to the laws of the state of domicile of the business. After the Articles of Incorporation are filed, a shareholder’s meeting is conducted and the Board of Directors is determined. The Board of Directors then, according to the by-laws, chooses the officers who will run the actual affairs of the entity. The structure seems straightforward and simple but it is also too simple to shield your assets.

The courts do not protect a corporation’s business or assets when creditors demand that debts be paid. In case a corporation is sued for IRS issues, both business and personal assets are exposed to liability.

Family Limited Partnership
A family limited partnership (FLP) is protected by the Uniform Limited Partnership Act, which makes it difficult for a creditor to access personal assets. A client may set up Family Limited Partnerships with a minimum of two partners. The ownership of personal assets, such as family home, stocks and bonds, and other investments is retained by the FLP. The FLP is revocable by the client and the limited partners. In the event the FLP is revoked after a unanimous vote, the assets transfer back to the appropriate parties without penalties or taxes.
The FLP structure operates in this way: The client, who becomes the general partner, does not have to distribute assets or income to the limited partners throughout the year. However, the limited partners have to pay the partnership’s taxes. The one way a creditor may access the partnership’s assets is with a court issued charging order that sends the debtor a foreclosure note and enables the creditor to be assigned the debtor’s portion of the partnership. Once the creditor becomes a limited partner, the credit now becomes responsible to pay its tax share of the FLP. For this reason, experts declare the FLP the usual option to safeguard personal assets of a client from a creditor. The FLP not only protects a client’s assets, it also offers 15 to 40 percent IRS discounts on the FLP’s total assets.

To recover assets from an FLP, a creditor would need to:
- Transfer pro-rata allocations from the FLP to the partners. This would direct the distributions to the client or a Revocable Living Trust.
- Determine how much management fees need to be remunerated by the FLP to the corporation so that the income is utilized to disburse salaries, retirement plans, employee benefits, etc.
- Arrange a loan from the FLP for the client and his or her family; repaying this loan is actually a payment to the self.
- Revoke the FLP by vote and gain direct ownership of assets.

Limited Liability Company

A limited liability company (LLC) has features of both a limited partnership and a corporation. A minimum of two individuals may form an LLC and, as in a limited partnership, the managing member is the equivalent of the general partner in an FLP. The managing member is in charge of the finances of the LLC. The other members are virtually silent partners who receive rights to profit distributions and are responsible for business losses. The LLC is a highly recommended form of asset protection. A simple explanation of why an LLC is such a good form of asset protection follows. If a client forms an LLC, the client will be the owner of the business but will not be held personally responsible for debts and obligations of the business. This type of entity protects the client’s personal assets from business liabilities and no lawsuits or tax obligations will have any personal financial impact.

Using Multi-Entity Plans

To protect business assets, clients may create LLCs, which would make use of legal contracts and the hired or appointed individuals to absorb liabilities. In all cases, the LLC is a shell, owning no assets and giving the client protection from creditors. In the event an LLC is sued, the client can declare it bankrupt and set up a new LLC.

The client can also use the corporation structure for protecting business assets. For example, the state of Nevada imposes neither state nor corporate taxes on income. It might be advisable for a client to establish a corporation in Nevada. As a partner of the client’s LLC, the corporation would own the business’ tools but lease them to the LLC. In the event of creditor issues, when the LLC files for bankruptcy, the corporation receives the tools and may lease them to a newly established LLC.
To protect personal assets, the client should use the Family Limited Partnership. A combination of multi-entity structures used in a single plan not only protects the client’s business and personal assets, but also helps to provide several other functions.

**Save Taxes**
A client can use the multi entity structures to save taxes. For example, assuming the client is using the LLC to operate a business that pays a net $60,000 per year to the LLC, the client receives a salary of $25,000 per year while the remaining $35,000 is paid as beneficial distribution. The taxes would amount to $3,825. Had the client not established an LLC, the self-employment tax of 15.3% would amount to $9,180. With an LLC, the client would save $5,355 because $35,000 is seen as a beneficial distribution. Similarly, in a corporation, the client can take advantage of benefits such as health insurance, disability insurance, accident insurance, etc. The corporation claims these expenses as tax deductions but they are not part of the client’s taxable income.

**Pension Plans**
The client can use the corporation to create corporate pension plans. As administrator and trustee, the client controls and manages these plans and can choose to make a contribution equal to 15% of the annual net taxable income. The resultant accumulated amounts are tax-deferred and taxable only at retirement. Also, for business owners with such corporate pension plans, there is a provision under the Internal Revenue Code to borrow 50 percent of the pension plan. In a corporation, a client not only saves a considerable amount of his or her salary from taxation but also is ensured a sizeable pension. A client must be alerted to certain conditions, which include:

- Should the client want to make an early withdrawal from the pension plan, will likely be required to pay a penalty;
- Distributions invite full taxation when withdrawn;
- At the age of 70 1/2, distributions must be taken;
- Annual reports must be filed and state administrative costs must be paid; and
- Lawsuits, along with tax liens, may be charged against these pension plans.

**Plan Pension Alternatives**
To avoid corporate pension plan conditions, multi-entity experts refer clients to the method of alternative pension planning. This method uses the Irrevocable Trust to receive the client contributions. The trust is not linked to the client’s business and is, in fact, run by a separate financial institution. The client might not have much control over the assets while it is placed in the trust, but should the client decide to stop making plan contributions, the assets are returned as tax-free withdrawals.

The alternative pension plan gives the client the options of 100 percent deductions of his or her business fringe benefit contributions with withdrawals that are tax-free. The client can safely plan an early retirement with these alternative pension plans because:

- The funds can offset estate tax since the ownership does not rest with the client and the contributions add to the trust’s assets and not to the client’s assets;
- The funds are protected from creditors while accumulating and the structure of the Irrevocable Trust renders it absolutely protected;
• The funds do not necessarily need annual reporting; and
• Distributions from a trust are not mandatory.

Alternative pension planning can also be used to convert distributions of the client’s previous pension plans into retirement withdrawals that are tax-free.

**Estate Plans**
A client can use advanced multi-entity estate plans to plan assets with the following benefits:

- Lowering of the client’s estate to save 55 percent of estate taxes. This lowering is accomplished based on established principles that give discounts on the fractional ownership and inadequate marketability of the assets. Use of the Family Limited Partnership structure allows clients to use this method of estate planning because, per the Internal Revenue Service, there is discount of 25 to 40 percent on assets in a FLP.
- Enabling lifetime gifts to charities, children, and grandchildren while maintaining control of the assets. Use of FLP allows the client to reduce the estate through gift giving and, in turn, reduces estate taxes after death.
- Managing family assets even after disability or death by instituting the corporation as General Partner in the FLP.
- Eliminating the probate of estate after death by ensuring the estate transfer to children and grandchildren through a trust.

Essentially, multi-entity estate plans ensure that the client has an estate plan wherein the estate information and financial paperwork is filed and the diversified investments are transferred as a single asset to the Family Limited Partnership.

If clients are short of adequate asset protection plans, they open themselves to exposure from third party creditors. A well-thought out asset protection plan ensures that ownership of the client’s assets stay within a Family Limited Partnership, and away from creditors. When a client transfers his or her assets to this format, a third party creditor will not acquire the client’s asset unless a charging order is produced from courts against the interests the FLP earns. Assuming the client is a debtor, the charging order gives the client’s share of distributions to the creditor. However, it is important to note that a charging order cannot force distributions, so the client has the option of not making any distributions to any of the limited partners, which includes the creditor. Once the creditor owns the debtor’s share of the FLP, the creditor also incurs the tax and business liabilities of the limited partnership.

A carefully planned asset protection plan helps a client by:

- Shielding assets from damages for business liabilities and personal injuries;
- Protecting assets from unfair financial claim and seizure by creditors;
- Insulating assets from bankruptcy, debts, or death of co-guarantors, and general partners;
- Ensuring control of the estate to an entity that is created by the client so that, after death, the estate passes to the entity and thus to the heirs—and not creditors or the probate court; and
- Safeguarding legacy assets by ensuring that heirs inherit the limited partnership.
**Charitable Trusts**

Multi-entity planners also suggest the use of Charitable Remainder Trusts as a means to protect client assets by giving these assets as gifts to charities. This enables clients to avoid taxes and protect assets. Such charitable trusts help by:

- Transferring assets such as the family home into a FLP and gifting the interests of the limited partnership to charity;
- Ensuring control of the assets transferred to the FLP as a limited partner despite gifting interests to charitable trust;
- Ensuring liquidity through taxes saved on the interests given to the charitable trust; and
- Retaining the option to reduce the value of the taxable estate by liquidating the entity on the votes of the limited partners and the charitable trust.

Using this method, a client can make a contribution of real estate valued up to $1,000,000 to a limited partnership, gift its interests to a charitable trust, and take advantage of a charitable deduction of up to $1,000,000 that will reduce taxable income. Additionally, the client can also sell the asset of $1,000,000 and the proceeds will be put back in the partnership for 25 to 55 years—the duration of the FLP.

Even after the client’s death, the asset is protected because it can be transferred from the partnership to the charitable trust and the heirs can be named as beneficiaries through a foundation.

**Implementing and Controlling Multi-Entity Assets**

The potential of asset protection plans reinforced by multi-entity structures helps clients to not only protect assets but also save on taxes, take advantage of discounts on taxable income, prevent being penalized by the IRS or other creditors, and pass on the legacy to heirs.

Responsible agents will confirm that such a multi-entity asset protection programs are suitable for their clients. Following are the due care concerns agents must address to determine if a client is the ideal candidate for such a plan:

- Is the client financially solvent enough to sustain a multi-entity plan?
- Does the client shoulder any debts or business liabilities?
- Does the client want ways to reduce taxes on his or her incomes?
- Does the client want to save and pass on the taxable estate to his or her heirs?
- Does the client want to protect assets from liabilities and creditors?
- Does the client want to give to charity yet keep his or her assets intact?

The one essential for such multi-entity asset plans to work is that the client finances must be strong and stable. Multi-entity plan genuinely seeks to protect those with significant financial assets and who need help to avoid over taxation. These plans do not help people who are on the brink of insolvency to transfer assets with the aim to delay or escape from their creditors. Multi-entity plans do help in emergencies when a financially solvent client must declare bankruptcy but are designed to protect the net worth of financially credible clients.
Clients using such protection plans should aim at maintaining control over the use of the multiple entities. Using a multi-entity plan requires the client to select business partners and associates very carefully. If setting up a LLC, the client should seek credible and financially solvent general partners. If setting up a corporation, there should be a serious effort to select the best board of directors, officers etc. Also, all agreements into which the client enters should be well-drafted and scrutinized by experts. The agreements should be in the client’s favor and ensure that the entities and members vote for the client as the general partner.

Adhering to these guidelines gives the client effective control and management of cash flow and asset transfer into and out of the partnership. It also ensures that the client will have control even after his or her death.

**Suitability – The Last Word**

As stressed earlier in this course, the crux of suitability practices is knowing the client’s needs and matching those needs to the right products and services. It is also important for agents to ensure that in order to cover certain client needs, they may have to look beyond insurance solutions. An agent cannot cater to a single need or aim for the purpose of making a sale. Suitability goes beyond sales production. It uncovers multiple needs and obligations and seeks to find suitable solutions.

Product suitability requires agents to research and understand groups, cohorts, and generations—including their underlying philosophies. Also important for agents to remember is that they must anticipate client needs and plan for eventualities that might emerge in the future. Additionally, suitability requires seeking solutions outside the insurance industry to make certain that the client is truly protected.

Suitability is multi-tiered; it is dynamic. While some clients are simply concerned with price, others demand quality service and see the agent as the manager of their risks. Consumers seeking insurance want products that are secure, trustworthy, provide value, and safeguard assets. Agents can no longer a single product to respond to the needs of an entire population. The world is changing and suitability skills must be honed to cater to the ever-changing consumer.

Suitability requirements are constantly changing and an agent needs to keep up with them. While the traditional suitability methods still serve as the groundwork, an agent must address client risks, anticipate needs, find the appropriate solutions, and earn the client respect. Agents must take insurance suitability to the next level.
Review Questions/Chapter 5

1. Which of the following is NOT a generational group?
   a] Generation Xers
   b] Baby Boomers
   c] Seniors
   d] Generation Ters

2. A creditor can hold which of the following liable for debt in the event they own community property?
   a] Parents and children
   b] Employers and employees
   c] Husband and wife
   d] Mother and father

3. What is the one essential for a multi-entity asset plan to work?
   a] The client’s finances must be strong and stable
   b] The client must own a home
   c] The client must own an automobile
   d] The client must declare bankruptcy

4. Knowing the client’s needs and matching those needs to the right products and services is the crux of which of the following?
   a] Insurance sales
   b] Insurance regulation
   c] Suitability
   d] Claims settlement
Chapter Six

Suitability and Solvency

Financial solvency is the ability of a person or company to have the required financial resources to meet debts, taxes, and other financial obligations. Due diligence demands that agents recommend ways to protect the solvency of clients by offering suitable insurance coverage issued by a secure and stable company. It also requires agents to offer protection for any gaps in insurance coverage with suitable alternatives other than insurance.

The strategies and advice of efficient and professional agents is what helps clients retain liquidity and safeguard assets. Suitability with regard to solvency requires that agents protect client against insurance shortfalls. Agents cannot afford to be negligent; they must:

- Know when insurance products are inadequate or incapable of covering all the client’s needs;
- Guard the client from being underinsured or over-insured;
- Seek alternatives to traditional insurance to help clients protect themselves from insurance inadequacies; and
- Examine the solvency of clients.

The preceding list a mere beginning to ensure that not only are a client’s assets and liquidity protected from exposure but also that agents are not culpable for exposures. Suitable solvency conduct requires agents to examine the need for supplemental coverage, referring the client to asset protection experts and maintaining the solvency of the client.

Inadequacies of Insurance

The usual behavior of the average American is to purchase multiple insurance policies, each of which contains different coverages, exclusions, and limits. Consumers are usually happy with their insurance purchases until an unanticipated catastrophe occurs that is beyond the scope of purchased coverage. Buying what seems to be an adequate policy, but which turns out to be inadequate at the time of loss, often motivates a consumer to sue an insurance agent.

For example, a life insurance of policy with a death benefit of $60,000 will most likely prove insufficient to provide for the financial needs of the deceased insured’s family. On the other hand, the client may not have been able to afford a policy with a higher death benefit. To avoid a situation requiring the agent, or the agent’s E & O carrier, to pay for damages awarded in a lawsuit, agents must abide by the suitability conduct required of professional, ethical insurance
agents. The objective of maintaining client solvency requires agents to explain the consequences of purchasing inadequate insurance coverages and limits.

**Disputing Coverage**

The sale of insurance policies with high premiums and/or high policy limits, and the resulting dissatisfaction of clients whose claims are denied, makes for an explosive situation. In the case Bell vs. O’Leary, the court ruled that from the time an agent counsels the prospective client concerning the sale of insurance for which he or she will earn commission, the agent is duty bound to provide service to the client with skill, due diligence, and care. The failure of agents to recommend proper coverage to the client, to inform the client of the unavailability of coverage, to inform the client of coverage lapses or cancellations, etc., may invite litigation.

Apart from the issue of litigation, another issue involves the different interpretations of insurance coverage by policyholders, agents, and insurance companies. Considering that people purchase multiple policies from multiple insurance companies, litigation stemming from such misinterpretations is extensive.

**Legal Strategies for Insurance Professionals**

As expansive as litigation can be, so are the strategies associated to counter it. This section discusses details agent should keep in mind with respect to litigation.

**Role of Attorneys**

The work of attorneys begins when efforts at settlements fail. Their responsibility is to process the available information about the insurance company, agent, policies—both in force and cancelled, and scrutinize to scrutinize all documents pertaining to the event that prompted litigation. Attorneys are responsible for:

- Creating drafting history that records details of the insurance company’s business and policy features, coverages, clauses, endorsements, and language in addition to their application to manage a client’s risk. Courts give a great deal of credence to the drafting history for giving clarifications to many issues and terms.
- Collating the filings insurance carriers give to government regulatory agencies and the state’s insurance departments.
- Examining underwriting and training manuals about the issuance of policies and the handling claims.
- Evaluating reinsurance documents that provide details about the interaction between the insurance carrier and the reinsurer about how a policy may apply to an underlying claim. It also helps attorneys to assess the insurance company’s coverage responsibilities. It should be noted, however, that courts often do not allow attorneys the right to these reinsurance documents.
- Scrutinizing marketing policies of the insurance company to review advertising claims, agent representation, and details of the handling of coverage for the case that is in dispute.
- Research and evaluate other court cases that might impact the current case.
Role of Agents
Agents are expected to assist attorneys on both sides of the lawsuit. Agents should be careful and cautious about the information provided and the party to whom it is given. Conscientious agents always follow the advice of their own attorneys and representatives of their E & O carriers. An agent’s oversight when following the instructions of an attorney or E & O carrier might impact the outcome of the litigation in a negative fashion.

Agent Files and Documentation
In the event a legal dispute arises between and an agent and client, the agent will be required to provide evidence and records of service, conduct, and all client transactions. The agent’s files and records might contain letters, memos, e-mails, faxes, computer records, telephone logs, and notes made during and after business transactions. The communication and documentation methods used by an agent are the most important aspect of the defense an agent and his or her attorneys will use to refute the client’s accusation.

The agent file and documentation should include meticulous and organized details of client correspondence and communication of all types, including written authorization to make changes, signed applications, and signed declinations of coverage offers.

Insurance Coverage Disputes
Most lawsuits are usually settled before they go to trial; however, legal disputes are seldom settled quickly. This section will address some of the major causes of conflict that invite lawsuits.

Coverage Triggers
A coverage trigger is an event covered by a policy that determines if it will respond to a claim. For example, death is the normal trigger in a life insurance policy. If an insured person’s death is caused by suicide, however, it will not trigger coverage if the suicide takes place during the contestable period of the policy.

Triggers in health and disability policies invite significant dispute. Arguments are made about what constitutes permanent disability, critical illness, etc. Further arguments are made concerning waivers and deductibles. Attending physician statements are often needed to clarify the exact nature of a client’s health history or current medical condition.

Policy language compounds disputes. For example, a client purchased an insurance policy that agreed to provide coverage for incidents that result in bodily injury or property damage resulting from a covered occurrence that takes place within the policy territory and during the policy period. The term “occurrence” will be defined in the policy as An event, either an accident or continuous or repeated exposure to the same general conditions, that causes bodily injury or damage to a third party. The term “bodily injury” will also be defined in the policy; its definition is Bodily harm, sickness, injury, or disease including required care, loss of services, and resulting death. The term “property damage” will be defined as Physical injury to tangible property, including the resulting loss of use of the property. The client’s dispute can be based on
the time frame of a repeated exposure. Could the exposure have begun several years before? There has been much debate about the continuous or repeated exposure principle.

**Conditions**

All policies include conditions that state the rights, duties, and responsibilities of the Named Insured and the insurance carrier, such as loss reporting, loss settlement, property valuation, other insurance, rights of subrogation, cancellation, non-renewal, etc. A condition can be as simple as the need for property inspection after a claim or the requirement for written notice of cancellation providing a specific number of days advance notice.

**Exclusions**

The exclusions clause in an insurance policy lists property, causes of loss, hazards, or circumstances that are not covered by the policy. The purpose of exclusions contains several elements.

Policies exclude coverage that can be found in another insurance policy to avoid duplication of coverage. For example, all policies (except workers’ compensation policies) exclude injuries that are covered—or required to be covered—by workers’ compensation policies. Policies also exclude coverage for losses of a catastrophic nature that cannot be insured, such as war and nuclear explosion. Finally, policies exclude coverage for circumstances that are not the subject of accidents or that are under the control of the insured, such as wear and tear, intentional injuries, and criminal activities. Additional exclusions may be found in policies for other reasons.

Although most agents explain the major exclusions contained in insurance policies, clients seldom have the time or desire to listen to an agent review all of them. For this reason, suitability conduct requires agents to provide clients with documentation of major exclusions and to refer the client to the policy for all other exclusions. When agents familiarize themselves with their clients' activities and risks, most exposures subject to policy exclusion are uncovered.

**Named Insured**

Each policy will define “named insured.” Typically, the named insured is the owner of property to be insured or the individual or business desiring coverage for its activities and/or operations. In personal lines insurance, such as for automobiles and homes, a resident spouse may also be considered a named insured. Disputes arise when parties believing themselves to be a “named insured” do not meet the policy’s definition and, as a result, coverage is not afforded to them.

For example, if a woman owns a home and hers is the only name on the deed to the property and the insurance policy covering the home, she and her live-in boyfriend may incorrectly assume that he is also a named insured.

**Assignments**

Most insurance policies include conditions regarding assignments to ensure that transfers cannot be made unless the policy owner provides written consent and secures it from the insurer.
Assignment conditions are enforceable and debate occurs on the ban of assignments without consent.

**Duty to Defend**

Insurance policies contain a clause that states the insurance company’s obligation to provide an insured with defense to claims made under the liability section of the policy. Typically, the insured only needs to show that there is the potential for coverage in order to trigger the insurance company’s duty to defend. The insurance company’s duty to defend is broader than its duty to indemnify because it may owe a duty to defend the insured against a claim that ultimately results in no claim payment.

Disputes arise when insurance companies decline coverage or when the insured is not legally liable for injuries or damage. Once coverage is declined, or the insurance company indicates the insured is not legally liable, it ceases its defense. This cessation, however, does not necessarily mean the party filing a claim or lawsuit against the insured agrees with the insurance company.

Insureds who find themselves in the position of having to hire their own attorneys to defend allegations, and to assume responsibility for their own legal costs, are seldom happy with their insurers.

**Breach of Contract**

An insured may file a breach of contract suit against an insurance company when it claims the insurance carrier failed to defend as promised. In such cases, the insurer must provide facts and evidence that show it completed a thorough investigation into the events of the claim, that the policy contract precludes coverage, and other pertinent details.

**Bad Faith**

Courts recognize that the relationship between the insurer and insured is fiduciary in nature and the insurance company must protect the interests of the insured. A claim of bad faith is alleged when an insurance carrier does not discharge its fiduciary duties to the insured. Bad faith claims can be made along breach of contract claims.

**Choice of Law**

The jurisdiction and place to file lawsuits also become issues of disputes. Although insurance policy contracts do not always specify a choice of law, insurance claims are usually the concern of state laws. Nevertheless, courts have ruled on venues, keeping in mind the location where the contract was signed, the primary place of residence or location of the insured, and the location where damage or injury occurred.

**Lost Policies**

Disputes also generate in circumstances where the insured misplaces or loses the policy and is unable to find the proof necessary to testify that the coverage was purchased. In these cases, the insured must prove that:

1. The policy is indeed lost, even after a thorough search; and
2. The policy, even though it is lost, did exist and provide details identifying the insured, insurance company, agent, etc.
Such disputes can be addressed with the provision of correspondence, claim files, agent files and testimony, corporate records, receipts, etc. that prove the policy was purchased and issued.

**Environmental Exposures**
Many disputes arise with respect to environmental claims. The Comprehensive General Liability (CGL) policy was initially intended to cover claims resulting from a business’ operations and activities. *Hidden exposure* was the term used to provide coverage to a broad range of environmental issues such as pollution. As a result of hidden exposures, cases were filed to seek damages for claims arising from waste generation and disposal, as well as the transportation of materials, and they translated into settlements of $4 billion.

These companies looked to their insurance providers for coverage, who then turned to courts to dispute coverage. The CGL policy was revised in the 1970s to redefine the definitions of “occurrence” and “property damage.” In the 1980s, additional revisions were made to the pollution exclusion to exclude damages resulting from accidental emissions or discharges of pollution. However, disputes now focus the fact that damage usually is caused by accidental discharges and the pollution exclusion excludes all types of pollution damage.

**Excess and Umbrella Liability**
Disputes often arise from the inadequacy of primary liability coverage and the lack of excess liability coverage—or umbrella liability. Excess and umbrella liability policies provide liability coverage in addition to the liability coverage on primary policies—such as auto, home, package, and CGL—to cover catastrophic losses.

Disputes arise when excess or umbrella carriers cite that underlying limits requirements weren’t met and a coverage gap results. Disputes also arise when clients claim agents did not offer excess or umbrella liability coverage after they learn their policies provide insufficient limits of liability in the event of a claim or lawsuit.

**Business Disputes**
An insurance agency—or any business—may invite disputes on stemming from many reasons, the most common of which include:
- Wrongful conduct of directors and officers;
- Poor customer service by staff members;
- Unfair business practices;
- Statutory violations; and
- Improper or misleading advertising.

For example, although directors and officers liability (D & O) insurance protects a business against claims and suits of wrongful acts by the directors and officers, it does not cover every type of wrongful act—nor does it provide personal coverage for the directors and officers. In most cases, a D & O policy excludes coverage for criminal acts, dishonesty, ERISA claims, employment-related practices, etc. Endorsements do exist to provide coverage for some of the wrongful acts that are excluded (i.e. employment-related practices), however, businesses are not
protected against all types of losses and claims and the failure of the agent to explain all exclusions, or failure of the client to understand them generates many disputes.

**Insurance Company Legal Defenses**

While policyholders and named insureds have many legal rights, and the court often rules in their favor when it comes to policy language disputes and claims against agents, insurance companies do have means to defend themselves and protect their interpretations of policies. Sometimes, however, the safeguards they use for their own protection contribute to insurance disputes—most notably, the denial of an insurance claim. This section discusses the major defenses insurance companies use.

**Concealment Condition**

Agents and clients are legally and contractually obligated to disclose all facts to the insurance company that might affect issuance of an insurance policy. Failing to do so may constitute concealment, which is defined as, *The willful holding back or secretion of material facts pertinent to the issuance of an insurance policy or a claim, even if the insured or applicant was not asked about the subject. Concealment can result in cancellation of the policy or denial of a claim.*

For instance, a consumer applying for an auto insurance policy will be asked to list on the application all licensed household members, all family members, and all regular drivers of the vehicle(s) to be insured. The consumer will also be asked to list all traffic violations and accidents, for all drivers, that took place within a specific period of time—usually the three years immediately preceding the effective date of insurance. If the consumer did not know a family member had been cited for speeding six months before, and did not list the violation, the consumer would not be guilty of concealment. However, if the consumer knew that a household member had received a DUI conviction during the preceding three years—and did not disclose the fact because he or she believed a DUI conviction did not qualify as a traffic violation or accident—the consumer would be guilty of concealment. It is common knowledge that DUI convictions appear on a person’s driving history and affects the rating of auto insurance.

**Misrepresentation**

Insurance policies are issued based upon verbal or written statements made by applicants requesting coverage. These statements, or representations, are made for the specific purpose of purchasing an insurance contract from an insurance company and should be true to the best of the knowledge and belief of the person making them. Representations are not warranties or guarantees. The only time a policy can be voided because of a representation is when the representation is fraudulent or material—in other words, a misrepresentation. A misrepresentation that would be considered material is one that, had the truth been provided to the insurance company, would result in the insurance company not issuing a policy.

**Right to Include Warranties**

Warranties in an insurance policy are tools that insurance companies use to incorporate requirements imposed upon the named insured. In certain circumstances, an insurance company will require a *promise* of the insured and insurance coverage will be based upon the fulfillment of the promise by the insured.
For example, if the client is a pawn shop, the insurance company might require the named insured to warranty that 70 percent of all firearms and jewelry on the premises is stored in a safe when the business is closed. The reason for this warranty is common; pawnbrokers experience a higher degree of theft losses than many other business industries and the target of most thieves breaking into pawn shops is firearms and jewelry. If 70 percent or more of the firearms and jewelry on the premises is locked in a safe, the extent of potential theft losses is significantly reduced.

The named insured must understand that if, after making this warranty, a loss occurs and more than 70 percent of the firearms and jewelry on the premises was not locked in a safe after hours, the insurance company will not pay the theft loss.

Insurance companies don’t require warranties very often but, when they do require them, their use is nearly always an attempt at loss control—which benefits both the client and the insurance company.

**Right to Set Limitations**

Insurance companies can set limitations in policy contracts. While warranties and conditions are subject to stringent definitions, limits help insurers to contain the coverages that are provided. Some of the limits imposed include:

- **Property limitations:** Homeowner policies contain special limits for certain items of personal property, such as $1,500 watercraft, $200 for money, $2,500 for business personal property, and $1,500 for firearms.
- **Coverage limitations:** Insurance policies always contain limits per coverage type, such as $250,000 for a dwelling or $1,000,000 per occurrence for bodily injury and property damage liability.
- **Time period limitations:** Policies are issued for a certain time period, usually one year. Coverage begins at 12:01a.m. on the effective date of the policy and ends at 12:01a.m. on the policy’s expiration date. Policies often contain time limits for the submission of claims, such as 1 year from the date of an injury for a claim under medical payments coverage.

Coverage limitations are core issues of dispute because policy language may be confusing to a client. To clarify disputes, the courts examine the actual language in the contract, focusing on specific definitions.

**Settlement Issues**

Life insurance policies are usually settled without incident because the contract stipulates the amount to be paid in the event of the insured’s death and the contract does not include an extensive list of conditions and endorsements, or riders. However, property and casualty policies generate far more disputes because the amounts of coverage are usually determined by the actual value of property either at the time of the loss or the extent of an injury or damage to a third party. Property loss disputes tend to be more contentious because of the valuation clauses contained in property policies.
**Replacement Value**

Most building policies provide loss settlement on a replacement value basis. Using this method, an adjuster determines the value of the damage property using current prices to replace the property with material of like kind and quality without deduction for depreciation. Depending upon the type of policy and the availability of a replacement cost endorsement for personal property, losses to personal property or business personal property may also be settled using this valuation method.

**Actual Cash Value**

Using an actual cash value loss settlement valuation generates more disputes than using replacement value loss settlement does. The reason hinges on depreciation. The actual cash value of property is its current replacement value minus applicable depreciation and obsolescence. Many clients do not understand that wear and tear, and use, reduce the value of property. For example, if two consumers bought the same model of sofa five years ago, each sofa would have a different actual cash value—especially if one of the owners allowed pets to sleep on the sofa and the other owner covered the sofa in plastic.

**Solvency**

Unfortunately, these are not financially stable times and the insurance industry has been plagued by several issues, including solvency. Consumer groups, Congress, and other factions are seeking to protect consumers from a recurrence of such events as the 1987 stock collapse, the 9/11 attacks, the dot com boom, and the recession. These events have affected the solvency of many businesses, including insurance companies.

Further complicating matters, financial markets have transformed in recent years—the world is a smaller place thanks to information technology and communication systems. The boundaries of geography and financial products have blurred. The roles of banks, insurance companies, and insurance agents are being redefined. ATMs are located in grocery stores, insurance agents sell mutual funds, and the Internet makes it possible to buy financial and insurance products online at the click of a mouse.

In this rapidly changing world of business, financial markets and insurance institutions are evolving, as well. For some, this means coping with the competition, financial jolts, restructuring, errors in judgment, and even financial collapse. Commercial banks, securities firm, and insurance companies have experienced their share of woe. Insolvencies make the situation harder not only for consumers but also for the insurance industry, affecting reputation and regulatory attention. Financial failures lead to compromised trust, the call for regulatory intervention, insurance expert evaluation, and other techniques to remove insurers from the spotlight created by of insolvency.

Thankfully, both consumers and regulators have worked to support insurers during these trying times. Incidents such as questionable securities practices have been tackled responsibly by insurance regulators, insurance companies, and other groups like National Association of Insurance Commissioners. State regulators opted to rehabilitate prominent insolvent insurers so that policyholders would not suffer losses.
Comparatively speaking, the world of insurance has been subject to substantially low rates of failure and the key to maintaining trust among consumers is to maintain solvency.

**Insurance Industry Failures**

The insurance industry was characterized by the following between the early 1980s and the late 1990s:

- Aggressive competition and escalating cost pressures;
- Higher interest rates;
- Deregulation of financial services;
- New financial instruments;
- New records in innovations and sales;
- High medical costs and shattering claims; and
- Entry into the marketplace of small insurers.

The industry that used to be known for being conservative in both investments and marketing, stable, and generating high profits, ended up as a high-risk industry earning meager results. Political and media scrutiny shook the confidence of consumers. As a result, claims increased, the recession set in, and real estate values plummeted. Natural disasters, increased rate, and competition put added strain on the industry.

Despite attempts of the federal government to discredit the insurance business and compare it to the 1980s banking debacle, statistics offered comforting facts. Studies by Standard & Poor’s and Weiss Research prove that while in 1989, 500 banking institutions failed or were part of assisted mergers, in the same year, about 40 insurance companies were bailed out. In 2001, a total of 56 insurance companies failed and in 2002, only 23 failed. It should be noted that most of the insurance companies that failed were smaller companies. Insurance company failures are on the decline and appropriate regulation and consumer confidence have helped retain solvency.

**Future Direction of Insurance**

The good news is that the insurance industry is not threatened with insurmountable obstacles, despite the breakdown of big companies like Mutual Benefit Life. A major part of the industry is financially strong, with assets restructured to adhere to the new standards of solvency. Weaker companies have merged with stronger ones, competition is aggressive, and the industry is cautiously optimistic. Ambiguity lies in the fact that there still is no standardized system of rules for solvency and safety and the onus is on agents to connect demanding clients and the recuperating insurance industry.

If the 1980s was marked by collapses in the insurance industry, and the 1990s were marked by competing prices and underwriting losses, the millennium has problems that involve sales conduct, risks to assets, dubious methods of handling balance sheets, etc. Negativity on these fronts invites investigation and, possibly, more pressure from regulators.

Most insurers have managed to stabilize capital by containing costs and selling selected assets. There are quite a few speculations that:
• The companies’ aim to overcompensate and build excess surplus to meet proposed capital rules, might affect future earnings because advantageous acquisitions and the emphasis on better products are being overlooked.
• The proposed model investment law might generate complicated limitations;
• Insurers might be affected by more natural disasters;
• The capability of insurance companies to take investment risks might also be impacted by legislation and this lack of investment could lead to liquidity issues for the industry; and
• The position of the industry is weakening with respect to being the capital source for bonds and real markets.

However, the Graham-Leach-Bliley Act (GLBA) provided opportunities to financial institutions for mergers, as well as to sell a plethora of products and services. Insurance companies, brokerages, and banks are working out strategies to reallocate capital and serve their clients extensive assortment of products.

**Insurance Operational Challenges**

The major challenges that insurance companies face revolve around issues of balancing profits and solvency. Some questions that have been raised are:

• What are the evolving standards for solvency safeguards, investments, and capital surplus and who is regulating them?
• Will compliance with the standards collide with the insurers’ capability to assure shareholders and meet financial goals?
• Is it possible to harmonize regulatory reporting with the testing of new products and investment strategy?
• How far would liquidity be tested by consequences of natural disasters, low profits, and lack of financial contingencies?
• Might insurers need to increase premiums?
• Will new demographic concerns reduce the need for life insurance?

**Industry Mergers**

For agents, insurance company mergers may decide issues of solvency and security for their clients. Essentially, the merger of insurance companies with banks or securities dealers enables the insurance companies to strengthen their finances, gain a wider range of customers, and sell a wider range of products. The aim is to retain satisfied customers who, with one service provider, take advantage of banking and brokerage services as well as insurance products. Insurance companies can:

• Merge or acquire banking and securities firms (Citigroup);
• Establish partnerships with banks; and
• Offer banking products with the help of federal charters.

The pitfalls of these mergers are a risk of exposure. Agents must address the solvency of a company and its partners, and conduct business responsibly with financially secure companies.

**Analyzing Insurer Safety**

Agents cannot be expected to accurately appraise the solvency of all insurance companies—a concern that is highly contentious. Financial rating services help with the process of evaluating
an insurance company’s financial strength, but they are not infallible. Ethics and professionalism require agents to show reasonable care when appraising the solvency of insurance companies.

**Role of Agents**

It is easy for agents to assume that A rated insurance companies are solvent and secure. However, a rating cannot always be taken at face value, even if it is given by a reliable rating agency. Rating agencies have systems of qualitative and quantitative measurements that are complex; explaining or understanding the criteria upon which they are based is difficult. The safe thing an agent can do is to assure clients that while an insurance company might have a high rating, the rating cannot be treated as a guarantee of future solvency. Agents should also refer to three different agency ratings before giving advice to a client. Dependence on a single rating is not wise.

Clients should be made to understand that while there are no guarantees of insurer solvency, insurance companies have secure financial bases, licensing requirements, and are required to exhibit ethical sales conduct. Responsible agents will offer to clients a disclosure that explains an insurance company’s current financial ratings without making a promise of the company’s future solvency.

**Role of Rating Companies**

With the questions of insurance companies’ solvency in the spotlight, rating agencies have become more visible and vocal. They usually give their ratings based on the financial well-being of the insurer and how it discharges its responsibilities to its policyholders. Rating downgrades are distressing for an insurance company because they impact consumer and client behavior.

The 1980s saw the rise of rating agencies apart from A.M. Best, which provides rating services for a variety of companies. Consequences of too many raters in an already nervous marketplace, and too many downgrades that were considered arbitrary and rash, generated serious questions:

- Are ratings inflated or overly positive?
- Are ratings arbitrarily low?
- Could the agencies be reacting to market vacillations?
- Could the agencies be reacting to resulting insurer failures?
- Could the agencies be reacting to lowered consumer confidence?

The solvency ratings of firms such as Weiss Research and Standard & Poor's have been criticized; the former for parroting bad news to consumers and the latter for using a scale that is lower than that of their own ratings for claims paying ability. Both companies say they are using stringent quantitative methods of analyzing data to provide unbiased accounts to customers.

There have been requests to evaluate rating agencies, limit their access to insurers’ databases, and enforce that working methods meet standards. Others question the correctness of restricting access to data and suggest that the only recourse is to educate consumers about the rating process and leave it to them to accept or reject the provided ratings.
**Understanding Rating Agencies**

At the center of the discussion about rating agencies are the most well-known firms: A.M. Best Company, Moody’s Investors Services, Standard & Poor’s, Duff and Phelps, Fitch Ratings, and Weiss Research. Agents are better equipped if they possess knowledge of insurance company ratings and benchmarks. In order to properly explain to clients the financial ratings assigned to an insurance company, agents should understand the scope, philosophy, methods, and process—as well as the fees rating agencies charge. Rating classifications are just the tip of the iceberg.
Since its inception in 1906, the A.M. Best Company declares its mission as being constructive, objective, and preventing insurer insolvencies. The company gives advice to insurance companies and sees its ratings as a means to encourage them to be cautious and financially stable. The company’s rating system seeks to:

- Evaluate qualitative and quantitative information derived from the insurance company sources;

### Insurance Company Rating Classifications

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<th>S&amp;P</th>
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<th>Weiss</th>
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<td>B2</td>
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<td>Below Standard</td>
<td>D</td>
<td>CCC</td>
<td>Caa</td>
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* Under state supervision  
** In liquidation
• Meet with insurance company officials and examine financial statements, questionnaires and other data;
• Analyze the factors that impact the carrier’s performance;
• Provide information regarding the company’s financial strength;
• Discuss harmful developments that may impact a company's financial state; and
• Avoid immediately downgrading a company when possible.

**Employee Composition**

More than half of the staff at A.M. Best consists of full time employees who work directly on rating activity. Temporary employees are hired each spring to help with insurer filings and the compilation of data. Analysts form the major part of the full-time force and are usually experts in studies of finance in insurance companies. A.M. Best employees use cutting edge computer-based diagnostic tools and gather extensive data on each insurance company it rates. The company also consults with professional reinsurers, accounting firms, and actuarial services.

**Rating Eligibility**

Prerequisites to earn an A.M Best's rating include:
- An insurance company must have been in business for five consecutively years;
- The insurance company should have a specified excess net premium in the specific area it is insuring. For example, life/health insurers must have $1.5 million; and
- The insurance must pay a fee of $500 and provide A.M. Best will all the financial information it requests.

In the event an insurance company does not qualify with A.M. Best eligibility, it receives an NA rating or Not Assigned classification. The insurance company may apply for or a Financial Performance Index (FPI) assignment but it must have been in business for three consecutive years.

A.M. Best gives the insurance company the option of not publishing its rating but, in this case, they will receive an assignment of NA-9 (Company Request) and will also have to wait for two years before securing a future rating from A.M. Best.

**Rating Methodology**

A.M. Best's ratings are arrived at with the use of the quantitative appraisal of the insurance company's performance in the context of, among other things, its management, profits, liquidity, the range of its risks, investments, and its reinsurance program. A.M. Best adopts a methodology that aims to:
- Quantitatively evaluate the previous five-year performance and financial well-being of the insurer against A.M. Best’s financial norms and industry peer groups. To do so, A.M. Best makes use of over 100 financial tests and supporting data.
- Analyze profitability by reviewing the detailed earnings of the insurer over the past five-years. This is done by evaluating the competence of management and its capability to provide competitively priced insurance while maintaining financial strength.
o Everything that can impact earnings, such as net investments, federal income taxes, reinsurance, expenses, regulatory constraints, and underwriting issues are analyzed.
o Premium volume is studied for stability, diversification, and type in the context of the insurer's reported operating results. A.M. Best keeps a watch on insurance companies exhibiting instability due to high risks and substandard underwriting.
o Leverage measures, such as ratios of premiums to surplus and capital, and affiliated investments, are reviewed.

A.M. Best also examines reinsurance premiums, loss ratios, loss reserves that measure an insurance company’s exposure, and dependence on reinsurance. It measures an insurance company’s quick liquidity position to ascertain the cash amounts needed as well as the liquid convertible investments insurance carriers have on hand to meet sudden contingencies and avoid the sale of investments. This is done by evaluating market value, cash flow, and diversification of assets, among other things.

A.M. Best watches out for single large investments and uses stress tests to gauge the impact of reduction in stock prices, bonds, mortgage loans, etc. It also performs qualitative evaluation of items that cannot be evaluated quantitatively but which affect the insurance company’s performance and its long-term viability. This kind of evaluation involves, among other things:

• Examination of books of business to determine the range of risks;
• Evaluation of reinsurance programs;
• Review quality, investment diversification, and market value;
• Gauge the adequacy of reserves, as well as surplus;
• Assess the management in the context of competency;
• Review programs that match asset or liabilities; and
• Evaluation of liabilities structures.

A.M. Best conducts a thorough evaluation of the information at hand. A red flag for A.M. Best is any inadequacy in reserves because it may impact profits, liquidity, and leverage. The insurance company’s book of business is examined on the basis of geography and line of business to gauge the range of risk. It looks for how much business the company has in volatile and hazardous industries because such exposures might impact financial stability. Reinsurance programs are scrutinized to verify that adequate coverage is provided. Excessive reinsurance or recoverable reinsurance may affect an insurance company’s financial rating.

Marketable assets are examined in detail, as well as liquidity reserves. An inadequate surplus is seen in context of the extent of risk connected with the insurance company’s book of business. With property and casualty insurers, losses and loss adjustment expenses are examined based on payout as well as company surplus. A.M. Best maintains working relationships with management of insurance companies to assess not only how competent they are but also to gauge objectives and the character of the insurers. A.M. Best also measures insurance companies in relation to policyholder confidence.

A variety of factors are considered and researched with the use of different analytical methods to report on the financial strength of an insurer. A.M. Best emphasizes it is aware of the role it
plays in the market and that it strives to give ratings based on detailed, careful research. These ratings are downgraded only if severe concerns are found during the analysis.

**Rating Classifications**
A.M. Best publishes financial ratings that are derived from their rating classification systems. A brief explanation of the alphabetical ratings follows:

- **A++ and A+:** A Superior rating is given to insurance companies that have superior overall performance against A.M. Best’s measurement of superior performance. These companies are deemed to be very strong financially and are able to honor their duties by contract and to policyholders.
- **A and A–:** An Excellent rating is given to insurance companies that have excellent overall performance and are expected to meet the demands and obligations of their contracts and policyholders.
- **B++ and B+:** A Good rating is given to insurance companies that have good performance and their capability to discharge their financial obligations but, at the same time, their financial state may be affected by issues such as substandard underwriting or other economic concerns.
- **B and B–:** A Good rating is given to insurance companies that have performed well and, while they seem to have adequate capabilities to carry out their duties, may face financial challenges due to substandard underwriting and other economic concerns.
- **C++ and C+:** A Fair rating given to insurance companies exhibiting fair performance and, although they have reasonable enough ability to discharge financial obligations, their financial stability is vulnerable to substandard underwriting and other economic concerns.
- **C and C–:** A Marginal rating given to insurance companies that have performed marginally and, while they currently do have the ability to discharge financial obligations, they are very vulnerable to substandard underwriting and other economic concerns.
- **D:** A Below Minimum Standards rating is given to insurance companies that have not merited a C rating. Although they qualify for A.M. Best’s eligibility for size and requirement standards, they fall short on performance standards. This used to be called rating NA-7 or Rating Not Assigned
- **E:** An Under State Supervision rating is given to insurance companies that are seen to need supervision by state insurance regulators for rehabilitation but do not require liquidation. This used to known as NA-10.
- **F:** An In Liquidation rating is given to insurance that warrant liquidation. This became a new rating in 1992.

Most insurance carriers are rated between A+ and C-.

**Performance Modifiers**
Performance modifier ratings are given to insurance companies for which the rating has been changed due to performance, contractual responsibilities, or affiliation. A.M. Best’s performance modifier ratings are:
• Qualified Ratings “q”: This rating is given only to property and casualty insurers that have been identified as companies whose financial condition is being negatively affected.
• By state legislation (either existing or pending), that have specific rate restrictions and/or surcharges that policyholders should not have access to.
• By payments that are equal to their policyholders’ surplus or in excess of it, from state market programs and reinsurance facilities.
• Watch List “w”: This rating is given to insurance companies added to A.M. Best’s watch list because the insurance companies are under close scrutiny for severely diminished financial performance or because adverse legal, market, or financial situations have left them critically exposed.
• Revised Rating “x”: This rating is given to insurance companies for which a rating was changed in the current year.
• Contingent Rating Modifier “c” has been removed.

Affiliation Modifiers
These are ratings given by A.M. Best to insurance companies that are affiliated with insurance companies with ratings:
• Parent Rating “e”: This rating is given to a subsidiary company to indicate that it carries the assigned rating of its parent because the parent company has more than 50 percent ownership. This rating is derived from the parent’s performance, along with subsidiary’s performance. To acquire an “e” rating, a performance review of the subsidiary during a five year period is needed and the subsidiary should have the same management, underwriting, liquidity, and leverage as its parent company.
• Group Rating “g”: This rating is given only to property and casualty insurers that are part of an affiliation of a group of property and casualty insurance companies. For a group rating, insurance companies must have the same management or ownership, share substantial net business, and--as much as is possible--have similar operating and underwriting performance. The rating is based on the consolidated group performance.
• Pooled Rating “p”: This rating is given to insurance companies that are among a group of insurance companies that have the same management or ownership but pool together 100% of their net business. The rating is assigned on the basis of consolidated group performance.
• Reinsured Rating “r”: This rating is given to insurance companies belonging to the same financial size category, and the same rating, as the one given to its affiliated reinsurance carrier that reinsures up to 100 percent of the insurance company's net written premiums.
• Consolidated Rating “s”: This rating given only to property and casualty insurers and is the rating that is assigned to the parent company. The rating is based on the performance of both the parent company and its domestic subsidiaries.

Not all insurance companies are assigned ratings by A.M. Best because they fail to conform to the standard requirements of size and operating experience. The following is a list of not assigned classifications:
• Special Data Filing NA-1: This is a classification is given to small mutual and stock insurance companies that are not required to file the NAIC annual statement.
• Less than Minimum Size NA-2: This classification is given to insurance companies that must file the NAIC annual statement, however, meet the minimum requirement with respect to size.
• Insufficient Operating Experience NA-3: This classification is given to insurance companies that meet, or are expected to meet, the minimum requirement of size but do not have the required years of operation.
• Rating Procedure Inapplicable NA-4: This classification is given to insurance companies whose nature of business does not allow for the usual rating procedure to be applied.
• Significant Change NA-5: This classification is given to insurance companies that have been rated before but which have undergone ownership or management changes resulting in changes to the book of business.
• Reinsured by Unrated Reinsurer NA-6: This classification is given to insurance companies that have purchased considerable reinsurance by unrated reinsurers. The insurance companies may also have purchased recoverable reinsurance that is a major portion of the policyholders' surplus.
• Below Minimum Standards NA-7: This rating was discontinued in 1992 and was replaced by financial rating D.
• Incomplete Financial Information NA-8*: This classification is given to insurance companies eligible to earn a rating but that have failed to provide complete financial information during its five-year performance period.
• Company Request NA-9: This is a classification is given to insurance companies that request the non-publication of their ratings. The insurance companies may not want publication of the rating because they disagree with them, because they have issues with the fee they’ve been charged, or they do not need to have a published rating.
• Under State Supervision NA-10: This rating was discontinued in 1992 was replaced by E and F ratings.
• Rating Suspended NA-11: This classification is given to insurance companies that have been rated before but have experienced unexpected events that impacted their financial positions or operations and, therefore, could not be evaluated.

According to A.M. Best, 52.6% of its ratings are for property and casualty insurers and 41.7% of its ratings are for life and health insurers.

**Financial Performance Index**

The Financial Performance Index (FPI) rating was introduced in 1990 to rate insurance companies that did not meet the A.M. Best requirement for size and operational experience. For an insurance company to acquire a FPI rating, it should have operating experience amounting to three years, present NAIC statements, answer rating questionnaires, and be qualified for the NA-2 or the NA-3 categories.

The process of acquiring FPI ratings is the same as that for the alphabetical financial rating classifications. The same quantitative appraisal is conducted but the qualitative review is not as extensive. The insurance company can be given a FPI rating from between 1 and 9, with 1 being given to insurance companies with less than three years of operating experience.
Publication of Rating Information

A.M. Best publishes its ratings in company reports and circulates them through information services and different publications. A.M. Best's Insurance Report is published every year and is accessible to anyone wanting to read the ratings. Ratings are available in public libraries as well as state insurance departments. Updates are made and similarly released and circulated. A.M. Best’s ratings are also available online.

Standard and Poor's

Beginning with the rating of bonds in 1923, Standard and Poor's (S & P) moved on to rating insurance companies in 1983. Since then, it has been considered second only to A.M. Best. To rate insurance companies, S & P delves into its expertise with rating debt issues and expert analysis of the insurance industry. S & P aims to provide risk estimation of the insurance carriers to the insurance buyers. It does not aim to be an advisor or to alert insurance companies about how to improve their financial conditions or ratings.

The Insurance Rating Services of S & P are one among six of the departments in the S & P Ratings Group. This department gives ratings regarding fixed income securities, commercial paper, long-term debt, preferred stock that is issued by insurance carriers, claims paying ability, and qualified solvency ratings.

Claims paying ability evaluation is what assesses an insurance company's financial capability to discharge its financial duties to policyholders. The rating for an insurer’s claims paying ability is derived from the analysis of qualitative and quantitative analysis. It utilizes myriad sources of data, including information gathering through interviews with people working in management.

S & P began qualified solvency ratings in 1991. These ratings are established based on the analysis of financial data that was submitted to the NAIC and which was purchased by S & P. The qualified solvency method aims to indicate statistically the financial condition among insurers and makes a broad distinction between ranges of risk to policyholders. S & P does not provide insurer ratings to encourage customers to buy, retain, or surrender policies from any specific insurer. These qualified solvency ratings have been questioned in the past and insurers have often been disappointed with the ratings they have been given. Some have felt markets do not understand these ratings.

The rating for claims paying ability are voluntary, necessitating insurers to pay a fee of anywhere from $15,000 to $32,000. The fee depends on the size of the company, the affiliated insurers count, etc. For the initial application, insurers are given the option to not complete the rating process or not have the rating published. Once the rating is published, there is an option for the insurers to withdraw it. S & P's observation of the insurance carrier's financial condition is usually released when the rating is withdrawn. In the event an insurer asks for withdrawal, S & P completes the review process, announces any downgrade of the rating, and then withdraws it.

Claims paying ability has been announced for 200 life and health insurance carriers, 25 financial guaranty insurers, 400 property and casualty insurance companies, and 80 alien insurers. 1,230 property and casualty insurance companies and 750 life and health insurance carriers have been given qualified solvency ratings. Insurance Solvency International is a subsidiary of S & P that
has given ratings to 900 alien property and casualty insurers and reinsurers. Reports on Lloyd's syndicates are created by S & P as well as for life insurance companies in United Kingdom.

**Employee Composition**
Insurance Rating Services group of S & P consists of approximately 80 employees in London and New York. 25 members of this staff are analysts who work to monitor, evaluate, and establish claims paying ability of insurers and the ratings for it. The analysts are experts with comprehensive professional and financial understanding of the insurance world. Each analyst rates and monitors 20 companies, assisted by 10 statistical evaluators, computer support employees, and others.

**Rating Eligibility**
The process to earn a rating from S & P for claims paying ability begins with completing the application and seeking the assistance of the insurance carrier to give S & P all the financial information they ask for. The appointed lead analyst coordinates with the insurer to gather information that includes:

- Statutory financial statements for the past five years;
- GAAP financial statements;
- Questionnaires that provide required information about debt securities, real estate investments and, mortgage loans;
- Spreadsheets, company profiles, and financial ratios that are prepared to furnish S & P analysts with an indication of the finances of the insurer according to A.M. Best; and
- Interviews with people in management to assess issues like goals, profitability, strategies, underwriting practices, and accounting policies.

S & P analysts actually spend a day at the insurance company’s premises to meet key officers and gather firsthand information. This day of interviews, along with the provided statements and documents, is analyzed to create a report along with a preliminary rating.

This report is then presented before a rating committee that consists of leading insurance industry experts and S & P specialists who have expertise in the field(s) of insurance business in which the insurance company is engaged. The preliminary rating is discussed in the context of the assumptions of the analyst, material facts are verified, and counterarguments regarding the rating are conducted. The final rating is established after the committee meeting.

The rating is then conveyed to the insurer, which is also given the basis of the rating. Neither the detailed discussions of the rating committee nor the identity of the members are given to the insurer. In the event the insurer submits information indicating that the rating is not accurate, the committee is compelled to revise the rating; otherwise, the rating remains unchanged. The insurer has the choice of not publishing this rating but most insurers do not exercise the option. If an insurer does refuse to accept the rating for claims paying ability, it is assigned the qualified solvency rating.

When a rating is assigned by S & P, it is circulated in publications and over telephone to consumers. S & P analysts, however, continue monitoring activities of an insurer they have rated through the appraisal of financial statements, reports, annual meetings, and other market and
industry changes. A rating is subject to review in the event of changes to the financial well-being of the insurer. Meanwhile, the insurer is notified of the change in rating through the S & P general advisory, called CreditWatch.

**Rating Methodology**

S & P conducts an all-inclusive evaluation of qualitative and quantitative data with the usage of qualitative principles common to all insurance companies and then customizes analytical methods for the primary insurance segments of life and health insurance, property and casualty insurance, consolidated property and casualty groups, and reinsurers.

Following is the brief outline of S & P’s rating methodology:

- **Risks in industry:** Industry risk is analyzed from the perspectives of the:
  - Entry of insurers who may pose a threat;
  - Substitute products and services that may provide alternatives and jeopardize business;
  - Existing rivalry with other insurance firms; and
  - Bargaining power of buyers and suppliers.

- **Management and corporate strategy:** S & P evaluates the management strategy against an insurer’s capabilities and how they relate to the marketplace. The insurance company is assessed on its execution of a chosen strategy along with the expertise of the management operations within the lines of business. Audit and control structures are reviewed. Financial risk tolerance is analyzed in light of debt in the capital structure and the operating leverage a company accepts. Additionally, interest rate management and issues of asset/liability matching are examined for life insurance companies. Loss reserve adequacy is assessed for property and casualty insurers. There is no specific statistical algorithm that is used but, in the course of qualitative analysis, insurance companies are "benchmarked" with industry norms.

- **Business review:** The fundamental character of the insurance company, and its competitive advantage or disadvantage, is studied. This study relies on a full description of the business units, product lines, business diversification, and distribution systems. Also, the capability to generate long-term revenue is assessed. Any issue that impacts the growth rate and the company’s revenue base is analyzed.

- **Operational Review:** S & P analyzes operating results to see how an insurance company capitalizes its strategy and strengths. While examining the company’s earnings performance, S & P chooses to see its core economic profitability and not just the net gain. GAAP financials are used if available. After-tax return on the insurer’s assets is a ratio viewed by S & P as being comprehensive. With life and health insurers, the expense structure, effective tax ratio, mortality and morbidity experience, pricing policies, and actual performance is analyzed. With property and casualty insurers, underwriting performance, premium growths, loss and expense ratios, adequacy of loss reserve, other items are reviewed. The stability of an insurer’s earnings and the trends it exhibits are also kept in mind.

- **Investments:** S & P reviews:
  - Insurer assets; for example, the allocation of assets in bonds, preferred stock, mortgages, real estate, and other invested assets and evaluates them in the context
of diversification and credit quality. This helps S & P to see how qualified the insurance company is to uphold policyholder liabilities.

- Asset quality; by reviewing the investment portfolio for problematic and risky assets, restructured mortgage loans, foreclosed real estate, and loans to be foreclosed. S & P reviews historical data and current trends to arrive at the required investment reserves for mortgages, bonds, etc. and evaluates the existing investment reserves of the insurance company. Equity assets, real estate, stocks, etc. are also reviewed.

Additionally, the management of interest rate risk, and strategies to match assets and liabilities, is analyzed. Specific assets, the duration of liabilities, and cash flows from interest rates of sensitive portfolios are identified. Any mismatch of maturity with duration helps S &P to estimate tolerance for risk.

- Capitalization: The analysis involves the review of:
  - Financial leverage, operating leverage, and fixed charge coverages. S & P uses the following ratios: total debt to capital, short-term debt to capital, fixed charge coverage, long-term debt to capital, preferred stock to capital, and fixed charge coverage of preferred dividends.
  - Operating leverage that is seen in the context of the lines of business. For example, for health and life insurance carriers, the operating leverage is the total liabilities to the statutory capital, separation of accounts from its liabilities, and the treatment of mandatory securities valuation reserves as capital.
  - Review of asset/liability mismatch in the context of level of capital.
  - Quality of reinsurance.
  - Quality of capital in relation to exposure amount to reinsurers, equity assets, and equity investments.
  - Adequacy of loss reserves for property and insurers.

- Liquidity: S & P looks at cash outflows because of lapses, policyholder loans, surrenders, and cash withdrawals. The type of liabilities of the policyholder, the related surrender charges, and market valuation are examined to see how prone the company is to an increase in cash outflow before the maturity of policies. The quantity of liquid assets insurance carriers possess to address increased cash outflow and policy maturities is also reviewed.

- Financial flexibility: S & P examines capital requirements, as well as capital sources.

### Rating Classifications

S & P gives ratings for claims paying ability and/or qualified solvency. The ratings for claims paying ability should be considered indicative of the financial competence of the carriers to discharge obligations to policyholders. The ratings are classified as secure or vulnerable. The following list indicates the ratings for claims paying ability:

- **AAA - Secure**: This rating is given to insurance companies with superior financial security. They are safe and have strong capacity to discharge policyholder obligations.
- **AA - Secure**: This rating is given to insurance companies with excellent financial security. They are safe and their strong capacity to discharge policyholder obligation is just a little less that of AAA rated insurers.
• **A - Secure**: This rating is given to insurance companies with good financial security. Their capacity to discharge policyholder obligations could be impacted by substandard underwriting and economic changes.

• **BBB - Secure**: This rating is given to insurance companies with adequate financial security. Their capacity to discharge policyholder obligations could be impacted by substandard underwriting and economic changes.

• **BB - Vulnerable**: This rating is given to insurance companies with seemingly adequate financial security. Their capacity to discharge policyholder obligations, especially long-term policies, is vulnerable because they could be adversely impacted by substandard underwriting and economic changes.

• **B - Vulnerable**: This rating is given to insurance companies that can discharge policyholder obligations in the present but their financial capacity is highly vulnerable to substandard underwriting and economic changes.

• **CCC - Vulnerable**: This rating is given to insurance companies with a financial capacity that is so highly vulnerable to substandard underwriting and economic changes that their ability to discharge policyholder obligations is questionable.

• **CC and C - Vulnerable**: This rating is given to insurance companies that might not meet policyholder obligations and might be under the jurisdiction of insurance regulators. These insurance companies might be liquidated in the future.

• **D - Vulnerable**: This rating is given to insurance companies that are scheduled for liquidation.

**Qualified Solvency Ratings**

Qualified solvency ratings, based on financial data provided by NAIC, aim to identify financially weak insurance companies from their stronger counterparts. The analysis used is the multi-variate discriminate type that develops a model responsible for assigning numerical scores, known as z-scores, to insurance companies based on financial results. A four-year period is used to study financial ratios and variables. Alternate data is used to test the model to make certain that it can spot insurers likely to fail.

The analyses for these ratings are completed in all four main industry segments; actuarial experts, as well accounting consultants, scrutinize the processes. There is a constant updating of models with newly available information.

Z-scores are classified into three broad groups: **Adequate, May be Adequate, and Vulnerable**. The following ratings for qualified solvency are given to insurance companies by S & P:

- **BBBq - Adequate**: These ratings are given to insurance companies with financial results that are similar to other companies with more than adequate, or even superior, financial security.

- **BBq - May be Adequate**: These ratings are given to insurance companies with financial results similar to other companies with adequate financial security.

- **Bq - Vulnerable**: These ratings are given to insurance companies with financial results similar to other companies with very vulnerable financial security.
There has been criticism on the grounds that the S & P’s BBBq seems lower than the rating for claims paying ability AAA, but S & P contends that while claims paying ability BBB indicates secure, but not superior, the BBBq indicates secure but possibly uncertain as to this security. Despite the extensive debate, S & P sees qualified solvency method as unbiased indicators of the financial well-being of insurance companies and a broad differentiator in classes of risk. According to recent data, S & P gave the rating AAA and AA on claims paying ability to 16% of the life and health insurance companies it rated.

**Publication of Rating Information**
The ratings for both claims paying ability and qualified solvency are published in a variety of publications, including the quarterly S & P Insurance Book. This book covers information about more than 500 insurance companies in the industry. Customers can access S &P's published ratings of 1,600 insurers and all the insurance company ratings for claims payment ability. Consumers can call S & P helpline for information about five insurers free of charge.

**Moody's Investor Service**
John Moody established Moody's Investors Service in 1900 and invented bond ratings in 1909. From humble beginnings, this company is now the rater of industrial companies, banks, public utilities, and other financial bodies totaling approximately 4,000. Moody’s performs ratings for bonds, credit ability of commercial paper, money market funds, bank deposits, and GICs.

While it has been, rating debt securities since the 1970s, it was only in 1986 that Moody’s began to assign ratings of financial strength to insurance companies. Moody’s has a reputation to reckon with, but rates a fewer number of insurance companies than A.M. Best or S & P do. Moody’s ratings are indicators of the insurance companies’ capabilities to address obligations of senior policyholders. It addresses credit risk which, to Moody’s, is the risk that the insurance companies might not cover senior policyholder claims in a timely and full manner.

Moody's bases its ratings on qualitative and quantitative analysis of the insurance company information it is provided in the context of the insurer’s business fundamentals, regulatory trends, and the industry. Moody’s rates 80 domestic life insurance companies, 20 alien insurance companies, and approximately 180 property and casualty insurance companies. It also rates reinsurers and provides debt ratings for 175 insurers.

**Employee Composition**
The rating for financial strength is founded on the work of Moody’s Insurance Group which, in turn, belongs to Moody’s Financial Institutions Group. This Insurance Group is made up of one associated director, approximately eight senior analysts with expertise in insurance financials, two actuaries, and four support employees. Together, these employees form part of the committee process that analyzes the extensive data to ascertain credible ratings.

**Rating Eligibility**
Large insurance companies writing annuities were the initial focus of Moody’s ratings but today Moody’s rates different types of life and property and casualty insurers. An annual fee of $25,000 is charged for life insurance companies. The fee charged to property and casualty insurers is $22,000. In the event Moody ascertains that a life insurance company has high
policyholder and investor interest in a rating, it will assign a rating even if the insurer has not requested it or if it has not paid the fee.

Ratings are created with the help of a committee process that collects the expert knowledge and insights of several analysts, directors, and associate directors. The appointed lead analyst is given the responsibility of analyzing the insurance company and preparing a rating that is sent to the Corporate Rating Committee for its recommendation. The final rating is issued by this committee, is conveyed to the insurance carrier, and is then made available to the public. A published rating is constantly under review and can be changed with submission of relevant information that is verified. The insurer may submit additional information to Moody’s if it would like the rating to be reviewed. The right to disclose a rating remains with Moody’s, even if the insurance carrier does not agree with the rating. Only property and casualty insurers have the right to ask for a rating not to be made available to the public.

**Rating Methodology**

Moody's ratings for financial strength of a company are based on details of:

* Industry analysis that seeks to examine the nature and framework of competition that exists in the operating environment of the insurance carrier and its own competitive position within it. For Moody’s, this study of the industry involves:
  o Amount of concentration in the industry;
  o Extent of competition between industries;
  o Degree of level and stability of competition; and
  o National protectionism level.

* Regulatory trends analysis that tries to understand the possible changes of a nation’s tax structure and regulatory system. For Moody's, the study of regulatory trends involves:
  o Evaluation of probable changes in tax and regulations that;
    ▪ Impact the insurer’s position in competition with other companies;
    ▪ Lead to restructuring of different areas of the industry; and
    ▪ Examination of state regulators’ practices of resolving failure.

* Business fundamentals analysis that seek to understand:
  o Financial fundamentals that include a close look the following issues:
    ▪ Capital adequacy: To estimate the capital of a company, Moody's makes and adjustments in the statutory data to consider:
      • The degree of conservatism in both statutory reserve as well as asset valuation;
      • The acquisition costs that are recoverable from any future earnings;
      • The hypothecation of any future earnings through the method of financial reinsurance; and
      • Any investments and interests in subsidiary companies.
    ▪ The risk-based capital ratio is employed to evaluate capital adequacy as it recognizes the company’s assortment business lines along with assets - of which each one has different risk characteristics.
  o Profitability and risks: Among the number of issues examined to gauge how profitable the insurance carrier might be in the long haul and its threats are:
    ▪ Insurer’s market focus;
Market segment competitive dynamics;
Distribution costs;
Standards and records of underwriting; and
Investment strategy.

- Liquidity analysis delves into aspects of the insurance company’s liability structure, the existing options, and the extent these liabilities are confidence-sensitive. In life insurance companies with high confidence-sensitive policyholders, Moody's evaluates the assets. The asset structure of an insurance company, its liquid portfolio, and marketable assets are considered.

- Qualitative evaluation of the insurance carrier includes:
  - Assessment of franchise value by noting its competitive position vis-à-vis the market. Moody’s takes a look at the products, the distribution system, if it is an essential product or service, and also the company’s competitive advantages in the core lines of business.
  - Management evaluation through the financial track record that would give insight into management strategy, investment risk taking, product innovation, and profitability.
  - Organizational evaluation through the appraisal of the insurance company’s relationship to its parent company, subsidiaries, and affiliated companies and how they affect its financial condition.

**Rating Classification**

Ratings symbols for financial strength and bond quality are the same. The following list indicates Moody’s ratings:

- **Aaa - Strong**: This rating is given to insurance companies with exceptional financial security, strong enough that it will not be affected by any adverse changes.
- **Aa - Strong**: This rating is given to insurance companies with excellent financial security; these are high-grade companies but their long-term risks seem larger than Aaa companies do.
- **A - Strong**: This rating is given to insurance companies with good financial security but change might affect their financial condition in the future.
- **Baa - Strong**: This rating is given to insurance companies with adequate financial security but they may lack insulation from adverse changes and be unreliable in the future.
- **Ba - Weak**: This rating is given to insurance companies with moderate financial security and moderate ability to discharge policyholder obligations.
- **B - Weak**: This rating is given to insurance companies with poor financial security and poor capability to discharge policyholder obligations.
- **Caa - Weak**: This rating is given to insurance companies with very poor financial condition that may not be punctual or may default in payments for policyholder obligations.
- **Ca - Weak**: This rating is given to insurance companies with extremely poor financial condition that may default in payments for policyholder obligations, along with other financial failings.
- **C - Weak**: This rating is given to insurance companies with the lowest level of financial security and with very poor capability to honor policyholder obligations.
According to recent data, Moody's has given the rating Aaa or Aa to 58.3% of its rated life insurance carriers and 77.4% of its rated property and casualty insurance companies.

**Publication of Rating Information**

The ratings given by Moody's can be found in various publications. Help lines can be called for Moody’s rating information. Moody's published literature carries details about insurers, expert industry-related commentaries on the industry, and access to analysts.

**Fitch Ratings**

Located in London and New York, Fitch Ratings began with investment research in 1913 and, from rating securities, expanded into the rating of the financial strength of insurance companies. Fitch Ratings introduced ratings ranging from AAA to D. In 1997, it merged with IBCA (London) and, in 2000, acquired Duff & Phelps. Both moves helped reinforce Fitch's position with respect to corporations, financial institutions, insurance companies, and more structured finance areas. As do S & P and Moody’s, Fitch believes in evaluating risk of the insurers from the perspective of the policyholder. It also values qualitative and quantitative analysis to establish ratings.

Fitch ratings indicate likelihood of payment by the insurer for policyholder obligations according to the terms of these obligations.

**Employee Composition**

Fitch employs experienced financial analysts, subject matter experts, and other financial and support staff to research on the development of ratings based on claims paying ability.

**Rating Eligibility**

To receive a rating from Fitch, insurers may apply and must pay an annual fee of $17,000. They must submit the required financial data and other types of information. Fitch has conducted ratings for three insurance carriers without a formal application from them. Fitch gives the insurers the option to not publish their ratings but most carriers do not exercise that option.

Fitch Ratings rates 91 life and health insurance companies, 7 property and casualty companies, and 6 bond insurers on claims paying ability.

**Rating Process**

To begin the rating process, Fitch requires the following financial information so it conducts thorough qualitative and quantitative research:

- The latest budget detailing expected statutory performance, along with five-year projections;
- All materials related to asset/liability matching, investment policies, and estimations of asset/liability timelines;
- The latest 126 filing—New York Regulation;
- Lists of problematic loans/assets;
- Organizational charts detailing corporate structure as well as executive reporting;
- Detailed information of key products;
- Strategies for each product line;
Distribution pattern of bond assets according to quality ranking, industry categories, and other relevant and important categories;
Comprehensive company history with major milestones;
Available industry comparison statistics detailing expenses, investments, market share, etc.;
Annual policyholder reports;
Annual statements (long form with all schedules) for the most recent six years;
Annual statements of subsidiaries for the most recent year;
Account statements of recent two years;
Account statement of all subsidiaries for the most recent year;
Statutory quarterly statements for the preceding and current year, along with quarterlies of subsidiaries;
Current report of insurance department triennial exam;
Yearly shareholder reports, most recent 10Ks for six years, current proxy, along with recent prospectus; and
Audited GAAP plus SAP financial statements.

Once all the above information is submitted, Fitch sends personnel to the office of the insurance carrier for on-site interviews with the company CEO, key investment officers, chief marketing officers, and with product managers. These officials may also be invited to New York for a meeting with Fitch rating committee members. This interaction is crucial to the qualitative and quantitative process.

Fitch analysts begin tests such as comparative analysis plus financial ratios in the context of the company’s profitability, investment risk, operating efficiency, liquidity, and leveraging. An extensive qualitative evaluation is carried out on the company's management, ownership structure, economic fundamentals, competitive position, and asset/liability practices. Quantitative and qualitative data is compared to arrive at the analytical conclusion of the finances of the insurance carrier.

Once the evaluation is complete, Fitch analysts submit a report for review to the rating committee along with a rating recommendation. The Fitch rating committee, made up of 11 experienced credit rating officers, sits to review the analysts’ reports and determine a rating which is then reported to the insurance carrier, which has the choice not to publish the rating. The rating is published in the media, by telephone, via e-mail, in press releases, and its in-house publications. The rating is always under review and Fitch insists that it be informed of any change and development that may affect this rating.

**Rating Methodology**

At Fitch, credit analysis is related to the analysis of the insurer's claims paying ability. It is a procedure that emphasizes the capability of the insurance company to discharge future payment of policy and contract obligation according to contract terms.

Fitch’s focus is maintenance of adequate liquidity and long-term solvency of an insurance company. To investigate these two aspects, it studies details of investment returns, liability structure—especially with regard to stability of liabilities, asset/liability management with
scenario tests in context of the control of interest rate risk, liquidity management with worst case test scenarios, profitability, product line returns, tax issues, reinsurance relationships, and marketing methods. Additionally, Fitch looks at reviews of pricing, product design, performance, and interest rate crediting – all from the actuarial perspective. Historical, present, and budgeted financial results are also evaluated for long-range strategic forecasts.

Fitch, with results of its investigation, seeks a comprehensive evaluation of the actual and expected financial performance. The Fitch methodology includes quantitative analysis involving tests that sort out the financial information of the insurance company with the help of the following ratios:

- Average Admitted Assets Returns;
- Adjusted Surplus Returns;
- Net Investment Income Yield;
- Expense Ratios;
- Combined Ratios;
- Surplus Formation;
- Investment in Affiliates to Adjusted Surplus;
- Higher Risk Assets to Adjusted Surplus;
- Adjusted Liabilities to Adjusted Surplus; and
- Premiums to Adjusted Surplus.

A detailed study of the adjusted surplus is carried out by Fitch through a summation of the reported surplus, deficiency reserves, reserves of mandatory securities valuation, and additional balance sheet items that Fitch considers as representing employed "capital." This is done with the aim to measure and identify total capital employed which, in turn, helps measure operating leverage and profitability.

Qualitative analysis includes the evaluation of the insurance company’s:

- Economic fundamentals regarding the main insurance lines;
- Competitive position in the market;
- Executive management ability;
- Relationship with the parent, subsidiary, or affiliate company; and
- Management techniques for assets and liabilities.

Fitch integrates both analyses and concludes if the current financial trend of the company is sustainable for the future—or if it could reverse adversely its claim paying ability. In addition, Fitch also explores the

- Exposure of the company to changes in underwriting and business;
- Mismatches in assets and liabilities;
- Management methods of controlling interest rate risk; and
- Adjusted surplus adequacy in context of economic volatility.

**Rating Classification**

Fitch uses the same scale for bonds, preferred stock, and claims paying ability—with different definitions. “+” and “-“are added for further quality delineation. The following list details Fitch’s ratings:
• AAA: This rating is given to insurance companies with maximum claims paying abilities and negligible risk factors.
• AA: This rating is given to insurance companies with a very high level of claims paying ability and strong protection factors. These insurance companies face modest risks that may vary because of underwriting and/or economic pressures.
• A: This rating is given to insurance companies with a high level of claims paying ability and average protection factors. These insurance companies face modest risks that may vary because of underwriting and/or economic pressures.
• BBB: This rating is given to insurance companies with below average level of claims paying ability and average protection factors. They face considerable risks that may vary because of underwriting and/or economic pressures.
• BB: This rating is given to insurance companies with uncertain level of claims paying ability. They might discharge policyholder obligations in a timely fashion but their protection is likely to vary considerably because of underwriting and/or economic pressures.
• B: This rating is given to insurance companies with risky levels of claims paying ability. These insurance companies might not discharge policyholder obligations in a timely fashion and their protection is likely to vary considerably because of their own finances and underwriting and/or economic pressures.
• CCC: This rating is given to insurance companies with substantially risky levels of claims paying ability. They cannot discharge policyholder obligations and may need supervision of state regulators.

According to recent data, Fitch's gave an A+ or higher rating to 68% of its rated life insurance carriers and approximately 2% of its rated property and casualty insurance companies.

**Publication of Rating Information**
The ratings given by Fitch's can be found via telephonic help lines, e-mail, press releases, and company reports. Fitch's in-house literature carries details about insurers, ratings, explanations, and commentaries on the industry.

**Weiss Research**
Since 1972, the founder of Weiss Research, Martin D. Weiss, has been a commentator of interest rates, money markets, bank safety, and economic forecasting. In 1989, Weiss Research expanded to include publication of safety ratings. Because Weiss Research is located in Florida’s West Palm Beach area, it has a different approach than other companies who rate insurance companies and invites considerable controversy.

The safety rating given by Weiss indicates an insurer's capability to honor policyholder commitments not just under present economic circumstances, but also in environments of economic extremities or increasing liquidity. Weiss employs a computer model based on 200 financial ratios to process financial data gathered from insurers and statutory statements. The emphasis is on collecting objective, quantifiable information rather than on subjective, unquantifiable judgments. For this purpose alone, Weiss chooses not to interact with an insurance company’s management team.
**Employee Composition**

There are 70 employees working at Weiss Research as analysts, computer programmers, technicians, customer service counselors, and clerks. Seven analysts and consulting actuaries work in the development and functioning of the Weiss computer model.

**Rating Eligibility**

Because Weiss ratings are involuntary, insurance carriers do not apply for or pay for ratings. To be as objective and independent as possible, Weiss funds its rating activities with earnings from selling its information to its clients rather than charging fees. Weiss reports ratings for over 1,700 life, health, and annuity insurance companies.

**Rating Process**

The five-step process employed by Weiss to establish a safe rating involves:

1. **Data collection:** Quantitative data about insurers is collected from:
   a. NAIC’s supply of computerized statutory data;
   b. Alternatively sourced statutory quarterly and annual data;
   c. Supplemental data drawn from company surveys; and
   d. Insurance company-supplied information.

2. **Data validation:** The data is reviewed for errors that are immediately rectified with hard copy references or company clarifications. This data is submitted for insurance company validation.

3. **Ratio analysis:** Various ratios are analyzed and used in the modeling process.

4. **Modeling:** A hierarchical sequence of calculations that makes use of ratio filtering, capping, and weighting, is used to automatically generate ratings. The rating is like a pyramid, according to Weiss, with the overall rating at the top. This overall rating is made up of indices and each index is representative of several components. These components build upon a series of sub-components. The sub-components are based on the collected data.

5. **Reality checking:** The fifth step requires manual verification of results and, to keep the process fair for all insurance companies, modifications to the overall model. The final results, along with ratings, are reported to the insurance companies; insurers can choose not to verify, while others may raise objections to the given ratings.

Weiss Research invites insurers to debate the ratings, ask for explanations for the methods used, and discuss conclusions. They can provide new information that will be analyzed using the 5-step process.

**Rating Methodology**

The model used by Weiss to give the safety rating makes use of five indicators:

1. **Risk adjusted capital** - To calculate this indicator, a summation of the insurance company's resources that are utilized to cover losses, whether they are capital, surplus, MSVR, or some amount from policyholder’s future dividends, is analyzed. Any hidden capital and conservative reserving assumptions are also taken into account. Then, the target capital of the insurance company is arrived at, as to the amount required by the insurer to deal with possible losses in an economic decline. Two ratios are used to
estimate the exposure insurance carriers have with respect to insurance risk and investment liquidity in the context of available capital to cover the risks:

a. The first ratio for risk-adjusted capital gauges how a company tolerates a moderate decline in the economy. Its equation is capital resources that are available, divided by the target capital. If this ratio equals to 1.0 or more, the insurance company is in possession of the capital it requires to cover probable losses from a moderate decline in the economy. If the ratio is below the required 1.0, the insurance company lacks the basic capital needed to carry it through bad financial times. Weiss makes allowances in the rating process to include contributions of additional capital before arriving at this ratio.

b. The second ratio for risk-adjusted capital gauges the how the insurance company tolerates a severe decline in the economy. Its equation is capital resources that are available, divided by the target capital computed in the context of severe economic downturns. Weiss defines severe recession as a drawn-out economic slowdown where one single worst postwar year lasts for a duration of three years. Weiss creates a capital index on a scale ranging from zero to ten. Seven would be seen as strong and ten would be seen as the best result.

According to Weiss, the safety rating of an insurer might be favorable if it had both risk-adjusted capitals of 1.0 and 7.0.

2. Profitability - This is used to measure the financial ability and is measured by:

a. Adequate investment income - This requires a comparison of the interest earned on life, health, annuity, and deposit funds with the investment income. It helps to calculate whether a company can cover its needs adequately. The safety rating is impacted if these income levels are not adequate.

b. Net gain average and weighted average – Average and weighted gains on operations of five years gives an insight into total profit levels over that time period. These net gains are estimated in the context of returns on assets and equity and reveal if a company has consistent and stable profits. Weiss also assesses the sub-component and the difference in the two averages because they are indicative of profit trends. A weighted average higher than straight average is indicative of upward profits.

c. Operating Gains Volatility - This is studied to secure an insight into surplus relief insurance.

d. Gains contribution to capital growth.

e. Control over expenses - How a company controls its expenses is a mark of management's skill. The expenses are seen by function and line of business and a mean cost is calculated on a sequence of unit costs.

3. Sources of Capital – An insurance company’s sources of capital are good indicators of its financial stability. Weiss views insurance companies favorably if are they are funding their growth on their own profits. Capital gains and capital from parent companies and stockholders would earn a better rating than would capital gains from surrenders. Also, reinsurance with non-affiliates and reserve valuation changes affect the rating. All such capital gains are seen in totality and Weiss evolves an index to measure capital source quality.

4. Liquidity - To arrive at a safety rating, Weiss uses a liquidity index to measure and compare:
a. Liquid assets that consist of cash, marketable securities like a bond with a maturity duration of under one year, common or preferred stock, and public traded bonds that are of investment grade.
b. Non-liquid assets that consist of items like mortgages, real estate, mortgages, and investments in affiliates.
c. Cash flows that involve premiums, investment income minus the benefits, and additional expenses.

There are also sub-components that Weiss examines in the context of potential liquidity:

a. Liabilities related to interest-sensitive products like deferred annuities, GICs etc;
b. Dependence on cash-out provisions;
c. Surrender experience;
d. Adjustments in market value; and
e. Surrender fees.

5. Spread of risk - Weiss researches several areas of risk such as investment portfolio size, net premium/deposit funds distribution according to lines of business, total number of contracts and policies traffic, ordinary/group life retention limits, and reinsurance use. Weiss also takes a closer look at the sources of insurance company earnings and capital to assess risks like reinsurance, realized and unrealized capital gains, investment earnings, and the appropriateness of dividend levels. The process investigates risks in investment categories in the context of the insurance company's risk-facing ability.

Weiss’ safety rating methodology prevents any subjective judgments from affecting its factual and objective interpretation of data except in warranted exceptions; for example, the 126 filings are seen in the context of the severe underlying assumptions used.

**Rating Classifications**

The safety ratings of “A” through “F” are what Weiss assigns to insurance companies. The “+” sign is an indicator that, with new data, the rating might be upgraded. The “-” sign is an indicator that, with new data, the rating might be downgraded.

“S” is assigned to insurance companies that have capital/surplus lower than $25 million, with “S” being an indicator that a policyholder should limit his or her policy size with these companies. “U” is given to insurance companies not rated because their business asset totals and premium incomes are less than a specified amount or because the insurance companies operate as holdings and not underwriters.

The following list details the basic ratings offered by Weiss:

- **A - Excellent:** This rating is given to insurance companies that have excellent financial security and have stable, conservative investment strategies, underwriting, and business operations. Weiss deems these insurance companies as having the needed resources to tackle economic severities.

- **B - Good:** This rating is given to insurance companies that have good financial security. They have adequate resources to tackle economic severities but this rating should be reviewed during recession or financial crisis to ascertain financial capability.
• C - Fair: This rating is given to insurance companies that have fair financial security. They are stable but might not be able to adequately handle economic severities and financial pressures.
• D - Weak: This rating is given to insurance companies that are weak and are expected to impact policyholders negatively.
• E - Very Weak: This rating is given to insurance companies that are significantly weak and do not pass basic financial stability tests.
• F - Failed: This rating is given to insurance companies that are under state department supervision.

According to recent Weiss ratings, 1,470 insurers received ratings; 3.8% obtained a rating of A, 15.2% obtained a rating of B, 48.2% obtained a rating of C, and 32.8% obtained ratings lower than C.

Publication of Rating Information
Confirmed Weiss ratings are reported over the telephone for a charge of $15. One-page personal safety briefs are available for $25 each, and 18-page analyses are available or $45 each. The quarterly Insurance Safety Directory can be ordered by customers for life and health insurance carriers. The ratings and insurance companies are continuously reviewed.

Financial Ratings – A Summary
Rating agencies have the same aims and techniques to evaluate the financial standings of insurers: to ascertain whether an insurance company can or cannot honor and discharge policyholder obligations according to the terms and duration of insurance contracts. The rating agencies gather and study qualitative and quantitative data and employ certain models and principles to prepare a rating. Why is it that the various rating agencies assign different ratings for the same insurer? Undeniably, it is a complex and difficult process. Some of the reasons include:

• Possible variation: Ratings of the various agencies use different financial ratios to appraise the quantitative data.
• Subjective judgment: Despite the struggle to maintain high degrees of objectivity, the review of qualitative criteria over long periods of time and using different levels of interaction with industry personnel might allow subjectivity creep into the process and account for varying conclusions.
• Rating philosophies: Each rating agency has its own business and operating philosophy. Fitch, Moody’s, and S & P focus on the insurer’s capability to honor financial commitment to policyholders. While Weiss shares this focus, it also founded its rating strategy on the reaction of insurers to economic circumstances. A.M. Best focuses on preventing rather than detecting insolvency. The differing philosophies also account for rating variations.
• Reliance on quantitative data: Rating agencies that use strictly statistical data tend to form a unique group. While quantitative appraisals are cost-effective and independent of insurer cooperation, by not considering qualitative criteria, they may not be seen as complete—which is something critics point out. The contention that such studies are free of bias and, therefore, more accurate is difficult to prove. However, it could be argued
that such solely quantitative ratings are limited by the choice not to factor in qualitative criteria.

Rating philosophies and methods should not be pitted against each other for the sake of debate. There is no single correct philosophy or method. The question of ratings accuracy cannot be answered in totality, even in context; despite good ratings, insurers have failed. New rating agencies that surfaced as a reaction to demands for more varied information seem to prove that despite the debate about methodology and philosophies, consumers want multiple ratings.

**Rating Changes**

What can an agent expect when attempting to assure consumers regarding the solvency of insurance companies? With events such as terrorism, natural disasters, and financial implosion being as unpredictable as ever, the motto is: be prepared to expect the unexpected.

Some insurer financial ratings will fall. With insurance companies weathering the storm of new insurance regulation and other setbacks, rating services are expected to lower ratings more often than they upgrade them. Recently, A.M. Best lowered ratings of 172 life insurance carriers and issued only 56 upgrades. These lowered ratings do not suggest the insurance companies will become insolvent but it they are indicative of a downward trend that might impact clients.

It is left to agents to place coverage with insurance companies after conducting due diligence research to gain the trust of consumers. An agent’s skill in evaluating the precarious financial environment will affect not only his or her success, but also the satisfaction level of clients.

In the face of insurance company failures, rating agencies will come forward with stringent criteria and apply new formulas methodologies. For the moment, changes will be reflected in the rating adjustments. A.M. Best began the process with lowering ratings of A+ and A++ to A. By adding six new ratings in 1993, A.M. Best now has a count of 15 ratings to capture an increased delineation between insurance companies. Also, A.M. Best’s attention to qualitative criteria is more marked.

Obviously, other rating agencies will follow suit and rethink solvency formulas—with concentration on the quantitative. A fragile line divides profit and insolvency. Agents should be alert to changes, especially multiple changes, to an insurer’s rating.

**Industry Benchmark Tools**

Regulators have made their presence felt. Heeding customer protests, they have clamped down on rate increases and initiated moratoriums on limiting annual rate increases and non-renewals—all in face of insurer losses from natural disasters such as hurricanes and floods.

Considering their liquidity is under regulators’ microscopes, life insurance companies are more preoccupied with organizational reformation geared toward regulatory solvency than they are with capitalizing on investment opportunities—which would earn them financial sustenance. Although banks and other financial service providers have begun to recover from solvency
situations, profit seems to have taken a back seat to solvency challenges in the life insurance sector.

**Risked Based Capital**

| NAIC developed Risk Based Capital as one of its model acts to regulate solvency and accounting methods. Risks are inevitable; therefore, they will be incurred by all insurance companies. The Risk Based Capital Model Act seeks to define acceptable risk levels for insurance companies with respect to their total assets, investments, insurance products, and additional business operations. For this purpose, the NAIC created forms for Risk Based Capital that necessitate being annual filings by all insurance companies. |

Risk Based Capital involves formulas that were developed to test capitalization thresholds that all insurers need to prevent regulatory action, recalculate the use of reserves, reduce capital needed for ownership of both affiliated alien insurers and non-insurance assets, and to meet certain eligibility criteria to be exempted from reinsurance capitalization so long as their reinsurance is not more than five percent of entire business written. The Risked Based Capital model will establish amounts for minimum surplus capital insurance companies need to have to sustain underwriting and additional business activities. Current state regulations require one single minimum capitalization requirement for all insurers, despite their separate business techniques and risk levels.

For example, by reporting a Risk Based Capital level lower than 70 to 100 percent, an insurer might face regulatory control. Levels from 100 to 150 percent might generate regulatory directives to act on inadequacies. Scores higher than 150 percent might warrant regulatory warnings, along with corrective actions. Levels 250 percent and higher would require that the insurer be relieved from any Risk Based Capital stipulation for that year.

To explain further, using an asset-default test (under Risked Based Capital): C-1 sets up varying reserve accounts to be established for different classes of investments; each class is based on its default risk. These reserve amounts can be up to 30% stocks and low quality bonds and 15% real estate owned from foreclosed mortgages. This will help achieve a high Risked Based Capital ratio.

It appears to solve major regulatory concerns. Critics argue that C-1’s surplus needs might be much more than other kinds of Risked Based Capitels (i.e. interest rate risks, mortality risk assumptions, and unexpected business risks). Some insurance companies have begun the change in investment portfolios by selling real estate mortgages and junk bonds and opting instead for securities to score a high Risked Based Capital ratio. This might impact the real estate industry. Some argue that insurance companies might not have the alternative to drop real estate that is foreclosed in a soft market. The concern is that, when enacted, the Risk Based Capital model could receive bad press.

One notable point is that Risked Based Capital will probably be more conducive to specific investment groups than others will. It could impact strong insurance companies that possess real estate. Another apprehension is the public-at-large could access and misunderstand these
reports, even though the NAIC promises to make the reports confidential, making insurance companies with low scores nervous in the context of absent state disclosure exemption laws.

Anxiety regarding Risk Based Capital data disclosure might be valid. Using the freedom of information Insurance Regulatory Information System or IRIS reports, in some states, can be accessed via court directives. However, in other cases, court rules in favor of insurance company privacy rights. The NAIC would like to believe they can prevent public disclosure, but foolproof safeguards are absent.

Apart from the privacy of the reports, the restrictive rules surrounding Risk Based Capital have been viewed with dismay. Low scores might pressure the already financially strong insurers due to the focus on investment type rather than quality.

**Solvency and Financial Enforcement Trust**

Formulated by State Farm Insurance Company, the Solvency and Financial Enforcement Trust offers an uncomplicated and straightforward solution. Known as SAFE-T, this trust seeks to purge complex formulas. It is as simple as creating a custodial trust account with a neutral institution that is neither affiliated nor related in any way with insurance companies. The trust would consist of real, liquid assets amounting to the sum needed to respond to loss adjustment expenses and loss reserves. A state’s guaranty fund would hold a lien against this SAFE-T account in order to enable insolvent insurers’ claim payments from the trust. This custodial account amount is subject to verification by certified public accountants.

Recent laws allow insurers ownership of the custodial account assets and rights to trade or sell these assets on the condition they qualify for standards set by the act. The accepted assets are cash equivalents, cash, and public traded securities the NAIC classifies as high or medium quality. Alternatively, to qualify assets requirements, insurers can submit letters of credit with an amount not more than 15% of what needs to be contained in the trust. In the event the asset value falls, the insurer is given some breathing space. As long as the trust has 80% of the stipulated value, insurers will not have to add assets mid-year. In the event the value falls below 80%, additional assets must be deposited. Failing to make required deposits would entail cease and desist orders that prevent the insurer from acquiring new business.

SAFE-T custodians report to insurance commissioners regarding the value and activity in the accounts. In the event of insolvencies, the account is used to enable payments.

With the Solvency and Financial Enforcement Trust, certain benefits exist:
- Trust accounts are easy to create and enforce because both certifications of loss reserves and certified public accountants already exist;
- The trust uses the most important assets that are intrinsic to the insurer's capability to honor policyholder obligations;
- The trust acts as a much needed easy alert system without the use of complex formulas and laws; and
- The trust minimizes insolvencies because there is always a liquid asset backup being guarded by a neutral custodian.
The Compact Approach

Proposed by the National Conference of Insurance Legislators (NCIL), the Compact Approach is intended to regulate solvency by improving the state guaranty system. The Compact Approach seeks to evolve uniform regulatory standards for all states regarding their guaranty funds. An interstate compact would be agreed upon by all states to enable:

- Standardization of guaranty funds; and
- Measures for rehabilitation and/or liquidation.

The U.S. Constitution, in Article 10, already creates provisions for such interstate agreements to establish fair and just practices for citizens. 100 interstate compacts have already been instituted concerning taxes, crime, and motor vehicle laws.

Guaranty fund limits fluctuate widely among states. In Kansas, limits are $100,000 for life and health insurance policies; limits in New York are $500,000. Only Utah has deductibles and they are $500. Some guaranty funds restrict coverage to state residents. Apart from variations in limits, variation in product coverage and service also exists.

The NAIC’s hope that its model acts would be adopted by all states went unrealized because some states chose to standardize several aspects, but not all of them. For example, while the property and casualty act set $300,000 as the maximum limit for workers’ compensation claims with unlimited coverage, approximately 14 states accept these NAIC limits.

The compact approach can modify the glaring differences between the states and create a standardized set of measures to handle insurer insolvencies. Some of the compact’s suggestions include:

- Creating the Insurance Claimant Protection Commission that would coordinate state fund activity in the participating along with shouldering the responsibility for rehabilitation and/or liquidation of insurance carriers.
- Instituting voting in the Commission to ensure that for a decision to be adopted by the commission, a majority of both premium and member votes would be required. The state representatives or commissioners would make up the Commission, with each state having a member vote and specified number of premium votes. The number of these votes would be based on the premium volume of the state. For a decision to be adopted by the Commission, a majority of both premium and member votes would be required. Commission meetings would be public, allowing no confidential information or trade secrets are revealed.
- Funding the commission with assessments from insurance companies carrying out their business in designated compact states.
- Reporting annually to the State governor and legislature in addition to the National Conference of Insurance Legislators.
- Implementing Commission-approved statutes and regulations in all state guaranty funds in each compact state. Allowing for a counter measure, the legislature would have the rights to reject a statute on votes – but should it be accepted by most compact states, the statute would need to be complied with.
The threat of a federal mandate to replace state guaranty funds would encourage the execution of the compact approach. Some states welcome the compact plan and its suggestions because it offers a viable attempt to control solvency issues.

**Federal/State Co-Regulation**
The Federal Insurance Solvency Act of 1992 was among the many initiatives enacted to address the issue of solvency. It arose to uphold the growing opinion of the enhanced role the federal government must play in insurance regulation. This act seeks to establish a solvency commission for the regulation of insurers; all reinsurers and insurance carriers would receive a solvency certificate enabling them to carry out business all over the United States. They would also have the comfort of a guaranty fund to address insolvencies.

Considering that rate regulation is left in the hands of each state, what emerges is a dual control system. Discounting the impediment that may occur from the polemics of federal/state co-regulation, this system is seen as a workable option. This is because it allows:
- Both federally and state licensed insurers to conduct business within the country;
- Both large and small insurers may opt for state or federal licenses; and
- Standardized limits will be established in guaranty funds.

This system works on the assumption that all insurers want to work on a national platform. Critics question that insurers with federal licenses might be preferred, leading consumers to believe federal guaranty funds are safer. Also, for such a federal-state regulation system, some might wonder if competition would be eliminated. Critics question the practicalities of this act and prefer proposals that give alternatives to an intervening federal dictum.

**Model Investment Laws**
The NAIC’s Model Investment Law aims at preventing insurers from investing excess cash in a few specific assets. Criticizing the NAIC’s insistence on classifications, investment, and risk types, reviewers say this gives no elbow room for regulators to use their own judgment.

**National Catastrophe Fund**
The goal of the government’s National Catastrophe Fund to reinsure insurance companies from the aftereffects of major disasters is a possible aid. Losing 20% of surplus would qualify an insurance company for help from such a fund. The assumption is that the fund will not be strained because only small and regional insurers would seek federal funds for assistance.

**State Catastrophe Funds**
State catastrophe funds are an option, but might not be permanent solution. They might not be sustainable after the disaster they fund is over. For example, Hawaii’s state hurricane fund provides hurricane insurance exclusively from a funding through premium taxes, real estate fees, and assessments. It can only reinsure writings confined to the catastrophe. State funds have limiting advantages.

**Financial Solvency Analysis**
Financial theories offering to decode solvency issues are dime a dozen. Most of the ratios focus on the insurer's surplus or capital – the larger the amount, the better. Simplistic non-
mathematical solutions would suggest avoiding investing in junk bonds and non-performing and repossessed real estate.

Agent should develop techniques, both technical and non-technical, that have been employed by others with a considerable amount of success to evaluate an insurance company’s solvency. Agents should also develop their own techniques. Logging details of the processes and evaluative methods would be required and would exhibit a concerted effort to gauge the finances of insurance carriers while assuaging the concerns of clients.

**Technical Analysis**

Bruce Bunner evolved five financial formulas founded on aggressive statistical research that might be used by insurers to carry out solvency self-tests. Bunner feels these formulae aid agents in due diligence procedures of safeguarding clients’ risks. The financial ratios can help to identify financial trends, both positive and negative.

Bunner’s five formulas may help in simple calculations of publicly available financial data of an insurance company:

**Gross Written Premiums to Surplus**

*Building on an IRIS test ratio, namely the Insurance Regulatory Information System, this formula engages in a comparison between net premiums written and surplus.* While IRIS test guidelines give the acceptable result as 3 to 1, Bunner opines that the preferable result be 2.5 to 1.

Bunner feels that IRIS test ratio must expand to include the comparison between gross premium written and surplus, not net premiums. If there is an excess of gross premiums written ranging 4 to 1, then it is an unacceptable surplus.

Why the emphasis on gross written premiums to surplus? Because comparing surplus against net premiums does not take into account the impact of disproportionate reinsurance activities. Reinsurance can affect results as perceived in the following example:

>An out-stationed insurer had excess writings of 20 to 1 surplus on a gross written premium basis. The ratio on written net premiums was 3 to 1. The carrier ignored Bunner’s request to reduce gross writings and wound up with a cease-desist order.

Gross premiums written uncover financial flaws. To allow for 25% reinsurance premium credit, 4 to 1 ratio is preferable for gross written premium to surplus. This will help the insurance company attain the 3 to 1 NAIC benchmark. Bunner says that if an insurance company’s reinsurance is greater than 25% of its direct written premiums, agents should verify the financial capabilities of both the reinsurer and the insurer.

**Two Year Operating Ratio**

This formula builds on the ratio of combined losses and expenses—where the investment income to earned premiums ratio is subtracted from the combined ratio. The use of financial data for
two years avoids aberrations. A quick calculation includes comparison between net income (that does not include realized gains and realized losses) and the previous year’s surplus; this calculation should be carried out on quarterly basis. A 10% result would indicate financial difficulties.

**Surplus to Admitted Assets**

Usually the ratio of surplus to admitted assets is more than 25% for the average insurance carrier. If, however, an insurance company’s ratio is lower than 20%, it should serve as an alert that the company’s finances are questionable. For all practical purposes, an insurance company cannot afford to be reliant on other entities in order to maintain solvency.

**Reserves to Surplus**

According to Bunner, this ratio receives more credit than it deserves. It is not even an IRIS test; it is a comparison between losses and loss expense reserves and surplus. Bunner feels that it would have been more beneficial to calculate this ratio after reinsurance, for example, on a gross basis and not before reinsurance (net basis). For an insurance company to be financially prudent, Bunner lays down a net loss/loss expense reserve to surplus of not greater than 3 to 1.

**The Acid Test**

A ratio that is Bunner’s own, this formula involves a quick estimation of an insurance company’s liquidity or, in his words, the hard surplus. This is how it is calculated:

- From the surplus, deduct the real estate, computers, all non-insurance receivable items, and non-insurance assets;
- The result is the adjusted surplus, as in the portion of surplus related to the insurance company’s operating assets;
- From the adjusted surplus amount, deduct affiliated investment and advances, surplus notes and subordinated debentures, unrealized loss on investment in bonds and preferred stocks, and contribution certificates;
- From the result obtained from the above calculation, add surplus appropriation accumulated and excess Schedule-p reserves; and
- From the surplus deduct pyramiding of assets (often the cause of insolvency in extreme cases) to obtain the affiliated investment and advances adjustment.

After the above adjustments, a surplus of lower than zero indicates liquidity problems. It is not that a failure of an insurance company to score well on these formulae would indicate insolvency. Complex financial aspects related to reinsurance, balance sheet commitments, letters of credits, etc. are not taken into account by these formulae. Nevertheless, if an insurance company continues to fail against these technical tests consistently for long timeframes, its finances are circumspect.

**Non-Technical Analysis**

**Reinsurance**

An extremely effective and widely used tool for countering risk and expansion of capacity, reinsurance is a financial cushion for insurance companies. However, an insurance carrier is as strong as its reinsurance company is and it is imperative for all agents to evaluate reinsurers.
In the context of the precept that an insurance company cannot afford to rely on other entities, insurance companies with high reinsurance levels are seen as having poor quality and practically non-existent controls. Experts in the insurance industry feel that an insurance company’s reinsurance should not be greater than 0.5 to 1.3 of its surplus.

Agents can perform the following evaluation of an insurance company’s reinsurance levels:

- Examine if the insurance company is being backed by foreign reinsurance. In this case, question the amount and value of assets the foreign reinsurer has in the U.S.
- Question the reinsurer if it has a bank letter of credit or direct guarantee of the ceding company. Letters of credit have not always been credible guarantees.
- Question whether the ceding contract term allows for the reinsurance to be "retroceded," i.e. given by another reinsurer.
- Does the insurer have reinsurance layers that would render legal maneuvering difficult in case of liquidation?
- Is there a cut-through clause in the ceding contract allowing reinsurers to pay policyholders or insureds directly or will the liquidator have to receive it?
- Is the insurer going to write new business that would necessitate expensive first year reinsurance?

First-year reinsurance refers to the initial year an insurer incurs losses associated with high expenses such commissions paid in the initial year and policy accounting valuations. Losses reduce the insurer’s surplus. Rather than strain the surplus, the insurance company seeks capital support from reinsurers to tide over first-year policy losses. Surplus reinsurance given to the insurer (known as the ceding company) shores up the weakened surplus with reserve credit that, in turn, boosts earnings and surplus.

Reinsurance is not a loan. It differs from a loan because of the reporting of the transaction. Unlike a loan, surplus relief reinsurance is not recorded as a liability in the statutory accounting report. The repayment of reinsurance is linked to reinsured policies’ future profits. Essentially, future profits are like collateral and reinsurers are taking risks in the event the ceding company is unable to pay. Reinsurance is provided at a fee, which is one to five percent of the amount they provide to the ceding company.

Regulatory authorities know how reinsurance is used and rules have been established to prevent the abuse of reinsurance.

**Restructured Loans**

This is the percent of nonperforming and underperforming real estate that has been restructured by the insurer by selling them or through self-financing at competitive terms to new owners. Such types of real estate can reduce the surplus.

**Size of Company**

Insurance companies with written premiums of $50 million and more experience fewer failures than other insurance companies. Insurance companies are considered more likely to weather economic hardship because of their plethora of products and product lines, larger sales teams,
and more efficient talent management. A.M. Best seems to favor larger insurance companies that tip the $600 million mark. It could be argued that smaller insurance companies have better protection from solvency.

**Lines of Business**

Attention should be given to the lines of business an insurance company writes. To gauge solvency, agents should evaluate multiline insurance companies based on the profitability of each separate line of insurance, the weak lines—if any, and also in the context of how a line of insurance might be affected by the threat of competition.

**Admitted Carriers**

Agents should write coverage with admitted carriers whenever possible. Unlike non-admitted carriers, admitted insurance companies have obtained lines of authority to conduct regular business in the state and are required to participate in the state’s guaranty fund.

**Mergers**

Mergers have materialized as options to increase credit and financial ratings. With mergers, insurance companies that might hear the financial death knell find strength in the combining of funds, policyholders, maintaining capital investments, and attracting new customers.

**Parent and Holding Company Affiliation**

Agents will gain a lot of knowledge about an insurance company’s solvency by studying the parent, subsidiaries, and affiliate companies. Some questions to ask might be:

- Which is the parent company and is it adequately solvent so as not to siphon the insurer’s funds?
- Which is the affiliated company and does it need funds or is the insurer using its affiliated funds? Does the affiliate hold the non-performing and underperforming investments of the insurance carrier?
- What are the possibilities of a merger and how does it benefit the carriers?
- What are the insurance carrier’s partnerships and joint ventures?
- Do the partnership and joint venture entities own the insurer’s real estate problem properties?

Association with a trusted business goes a long way toward giving comfort to a client. The tendency, however, toward abuse of parent company and affiliates is not uncommon and sometimes a brand name is not enough. Cal Farm Insurance used to take pride in citing the 100-year-old California Farm Bureau as its owner. When it was liquidated for overextensions on guarantee bonds, neither the name nor the parent company could salvage it.

**GAAP Bending**

The Generally Accepted Accounting Principles are rules adopted by auditors requiring that foreclosed property and underperforming real estate to be valued at the current market value. This process requires insurers to assess when it is financially sensible to sell such an asset or be hampered by deteriorating market prices. This is detrimental to the insurer if the market is showing downward trends. Also, with risked based capital, insurers with nonperforming real
estate would need additional reserves. In the past, insurers could keep such assets on the books and had the option to shore up with reserves from parent companies.

**Asset Spinoffs**

In the event balance sheets are out of sync due to underperforming and nonperforming real estate, insurers may opt to spinoff or transfer these assets to entities they create for this very purpose. Once the entity is established, it buys the problem asset with the sales earnings of bonds and stock to the public. The asset is off the books and the insurer records the spinoff as a sale. This solves the issue of setting aside reserves as well as adhering to GAAP principles. This is a business strategy and not a deception. It is an attempt to hold assets until they can be sold profitably. However, spinoffs carry the risk of draining cash to set up a new entity, bear the discount of the sale, and tax consequences.

**Collateralized Mortgage Obligations and Derivatives**

Collateralized mortgage obligations and derivatives enable the insurer to be involved in high yield investments, such as non-investment grade bonds and real estate, without the added pressure of actually owning them. These are the same as stock certificates but backed essentially by bonds and mortgages. The ownership is placed in a trust. These are divided into maturity amounts consisting of principal and interests, which are divided again into tranches or the issue classes. While one tranch might get the initial principal payment, another might get the interest. Investors bid for specific tranches depending on rates of interest, individual requirements, etc. Agents should examine an insurance company for these collateralized obligations and derivatives.

**Tax Angles**

Insurance companies can use taxation to their advantage; for instance, making up for losses in insurance operations by lowering taxes on capital gains from real estate. Insurers with different business lines can offset profits from health insurance with losses from casualty claims.

Certain amounts of loss percentages might be used for tax credit, shown in theory with the insurer needing to convince authorities of its use in the future. Critics charge these are only ineffectual paper profits, since they cannot pay claims. However, during times of great losses, these tax credits could be an operating income amount equal to 70%.

One way for agents to look at an insurance company’s solvency is to review its tax management:

- What percent of the operating income is in tax credits?
- What percent of the operating income is in capital gains derived from real estate or longstanding bonds?

**Restructuring Loans and Partnership Deals**

Usually, an insurer wants to keep foreclosed and underperforming real estate on the books until a profit can be made. GAAP and Risk Based Capital are not lenient about this, although this asset type is the most common one. To reduce the pressure of such assets, insurers can choose to switch the assets to loans. Basically, it’s all about refinancing the assets into easy-to-pay loans.
Liability Adjustments
One way of making surplus look larger than it is would be to reduce liabilities. Oftentimes, insurers adjust their liabilities so they look smaller. This is done by the deduction of surrender charges that policyholders pay when surrendering policies before the maturity date. Many insurers use this surrender deduction on the basis that not all policyholders will be asking for full surrenders or early withdrawals of policies.

Cash and Stock Swaps
Another way to get out of financially tight situations is for insurers to swap cash and stock. This swap system enables insurers to invest in another insurance company or subsidiaries using complicated cash and stocks. Charter Life, when faced with bankruptcy, worked with Providence Life and Capitol Life. It received cash for its preferred stock from Capitol Life which, in turn, transferred the stock to a Providence subsidiary that absorbed the loss to protect Capitol Life from Charter's bankruptcy filing.

Selling Loss Reserves
In a bid to improve earnings, insurers sometimes sell losses by paying other insurance companies on the promise of future claims. Loss reserves can be sold to reinsurers. While critics call it an accounting stunt, insurers call it risk transfer.

Addressing Insolvency
Sometimes, despite all efforts, an insurance company will face the threat of insolvency. The state takes a look at the insurer to determine its position and, depending upon the circumstances, the insurance commissioner files a court application. The court then holds a hearing, places the insurance company under supervision, and follows the process up with an injunction for either of the following:
• Rehabilitation: This allows the insurer time to restructure the company under the commissioner’s guidance. Usually, insurance companies are placed under rehabilitation until it is proved that restructuring cannot resuscitate it.
• Liquidation: This is the most rigorous condition involving the commissioner, who takes the titling of assets from the insurer to pay policyholders and creditors. In the event of liquidation, all claimants and policyholders must be informed about the liquidation and allowed time to file their proofs of claim. The claims are assessed and valued, often at lower amounts. Policyholders may appeal the valuation and seek court intervention before actual liquidation. There are time limits for these appeals.

After appropriate valuation, the insurer’s assets are distributed according to a statutory process that will pay in full to some holders and divide the rest among others. The following list shows the priority of payments for a liquidation:
• Expenses and costs of liquidation;
• Wages of the company employees that are not paid;
• Taxes owed;
• Payments to insureds and guaranty funds; and
• Payments to reinsurers and other claims.

In the event a reinsurer indemnifies the insurance company being liquidated, the reinsurer need only pay the loss exposure it has agreed upon, after all possible payments have been made. This
is the insolvency clause. The insolvency clause makes it impossible for guaranty funds, policyholders, and third-party claimants to make claims on the reinsurance proceeds. However, should a cut-through clause exist, the reinsurer would have to pay for the loss, or a specified portion directly, and only to the insureds.

**Creating Safe Harbors**

Insolvencies are inevitable. In a competitive industry, and despite insurance regulation, insolvencies will occur for a variety of reasons. Some occur because the insurance company’s products were not properly priced or underwritten. Some insurance companies are prey to disproportionate increases over premiums written, risky investments, exotic lines of business, drops in surplus, excessive reinsurance, low claim reserves, and high dividends to parent companies.

A.M. Best's Insolvency Study ascertains that, since 1969; insolvencies resulted from inadequate pricing and the resulting inadequate loss reserves, alleged fraud, significant business change, overstated assets, catastrophic losses, and reinsurance failure. It is held that some of these factors could have been recognized in advance with the help of regular market conduct exams, reports of holding companies, etc.

Following are few of the questions raised about the lack of a safe harbor for insurance:

- *If reinsurance is the reason for insolvency, why can’t regulatory authorities deny credit for unauthorized reinsurance?* Denying reinsurance cannot prevent insolvency. Sometimes reinsurance failure is not the cause of insolvency it is a factor among many other factors like poor management or the purchase of inadequate reinsurance protection.

- *Why do insolvencies happen in states with fewer resources and inexperienced workers?* This is not entirely true because even larger states with well-equipped insurance departments have their share of insurer failures. A.M. Best cites California as having 35 insolvencies. More state funds will not stop insolvencies.

- *Why do rich states allow occurrence of large insolvencies instead of preventing them?* Some blame politics in insurance regulation and guaranty associations, saying that regulators have changed their focus from solvency to pricing. The debate is about policy rates and limits consuming regulatory resources that should be addressing solvency concerns.

Admitting financial failure is hard. Saying that, despite stringent regulation, insolvencies will occur is a weak apology but the failure has been accepted--both personally and institutionally. Effusive regulator promises of cash infusions, improved payouts, and better quality investment and business seem a bit unrealistic.

In this uncertain environment, agents still need to sell insurance to clients who want to insurance their risks and exposures. To be better informed about products, risks, solvency issues, and their solutions is something agents can address even as business is being written at low prices to maintain liquidity.
State Guaranty Funds

State guaranty associations seek to give a financial guarantee to policyholders. These funds maintained in state funds cannot underwrite all contractual promises and claims; limitations exist. In the case of insolvency, an insurer terminates conducting business with more liabilities than assets. Somebody has to cover for the shortfall. The state guaranty funds provide funds for policyholder losses to the extent and limits of the respective funds. Without this fund protection, losses would be entirely borne by policyholders.

These funds give the needed protection to policyholders once the insolvent insurer’s available finances are assessed and the shortfall is defined against the overall amount needed to discharge all claims. The insolvent insurer’s management allocates the absorption of the assessment among the policyholders, equity holders, employees, and taxpayers. Tax credits are generally allotted to taxpayers.

The Liquidation Process

One of the reasons for creation of guaranty funds is that the liquidation process can be lengthy and intensive. The fund makes available advance payments for those who might be overwhelmed by the lengthy liquidation process. Claims from guaranty funds are usually limited to state residents. Payments are also limited according to the type of insurance policy purchased. On payment of a claim, the guaranty fund is subrogated to the policyholder's rights to further payments, meaning that a policyholder who collects a claim payment from the guaranty fund cannot make claims from the insolvent insurer.

A non-profit legal entity, each guaranty association is made up of members from different insurance companies who have the licenses to write annuities or insurance in the state. The association is presided over by an approved board of directors.

Exclusions

Insurance policies must be issued through an entity regulated by standards that apply to legal reserve carriers to merit coverage of guaranty acts. Some who are not legal reserve carriers, and are excluded, include fraternal organizations, HMOs and, sometimes Blue Cross. Policies or parts of policies where the policyholder bears risk, or for coverages that insurers do not guarantee, are excluded. Examples of these are variable life insurance policies and variable annuity contracts.

Limits of Protection

As stated previously, guaranty funds are usually limited to state residents, irrespective of where the beneficiaries live. Many states, like Oregon and Virginia, have life and health guaranty acts to cover only their residents.

In the event the insolvent insurance company's domiciliary state A adopts the NAIC model, insurance coverage would extend to residents of state B that have the same guaranty act. Should the insolvent company not be licensed in state B, the policyholder cannot be covered in state B.

Some states, like Alabama, adhere to a model act that is old and that gives guaranty benefits for insolvent insurers domiciled home state, irrespective of where policyholders reside. It also gives
coverage to their own residents, even if they are policyholders of a licensed insurance company domiciled in another state.

**Triggers**

Usually, the court liquidation declaration of an insolvent insurer is what triggers the state guaranty fund to provide coverage to the policyholders who have been affected. There are other triggers, for example, judicial actions that involve more than one association to ensure coverage to the insolvent insurer's policyholders--especially for death benefits, health benefits, and immediate annuity payments. The underlying purpose is to safeguard policyholders, not to bail out the insolvent carriers. Ideally, funds would not make payments before a liquidation order unless the circumstances are extenuating.

**Dollar Limits**

The following table shows a usual payout that would be given to policyholders of insolvent insurance companies:

<table>
<thead>
<tr>
<th>Life/Health Guaranty Funds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum death benefit</td>
</tr>
<tr>
<td>Maximum cash value covered</td>
</tr>
<tr>
<td>Maximum Annuities</td>
</tr>
<tr>
<td>Maximum Health and Disability</td>
</tr>
<tr>
<td>Maximum Aggregate Per Person</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Property/Casualty Guaranty Funds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum Claim</td>
</tr>
</tbody>
</table>

There are additional limits for people with multiple policies. However, irrespective of the number of policies purchased, the guaranty fund fixes the maximum claim of $300,000 - $500,000 *per individual* for property and casualty coverage.

Note that the state guaranty fund limits are restricted to the basic coverage. Extra payments to cover issues such as punitive damages and legal expenses beyond the basic limits are not entertained by state funds.

**Coverage Options**

State Funds can give direct coverage or channel it through other insurance carriers or outside administration. In some cases, the state guaranty association provides coverage for the entire duration of the policy; this may be given directly or through an administrator or another insurer.

In cases of multi-state insolvencies, the National Organization of Life & Health Insurance Guaranty Associations (NOLGHA) steps in to provide a stable assumption reinsurance agreement between the state fund and another insurer or a servicing agreement on a multi-state basis with third party administrators. If the insolvent carrier is licensed in multiple states,
NOLHGA’s member associations to work with policyholders and give prompt coverage from guaranty associations.

**Reinsurance – Another Look**

For all the bad press it gets for being the reason behind insolvencies, reinsurance is closely linked to insurer safety. Reinsurance is a crucial player in the game of supporting all insurance companies, no matter what sectors they cover. Reinsurance helps insurance companies meet commitments, especially during crisis.

Major insurer failures have impacted reinsurance with damaging effects. Huge losses and atrocious mismanagement have caused reinsurers to call it a day. The insolvencies have made it necessary for reinsurers to take a good look at themselves and the insurance companies they reinsure. Insolvencies have also caused insurance companies to scrutinize their reinsurance arrangements.

Some insurance companies are also in the reinsurance business and have suffered doubly, because they had to make payments from both their reinsurance and primary insurance departments. The view in some sections of the industry is that an inadequate reinsurance system, along with questionable schemes, was the underlying factor for most insolvencies. For its ambiguous link to insurer safety and insurer insolvency, agents need to take another look at reinsurance.

**Some Reinsurance Definitions**

Reinsurance is essentially insurance for insurance companies because it reimburses insurer's losses incurred by certain policies mentioned in the reinsurance contract. Some reinsurance terms and processes to be familiar with are:

- Ceded amount is the reinsurance amount provided to companies;
- Ceding insurer is the insurer who receives reinsurance;
- Retrocession is the insurance reinsurers buy to cover their losses;
- The reinsurance process entails a transaction whereby, for a premium, the reinsurer indemnifies the ceding insurer; alternatively, the reinsurer can reinsure the ceding insurer against part or all of its losses for written policies;
- The reinsurance transaction is independent of the policyholder who continues to hold the insurer responsible for coverage and protection from loss;
- A primary or excess ceding insurer can purchase reinsurance for its own benefit to distribute risks and reduce liabilities large losses; and
- Reinsurance is not to be confused with excess and surplus lines insurance, which provide consumers with from non-admitted carriers. Surplus lines and excess insurers also purchase reinsurance.

**Sources and Reasons for Reinsurance**

A ceding insurer can purchase reinsurance from:

- Professional reinsurers;
- Reinsurance departments;
- Primary insurance companies; and
- Unauthorized alien reinsurers.
The premiums paid by policyholders already have the reinsurance premium amount factored in. This is done according to requirements for the insurers to evaluate the risk and price it to cover any losses. The way the reinsurance premium is distributed, and all the transactions involved in the reinsurance management, has nothing to do with the policyholder.

The most important reasons that necessitate reinsurance are:

- **Limiting Liabilities**: An insurer can cover this loss exposure in any combination of the following:
  - Per risk Limitation: Management, as well as regulation, necessitates that an insurance company have a limitation corresponding to the company's equity or surplus on any potential loss, even if the insurance company provides coverage through insurance policies in amounts much more than the retention. Here, reinsurance steps in and no matter what, even if the loss is beyond the retention, the loss exposures are the reinsurer’s responsibility within policy limits and per the reinsurance contract.
  - Catastrophic loss limitation: Most insurance companies want protection for themselves during a major accumulation of losses such as those generated by hurricanes. A single loss payment would not exceed the insurer’s retention level; however, several losses could prove to be excessive. All insurers estimate probable maximum loss exposure and, depending upon business concentration, compare that loss exposure against surplus and then purchase the reinsurance amount, which would pay for potential losses that exceed catastrophic retention level.
  - Aggregate of loss limitation: Insurers can seek to cap aggregate losses borne in a given year. This can be with regard to total combined losses for a year or combined losses for specific insurance lines. With reinsurance, the insurer can stabilize yearly operations.

In aiding the insurer limit loss exposure, reinsurance enables companies to give coverage limits much more than what would have been possible without the reinsurance. This is a beneficial function for small and medium sized companies as it gives them a chance to give a coverage limit that can suit policyholder’s needs.

- **Increasing Capacity**: Reinsurance helps the insurer to enhance enlarged capacity with methods related to:
  - Accounting Methods. Upon issuance of a policy, expenses related to the issue such as taxes, administrative expenses, and agent commissions are current charges on the surplus. The premium collected is set aside as unearned premium reserve. This accounting mismatch of premium and expenses is good from the regulatory perspective as it enables conservative accounting—which is much needed for solvency. However, it can be harsh on the insurer because as more business is written, more is drawn on the surplus. This reduces capacity. Using reinsurance for portion of the business an insurer writes enables the insurer to reduce effects of the mismatch because the reinsurer reimburses the insurer for a proportionate part of expenses. It is the reinsurer who must reduce surplus with the expenses it must absorb from its reinsured. Also, in cases of claims submitted to an insurance carrier, in anticipation of the claim payment, a loss reserve must be set up. This
reserve also is drawn from company's surplus. The insurer can limit its loss reserve, as it can anticipate a reinsurance recovery on the claim.

- Loss portfolio transfer: This entails that the insurer sell the reinsurer a fraction of the loss reserve. The reinsurer makes a promise to pay the amount the reserves represented in the final adjustment. On the assumption that the transferred loss reserves are more than the payment an insurer owes a reinsurer, this difference is then added to insurer's surplus enabling it to enhance its capacity.

Insurers can use the experience of reinsurers in areas such as underwriting, investments, claims handling and reserving, and general management. Smaller insurance companies especially benefit from reinsurance guidance.

**Limitations of Reinsurance**

Reinsurance cannot prevent risk by changing its nature, nor can it insure a bad risk. Reinsurance cannot predict risk although it might limit risk for the individual insurer. Reinsurance has to be used as an ally, not mismanaged to subsidize and under price risks.

**Regulation of Reinsurance**

Many opinions seek the regulation of reinsurance, including the denial of reinsurance by regulatory authorities. The crux of the matter is not regulation but efficient management practices. How reinsurance is managed would regulate its misuse. There are many checks and balances about managing reinsurance companies. States have instituted the need for reinsurance contracts to contain clauses, especially the insolvency clause that requires reinsurance proceeds to be remunerated to the liquidation by the reinsurer in insolvency cases.

The control of alien or offshore reinsurers is a major concern. Alien insurers can operate in the U.S. through branches or wholly owned subsidiaries and, in fact, through both. While it would be simple to restrict U.S. reinsurance markets to U.S licensed insurance companies, facts show that international reinsurance have been the main sources of retrocession insurance. (For example, Lloyd’s of London.) While all reinsurers must be examined and file financial reports, regulation in the context of alien reinsurers is not adequate. Some points to bear in mind are:

- Reinsurance regulation cannot be so restrictive that it precludes adequate capacity nor can it be rigid enough to banish the reinsurance supply.
- The U.S. tax policy is preventing the channelization of reinsurance to secure markets as the U.S. excise tax (1% gross premium) is the only the tax ceded to alien reinsurers on U.S. reinsurance premiums. U.S. reinsurers wind up paying income tax of 7.5% percent of premiums. This difference impacts U.S. reinsurers.
- Regulating international entities and addressing the difference is accounting conventions is a challenge. This also challenges the formation of minimum solvency standards that can be applied for all companies.
- The currency fluctuation also impacts the domestic and international regulatory system.

More than being “bad,” reinsurance is a tool that, when used along with mature management philosophy, can help an insurer shore up the capital. While it cannot be blamed as the only cause of insolvencies, reinsurance has opened up the debate on mismanagement and irregularities that
have not only caused financial implosions but have also shaken the confidence of people in the inherent integrity of insurance.

Review Questions/Chapter 6

1. When are most lawsuits settled?
   a] Before they go to trial
   b] Five years after the lawsuit is filed
   c] Lawsuits are never settled
   d] Within thirty days

2. Who is the Named Insured in an insurance policy?
   a] The insurance company
   b] The agent
   c] The owner of property or the business to be insured
   d] The mortgagee

3. What is the name of the clause that outlines the insurance company’s obligations to provide the insured with a defense to claims made under the policy?
   a] Loss settlement provision
   b] Concealment provision
   c] Duty to defend
   d] Policy conditions

4. The willful holding back or secretion of material facts is the definition of which of the following?
   a] Subrogation
   b] Loss valuation
   c] Representation
   d] Concealment

5. The ________ of property is its current replacement value minus applicable depreciation and obsolescence.
   a] Insurable interest
   b] Actual cash value
   c] Underwriting requirement
   d] Owner’s interest

6. What are the pitfalls of industry mergers?
   a] Bankruptcy
   b] Lawsuits
   c] Risk of exposure
   d] E & O claims
7. Which of the following is NOT a rating agency?
   a] Weiss Research
   b] A.M. Best Company
   c] Standard and Poor’s
   d] FCRA

8. Risk Based Capital was developed by which of the following?
   a] The NAIC
   b] The A.M. Best Company
   c] An insurance company
   d] An insurance agent
Chapter Seven

Suitability and Underwriting

Underwriting is like reverse suitability. An extremely vital process, underwriting determines if a prospective insured is suitable to the insurer before a policy is issued. Apart from state and federal regulations, underwriting is founded on basic standards set by insurers. The aim for the insurer is to balance the earning of premiums with the capability to provide coverage and still reap a profit in compliance with financial regulations. Comprehensive understanding of the underwriting process includes defining what underwriting is, the main aspects and components used in this process to insure a risk, the different types of underwriters and their responsibilities, and the associated underwriting decisions and how underwriting is monitored.

Underwriting – a Definition

Underwriting seeks to evaluate if an individual, a property, a profession, a business, or any other insurable entity has a risk worth insuring. During evaluation, an underwriter needs to bear in mind standards of the insurance company in determining a risk that is acceptable. In short, underwriting is the insurance industry’s basic underlying principle.

Seventeenth century merchants prepared dangerous voyages, and listed the risks of voyage in a contract and would either “write” or sign “under” the contract agreement; hence, the term underwriter. Although the insurance process has gone beyond the simple signing under contract terms, the term underwriter remains and applies to the people involved in the review of risks and the selection of insurable risks.

Tasks of an Underwriter

An underwriter is responsible for a host of tasks that include:

- Appraisal of application forms and supplemental documents such as medical reports, forms certifying property value, business profiles, financial reports, photographs, etc;
- Assessment of insurance maps to determine the statistical likelihood of loss;
- Evaluation of statistical data pertaining to risks;
- Analysis of insurance company records; and
- Review of site inspection reports.

During the process of assessment, underwriters must have conversations with agents, inspectors, and other staff in the field. Once an underwriter examines the data at hand, he or she then assigns rates based on the particular nature of the risk being insured. In the event the prospective
insured fails to qualify for coverage based on the specified underwriting standards, the underwriter must deny the request for insurance coverage.

**Underwriting Components**

As explained earlier, an underwriter evaluates the proposed risk—be it a person, building, item of personal property, business, or any other entity— to ensure that the risk is eligible for coverage according to company standards. Certain standard components must be factored into an underwriter’s evaluation process.

When a person is evaluated for insurance, the factors considered include:

<table>
<thead>
<tr>
<th>Underwriting Factors to Evaluate People</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
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<tr>
<td>Gender</td>
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<tr>
<td>Occupation and occupation history</td>
</tr>
<tr>
<td>Health and health history</td>
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<tr>
<td>Financial condition and credit score</td>
</tr>
<tr>
<td>Personal habits that impact risk</td>
</tr>
<tr>
<td>Amount of insurance being applied for</td>
</tr>
<tr>
<td>Existing insurance</td>
</tr>
</tbody>
</table>

When property (building, personal property, motor vehicle, equipment, etc.) is evaluated for insurance, the factors considered are:

<table>
<thead>
<tr>
<th>Underwriting Factors to Evaluate Property</th>
</tr>
</thead>
<tbody>
<tr>
<td>Property age</td>
</tr>
<tr>
<td>Property use or occupancy</td>
</tr>
<tr>
<td>Property location</td>
</tr>
<tr>
<td>Type of property</td>
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<tr>
<td>Value of the property</td>
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<tr>
<td>Condition of the property</td>
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<tr>
<td>Maintenance of the property</td>
</tr>
<tr>
<td>Prior losses on or to the property</td>
</tr>
<tr>
<td>Existing insurance on the property</td>
</tr>
<tr>
<td>Construction of the property</td>
</tr>
<tr>
<td>Potential hazards around or within the property</td>
</tr>
<tr>
<td>Security measures and other loss control measures associated with the property</td>
</tr>
</tbody>
</table>
When a business or commercial operation is evaluated for insurance, the factors considered are:

<table>
<thead>
<tr>
<th>Underwriting Factors to Evaluate Businesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of business</td>
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<tr>
<td>Activities and operations of the business</td>
</tr>
<tr>
<td>Size of the business</td>
</tr>
<tr>
<td>Financial condition of the business</td>
</tr>
<tr>
<td>Financial condition of the business’ owners</td>
</tr>
<tr>
<td>Experience of key employees and owners</td>
</tr>
<tr>
<td>Business cycles affecting the business</td>
</tr>
<tr>
<td>Past losses experienced by the business</td>
</tr>
<tr>
<td>Liability exposures</td>
</tr>
<tr>
<td>Existing insurance</td>
</tr>
</tbody>
</table>

**Classifying Underwriters**

Underwriters are specialists. Depending upon the insurance type being applied for, the insurance company will assign an underwriter who specializes in an insurance line; for example, underwriters will review applications for life insurance, or health insurance, or property insurance, or commercial insurance, etc.

**Life and Health Underwriters**

A specialist in this area, a life or health insurance underwriter has expertise in comprehending medical reports such as attending physician statements and documents from Medical Information Bureaus. A life or health insurance underwriter can gauge the medical history in the context of the particular type of insurance being applied for. The underwriter will also have in-depth knowledge of regulations with regard to the type insurance coverage being written.

**Liability Underwriters**

This type of underwriter is an expert in the liability risk associated with a person or family, a professional, or a business. Liability underwriters review prior losses, settlements, and judgments in the context of recurrence and risks in the future. They are extremely knowledgeable about court judgments and liability laws that help assess applicants in the high-risks category.

**Property and Casualty Underwriters**

There are further specializations within this category of underwriter. An underwriter may be a specialist in specific coverage such as homeowner or fire, automobile, inland marine, commercial property, professional liability, or workers’ compensation. Property and casualty underwriters have in depth understanding of the risks linked to each of these categories of insurance, as well as methods to counter these risks. Such underwriters use applicable resources such statistical and site reports, surveys and inspection reports, property valuations, and personal or business financial statements that help to evaluate a risk.
Personal and Commercial Lines Underwriters

These categories of underwriters specialize in a certain line of insurance to evaluate applications for either personal or commercial lines of business. The risks and needs of a person or family vary greatly from those of a business or commercial entity. Also, certain commercial lines risks require a very different kind of underwriting expertise. Risk management differs between personal and commercial lines depending on the kind of risk being insured. A department store has an entirely different set of risks from those of a family living in a house.

Each type of risk requires a specialized underwriter familiar with the respective applications, statistical data, and other materials pertinent to the underwriting process before being able to make a decision whether to issue insurance.

Group Insurance Underwriters

Group insurance requires different underwriting processes than those required for the writing of individual insurance. Among the types of insurance issued on group basis, health is the major type. Group health insurance programs need a separate kind of underwriting to determine eligibility and a rate for an entire group. A group insurance underwriter must scrutinize the traits of the individual members of the group and how they translate into a whole. If group insurance is part of an employee benefits package, the underwriter must examine the criteria of the group in the context of state and federal regulations.

Underwriting Decisions

After evaluating an insurance application and all related information, it is the underwriter’s job to make a decision about whether an applicant qualifies for insurance coverage. The decisions are made based on an insurance company’s underwriting standards, which were included in their rate filing with the state. They take into consideration state statutes, market competition, insurer’s profit, etc.

Underwriters have the final say about whether an applicant’s policy is to be:

- Issued policy on a preferred basis: When the underwriter finds the least risk margins, an applicant is given a policy on preferred basis. Such issuances of policy receive the most competitive rates offered by the insurer.
- Issued on a standard basis: When the underwriter determines that the applicant qualifies within the insurance company’s normal limits, the applicant will receive coverage rated using standard premium rates.
- Issued on a substandard basis: When the underwriter finds that an applicant does not meet the insurance company’s underwriting standards, a policy may be issued with substandard rates. These applicants are seen to have risks that are higher than normal and, depending on the pertinent factors, their policies are issued:
  - With a rated premium: The underwriter will recommend a premium that is higher than what a standard risk would pay. These higher rates need to be charged within the parameters of the insurance company’s rate filing and state regulations.
  - With limited benefits: The underwriter may suggest a policy be issued with limited benefits, again within the parameters of the insurance company’s rate filing and state regulations. If the state stipulates that a benefit limit is permitted on home health care as part of a nursing home benefits limit, an insurer issuing a
long-term care policy would have to bear this in mind this statute when issuing a policy with limited benefits.

- With exclusionary endorsements or riders: An underwriter may, in certain circumstances, issue policies that preclude coverage for specific risks, conditions, or circumstances. An exclusionary rider might not cover a medical condition, such as asthma. An exclusionary endorsement may not provide coverage for pollution.

- Rejected: When the underwriter determines that a risk does not meet the insurance company’s underwriting standards, he or she may decline to write insurance.

**Monitoring Decisions: Agent-Underwriter Nexus**

Even after its issuance, a policy may be reviewed by an underwriter, usually at renewal or anniversary. Premium rates may be increased at that time or the underwriter may decide to recommend non-renewal in accordance with provisions in the policies and state insurance code. Each state has regulations about rate increases and non-renewals. Typical reasons requiring non-renewal include excessive losses or claims, increased hazard or exposure, and poor payment history.

Agents often influence the underwriting process at renewal or policy anniversary. It is the work of the agent to interact with the client on a regular basis in order to examine the insured risk, to obtain updated information, and to confirm that the client is receiving adequate coverage for his or her needs. Agent reviews prove more accurate than any other type of renewal survey and help underwriters monitor risks for the purpose of making appropriate decisions.

**The Underwriting Process**

The process of underwriting determines if the applicant is a suitable risk based on company standards and, if eligible, what rate should be charged. The underwriting process ensures that the appropriate risks are being insured at the appropriate premiums, making certain an insurer fulfils its obligation to policyholders.

In the event the underwriting process does not identify uninsurable risks that require higher than standard premiums or that are ineligible, the insurer might not be able to meet the demands of existing policy contracts when claims are submitted. The underwriting process is invaluable because it prevents insurers from assuming risks that will prove financially harmful to both the insurance carrier and its clients; it also assures that applicants secure coverage of the most appropriate type at the most appropriate rate. The underwriting process must adhere to state and insurance regulations, avoid discrimination, and follow strict guidelines in selection of acceptable risks.

**Reviewing Applications**

The underwriting process begins when the insurance application is received. An underwriter will scan it to see that it is complete and that it is accompanied by all required supporting documentation. One of the major reasons the underwriting process is delayed is because agents fail to complete applications fully or they overlook submitting required documentation and reports. In most cases, if an incomplete application is submitted, the underwriter will notify the
agent that requirements must be submitted within a particular time frame to avoid closing of the file.

Details contained on an application and supplemental forms and documents are reviewed for conformity to underwriting guidelines. For example, if an applicant is requesting health insurance, the underwriter will review the applicant’s medical history to verify that it does not contain treatment or illnesses that would prevent the insurance company from issuing an insurance policy. If an applicant is requesting property insurance on a dwelling, the underwriter will review the construction information, the occupancy, loss history, and any surveys to confirm that the dwelling meets the insurance company’s guidelines for coverage.

**Appraising Insurable Risks**

Given the fact that not all risks are insurable, an underwriter evaluates an insurable risk as being one that:

- Arises from pure risk: Pure risk is defined as risks with no chance for profit—as opposed to speculative risks, which allow the potential for gain. Insurers seek to issue insurance coverage on pure risks; for example, owning a building involves a pure risk. If nothing happens to the building, the owner’s position does not change. If the building is consumed by fire, however, the only opportunity is for loss. Speculative risks (such as betting on the outcome of a card game) are not covered by insurance.
- Involves tangible loss: An insurable risk is exposed to actual harm, injury, or damage. Examples of tangible loss to a person include death or illness; examples of tangible loss to property include a tree falling through the roof of a house or a pickup truck striking a parked car.
- Involves calculable loss: An insurable risk should be one where issued insurance will cover losses that can be calculated in actual amounts. Premiums are based on the calculated and expected losses of an insured; actual incurred losses help insurers to adjust future premiums.
- Involves unexpected loss: An insurable risk is one for which the underwriter cannot foresee particular losses. Intentional losses are uninsurable; the purpose of insurance is to provide coverage for unforeseeable events and occurrences.

**Insurable Interest**

It is the underwriter’s job to verify that the applicant has insurable risk in the subject of insurance at the time insurance is issued. For example, a homeowner has insurable interest in the home he or she owns; if the home is destroyed by fire or hurricane, the homeowner will suffer a financial loss. Similarly, a wife has insurable interest in her husband. If the husband dies, the wife will suffer a financial loss; for this reason, an underwriter will issue a life insurance policy with a husband as insured and the wife as owner.

The type of policy defines the insurable interest; for example, a person wishing to purchase an insurance policy on owned or leased property must:

- Suffer financially if the insured property is lost, damaged, or destroyed;
- Not profit from a loss to insured property;
- Have financially motivated interests in the prevention of loss to insured property.
Similarly, with respect to life insurance policies, the insurable interest depends on whether the death of the insured impacts the policyholder financially. Insurable interest is evident in the following types of life insurance policies:

- When the policyholder is the insured;
- When policyholder’s spouse is the insured;
- When the policyholder’s child, grandchild, or other dependent is the insured; and
- When the policyholder’s key employee or business partner is the insured.

In the event the policyholder wishes to insure a debtor, insurable interest exists only for the debt amount.

### Components of a Legal Contract

Insurance policies are legal contracts and all parties to a contract are bound by its terms. Underwriters review information to ensure that all insurance policies are issued in accordance with state and other laws. The following are the required components of a legal contract:

1. **Competent Parties, Mutual Consent, A Meeting of the Minds**—All parties to a contract must be legally permitted to enter into a contract. Those deemed to be incompetent parties typically include minors, those who are mentally challenged, and those who are impaired by alcohol or drugs. The competent parties must also have a shared concept of what the contract involves.

2. **Offer and Acceptance**—One party must make and communicate an offer to the second party. With respect to an insurance contract, the application for coverage is typically considered the Offer. When the second party accepts the offer, the contract has been effected. The issuance of a counteroffer is NOT deemed acceptance. The first party must accept the counteroffer for acceptance to exist; once the counteroffer has been accepted, a contract has been effected.

3. **Mutual Consideration**—A contract is not valid unless something of value has been exchanged. With respect to an insurance contract, the valuable consideration is the premium paid by the insured and the insurance company’s promise to pay for a covered loss.

4. **Good Faith/Legal Purpose/No Violation of Public Policy**—Parties to a contract must act in good faith. If an applicant for insurance lies on his application, this is not considered acting in good faith. A contract must be based on a legal purpose and cannot violate public policy. For example, if a policy insures a farm, and the growing crops insured are marijuana plants, and the marijuana plants provide the raw material involved in a drug operation, the entire operation is illegal and a violation of public policy. The insurance contract will not be enforceable.

### Influence of Regulations on Contract Validity

Depending upon state regulation, insurance policy contracts must meet certain requirements. For example, advance written notice is required before an insurer can cancel or non-renew a policy; provisions are included in these policies or in endorsements that are attached to them that clearly state requirements of advance written notice. State law also requires mandatory endorsements to be attached to policies if state law alters any of the provisions concerning the insured, insurance coverage, limits, conditions, exclusions, etc.
Determining Policy Rates
Apart from determining an insurable risk and insurance interest, and verifying the components of a legal contract, the underwriting process involves premium determination. Policy rates are dependent upon underwriting decisions and future losses.

Insurance companies must file their premium rates with the insurance departments of the states in which they do business. Actuarial and statistical data must be submitted to support an insurer’s request to charge premiums and will include details of prior losses and loss adjusting expense, expected losses, insurance company expenses, the natures of the hazards and risks insured, etc. It should also be noted that insurance companies may only charge premium rates for lines of business, and types of coverage, for which their filings have been approved by the insurance department. For example, if an insurance company has not filed rates to write auto insurance in a particular state, and an applicant submits a request for auto insurance, the insurer is not permitted to issue a policy and charge a premium.

Judgment Rating
Judgment rating is a method where underwriters apply their special understanding of the nature of a particular class of risks to establish the premium rates for applicants. This type of rating is not common and pertains to unique lines that do not make use of standard specified rates. These rates do not require state approval.

Manual Rating
Used in insurance lines that are regulated, manual rating uses rates that have been approved by the state and are published in manuals. Manual rates are applied uniformly to all applicants and existing policyholders.

Merit or Experience Rating
These methods involve the modification of manual rates according to a risk’s specific characteristics—typically loss experience within a prescribed period. For example, auto insurance policies modify manual rates based on the driving history of listed drivers. The premiums charged to a client with no loss history in the preceding three years would be lower than those charged to his brother who had two speeding tickets and an at-fault accident on his driving record in the preceding three-year period.

Experience rating is also used in workers’ compensation insurance. Depending upon the type of experience rating, factors are applied to manual rates based upon actual loss experience in a fashion similar to that used in auto insurance. In order for an insured to qualify for experience rating, the workers’ compensation premium must meet certain minimums.

Setting Rates in Competitive Markets
The type of market also affects the setting of policy premium rates. Being in competitive markets gives consumers a wide choice in insurance products at comparative rates. For clients in a high-risk category (for example, people living in hurricane areas), they are likely to have more claims than people living in other areas. As a result, they will seek insurance in a non-competitive market. It is difficult for them to find affordable insurance coverage.
Under such circumstances, the state insurance department might take one or more of the following actions to provide access to insurance coverage for those in non-competitive markets who cannot afford them:

- Set rates for products;
- Keep the rates within certain limits; or
- Create a pool to cover insurance needs.

**Insurance Applications**

The most basic underwriting tool is the insurance application. A thorough scrutiny of the insurance application allows an underwriter to uncover to review the quality of a risk, decide if supplemental forms or information is needed, and establish pricing. Because the basis for an insurance contract is the application, it is imperative that agents have a clear understanding of its main components for different insurance lines of insurance.

**Life Insurance**

**Applicant, insured, and general information**

The application must contain information about both the applicant/owner and the person(s) to be insured, including gender, date of birth, social security number, address, telephone number, and employer. If the applicant and insured are not the same person, the relationship between the two must be indicated to establish insurable interest. Similar information for policy beneficiaries is also required.

**Medical information**

Depending upon the face amount of the policy being applied for, the insurance company may require the proposed insured to submit to a paramedic or other medical exam. If an exam is required, the application usually limits its request for medical information because the majority of information required will be provided during the exam.

At the very least, an insurance application will ask for the following types of medical information within a specific time frame, such as the five or ten years preceding the date of the application: tobacco use, history of heart attack, stroke, cancer, diabetes, or surgery.

In addition, regardless of whether an exam is required, all applicants must provide the following types of medical information for the prescribed time frame(s) requested:

- Details of hospitalization and treatment in out-patient or rehabilitation facilities;
- Any medical treatment or diagnosis, with specific questions being asked concerning illnesses and diseases affecting the kidneys, respiratory system, etc.
- Drug and alcohol use;
- Any prescription or non-prescription medication taken;
- Mental or nervous disorders; and
- Family medical history.
Replacement

Replacing existing insurance policies is not always in the best interests of the client. Each state has specific requirements when the replacement of insurance is involved in an insurance sale of life insurance or annuities. Replacement forms, signed by both applicant and agent, are designed to allow applicants to study the comparative information between the existing and proposed policies.

Agents have certain legal and ethical duties to perform when replacing insurance and NAIC has Model Regulation directives addressing the issue of replacement of insurance. The writing agent and applicant must sign a statement listing policies or contracts currently in place, or that have already been surrendered, and which pertain to the application for new insurance.

If replacement is involved, the agent must make certain the applicant reads the state-approved replacement form. The NAIC’s disclosure form encourages the applicant to:

- Provide details of the existing policies that are to be replaced;
- Explain why the policies are being replaced;
- Acknowledge possible acquisition and surrender costs that will result from the replacement transaction;
- Possess a comparative understanding of the existing and proposed policies and understand what replacement entails in terms of premiums, coverages, limitations, conditions, surrender penalties, etc.

In addition to submitting the signed replacement form to the insurance company, the agent needs to submit to the insurer copies of all sales material used in the sale. Model Regulation directives impose penalties when agents mislead applicants with deceptive sales material, fail to ask or inform an applicant about replacement laws and requirements, or fail to inform an insurer that replacement has taken place to circumvent the steps established by law.

Agent Statement

Agents must answer questions on the application that confirm the accuracy and truthfulness of information contained in the application. For example, if an applicant stated he did not use tobacco and the agent saw the applicant smoking prior to entering the insurance office, the agent would need to note this detail in the agent statement.

Policy Details

Once a sale has been made, it is important for the agent to indicate on the application the proper policy type, face amount, premium mode, and any riders chosen by the applicant. If the agent makes a mistake when entering this information on the application, the insurance policy will be issued as the agent requests—which may not be what the client wants.

For example, if a client wishes to purchase a level term insurance policy with a 20-year premium guarantee and the agent enters the policy code for a 10-year term policy, the policy will be issued for a 10-year term. If the agent does not catch the mistake when reviewing it before delivery to the client, the client’s coverage will not be as requested. Not only will the client be harmed, the agent risks an E & O claim.
**Occupation and hobbies**
The underwriting process requires the application to collect information about the applicant’s occupation and hobbies. Certain occupations and recreational activities generate greater risks and, in some cases, may render an applicant ineligible for coverage. Occupations of note include race car driver, commercial pilot, and steelworker. Hobbies of note include skydiving, parachuting, and mountain climbing.

**Disclosures**
Federal and state laws require that certain information be disclosed to applicants. The insurance application requires applicants to sign disclosure forms indicating their receipt, and understanding, of this information. Sample disclosures include:

- Those required by the Fair Credit Reporting Act and the Health Insurance Portability and Accountability Act;
- To authorize the use of consumer reports;
- To authorize AIDS testing;
- Replacement forms; and
- Other requirements concerning sales material, illustrations, etc.

**Premium payment**
When submitting a life insurance application to an insurer, an applicant has the choice of submitting the application with or without a premium payment. If the application is submitted without a premium payment, no insurance coverage is bound at the time of application. If the insurance company chooses to issue coverage after reviewing the application, medical exam, and all other underwriting requirements, coverage will be issued and bound at a future date—after a premium payment is made.

If the applicant makes a premium payment at the time of signing the application, coverage may be bound per the terms of a temporary receipt. The receipt will indicate that coverage is bound at certain limits and under certain conditions. Usually, the temporary receipt indicates that coverage is bound based on the assumption that all underwriting and medical requirements will be met. If, for example, a medical exam indicates that an applicant is suffering from diabetes, the insurer may rescind coverage issues by the temporary receipt and decline to issue a policy.

In all cases, in order for life insurance coverage to be bound at the time of application and with a temporary receipt, the premium payment must be equal to at least a modal premium. For example, if the applicant chooses to make semi-annual premium payments, the payment accompanying the application must equal a semi-annual premium.

**Health Insurance**
Health insurance policies can be issued on an individual or group basis. Depending upon the size of a business, and state requirements, employee applications may require less information than individual health insurance applications.

**Group Health Insurance**
If a group health insurance policy is being requested, the employer must fill out an application and each employee to be covered must fill out a separate application that requests information
pertaining to each family member to be insured. For example, if ABC Company is applying for
group health insurance coverage on its ten employees, ABC Company will complete an
application and each of the ten employees will complete his or her own application. Each
employee application will request information about the employee and any dependents to be
covered.

The employer’s application will ask details about the business industry, the duties and activities
of each employee, how payments will be made, etc. The employer’s application will also require
information about the type of coverage desired. The employer chooses the plan coverages and
features, such as deductibles, coinsurance percentage, whether dental, disability, or prescription
coverage is included, etc.

Medical information requested on health insurance applications is similar to that requested on life insurance applications, with an emphasis on requesting more details. Other required information that is similar to that required on a life insurance application pertains to occupations and hobbies.

Underwriters review the information provided by the employer and employees to determine
pricing. In some states, an application for group health coverage cannot be declined. In most
states, pricing is not based on individual employees and, instead, is based on employee classes and/or and ages. For example, different rates apply to employees in different age groups; employees ages 25-29 will pay lower rates than employees ages 30-34.

In circumstances where group coverage cannot be declined, underwriters review each employee’s application and arrive at a group price based on the collective experience of the group. For example, if two of ABC Company’s employees have had heart attacks in the past, and three employees have undergone surgery in the past five years, ABC Company’s monthly premiums, per employee, will be higher than if only one person in the group had a medical condition.

**Individual Health Insurance**

Individual health insurance applications are underwritten based on the specific individuals seeking coverage. If Bob wants to secure coverage for himself, his wife Sue, and his son Michael, information provided for each individual will establish the rate the insurance company charges for each covered person. If Bob is a smoker, and Sue doesn’t smoke, the premiums charged for each of them will reflect these facts. If their son Michael has an uninsurable medical condition, the insurance company will decline to write coverage for Michael but will issue coverage for Bob and Sue.

**Disability Income Insurance**

Because disability income insurance is a form of health insurance, its underwriting process is similar to that of health insurance. For individual policies, the same information pertaining to medical history is required, however, more details concerning occupation and hobbies are required. In addition, employer, financial, and wage information is also required on the application. Details of existing disability income coverage are also required because they will impact the amount of insurance for which the applicant is eligible.
If an applicant for disability income insurance is self-employed, the underwriting process is more detailed. Self-employed individuals need to provide copies of tax returns and other documents to prove their income levels.

When applying for group disability income, applicants will find the process similar to that of those applying for health insurance. The larger the group, the less stringent the requirements and the fewer the application forms.

**Long-Term Care Insurance**

Applications for long-term care insurance are designed to capture medical and health statistics related to long-term care so that underwriters can identify the risks and determine appropriate policy rates. In the early years of long-term care insurance, insurance companies discovered they’d been unaware of a number of factors that affected coverage; as a result, a disruption in rate occurred and forced many carriers to drastically increase premiums.

In addition to reviewing the same information health insurance applications require, long-term care underwriters evaluate medical information and gender in a different light due to the different nature of coverage and the variances in the expected life spans of men and women.

**Homeowner Insurance**

An application for a homeowner or other residential property insurance policy seeks to gather information about both the property and the owner of the property. The same general information is required concerning the property owner, who will be the named insured on the policy, however, medical information and details concerning occupation and hobbies are not required.

**Property Information**

The majority of the property information required a homeowner insurance application revolves around the construction of the dwelling and its occupancy, or use:

- **Construction:**
  - Year built;
  - Construction
    - Framing and exterior (i.e. wood, brick, log)
    - Plumbing (i.e. copper or PVC)
    - Electrical (fuse boxes or circuit breakers)
  - Square footage;
  - Number of families;
  - Number of stories;
  - Age and type of roof (i.e. metal or asphalt shingle);
  - Presence of wood stoves or fireplaces;
  - Details of the home used to establish replacement cost:
    - Number of bathrooms and kitchens;
    - Construction grade of materials used to build home;
    - Flooring and wall surfaces;
    - Basement details:
      - Finished or unfinished;
• Daylight or walk-in;
• Square footage;

• Location:
  o County;
  o Distance to nearest fire hydrant;
  o Distance to nearest fire station;

• Occupancy:
  o Owner-occupied (required for eligibility);
  o Any tenant occupancy?
  o Any business conducted on the premises?
  o Do residents use tobacco?

• Liability issues:
  o Any business conducted on the premises?
  o Any pets or animals?
  o Any pools or trampolines?

• Protective devices:
  o Smoke or CO2 detectors?
  o Burglar or fire alarms?

In addition to the details listed above, underwriters are also concerned with the risk the applicant/property owner presents. In states where credit scoring is permitted, the underwriter will obtain a consumer report from a credit reporting agency that is based upon the applicant’s credit. Loss history will be reviewed and special attention will be paid to circumstances that might indicate past history pertaining to arson and fraud.

**Personal Automobile Insurance**

An application for a personal auto insurance policy seeks to gather information about the vehicles to be insured, the vehicle owners, and the drivers of all vehicles. The same general information is required concerning the vehicle owners, who will be the named insured on the policy, however, medical information and details concerning occupation and hobbies are not required.

An application for personal automobile coverage requires the following information:

• Vehicle:
  o Year, make, and model of all vehicles to be insured;
  o Vehicle identification numbers of all vehicles to be insured;
  o Use of all vehicles: business, commuting, or pleasure;
  o Estimated annual mileage of each vehicle;
  o Overnight location of each vehicle to be insured; and
  o Safety equipment, such as anti-lock brakes, airbags, and anti-theft devices;
  o Auto’s annual mileage; and
  o Existence of prior damage.

• Driver information:
  o Names of all vehicle owners, licensed household members, and regular drivers of all vehicles to be insured
  o Marital status for all drivers;
Dates of birth, social security numbers, and drivers’ license numbers/states for all drivers;
Driving history for all drivers;
Loss history for all drivers;
• Existing policy information, including limits;
• Discount eligibility:
• Driver safety courses; and
• Insurance company-specific discounts.

Business Automobile Insurance
In addition to requiring the same vehicle and driver information that a personal auto insurance application requires, a business auto insurance application requires more details about the applicant/named insured and the nature of the use of all vehicles to be insured.
• Vehicle owner/Named insured:
  o List all named insureds;
  o Legal status of all named insureds;
  o All business locations;
  o Does the named insured hire or rent autos?
  o Does the business use non-owned vehicles (i.e. employees pick up and drop mail off at the post office);
  o Does the business have any of the following exposures:
    • Garage operation?
    • Transportation operation?
• Details for each vehicle to be insured:
  o Radius of operations;
  o Use: service, retail/delivery, or commercial;
  o Gross vehicle weight;
  o Are FCC or other filings required?
• Driver details:
  o Do drivers use their own vehicles on the job?
  o Are drivers covered by workers’ compensation insurance?
• Loss control measures:
  o Is a driver selection program in use?
  o Is a driver maintenance program in use?
  o Are drivers permitted to use company vehicles for personal use?

Commercial Property Insurance
Like an application for a homeowner or other residential property insurance policy, an application for commercial property insurance seeks to gather information about both the property and the owner of the property. In addition, underwriters need to review not only the operations and activities taking place at the insured property, but also those taking place on nearby property and buildings.

The same general information is required concerning the property owner, who will be the named insured on the policy, and the building. Property valuation is especially important when insuring commercial property, because an applicant has many more options to choose from than a
residential property owner does. In addition, the nature of the business and operations have a much more significant effect upon eligibility and rating.

A commercial property application will ask the applicant if certain types of coverages, valuations, and other items are to be included in the policy; a representative list includes:

- Coverage type: basic, broad, or special;
- Loss settlement: at replacement value or actual cash value;
- Business Interruption: business income and/or extra expense;
- Co-insurance percentage;
- Reporting clauses;
- Inflation protection;

**Commercial General Liability Insurance**

Because Commercial General Liability (CGL) insurance excludes professional liability, worker’s compensation, and business auto exposures, it is especially important for the CGL application to capture as much information about the applicant as possible. The different types of liability coverage usually found on a CGL policy include:

- Bodily injury liability;
- Property damage liability;
- Fire damage legal liability;
- Personal and advertising injury liability;
- Products and completed operations liability; and
- Medical payments.

Applicants may choose which forms of liability coverage they want to purchase. Availability of coverage, and pricing, depend upon a number of issues that include:

- Legal status of business;
- Number of years in business;
- Business and management experience of the owner and members of management;
- Business operations and activities;
- Business location(s);
- Existence of prior insurance;
- Number of employees and their duties and responsibilities;
- Total annual payroll;
- Annual gross sales;
- Five-year loss history; and
- Exposure to hazardous materials.

It is important for agents to understand that the specific nature of each applicant for liability will be scrutinized in detail. Two retail stores may apply for coverage with the same company and be issued policies with very different premiums and coverages. For example, if client A has been in business for five years, has five employees, and has had no losses, it will be issued coverage on a more advantageous and less costly basis than client B, which has been in business for twelve months, has twenty employees, and never had insurance before.
Professional Liability

Professional liability insurance offers very specific coverage and complete, detailed information is required about the business, its directors and officers, employees, and finances. Types of professional liability insurance include:

- Medical malpractice;
- Errors and omissions;
- Directors and officers;
- Employment-related practices; and
- Fiduciary coverage.

The information required on a professional liability insurance application will be specific to the nature of the professional who seeks coverage. For example, if a surgeon requests coverage, the information an underwriter needs to evaluate will be far different from the information needed from an architect, insurance agent, or attorney.

In addition to the information typically requested on other insurance applications, professional liability applications may request the following details:

- Professional education, history, and background;
- Memberships in professional and trade organizations;
- Details of previous professional liability policies issued;
- Details of other types of insurance coverage in place (oftentimes, insurers will not issue professional liability if general liability insurance is not in place);
- Details of previous losses, claims, or incidents from which claims might arise;
- Details of disciplinary or regulatory action taken against the applicant; and
- Number of employees, along with duties, responsibilities, etc.

Inland Marine Insurance

Inland marine insurance is written in both personal and commercial lines. In personal lines, it provides coverage for certain types of personal property that are valued in excess of the limits provided for in homeowner policies or to provide coverage on a more comprehensive basis.

The unendorsed homeowner policy provides personal property coverage on a named perils basis; many clients choose to insure certain types of personal property (i.e. jewelry, furs, antiques, fine arts, cameras and equipment, etc.) on inland marine policies because coverage is provide on an open perils basis and available limits are much higher than those provided for in homeowner policies. In addition to requiring general information about the applicant/named insured, a personal inland marine insurance application will require the following information:

- Location of property:
  - At a fixed location, for example, a home, or
  - Not at a fixed location, for example, cameras and equipment that travel with the insured.
- Security:
  - Is jewelry in a locked safe or vault?
  - Are firearms in a locked cabinet?
Is the building in which the property is located protected by an alarm system or other protective devices?

- Exhibitions:
  - Is property, or will it be, located for display or exhibition at other locations (i.e. fine arts)?
- When not being used, where and how is property stored?
- Prior loss history;
- Property valuation:
  - Date and amount shown on most recent appraisal;
  - Is replacement cost coverage desired and/or available?

Types of personal property that can be insured on a personal inland marine policy include jewelry, furs, precious and semi-precious stones, silverware, musical instruments, firearms and their equipment, cameras and their equipment, coin and stamp collections, fine arts, collectibles, and golf clubs. Applications for personal inland marine insurance focus on valuable property, therefore, underwriters insist on additional supporting documents, such as recent appraisals and photographs, to verify and confirm the value of items to be insured. Security measures that protect the property from damage or theft are also very important factors to be considered by underwriters.

In commercial lines, inland marine insurance protects an even wider variety of property. In addition to property of the types listed in personal lines, commercial inland marine policies provide coverage for:

- Commercial property floaters:
  - Physicians’ and surgeons’ equipment;
  - Patterns, tools, and dies;
  - Theatrical equipment and property;
  - Film;
  - Salesman’s samples; and
  - Builder’s risk and installation.
- Imports;
- Exports;
- Domestic shipments and property in transit;
- Instrumentalities of transportation and equipment:
  - Bridges;
  - Tunnels;
  - Transmission towers, including radio and television transmitting equipment;
  - Piers, wharves, docks, slips, dry-docks, and marine railways;
  - Pipe lines; and
  - Outdoor cranes, loading bridges, and similar equipment.

Because of the wide variety of the subjects eligible for insurance on a commercial inland marine policy or floater, the nature of an underwriter’s inquiries usually take the form of supplemental applications and forms submitted with the general application—or afterward. Commercial inland marine policies are issued on one of two forms: controlled (filed) and uncontrolled (unfiled).
Controlled lines of coverage share similar exposures and characteristics and allow for the establishment and filing of standard eligibility, underwriting, and rates. Types of controlled lines include the following coverage forms:

- Accounts receivable;
- Camera and musical instrument dealers;
- Equipment dealers;
- Jeweler’s block;
- Signs; and
- Valuable papers.

Uncontrolled lines of coverage are considered too unique for the establishment of categorized classes of business. As a result no standards for eligibility, underwriting, and rate filings exist. Types of uncontrolled lines include the following types of policies:

- Builder’s risk policies;
- Contractor’s equipment floaters;
- Installation floaters;
- Specialized computer policies;
- Cargo policies for domestic shipments; and
- Bailee policies.

**Ocean Marine Insurance**

Ocean Marine insurance covers the transportation of property (goods and merchandise) by vessels crossing domestic and foreign waters, including inland or aviation transit connected with the shipment. The four major types of property coverage on an Ocean Marine policy include:

- The vessel, or hull;
- The cargo;
- The freight revenue to be earned by the owner of the vessel; and
- Legal liability of the shipper or carrier.

Hull insurance covers losses to the vessel itself and is written on one of two types of policies:

- Voyage Policy -- Covers the vessel for a specific voyage.
- Time Policy -- Covers the vessel for a specific period of time, usually 12 months.

Cargo Insurance is usually written on an Open Perils basis, but can be written for specific perils, whereby the interests of the shipper are protected for shipments of approved merchandise, both incoming and outgoing. The insured shipper reports the values on a regular basis and pays premiums based on the values. Coverage can be provided on a special basis, for a particular transaction of the journey, or on an open-ended basis, from the point where the cargo is picked up to the point where it is delivered. Open-ended coverage is the most common.

Freight Revenue may be insured in a number of ways and depends upon the agreement between the shipper and the carrier. If the shipper is required by agreement to pay the carrier’s freight bill without regard to delivery of the goods, the freight revenue is considered part of the cargo and is insured in this limit. If the freight revenue depends upon the safe delivery of the goods, it is insured as part of the hull value.
Because of the complex nature of ocean marine insurance, applications are very detailed and require specific information about the insured and all interested parties.

**Workers’ Compensation Insurance**

In addition to requiring the same business and general information that other business insurance applications require, workers’ compensation insurance applications request more details about employees and the nature of their duties and activities. The addresses of all business locations and *operations* are crucial to the underwriting and rating processes of workers’ compensation policies.

Employee information that must be provided includes:

- Total estimated annual payroll for all employees:
  - By job classification, and
  - For owners and partners.
- Employees under 18;
- Employees over 65;
- Employees working from home;
- Leased and temporary employees;
- Volunteer workers; and
- Employees covered by federal programs.

Unlike other policies, with few exceptions, a workers’ compensation policy provides coverage only in the states listed on the policy. Failure of an agent or applicant to provide accurate information about the business locations and states in which any business activities are being conducted could result in the denial of coverage for workplace injuries.

In addition to general business and employee information, workers’ compensation applications also ask for the following information:

- Workplace safety Information;
- Availability and types of safety programs and meetings;
- Prior insurance details;
- Prior loss history;
- Detailed ownership information of the business.

Rates for workers’ compensation insurance are based on job classifications. Classification codes are assigned by business industry and by the specific duties of the employee. High-risk jobs have high premium rates. For example, the basic rate for a clerical employee is far less than the rate for a roofer is.

**Medical and Physician’s Reports**

Although the application is the primary source of information underwriters make use of when evaluating a risk, other resources are used and depend upon the line of insurance. In life, health, and long-term care insurance, the applicant’s medical information is examined. Basic medical data is provided on the application form but specific information may be required by underwriters to properly evaluate a risk. For example, if an applicant reveals that she had
surgery six months before applying for insurance, an underwriter will want to review the surgeon’s notes and records about the condition.

In order to choose the appropriate rate tier, choose the appropriate benefit levels, and select pertinent endorsements or riders, an underwriter needs reports certified by medical experts. Also, requests for a high coverage amounts are usually supplemented by reports by experienced and registered nurses or paramedics. If additional medical details are needed, an Attending Physician’s Statement (APS) is required.

**Attending Physician Statement (APS)**
The APS is a questionnaire that must be completed by physician—it cannot be completed by a member of the physician’s staff or any other medical provider, such as a registered nurse. The applicant must provide the insurance company and the physician with a written authorization before the APS may be provided. The APS includes:

- Physician details, such as name, address, telephone and fax numbers, license number, and signature;
- Insured’s (Patient’s) name and address;
- Details about the medical condition in question;
- Details of the physician’s diagnosis and prognosis; and
- The physician’s remarks and comments.

**Medical Information Bureau (MIB)**
The Medical Information Bureau (MIB) has been in continuous operation for over one hundred years and is owned by nearly 500 member insurance companies. The primary mission of the MIB is to detect and deter fraud in the course of applying for life, health, disability income, critical illness, and long-term care insurance.

Health care providers report to the MIB details of medical treatment they provide to patients. Member insurance companies may access that information with the written authorization of an applicant for insurance. The information provided helps underwriters make underwriting decisions when reviewing insurance applications. At the time of completing an application for life, health, disability income, critical illness, or long-term care insurance, an applicant authorizes insurers to access his or her medical records in the MIB. It is vital for agents to be sure applicants understand the details of the authorization and that it is fully disclosed to them. Member insurers routinely request reports from the MIB when reviewing applications. For example, if an applicant reported on her life insurance application that she experienced chest pains six months ago, the pains were diagnosed as indigestion, and no further treatment was necessary, an underwriter would want to verify that medical information. If the MIB report confirms the details the applicant reported, the underwriter would probably not request additional information or an APS. If the MIB reports that the applicant underwent several tests, spent a week in the hospital, and is currently taking medication for a heart ailment, the underwriter would definitely request an APS and more details.

**Inspection and Financial Reports**
In any case where an applicant seeks a coverage amount above certain levels, underwriters may require additional documents to justify issuing coverage at the requested limits. For example, if
a thirty year-old man applied for $5,000,000 of life insurance, the insurance company would want to verify that an insurable interest existed to justify issuing the policy. The underwriter would request financial statements and would likely order an inspection. Surveys might be conducted and the insurer might hire a national organization to conduct inquiries. Inspection reports might be based on interviews with the applicant, his or her employer, colleagues, associates, etc. When the financial statements, surveys, and inspections reported that the applicant is a multi-millionaire with a wife and five children and that the applicant is CEO and major stockholder of a large corporation, the insurer will likely issue the policy.

**Consumer and Credit Reports**

Underwriters glean the financial status of an applicant from consumer and credit reports. An applicant with poor credit might contribute to policy lapses which, in turn, would increase the expenses of the insurer. Enacted in 1970 to regulate consumer and credit reports, the Fair Credit Reporting Act (FCRA) has been amended several times to give a clear definition about consumer reports and how they may be used. Disclosure requirements about the use of consumer and credit reports must be complied with and agents must be sure to not only understand these requirements, but adhere to them.

The FCRA defines a consumer report as an oral or written communication giving information about a consumer's credit standing, credit worthiness, credit capacity, general reputation, lifestyle, and personal characteristics. This information may make a person eligible or ineligible for the following purposes:

- Credit or insurance;
- Employment; and
- Other purposes specified by the act.

The act also makes it clear that consumer reports are not reports that include only the transactional information between the party making the report and the consumer. The FCRA defines investigative consumer reports (also known as inspection reports) as consumer reports that provide information via personal interviews with friends, neighbors, and associates pertaining to a person’s character, lifestyle, general reputation, and personal characteristics. The act makes it clear that inspection reports do not include credit data directly obtained from a creditor.

The FCRA clearly states that only consumer reporting agencies may provide consumer reports and they may only be provided for purposes of insurance underwriting. Additionally, consumers must authorize consumer reporting agencies to release information to an insurer. If there is no authorization, then only details of name, address, and an identifier to confirm the consumer’s identity may be provided.

The following information may not be contained in consumer reports:

- Details of bankruptcy ten years prior to the report;
- Any records of arrest, civil judgments, and civil suits more than seven years old;
- Details of paid tax liens;
- Accounts charged to profit/loss or for collection; and
- Adverse information, excluding crimes.
According to the FCRA, the applicant/consumer must be informed of the intent to prepare an investigative report to gain data about the applicant’s character, reputation, lifestyle, etc. This intent must be made explicitly to applicants:

- In writing;
- Mailed or delivered within three days of the report request date; or
- Contained in a statement declaring that the applicant can ask about the nature and scope of the investigations.

Should the applicant/consumer ask for the extent and nature of the report, the requestor of the report (which could be an agent) must provide an explanation to the applicant/consumer in writing and within five days of the applicant’s request.

Along with other legislation, the FCRA enforces proper disclosure and release of information by consumer reporting agencies after receiving the written authorization of the applicant/consumer of:

- Detailed information other than risk predictors like credit scores;
- Information sources, other than those needed for applicable court case processes;
- Details of persons who obtained a similar consumer report within the past year; and
- Details of dates, payees, and amounts giving adverse information about the consumer.

Consumer reporting agencies are required by the Act to provide the Summary of Rights for the consumer that includes:

- Fair Credit Reporting Act’s description and its stated consumer rights;
- Explanation of exercising consumer rights under the act;
- Listing of federal agencies that enforce the Act’s provisions, with contact details;
- Statement declaring the possibility of additional rights under state laws for consumers; and
- Statements declaring that consumer reporting agencies do not necessarily have to remove accurate but derogatory information that is in accordance with the Act.

Should a consumer dispute the consumer reporting agency’s report or information contained in a report, the agency must reinvestigate without charge. The disputed information must be deleted if found to be inaccurate or the record current status must be changed within thirty days of the customer’s notice of dispute. Depending on the validity of the request, the agency may turn down the request or inquire into it to either modify or delete the disputed information.

Consumer reporting agencies cannot add adverse information unless it pertains to public record, is in accord with the Act, has been through the verification process, and was received within the three months period of the report’s completion.

According to certain legislation and the FCRA, should an insurer choose to take adverse action based on information contained in consumer report, the consumer must to be informed by the insurer through written, oral, or electronic notice of:

- Adverse action taken;
- Contact details of the consumer reporting agency responsible for the report;
• A statement declaring that consumer reporting agency cannot provide reasons for including adverse action; and
• The consumer’s rights to access the report free of charge and dispute the information contained in it.

Should a consumer be solicited on the basis of a consumer report, the following written statements are necessarily included in solicitation:
• Declaration that the insurance transaction stems from the customer’s eligible insurability criteria given in the consumer report;
• Declaration that should the customer not qualify for insurability criteria, the issuance of insurance may be denied; and
• Declaration of the consumer’s right to disallow consumer report from being used

Consumers do not initiate these solicitation transactions, and the agent/person soliciting insurance based on consumer report information must keep a file containing the criteria of customer selection, along with the collateral used, for three years from the date of offer.

Site Inspections and Reports
Site inspections are valuable resources when underwriting commercial insurance and other types of property insurance. The property is inspected to assess the property type, construction materials, safety devices, presence of hazardous elements, and overall condition and maintenance for risk management purposes. Underwriters often make use of risk management processes and personnel who are appointed to review business operations or commercial property. Apart from inspecting premises, some of the methods employed to manage risks are:
• Exposure checklists - Lists are studied in the risk locating process;
• Financial statement reviews - All items on financial statements are investigated individually for risks they may cause;
• Business activities identification - Activities such as hiring, training, accounting, and customer service are scrutinized for related risks and actual losses;
• Business operation flowchart analysis - A chart capturing detailed operations of a business is studied for uncovering any areas of risk;
• Business interviews - Interviews with key business people, such as managers and workers, to learn about risks and losses.

The information gathered through inspections and interviews are then complied into a report so underwriters can study risks and suggest compliance with certain safety measures.

Company Records
Information is readily available to the underwriter from insurer company records. These have specific data about applicants, along with loss statistics about risks that can be applied in general. Similar policies with the same insurer might also give underwriters a chance to make comparisons in the context of the applicant’s total coverage. Insurance company records also include the insurer’s own loss statistics, which may prove helpful to the underwriter.
**Insurance Industry Statistics and Reports**

Insurance related statistics and reports might also be obtained from various organizations and associations such as:

- National Association of Insurance Commissioners (NAIC);
- Insurance Services Office (ISO);
- Health Insurance Association of America;
- Insurance Management Society, Inc.;
- Inland Marine Underwriters Association;
- Insurance Research Council;
- National Association of Health Underwriters;
- International Risk Management Institute (IRMI)

Such organizations are replete with statistical data, research papers, and insurance reports that underwriters may use.

**Identifying Hazards**

Underwriters must use all the resources available to identify hazards and insurable risks. Hazard is defined as a condition that increases the likelihood or severity of a loss. A hazard is a condition, one that offers a larger opportunity for loss or one that offers a probability for a loss to result in greater financial consequences. Insurance companies look at three major types of hazards when deciding whether or not to insure a risk.

- **Physical** - These hazards are created by the use, condition, or occupancy of property. For example, running a woodworking shop in the attached garage of a dwelling; an old roof with numerous shingles missing; a business concern that manufactures dynamite.
- **Moral** - These hazards are created by certain characteristics of people. For example, poor financial stability (undergoing bankruptcy); personal habits (i.e. drunk driving); associates (drug dealers); dishonesty (deliberately causing a loss to collect the insurance).
- **Morale** - These hazards are created by the attitudes of people. For example, indifference of a building owner because his home is being foreclosed upon; irresponsibility of an individual who owns dogs but does not keep them leashed.

**Agents and the Underwriting Process**

Agents are considered field underwriters. The agent’s role in underwriting is probably more important than the role of anyone else. Agents meet with consumers face-to-face, visiting them at home and at their businesses. Agents gather underwriting information, assess risks, and matching risks with appropriate products. Many agents have binding authority. Some of the key ways in which agents support the underwriting process are reviewed in the following paragraphs:

**Suitability Quotient**

When an agent offers the client suitable financial products, suitable underwriting is also applied. This is because agents determine client suitability from perspectives of age, tax bracket, financial condition, existing investments, investment objectives, and net worth.
Needs Evaluation

Agents have the responsibility for determining needs. Whether they use questionnaires (like the sample shown on the next page) or interviews, this process provides the underwriter with a wealth of information to use in making decisions. This is because the agent’s needs analysis process researches:

- **Basic Information:** The agent gathers the consumer’s name, address, contact details, age, marital status, gender, occupation, etc. The agent develops a rapport with a consumer to ascertain the person’s concerns and understand the insurance needs that require insurance planning, such as pensions, college funds, health plans, etc.
- **Financial Information:** An agent aims to establish an understanding with a consumer to elicit financial information that is crucial to underwriters. Agents gauge a client’s net worth in the context of the client’s earned income, assets, and the liabilities.
- **Current Investments:** The agent also evaluates needs in terms of the consumer’s current investments. Post inventory of the existing insurance, mutual funds, individual stocks, certificates of deposits, etc., the agent determines the consumer’s risk tolerance. Underwriters value this information as it gives insight into the products the applicant is comfortable with which, in turn, reveals the financial character of the applicant as conservative or otherwise
- **Current Plans:** Needs analysis will direct agents to immediate plans of consumers, whether they need to plan for retirement, set up college funds, arrange for long-term care, etc.
- **Goals:** An agent’s needs analysis also uncovers short-term goals like a family vacation or buying a car.

All these components of needs analysis help agents not only understand the consumer as a unique human being with needs and risks that require coverage but also the details of finance and investment that help the agent match the correct insurance product to the consumer. This also provides the underwriter with valuable statistics in the policy issuance process.

---

**Sample Questionnaire for Needs Assessment**

<table>
<thead>
<tr>
<th>I. Personal Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Customer Name</td>
</tr>
<tr>
<td>Customer Address</td>
</tr>
<tr>
<td>Customer Phone Number</td>
</tr>
<tr>
<td>Day:</td>
</tr>
<tr>
<td>Evenings:</td>
</tr>
<tr>
<td>Customer Birth Date</td>
</tr>
<tr>
<td>Customer Occupation</td>
</tr>
<tr>
<td>Customer Marital Status</td>
</tr>
<tr>
<td>7 Number and Age Of Dependent Children Living At Home</td>
</tr>
</tbody>
</table>
II. Financial Information

<table>
<thead>
<tr>
<th>8</th>
<th>Estimated Net Worth (not including primary residence)</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>Value Of Primary Residence</td>
</tr>
<tr>
<td>10</td>
<td>Monthly Income from Employment</td>
</tr>
<tr>
<td>11</td>
<td>Monthly Income from Retirement Plans (Identify Each Source And Amount)</td>
</tr>
<tr>
<td>12</td>
<td>Other Income: Income Amount and Source</td>
</tr>
<tr>
<td>13</td>
<td>Marginal Tax Bracket</td>
</tr>
</tbody>
</table>

III. Current Savings and Insurance

<table>
<thead>
<tr>
<th>14</th>
<th>Mutual Funds: Fund Company, Objective, Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>15</td>
<td>Bank Certificates of Deposit: Maturity, Interest Rate and Amount</td>
</tr>
<tr>
<td>16</td>
<td>Life Insurance In Force: Company, Type of Policy, Face Value and Cash Value</td>
</tr>
<tr>
<td>17</td>
<td>Annuities in force: Company, Type, Accumulated Value and Yield</td>
</tr>
<tr>
<td>18</td>
<td>Individual Stocks: Company and Amount</td>
</tr>
<tr>
<td>19</td>
<td>Individual Bonds: Type and Amount</td>
</tr>
<tr>
<td>20</td>
<td>Other Investments (e.g., real estate): Type and Value</td>
</tr>
<tr>
<td>21</td>
<td>Investments previously held but now liquidated: Type, when held, why liquidated</td>
</tr>
</tbody>
</table>

IV. Risk Tolerance

<table>
<thead>
<tr>
<th>22</th>
<th>Able to tolerate significant degree of fluctuation in return for opportunity for high return _______</th>
</tr>
</thead>
<tbody>
<tr>
<td>23</td>
<td>Able to tolerate some fluctuation of principal in return for opportunity for moderate return _______</td>
</tr>
<tr>
<td>24</td>
<td>Conservation of principal is primary consideration _______</td>
</tr>
</tbody>
</table>

Comments:

V. Financial Plans

<table>
<thead>
<tr>
<th>25</th>
<th>Retirement Savings: Type of plan, how long has it been in existence, value, amount and frequency of current contributions, satisfaction level, concerns and questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>26</td>
<td>Estate planning: Will? Living Trust? Testamentary Trusts? Key objectives of these tools, satisfaction level, concerns and questions</td>
</tr>
</tbody>
</table>

VI. Goals

<table>
<thead>
<tr>
<th>27</th>
<th>Short-term (1- 5 year): Financial goals, amount needed.</th>
</tr>
</thead>
<tbody>
<tr>
<td>28</td>
<td>Intermediate term (5-10 year): Financial goals, amount needed</td>
</tr>
<tr>
<td>29</td>
<td>Long-term (10+): Financial goals, amount needed</td>
</tr>
</tbody>
</table>

COMMENTS:

**Product Matching**

Once an agent has a good grasp of the consumer’s needs, the agent should review the available insurance products and suggest those most appropriate to the consumer’s needs. Not all risks can
**Documentation**

Whether or not a sale is made, the agent must maintain documentation of the interactions with the client, along with copies of the brochures, explanations, and advertising documents. This documentation goes a long way toward helping maintain a good relationship with the client and providing evidence of the agent’s effort at finding the most suitable product.

It is imperative for the agent and the insurer to bear in mind NAIC regulations. Per NAIC model regulations, insurers must follow guidelines for insurance producers with regard to suitable recommendations for annuity products and fixed life insurance plans that require:

- Ensuring that insurance producers understand the model act and regulations requirements;
- Developing procedures to collect the necessary information from the consumer prior to making recommendations;
- Determining that practices of insurance producers are compliant with the NAIC’s model through systems like consumer surveys, confirmation letters, etc; and
- Dealing with noncompliance.

The NAIC requires an insurer to have approved procedures for data collection and guidelines about what constitutes relevant data. For example, what processes uncover the consumer’s financial needs and objectives? The agent, in accordance with suitability conduct dictates, should use insurer-approved methods of data collection and insurer-approved materials and training to assess a consumer’s needs, and make suitable recommendations accordingly.

**Screening Risks**

An agent is the consumer’s and the insurer’s risk manager. The agent’s primary aim should be to covering the client’s risk adequately and screen out risks unacceptable to the insurer. The data the agent collects in the process of studying risks is key to the work of underwriters. Similarly, an agent’s familiarity with underwriting principles is equally important. Should an underwriter deem that there is no insurable interest or that the applicant fails to meet minimum underwriting standards, agents need to communicate the insurer’s decisions not to issue policies. Alternatively,
agents might suggest other suitable products that meet both requirements of insurable interest and underwriting.

The agent’s role in underwriting is to reduce losses. An agent has to act as an insurer’s risk manager by explaining the following techniques:

• **Avoidance** – The consumer can refrain from participating in particular activities, or choose not to own particular property, that might result in a loss. For example, if the consumer is concerned with auto accidents, he can refrain from driving or not purchase an automobile. Avoidance is not always realistic.

• **Reduction** – The consumer can take steps to reduce any loss that may occur. For example, he can wear a seat belt when he drives a car or he can install a smoke detector in his home.

• **Retention** – The consumer can accept that a loss may result from participating in a particular activity, or purchasing property, but decide to assume responsibility for that loss himself. A policy deductible is a form of retention because an individual assumes responsibility for a portion of the loss along with the insurance company.

• **Transfer** – The consumer can take steps to transfer the financial consequences of loss to another party. For example, legal contracts transfer risk; hold harmless agreements and insurance policies are two common ways to transfer risk via contract.

**The Agent, the Underwriter, and the Insurer**

Once a risk response is decided on, it must be implemented. Implementation of these risk responses, however, does not end the process. Considering the way business changes, there are possibilities of new exposures, which necessitates that the risk be monitored regularly. At annual policy renewals, an agent helps clients monitor risks by reviewing risk management processes. This monitoring by the agent helps to set the appropriate types and amounts of coverage. Through this entire process, the agent, the underwriter, and the insurer collaborate to provide continued coverage:

• **Taking applications**: The agents and applicants complete applications, which are then submitted to the insurance company underwriters for review.

• **Underwriting requirements**: During the regular risk management monitoring, in the context of a business, its assets, and operations, the underwriter has to act appropriately to ensure continued insurance coverage for the business. There may be underwriting requirements for a safety program or the replacement of the old sprinkler system. The agent steps in to ensure, and later inspect, that the client follows through with the requirement.

• **Discounts on premiums**: By adhering to the underwriter’s requirements, the client may earn a reduced premium. There are offers of total loss control programs, including a discount on the premium, should the key staff of a business attend safety and loss management seminars and training arranged by the insurer. An individual insured may earn a discounted premium by implementing safety requirements of insurers. The agent can aid clients earn a reduced premium and aid insurers by reducing the risks.

• **Documentation**: The agent is in charge of obtaining and submitting the supporting documentation that will be used by underwriters in addition to the application. The agent also ensures that this supporting supplemental documentation is submitted per the
insurer’s standards. Should the underwriter require additional documentation, the agent
coordinates the process of formatting, obtaining, and submitting the same.

- **Binding Coverage:** To bind coverage, the agent scrutinizes the applicant’s information to
ensure that he or she qualifies, based on the underwriting criteria. Accordingly, after the
underwriting process is complete, a policy is issued, renewed, or denied. For an agent,
binding coverage is a core responsibility that has to adhere to the insurer standards and
state laws.

- **Managing Premium:** As a field underwriter, an agent collects and deposits the client’s
premium. The premium, if not payable to the insurer, must be deposited in an agent’s
trust account. NAIC’s model law has rules in place that govern agent trust accounts,
which are regulated by many states’ insurance departments, and covers all policy
premiums or return policy premiums received from anyone acting as an agent, sub-agent,
insurance producer, managing general agent, solicitor, broker, life analyst, life agent, etc.
According to this law:
  - The trust account should be created established in legitimate financial institutions
under the court’s jurisdiction in the state in which the agent works;
  - The trust account can receive premiums and return premiums not payable to the
insurer but provided for negotiating, soliciting, effecting, renewing, procuring, or
binding policies of insurance;
  - The trust account can also receive funds collected by agents from policyholders,
premium finance companies, etc., for forwarding to the insurer as premium
payments;
  - The trust account can receive voluntary additional funds for use as premium
advances, reserves for premium returns, and other contingencies;
  - The trust account may be a savings account, checking account, etc.;
  - The trust account may be an investment fund investing only in government bonds,
or treasury certificates and would be called a Premium Fund Trust Account. It
can be interest bearing, with the agent earning the interest;
  - Trust accounts records must be maintained by the agent for the insurance
commissioner’ inspection
  - Trust fund withdrawals may be made solely for:
    - Premium payments to insurers and entitled others;
    - Return premium payments to the insurer and entitled others;
    - Withdrawals from the agent’s voluntary deposited additional fund;
    - Transfer of interest to other accounts;
    - Transfer of average or actual commissions to other accounts;
    - Payment of bank charges and fees;
    - Movement of funds to a new trust account in adherence with model law.

These trust accounts are not personal accounts of agents; therefore, they cannot be used as
collateral for loans. The accounts can be inspected, audited, and any transfer of funds must be
documented by the agent. Any violation makes the agent subject to prosecution.

Once a policy has been issued, an agent may have some additional underwriting duties that arise
due to any changes in the coverage or conditions of the risk. Submission of renewal
applications, other documentation, site inspections, and additional premiums may be required of the agent.

Managing general agents can be persons, firms, associations, or corporations that manage insurance businesses of insurers and act as the agents of insurers. A written contract must be executed to establish a managing general agent relationship. Once the contract is in effect, the following underwriting guidelines apply:

- Maximum limit on annual premium volume;
- Basis of rates charged;
- Types of risks written;
- Maximum limit of liabilities;
- Any applicable exclusions;
- Any specific territorial limitations;
- Provisions for policy cancellation;
- Maximum policy period.

Should the responsibilities of managing general agents be settling claims, the following rules must be followed:

- Reports must be made capturing all the insurer’s claims in a timely fashion;
- Claim file copies must be sent to insurer if the claim exceeds the insurer’s set amount, involve a dispute in coverage, or go beyond claim settlement authority of managing general agents;
- Notifications of claims must be sent to the insurer regarding closed claims or claims open for over six months;

In some states, managing general agents cannot commit insurers to participate in reinsurance and insurance syndicates. Should producers be appointed, they must have a license to transact business in the appointed insurance line. Separate records must be kept by managing general agents from those of other agents.
Underwriting – In a Nutshell

• Underwriters begin work upon receipt of the application, which states an insurable interest.

• Underwriters use applications to determine if policy issuance will occur.

• Underwriters verify if a risk described in the application as an insurable risk.

• Underwriters, after establishing insurable interest, the four components of a legal contract, and insurable risk, must assess the risk characteristics.

• Underwriters use the application and relevant documents to understand risks and then decide if coverage will be issued.

• Underwriters require certain underwriting requirements that must be complied with for policy issuance and rate determination.

• The main resource of underwriters is the application, supplemental documents, reports, site inspections, etc.

• Underwriters evaluate information to ascertain physical, moral, and morale hazards.

• Underwriters use the information the agents collect using needs-based analysis to determine the suitability of financial products.

• The underwriting process requires agents to have many underwriting duties that range from taking applications to binding coverage.

Improving Underwriting

Because an agent is a field underwriter, he or she has the opportunity to improve underwriting results. Improved underwriting helps to:

• Follow basic suitability requirements and provide the right coverage to the right client, for the right needs and at the right rates rather than submit applications that are later rejected because applicants are not eligible for coverage;

• Earn better commissions, retain customers, and create options for future business;

• Price coverages appropriately without placing a strain on the insurer or the client; and

• Adhere to federal and state regulations and increase chances for a better future in the insurance industry.
Improved underwriting practices minimize the acts of irresponsible agents, applicants who purchase insurance policies with the intent to commit fraud, fines and penalties, solvency issues. Overall, improved underwriting increases capacity and insurance affordable coverage.

Unfortunately, some insurers have been accused of substandard underwriting practices. There are instances of policy issuance based on post claims underwriting, a practice that is now illegal. Applications have been accepted without stringent underwriting practices. As a consequence, if a claim was made, the insurer had to defend itself with investigations that could have been conducted before policy issuance. Substandard underwriting has also led to unfair rate increase practices that burden clients with increased premiums. Lack of structured questionnaires, proper guidelines for agents and underwriters to follow, and proper rate setting techniques usually challenge the solvency of the insurer.

There are some factors that responsible agents must keep in mind, even in light of simplified applications, clear benefits, disclosures and limits, and better policy choices. The fact is that some consumers will be charged high premiums or rejected. Rather than unleash resentment toward underwriting and the insurance carrier, agents should understand that without underwriting there would be no fair assessment of potential clients or standards of rate setting.

To support best practices and improve underwriting, responsible agents must:
- Read and understand the insurer’s underwriting guidelines;
- Review sample policies and have queries answered before submission of an application;
- See applications as the greatest resource for information collection;
- Be accurate and diligent when completing applications;
- Submit applications on time, keeping in mind the insurer’s deadlines;
- Respect underwriting and allow for enough time for application processing;
- Be aware of the state’s special rules, rates, and disclosures;
- Be the underwriter’s ally and give as much information as the underwriters require;
- Add the confirmation number in case an inspection or paramedic exam is scheduled;
- Note the applicant’s physician’s contact details on the application, in case an APS requirement is needed;
- Complete all questions and sections of the application and supplemental forms;
- Request all riders, endorsements, and policy options that the applicant wishes to purchase;
- Know the policy’s limits; and
- Keep open the option to consult with the underwriter to help applicants secure affordable coverage.

To support best practices and ensure insurers are meeting sales requirements, responsible agents must:
- Ensure that applications have clear-cut questions aimed to elicit the required information;
- Ensure that a caution message is included warning clients that false and incorrect information can result in denial of benefits or withdrawal of coverage;
• Ensure that should an insurer not conduct a comprehensive underwriting evaluation, or fail to assess answers to all questions in an application properly, the insurer can then only refuse coverage for a claim payment based on fraud or material misrepresentation; and
• Deliver a copy of the completed application to the applicant at the same time the policy is delivered.

The insurer’s sales guidelines may differ in each state; agents should have a checklist of the documents and disclosures required for each state.

Make a Difference
Apart from all the steps suggested to improve underwriting, and insurer best practices, agents should strive as individuals to stay ahead of the competition. Agents should assess the credit ratings of insurers and duly inform clients of changes of concern. Agents should inform clients of the options available to them and should remember that safeguarding client interests is more important than pushing for a sale.

Review Questions/Chapter 7

1. Which of the following is NOT one of the components of a legal contract?
   a] Competent parties
   b] Bad faith
   c] Offer and acceptance
   d] Mutual consideration

2. Which of the following statements is true about the replacement of insurance?
   a] Replacement is always in the best interests of the client
   b] No laws exist concerning the replacement of insurance
   c] Clients do not have to sign replacement forms
   d] Replacement is not always in the best interests of the client

3. What section in an insurance application contains the agent’s confirmation of the accuracy and truthfulness of information contained in the application?
   a] Medical information
   b] Agent statement
   c] Insured information
   d] Signatures

4. Which of the following is NOT a type of professional liability insurance?
   a] Directors and officers
   b] Errors and omissions
   c] Medical malpractice
   d] Fire legal liability
5. Workers’ compensation insurance rates are based on which of the following?
   a] Employer’s gross sales
   b] Employer’s business industry
   c] Employees’ job classifications
   d] Employees’ dates of birth
Answer Key to Review Questions

Chapter One

1. In the insurance industry, who makes the choice about whom or what to insure?
   a] The insurance company
   b] The client
   c] State regulators
   d] The NAIC

   Correct answer: b] The client makes the choice about whom or what to insure.

   Incorrect answers: a, c, and d. See page 1 for review.

Chapter Two

1. What process begins with the client providing details in questionnaires and application forms?
   a] Policy issuance
   b] Claims settlement
   c] Risk identification
   d] Policy declination

   Correct answer: c] The risk identification process begins with the client providing details in questionnaires and application forms.

   Incorrect answers: a, b, and d. See page 4 for review.

Chapter Three

1. Suitability is based on what two factors?
   a] Property and casualty
   b] Life and health
   c] Risks and needs
   d] Losses and claims

   Correct answer: c] Suitability is based on risks and needs.

   Incorrect answers: a, b, and d. See page 6 for review.
2. Needs-based analysis requires all of the following EXCEPT ____?
   a] Analyzing the client’s needs in detail
   b] Requiring the client to express his or her opinion
   c] Pinpointing the actual needs and goals of the client
   d] Paying claims promptly

Correct answer:   d] Paying claims promptly is not part of needs-based analysis.

Incorrect answers:   a, b, and c. See page 6 for review.

Chapter Four

1. What is at the core today’s insurance industry?
   a] The focus on client needs
   b] The Internet
   c] The Fair Credit Reporting Act
   d] Premium payments

Correct answer:   a] The core of today’s insurance industry is the focus on client’s needs.

Incorrect answers:   b, c, and d. See page 10 for review.

2. A disability generates a loss of income and is caused by which of the following?
   a] An accident or an illness
   b] A broken leg
   c] A heart attack
   d] Food poisoning

Correct answer:   a] A disability is caused by an accident or an illness.

Incorrect answers:   b, c, and d. See page 12 for review.

3. In long-term care insurance, what does the acronym ADL represent?
   a] Answers in daily life
   b] Activities of daily living
   c] Accidents, disabilities, and long-term care
   d] Accidents in daily life

Correct answer:   b] Activities of daily living is represented by the acronym ADL.
Incorrect answers: a, c, and d. See page 15 for review.

4. **In auto insurance, what are the two types of liability limits that are offered?**
   a] High and low limits
   b] Expensive and inexpensive limits
   c] **Single and split limits**
   d] Collision and comprehensive

   Correct answer: c] Auto liability coverage is offered in either single or split limits.

   Incorrect answers: a, b, and d. See page 23 for review.

**Chapter Five**

1. **Which of the following is NOT a generational group?**
   a] Generation Xers
   b] Baby Boomers
   c] Seniors
   d] **Generation Ters**

   Correct answer: d] Generation Ters is not a generational group.

   Incorrect answers: a, b, and c. See page 29 for review.

2. **A creditor can hold which of the following liable for debt in the event they own community property?**
   a] Parents and children
   b] Employers and employees
   c] **Husband and wife**
   d] Mother and father

   Correct answer: c] Husband and wife can be held liable for debt by a creditor if they own community property.

   Incorrect answers: a, b, and d. See page 42 for review.
3. **What is the one essential for a multi-entity asset plan to work?**
   a] The client’s finances must be strong and stable
   b] The client must own a home
   c] The client must own an automobile
   d] The client must declare bankruptcy

   Correct answer: a] The one essential for a multi-entity asset plan to work is that the client’s finances must be strong and stable.

   Incorrect answers: b, c, and d. See page 50 for review.

4. **Knowing the client’s needs and matching those needs to the right products and services is the crux of which of the following?**
   a] Insurance sales
   b] Insurance regulation
   c] **Suitability**
   d] Claims settlement

   Correct answer: c] The crux of suitability is knowing the client’s needs and matching those needs to the right products and services.

   Incorrect answers: a, b, and d. See page 51 for review.

**Chapter Six**

1. **When are most lawsuits settled?**
   a] **Before they go to trial**
   b] Five years after the lawsuit is filed
   c] Lawsuits are never settled
   d] Within thirty days

   Correct answer: a] Most lawsuits are settled before they go to trial

   Incorrect answers: b, c, and d. See page 55 for review.

2. **Who is the Named Insured in an insurance policy?**
   a] The insurance company
   b] The agent
   c] **The owner of property or the business to be insured**
   d] The mortgagee

   Correct answer: c] The owner of property or the business to be insured is the Named Insured in an insurance policy.

   Incorrect answers: a, b, and d. See page 56 for review.
3. **What is the name of the clause that outlines the insurance company’s obligations to provide the insured with a defense to claims made under the policy?**
   a] Loss settlement provision  
   b] Concealment provision  
   c] **Duty to defend**  
   d] Policy conditions

   **Correct answer:** c] The clause that outlines the insurance company’s obligations to provide the insured with a defense to claims made under the policy is called the **Duty to Defend**?

   **Incorrect answers:** a, b, and d. See page 56 for review.

4. **The willful holding back or secretion of material facts is the definition of which of the following?**
   a] Subrogation  
   b] Loss valuation  
   c] Representation  
   d] **Concealment**

   **Correct answer:** d] Concealment is the willful holding back or secretion of material facts.

   **Incorrect answers:** a, b, and c. See page 59 for review.

5. **The _________ of property is its current replacement value minus applicable depreciation and obsolescence.**
   a] Insurable interest  
   b] **Actual cash value**  
   c] Underwriting requirement  
   d] Owner’s interest

   **Correct answer:** b] The actual cash value of property is its current replacement value minus applicable depreciation and obsolescence.

   **Incorrect answers:** a, c, and d. See page 61 for review.
6. What are the pitfalls of industry mergers?
   a] Bankruptcy  
   b] Lawsuits  
   c] **Risk of exposure**  
   d] E & O claims

   Correct answer: c] The pitfalls of industry mergers are the risk of exposure.

   Incorrect answers: a, b, and d. See page 63 for review.

7. Which of the following is NOT a rating agency?
   a] Weiss Research  
   b] A.M. Best Company  
   c] Standard and Poor’s  
   d] **FCRA**

   Correct answer: d] FCRA is not a rating agency; it’s the Fair Credit Reporting Act.

   Incorrect answers: a, b, and c. See page 64 for review.

8. Risk Based Capital was developed by which of the following?
   a] **The NAIC**  
   b] The A.M. Best Company  
   c] An insurance company  
   d] An insurance agent

   Correct answer: a] The NAIC developed Risk Based Capital.

   Incorrect answers: b, c, and d. See page 88 for review.

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Chapter Seven

1. Which of the following is NOT one of the components of a legal contract?
   a] Competent parties  
   b] **Bad faith**  
   c] Offer and acceptance  
   d] Mutual consideration

   Correct answer: b] Bad faith is not a component of a legal contract.

   Incorrect answers: a, c, and d. See page 112 for review.
2. **Which of the following statements is true about the replacement of insurance?**
   a] Replacement is always in the best interests of the client
   b] No laws exist concerning the replacement of insurance
   c] Clients do not have to sign replacement forms
   d] Replacement is *not* always in the best interests of the client

   Correct answer: d] Replacement is not always in the best interests of the client.

   Incorrect answers: a, b, and c. See page 115 for review.

3. **What section in an insurance application contains the agent’s confirmation of the accuracy and truthfulness of information contained in the application?**
   a] Medical information
   b] Agent statement
   c] Insured information
   d] Signatures

   Correct answer: b] The agent statement in the application contains the agent’s confirmation of the accuracy and truthfulness of information contained in the application.

   Incorrect answers: a, c, and d. See page 115 for review.

4. **Which of the following is NOT a type of professional liability insurance?**
   a] Directors and officers
   b] Errors and omissions
   c] Medical malpractice
   d] Fire legal liability

   Correct answer: d] Fire legal liability is not a type of professional liability; it appears on a Commercial General Liability policy.

   Incorrect answers: a, b, and c. See page 122 for review.
5. **Workers’ compensation insurance rates are based on which of the following?**

a] Employer’s gross sales  

b] Employer’s business industry  

c] **Employees’ job classifications**  

d] Employees’ dates of birth  

Correct answer: c] Workers’ compensation insurance rates are based on employee’s job classifications.  

Incorrect answers: a, b, and d. See page 125 for review.