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General California Insurance Law

This section outlines regulations from the Supplemental California Insurance Code regarding the business of insurance in general, and conduct of insurance professionals in particular. You will learn about the California Insurance Guarantee Association and its functions, and read about regulations for fair claims settlement practices. You will also review requirements for producers for displaying of license, advertisements, and recordkeeping. Pay close attention to any numbers associated with these regulations, such as time limits and dollar amounts.

A. Basic Insurance Concepts And Principles

1. Definition of Insurance (CIC 22)

Insurance **transfers** the risk of loss from an individual or business entity to an insurance company, which in turn spreads the costs of unexpected losses to many individuals. If there were no insurance mechanism, the cost of a loss would have to be borne solely by the individual who suffered the loss.

In the law, a **person** is a legal entity which acts on behalf of itself, accepting legal and civil responsibility for the actions it performs and making contracts in its own name. **Persons** include individual human beings, associations, organizations, corporations, partnerships, and trusts.

Insurance is the legal agreement, or contract, whereby the two parties involved agree to the limits of the indemnification, the circumstances under which it will occur and what things of value (consideration) will be exchanged by the parties to the contract.

2. Definition of Insurable Events (CIC 250)

According to the California Insurance Code, *"...any contingent or unknown event, whether past or future, which may damnify a person having an insurable interest, or create a liability against him, may be insured against..."* In other words, if a possible future event could result in loss or liability to a person, it may be insurable under the Insurance Code. These insurable events may never occur, but insurance policies can provide protection when those times come.

The more **predictable** a loss becomes, the **more insurable** it becomes. The more **unpredictable** a loss, the **less insurable** it becomes. *For example*, a person cannot be insured against gambling loss or lottery outcomes because they are unpredictable.

The law does not address a limit as to the level of loss that may be insured against; it only specifies the type of event that is insurable. The level of loss to be indemnified is agreed upon by the parties to the insurance contract.

3. Reinsurance (CIC 620)

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Reinsu company (the reinsurer) indemnifies another i y for part or all of its liabilities. The purpose of reinsurance is to protect insurers against catastrophic losses. The originating company that procures insurance on itself from another insurer is called the *ceding insurer* (because it cedes, or gives, the risk to the reinsurer). The other insurer is called the *assuming insurer*, or reinsurer.

When reinsurance is purchased on a specific policy, it is classified as *facultative reinsurance*. When an insurer has an automatic reinsurance agreement between itself and the reinsurer in which the reinsurer is bound to accept all risks ceded to it, it is classified as a *reinsurance treaty*. Treaties are usually negotiated for a period of a year or longer.

4. Classes of Insurance (CIC 100-120)

In California, insurance is divided into the following classes:

- Life
- Disability
- Fire
- Liability
- Marine
- Automobile
- Title
- Credit
- Surety
- Plate glass
- Workmen's compensation
- Common carrier liability
- Boiler and machinery
- Burglary
- Sprinkler
- Team and vehicle
- Aircraft
- Mortgage
- Mortgage guaranty (Insolvency, and Legal insurance), and
- Miscellaneous.

Here is how these classes of insurance are defined by the California Insurance Code:

Life insurance includes life insurance and annuity coverage upon the lives of persons.

Fire insurance covers losses in the following categories:

- By fire, lightning, windstorm, tornado or earthquake;

- Loss or destruction of, or damage to different types of property;
- All-risk policies known as *Personal Property Floater* against any kind of loss of, or damage to any personal property other than merchandise.

Liability insurance includes insurance against loss resulting from liability for injury, fatal or nonfatal, suffered by any natural person, or resulting from liability for damage to property, or property interests of others but does not include workers compensation, common carrier liability, boiler and machinery, or team and vehicle insurance.

Marine insurance covers losses to vessels, craft, aircraft, automobiles, etc., as well as persons or property in connection with these losses. It also extends to precious stones, jewelry, silver and gold.

Automobile insurance includes insurance of automobile owners, users, dealers, or others having insurable interests against hazards incidental to ownership, maintenance, operation, and use of automobiles. Automobile insurance also includes any contract of warranty or guarantee that promises service, maintenance, parts replacement, repair, money, or any other indemnity in event of loss of or damage to a motor vehicle or any part from any cause.

Title insurance indemnifies owners of real property or the holders of liens.

Surety insurance includes the following types of coverage:

- Guaranty of performance of contracts other than insurance policies;
- Loss resulting from the forgery or alteration of any instrument or signature;
- Protection against loss or destruction from any cause of evidence of debt, evidence of ownership of deeds, mortgages, bills of lading, etc.

Disability insurance includes insurance relating to injury, disablement or death resulting to the insured from accidents and relating to disablements resulting to the insured from sickness. Please note that the term *health insurance* means individual or group disability insurance, but excludes accidental death and dismemberment, disability insurance for hospital indemnity or accident only, credit disability, long-term care, and other limited coverage policies.

Plate glass insurance protects against breakage of glass.

Workers Compensation insurance includes insurance against loss from liability imposed by law upon employers to compensate employees and their dependents for injury sustained by the employees arising out of and in the course of the employment, irrespective of negligence or of the fault of either party.

Common carrier liability insurance includes insurance against loss resulting from liability of a common carrier for accident or injury, fatal or nonfatal, to any person but does not include liability or Workers Compensation insurance.

Boiler and machinery insurance includes insurance against loss of property and liability for damage to persons or property from explosion of, or accident to, boilers, tanks, pipes, pressure vessels, engines, wheels, electrical machinery, or apparatus connected to or operating nearby.

Burglary insurance includes insurance against loss by burglary or theft or both, as well as against loss or destruction of, or damage to, any of the following property, resulting from any cause:

- Moneys, stamps, coins, and bullion;
- Securities, notes, drafts, and accounts;
- Books, maps, manuscripts, indexes and other valuable papers; or
- Documents and records incidental to the business or profession or activity in which the insured is engaged.

Excludes coverage of property listed above while in the custody of, or possession of, or being transported by, any carrier for hire or in the mail.

Credit insurance includes insurance of persons engaged in business against loss by reason of extending credit to those dealing with them, and insurance against loss from the failure of persons to meet existing or contemplated obligations to the insured.

Sprinkler insurance includes insurance against loss through damage by water to goods or premises arising from the breakage or leakage of sprinklers, pumps, or other apparatus placed for extinguishing fires, or loss arising from the breakage or leakage of water pipes, or through accidental injury to such sprinklers, pumps, or other apparatus.

Team and vehicle insurance includes insurance against loss through damage or legal liability for damage, to property caused by the use of teams or vehicles other than ships, boats, or railroad rolling stock, whether by accident or collision or by explosion of engine, tank, boiler, pipe, or tire of the vehicle, and insurance against theft of the whole or part of such vehicle.

Mortgage insurance includes the guaranteeing of the payment of the principal, interest and other sums agreed to be paid under the terms of any note or bond secured by mortgage.

Mortgage guaranty insurance includes insurance against financial loss by reason of the nonpayment of principal, interest and other sums agreed to be paid under the terms of any note or bond or other evidence of indebtedness secured by a mortgage, deed of trust, or other instrument constituting a lien or charge on real estate.

Aircraft insurance includes insurance of aircraft owners, users, and dealers, against loss through hazards incidental to ownership, maintenance, operation and use of aircraft, other than against loss resulting from accident or physical injury, fatal or nonfatal, to any natural person.

Insolvency insurance includes insurance against loss arising from the failure of an insolvent insurer to discharge its obligations under its insurance policies.

Legal insurance includes the assumption of a contractual obligation to reimburse the insured against all or a portion of his fees, costs, and expenses related to or arising out of services performed by or under the supervision of an attorney who is an active member of the bar of any jurisdiction or jurisdictions of the United States, in which these legal services are performed.

Miscellaneous insurance includes the following:

- Against loss from direct or indirect damage by lightning, windstorm, tornado, earthquake; or
- An open policy indemnifying the producer of any motion picture, television, theatrical, sport, or similar production, event, or exhibition against loss by reason of the interruption, postponement, or cancellation of such production, event, or exhibition due to death, accidental injury, or sickness preventing performers, directors, or other principals from beginning or continuing their performances or duties; and
- Any insurance not included in any of the classes which is a proper subject of insurance.

B. Contract Law

1. Insurance Policy (CIC 380)

The **insurance policy** is the written instrument in which a contract of insurance is set forth.

2. Legal Terms

Fraud (CIC 338, 1871.1-1871.4)

In order for an insurer to determine whether it wants to provide coverage to an applicant, the insurer must be able to determine all relevant facts relating to the likelihood of a claim being filed. Once the insurer has all the facts, its underwriting department can decide whether the risk of a claim is small enough to, over a large number of clients, generate a profit.

One of the major sources of information for an insurer is the insurance application. The information provided by an applicant on an insurance application is considered to be a warranty. A **warranty** is a written guarantee that the information provided is true and accurate.

When an insurance applicant intentionally fails to communicate information that the insurer needs, the insurer has the right to cancel the policy if the failure to communicate is discovered after the policy has been issued. This act is called **rescission**, and the insurer is said to have **rescinded** the policy. Upon rescission, the client loses any right to file a claim on the policy, and the insurer refunds all money paid. It is important to note that the insurer must prove that the omission of information was intentional and was done for the purpose of obtaining insurance fraudulently.

Penal Code Section 550 makes it illegal to intentionally commit any of the acts specified below or to, in any way, intentionally enable someone else to commit any of the acts specified. The wording of the law includes the phrase “false or fraudulent.” Mistakenly presenting a false claim would normally not be viewed as a criminal act. Knowingly presenting a false claim for the purpose of taking something of value, however, is fraud and will be prosecuted as a crime.

When determining whether fraud has been committed, consideration will be given to whether any false statement is **material to** the transaction. This means

that the statement contains information which is relied on by the insurer in making their decision to issue the coverage.

We have condensed the Penal Code Section to clarify the violations which apply to all types of insurance claims and deleted wording which specifically refers to auto insurance. Please note that it is equally illegal to do any of the following in order to contest a claim:

- Conspiracy to file, assistance with, or presentation of, a false or fraudulent claim;
- Making more than one claim for a single loss, including claims to multiple insurers;
- Creating paperwork or making an oral statement to support a false or fraudulent claim;
- Not disclosing an event which would affect an insurance benefit.

All of the above acts are felonies punishable by

- Imprisonment in a county jail for 1 year or in a state prison for 2, 3, or 5 years;
- A fine not to exceed $150,000 or double the value of the fraud - whichever is greater; or
- Both - fine and imprisonment.

If a person is convicted of a felony under this section and has twice been previously convicted of such a felony or felony violations of related sections of the Penal and Insurance Codes, he/she cannot receive probation. In addition, for each prior conviction, the person will be sentenced to 2 additional years in state prison. Criminal penalties can be applied in addition to these penalties and enhancements.

The *Coalition Against Insurance Fraud* says that since most health care fraud goes undetected, the amount of fraud is unknown. Estimates vary widely, from 3% to 10% of health care costs. They conservatively estimate that it is more than $53 billion per year. This results in a significant increase in health care costs for everyone.

All insurance Notices of Claim and Claim Forms must have the following wording to warn those who file claims about the legal ramifications of a false claim.

For your protection California law requires the following to appear on this form, "Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison."

The obvious exception to this wording requirement is reinsurance policies, which are transactions directly between insurers.

Concealment (CIC 330-339)

Concealment is the legal term for the intentional withholding of information of a material fact that is crucial in making a decision. In insurance, concealment is the withholding of information by the applicant that will result in an imprecise underwriting decision. Concealment may void a policy.

Concealment is the failure to disclose known facts. An injured party is entitled to rescind the policy regardless of whether the concealment was intentional or unintentional. Each party should have the reasonable expectation that the other is acting in good faith without attempting to conceal or deceive the other. Neither party of the contract is legally bound to provide information pertaining to matters of their own judgment or opinions, even in matters in question. The right to rescind the policy is permissible for an intentional and fraudulent omission on the part of either party.

The following information does **not** need to be communicated in a contract:

- Known information;
- Information that should be known;
- Information that the other party waives;
- Information that is excluded by a warranty and not material to the risk;
- Information that is excepted from insurance and not material to the risk; and
- Information based on personal judgment.

Warranty (CIC 440-445, 447)

A **warranty** is a statement considered to be guaranteed to be true and becomes part of the contract. According to the California Insurance Code, a certain format of words is not necessary to create a warranty. Warranties can either be *expressed* or *implied.* Statements in a policy are considered express warranty. Every express warranty becomes part of the insurance contract. Implied warranty is an unwritten or unspoken guarantee presumed to be made based on the circumstances of a transaction.

Representations in insurance contracts qualify as **implied** warranties*.*

The creation of the warranty will take place at or before the execution of the policy and will be contained in the policy itself. The warranty is not limited by time; therefore, it may relate to the past, the present, the future or any combination of these time frames. **Violation of a material warranty on either party entitles the other to rescind the policy.**

Furthermore, the breach of an immaterial provision (meaning that it is not important) does not void the policy unless specified by the policy itself. In addition, if the policy contains a statement implying that there is an intention to do or not to do that which affects the risk, it will be taken as a warranty that such an act or omission will take place.

Materiality (CIC 334)

The concept of **materiality** is based on the idea that all parties to a contract are entitled to all information necessary to make an informed decision about the quality or nature of the contract. Materiality is determined by the “probable and reasonable influence of the facts” that they would have on the party that needs the facts to make a decision, whether that party is the insurer or the insured. Failure to disclose material information may entitle the “injured” party to rescind the contract.

Of paramount importance is the weight of **disadvantages** on either party. Disadvantages are always material information. Every contract has disadvantages for both parties, but they may not be compelling when it comes to deciding whether or not to accept the contract. Insurers are entitled to know material information about prospective insureds: *Have they been diagnosed or treated for cancer, heart disease, or diabetes? Have they ever been hospitalized? Do they fly an aircraft? Have they ever been convicted of a felony?*

If an insured intentionally conceals information about a recent heart attack, this would probably have a larger impact than if the insured had misrepresented his age by 5 years. **The materiality of a given concealment determines the importance of a misrepresentation.**

Insureds, however, are also entitled to know the disadvantages the contract has for them: cash value surrender charges, principal exclusions (war, terrorism, aviation, suicide), length of term, increase in premium at end of term, internal fees and expenses, or a substandard rating, for example. Producers have a responsibility to share disadvantages with the prospect, not just the advantages of the contract.

Representations and Misrepresentations (CIC 350-361, 780-784)

Representations are statements believed to be true to the best of one's knowledge, but they are not guaranteed to be true. For insurance purposes, representations are the answers the insured gives to the questions on the insurance application.

Untrue statements on the application are considered **misrepresentations** and could void the contract. A **material misrepresentation** is a statement that, if discovered, would alter the underwriting decision of the insurance company. Furthermore, if material misrepresentations are **intentional**, they are considered fraud.

Know that a representation may be **changed or withdrawn** prior to the effectuation of the policy, but not after. Misrepresentations that are pertinent to underwriting the insurability, level of risk, and decisions of either party are grounds to void a contract. However, it must be determined that the information was given under a false pretense, done so with the intent to commit fraud, and was material in making the decision to enter the contractual terms.

According to CIC 782, any person violating this provision is guilty of a **misdemeanor** punishable by a maximum **fine** of $25,000, **imprisonment** in a county jail for a period no longer than 1 year, or by **both a fine and imprisonment**. If the loss to the victim exceeds $10,000, the fine should not exceed three times the amount of the loss. In addition, the Commissioner may suspend the license of the agent for a maximum period of **3 years.**

3. Six Specifications for Insurance Policies (CIC 381)

I.B.7. Be able to identify six required specifications for all insurance policies (CIC 381).

Every contract of insurance is required to identify the following 6 specific elements:

1. The parties to the contract;
2. The persons or property being insured;
3. A statement of the insurable interest that exists if the insured is not the owner;
4. The risks insured against;
5. The time period during which the policy will be in force or continue; and
6. The stated annual, semi-annual, quarterly, or monthly premium or a statement of the manner in which a premium rate and total premium will later be calculated, if it can only be determined at the termination or expiration of the contract.

Note that an insurer's financial rating is not required to be specified in an insurance policy - *CA Educational Objective.*

4. Rescission (CIC 331, 338, 359, 447)

Rescission is the revocation of a contract.

An injured party is **entitled to rescind the contract** if any of the following occurs:

- A false material representation (rescission is effective from the time the representation becomes false);
- Concealment (regardless of whether the concealment is intentional);
- Violation of a material warranty or any other material provision of a policy.

C. The Insurance Marketplace

1. Distribution Systems

Agency

A **producer** is a legal entity, either human or corporate, that acts on behalf of, or in the place of, its **principal.** In insurance, the producer is the agent, and the principal is the insurer.

An insurance agent must first establish a licensing relationship with the state or states within which the agent wishes to conduct business. This requires meeting educational standards and passing required tests for the type of insurance which will be sold. This licensing relationship is separate from, and can exist without, any agent/insurer relationship being established.

The **independent agent** has contracts with more than one insurer and, ideally, is then in an enhanced position to offer clients a wide range of product options.

When the time to renew a policy comes, the independent agent is said to **own the renewal** or **own the expiration.** This means that the independent agent can move the client to a different insurer for the renewal. This would best be done only if it is to the client's advantage. An ethical challenge facing the independent agent is to avoid moving clients simply to generate new or higher commissions.

The **exclusive** or **captive** or **career agent** chooses to have a contract with one company. An agent may choose to do this when he or she finds the insurer's products to be of extraordinary quality and applicability and feels no need to

have other insurer relationships. An agent might also make this choice because the insurer only allows its products to be sold through its own, exclusive agents.

Exclusivity, depending on the viewer, can appear to be a positive or a negative. Positively, the agent can represent a product that would otherwise be unavailable to the client. Negatively, the agent is not able to search throughout the industry for a product which will be more to the client's advantage.

Direct Response

Mass marketing of insurance products through mail solicitations, print media advertisements, or television and radio are referred to as **direct response** marketing. The policies provided are generally low in benefits and low in premiums.

The term "direct response" refers to the necessity of the potential client to take the initiative and respond to the advertisement through a telephone or mail contact with the insurer as directed in the ad.

Home Service

Home service (industrial life) insurance is exactly what it sounds like. It is the opposite of direct response insurance. With home service products, the agent solicits and sells insurance in the home or business, and returns to collect the premium in person. Home service policies are sold through *home service* or *debit* insurers; the face amount usually doesn't exceed $2,000 and the premium is paid weekly.

This type of service generally comes at a very high price, and the purchasers are frequently unsophisticated consumers of financial products.

Insurance companies market their products in different ways: through agents or direct solicitation to the customers.

TYPE OF MARKETING ARRANGEMENTS	CHARACTERISTICS
Independent Agency System/ American Agency System	• 1 independent agent represents several companies • Nonexclusive • Commissions on personal sales • Business renewal with any company
Exclusive Agency System/ Captive Agents	• 1 agent represents 1 company • Exclusive • Commissions on personal sales • Renewals can only be placed with the appointing insurer
General Agency System	• General agent-entrepreneur represents 1 company • Exclusive • Compensation and commissions • Appoints subagents
Managerial System	• Branch manager (supervises agents) • Salaried • Agents can be insurer's employees or independent contractors

Direct Response Marketing System	• No agents • Company advertises directly to consumers (through mail, Internet, television, other mass marketing) • Consumers apply directly to the company

2. Producers

Definition of "Transact" and Types of Licensees

When a person performs any of the following actions, he or she is **transacting insurance:**

- Solicitation of insurance;
- Negotiations preliminary to the execution of a contract;
- The actual execution of a contract;
- Any transactions that later result from the operation of the contract.

With the exception of certain persons who receive non-commission compensation from their employer for these actions, any other person who receives compensation for “transacting insurance” must be licensed as an agent or broker. It is a **misdemeanor** to transact insurance without a license. The maximum penalty for **transacting insurance without a valid license is a fine of up to $50,000** or imprisonment in a county jail for up to 1 year, or both.

The California Insurance Code defines a variety of specific licenses which may be issued to qualified persons:

- Property and casualty broker-agent
- Life-only agent *(formerly life agent)*
- Accident and health agent *(formerly life agent)*
- Personal lines agent
- Surplus line broker.

An **insurance agent** in this state means a person authorized to transact all classes of insurance on behalf of an admitted insurer **other than life, disability, or health insurance**.

Life-only agents in California are authorized to transact **insurance on human lives** including the following benefits:

- Endowments
- Annuities
- Death or dismemberment by accident
- Disability income.

Accident and health agents may transact the following types of insurance:

- Sickness
- Bodily injury
- Accidental death
- Disability income
- 24-hour coverage.

A **property and casualty** licensee (former fire and casualty licensee) may be authorized to transact any of the following coverages:

- Automobile insurance

- Personal watercraft
- Residential property (including earthquake and flood)
- Inland marine insurance
- Umbrella or excess liability insurance.

A **personal lines agent** may transact only personal automobile, inland marine for personal property, residential property, and umbrella or excess liability lines of insurance.

A **limited lines automobile insurance agent** is authorized to transact auto insurance, including automobile liability coverage, physical damage coverage, and collision coverage.

A **surplus line broker** is authorized to transact insurance with a nonadmitted insurer only if a specific class of insurance cannot be obtained from admitted insurers (after proof of a diligent search).

Regardless of the type of license held, with the exception of a surplus line broker, agents or brokers may not advertise or transact insurance on behalf of a nonadmitted insure or aid a nonadmitted insurer in any way to transact insurance in California.

Prohibited Actions (CIC 1631, 1633)

No person may perform the activities of an insurance agent or broker without holding the appropriate valid licenses described in the Insurance Code. This includes soliciting, negotiating, and executing contracts of insurance.

As a result, “any person who acts, offers to act, or assumes to act” in any manner that would require a license, but does not hold a valid license, is guilty of a **misdemeanor**. A misdemeanor conviction in California can result in imprisonment in the county jail for up to 1 year, a fine of up to $50,000, or both.

Written Consent in Regard to Interstate Commerce

It is considered **unlawful insurance fraud** for any person engaged in the business of insurance to willfully, with the intent to deceive, make any oral or written statement that contains either false statements or omissions of material fact. This includes information and statements made on an application for insurance, renewal of a policy, claims for payment or benefits, premiums paid, and financial condition of an insurer.

Anyone engaged in the business of insurance whose activities affect interstate commerce, and who knowingly makes false material statements may be fined, imprisoned for up to 10 years or both. If the activity jeopardized the security of the accompanied insurer, the sentence may be extended up to **15 years**. Anyone acting as an officer, director, agent or other insurance employee that is caught embezzling funds faces the aforementioned fines and imprisonment. However, if the embezzlement was in an amount that is **less than $5,000**, prison time may be reduced to 1 year.

Federal law makes it illegal for any individual convicted of a crime involving dishonesty, breach of trust or a violation of the Violent Crime Control and Law

Enforcement Act of 1994 to work in the business of insurance affecting interstate commerce without receiving written consent from an insurance regulatory official (Director of Insurance, Commissioner of Insurance, etc.) - known as a **1033 waiver**. The consent from the official must specify that it is granted for the purpose of 18 U.S.C. 1033. Anyone convicted of a felony involving dishonesty or breach of trust, who also engages in the business of insurance, will be fined, imprisoned for up to 5 years or both.

Any person who engages in conduct that is in violation of Section 1033 may be subject to a civil penalty of **not more than $50,000** for each violation or the amount of compensation the person received as a result of the prohibited conduct, whichever is greater.

Agents vs. Brokers

Agents legally represent the insurer, not their clients. In other words, all of an agent's actions are considered to be made on behalf of the insurer, not the insured. With brokers, however, this is reversed. **Brokers legally represent their clients**, not insurance companies. They negotiate contracts of insurance on their clients' behalf.

The broker represents, and is expected to act in the best interests of the client, not those of the insurance company. Although a broker could receive compensation from an insurance company for a transaction, typically the broker receives a fee for his or her services directly from the client. It could be unethical for a broker to accept both a fee from the client and a commission from the insurer.

Insurance Agents and Insurance Brokers

Insurance agent in this state means a person authorized to transact all classes of insurance on behalf of an admitted insurer *other than life, disability, or health insurance.* The term **insurance broker** refers to a licensee who, for compensation and on behalf of a person *other than an insurer,* transacts insurance *other than life, disability, or accident and health*. Note that there is **no such license** as "life broker" or "health broker." However, a person can be life licensed (as an independent), acting in a broker's capacity.

A **life licensee** is a person authorized to act as a life agent on behalf of a life insurer or a disability insurer to transact life insurance, accident and health insurance, or a combination of life and accident and health insurance.

Life Settlement Brokers

The term **life settlement** refers to any financial transaction in which the owner of a life insurance policy sells a policy that is no longer needed to a third party for some form of compensation, usually cash. While *viatical settlements* are still used for persons who are terminally ill, most states regulate policies that are sold to a third party for compensation under the term *Life Settlements.*

In life settlements, the seller (the policyowner) could have a life expectancy of more than one year. Policyowners may choose to sell their policies because they

feel they no longer need their coverage, or the premium costs have grown too high to justify continuation of the policy.

Definitions

The term **Business of Life Settlement** refers to **any** activity relating to the solicitation and sale of a life settlement contract to a third party who has no insurable interest in the insured.

The term **owner** refers to the owner of the policy who may seek to enter into a life settlement contract. The term does not include an insurance provider, a qualified institutional buyer, a financing entity, a special purpose entity, or a related provider trust.

Insured is the person covered under the policy that is considered for sale in a life settlement contract.

Qualified Institutional Buyer is one that owns and invests at least $100 million in securities and is allowed by the SEC to trade in unregistered securities. A life settlement provider may sell, or in some other manner approved by the Superintendent, transfer ownership of a settled policy to a qualified institutional buyer or other investment entity approved by the Superintendent.

Life Expectancy is an important concept in life settlement contracts. It refers to a calculation based on the average number of months the insured is projected to live due to medical history and mortality factors (an arithmetic mean).

Life Settlement Contract establishes the terms under which the life settlement provider will pay compensation to the policyowner, in return for the absolute assignment, transfer, sale, or release of any portion of any of the following:

- The death benefit;
- Policy ownership;
- Any beneficial interest; or
- Interest in a trust or any other entity that owns the policy.

A life settlement contract also includes a premium finance loan that is made on or before the date of issuance of the policy if one or more of the following conditions apply:

- The loan proceeds are not used solely to pay premiums for the policy;
- The owner receives a guarantee of the future life settlement value of the policy; and
- The owner agrees to sell the policy in the event of a default.

The following **would not constitute** a life settlement contract:

- A policy loan issued by a life insurance company;
- A loan made by a bank or a lender;
- A collateral assignment of a life insurance policy by the owner;
- An agreement between closely related parties (by blood or by law);
- A bone fide business succession arrangement;
- Employer-owned life insurance on key employees;
- An agreement between a service recipient and a service provider;

- Any other form specified by the Commissioner.

A **Life Settlement Broker** is a person who, for *compensation*, solicits, negotiates, or offers to negotiate a life settlement contract. Life settlement brokers represent only the policyowners, and have a fiduciary duty to the owners to act according to their instructions and in their best interest.

This does not include a licensed life settlement provider or its representative, an attorney, an accountant, or a financial planner. This category includes persons who would not receive a commission upon completion of a life settlement contract, but charge a fee for their services, whether or not ownership of the policy is transferred.

Life Settlement Producer is a person licensed as a resident or nonresident insurance agent who is qualified to transact life settlements.

Financing Entity includes any accredited investor who provides funds for the purchase of one or more life settlement contracts and who has an agreement in writing to do so.

Financing Transaction takes place when a licensed settlement provider obtains funds from the financing entity.

Broker License Requirements

Before a person can act as a life settlement broker in this state, he or she must be properly licensed. The following are the required qualifications for a licensee:

- Complete required prelicensing education (15-hour training course);
- Pass the licensing exam;
- Submit an application to the Commissioner on the approved form;
- Pay any required fees (currently, a 1-year license fee is $136); and
- Be determined competent and trustworthy.

If an individual has been licensed as a **life agent for at least a year**, he or she may act as a life settlement broker; however, they must notify the California Department of Insurance within 10 days of transacting life settlements. In lieu of a broker's license, life agents will be required to pay the notification fee of $136 dollars, and renew that notification biennially, at the time of life license renewal.

Licensed **viatical settlement brokers** or providers will be considered to have met the licensing requirements for life settlement brokers or providers.

Acting as an Agent without Appointment

A licensed life or accident and health agent who is not specifically appointed for a particular insurer may not solicit insurance to a prospective client with that insurer or pass on an application for insurance to that insurer if the insurer requires that all its agents represent only that insurer.

If an insurer does not specifically require all of its agents to be appointed, then any licensed agent may present a proposal for insurance to a potential client on behalf of an insurer for which the agent is not specifically appointed and may also give an application for insurance to that insurer. If an insurance

policy is issued, the insurer is considered to have authorized the agent to act on its behalf, and the insurer is responsible for all actions of the agent that relate to the application and policy as if the agent had been properly appointed for the insurer. The insurer must forward to the Commissioner a **notice of appointment** of the agent as the insurer's agent within **14 days** after the agent submitted the insurance application. An insurer is not obligated to accept an application for underwriting from a life agent.

Some insurers employ **exclusive/captive/career** agents and will not allow any other agents to sell their products. The Insurance stipulates that licensed agents not contracted with such companies are not allowed to present insurance applications to those companies. However, if an insurer does not require that all agents be appointed by them in order to sell their products, an agent is allowed to represent that company to a client and to receive an application for insurance with that company. All payments by the client must be made payable to the insurer, not to the agent. If the insurer does not accept the application, no agency appointment exists. However, the insurer, by issuing a policy in response to such an application, is deemed to have thereby appointed that agent. The insurer must then notify the Commissioner of that appointment within **2 weeks** of receiving the application.

Solicitors

An **insurance solicitor** is a **natural person** employed to assist a property and casualty broker-agent acting as an insurance agent or insurance broker in transacting insurance **other than life, disability, or health**. In this state an insurance solicitor is not eligible to act as an insurance agent or broker at the same time. A person authorized to act as either an insurance agent or broker is not eligible at the same time to act as an insurance solicitor.

A solicitor may make prospecting telephone calls, set appointments, even offer quotes, or take applications for insurance other than life insurance. A solicitor may be employed by more than one broker-agent at a time. A notice of appointment appointing a solicitor may be filed by a second or subsequent property and casualty broker-agent. In order to perform the duties of an insurance solicitor, the Insurance Code requires that a person hold an insurance solicitor's license.

There is no such license as "life solicitor."

Take note:

- **"LIFE SOLICITOR" is NOT a license.** *(CIC 1704)*
- **"ACCIDENT AND HEALTH SOLICITOR" is NOT a license.** *(CIC 1704)*

Agent's Errors & Omissions Insurance

An insurance agent or broker may wish to obtain professional liability insurance to protect against financial losses that could occur due to the agent's negligent acts or actions. This is known as **errors and omissions (E&O)** liability insurance.

Need for Coverage

Because of the risk of injuring a person as a result of the advice or services rendered (an error) or not rendered (an omission) to that person, E&O insurance is a necessity.

At any time during the sales process, there can be a misunderstanding or misrepresentation that could lead to legal action being taken by the insured. Agents should "document, document, document"— interviews, phone conversations, requests for information, etc. The sales interview and the policy delivery are the most common time for E&O situations to occur.

Types of Coverage

Errors and Omissions insurance is written for professionals (such as insurance producers) to provide protection resulting from actions charging that the professional failed to render reasonable duties or services. While some professional liability insurance coverage is written with a limit of liability on an occurrence basis and the insurance company is required to obtain the insured's consent for any out-of-court settlement, the modern trend is to provide coverage on a claims-made basis and to delete previous requirements for consent of the insured for out-of-court settlements.

Errors and omissions liability contracts are renewable annually and are usually written with “per claim” deductibles of at least $500 or $1,000, and have either a “limit per claim” or “limit for all claims during the policy period” provision that describes the contract’s maximum benefit.

Types of Losses

The following are examples of acts or omissions that could lead to professional liability claims:

- An agent unintentionally records an answer incorrectly on an application for insurance, concealing the client’s actual response to a question regarding qualifying information. Upon investigation of a claim, the insurer discovers the correct information and lawfully rejects the claim and voids the contract on the basis of the incorrect answers in the application, refunding premiums paid. The E&O policy would pay for the actual claim losses of the agent’s client.
- The agent fails to disclose material information about a contract of insurance, such as deductibles, coinsurance, copayments, surrender charges, premium increases, or principal exclusions. Actual demonstrated damages incurred by the agent’s client could be covered by the E&O policy.
- The agent tells a client, “I guess I made a mistake,” in calculating the original premium quotation when, in fact, the increased premium was due to the client’s substandard rating. If an insured later discovers the misrepresentation and decides to cancel the contract, an E&O policy could pay the difference between the actual premiums paid and what the client was originally quoted by the agent as the periodic premium, from the date of the client’s discovery of the error.
- The agent leads a client to believe that projected investment results in a variable contract, or that the sales illustration for a contract with non-guaranteed interest, are guaranteed elements of the contract. Actual client losses could be paid for by an E&O policy.
- The agent accepts a check from a client, representing an unscheduled deposit to the cash account in a variable or flexible premium policy, and fails to send it

to the insurer on a timely basis. Actual investment or interest losses could be restored by an E&O policy.

Losses Not Covered

Errors and Omissions insurance does not offer any protection for liabilities that result from a person's criminal acts, such as fiduciary crimes, unfair business or trade practices, or material misrepresentations which result in financial loss or damages to a client.

It must be understood that if any of the previously named liability claims arise out of a criminal conviction, or result in a criminal conviction, the E&O policy will not pay the claim, and the agent or broker will remain personally liable for the client's damages.

Prohibited Acts Regarding Nonadmitted Insurers (CIC 703)

I.C2.10. Be able to identify acts prohibited (unless a surplus line broker) with regard to nonadmitted insurers (CIC 703).

A *nonadmitted* insurer is one which has not met the requirements, either by choice or by failure, to legally have its representatives physically present in order to conduct business in California. Such an insurer can be represented within the borders of California by specially licensed individuals, called “surplus lines brokers.” A valid Certificate of Authority must first be secured from the department of insurance prior to conducting business in California.

Surplus lines brokers are of value to the residents of California: they help the residents purchase types of property and casualty insurance that are not available from an admitted insurer.

Advertising Requirements

This is a rather clear-cut portion of the Insurance Code: a person is either a licensed surplus lines broker or not. If not licensed as a surplus lines broker, a person may not in any way represent, advertise or assist a nonadmitted insurer.

Prohibited Acts (Unless a Surplus Line Broker)

The following acts are **misdemeanors** except when performed by a surplus line broker:

- Acting as an agent for a nonadmitted insurer in the transaction of insurance;
- Advertising a nonadmitted insurer in any way;
- In any way aiding a nonadmitted insurer to transact insurance.

In addition to any penalty given for committing a misdemeanor, a person violating any provision of this section will be fined $500, along with a $100 fine for each month or part of a month during which the person continues the violation.

New legislation was recently passed to streamline the surplus line broker licensing laws, and the following changes were included. All individuals must

hold an individual surplus line broker license. Applicants for such a license must already be licensed to transact fire (property) and casualty insurance.

Additionally, the application and renewal fee for a surplus lines broker is $700. This fee allows for a **2-year** license term.

The fee for a licensed surplus line broker organization to endorse a licensed individual line broker is $24. When terminating such a broker, the CDI must be notified (which is also a $24 fee).

Surplus Line brokers transacting insurance on behalf of a licensed surplus line broker organization will not be required to file a bond. However, all other surplus line brokers must file a $50,000 surplus line broker bond.

Prohibitions of Free Insurance (CIC 777.1)

I.C2.11. Be able to identify the prohibitions of free insurance (CIC 777.1).

To protect the integrity of the insurance industry in California, the state has adopted the philosophy that insurance is a product of sufficient importance and that it should be paid for by the insured because of its intrinsic value. To this end, it is **illegal** for any insurance licensee to offer **free insurance** as an incentive to conduct some other type of business.

If any insurer, agent, broker or solicitor willfully violates this provision, the Insurance Commissioner may suspend or revoke that person's certificate or license or other authority to do business for a period not exceeding 1 year.

The following are *exceptions* to the free insurance prohibition:

- Insurance provided in connection with newspaper subscriptions;
- The purchase of credit union shares;
- Insurance to guarantee the performance of a product and reimburse a customer for losses resulting from such product's failure;
- Title, life, or disability insurance which will pay off a debt in case a debtor becomes disabled or dies;
- Services provided by an attorney; and
- The services of a motor club (AAA, for example) in regard to towing, emergency roadside service, bail bond service, DMV transactions or other normal motor club services that are not defined as the transaction of insurance.

Miscellaneous Code Requirements and Specifications
General
Agency Name/Use of Name (CIC 1724.5, 1729.5)

California state regulation has no ability to limit a human being's right to use his/her actual name to conduct the business of insurance. Other than that, the regulators of insurance have a responsibility to ensure that California's residents not be misled by the name or names attached to a licensed entity.

Every licensee, individual and corporate, must reveal to the Insurance Commissioner the real name of the legal person as well as all fictitious ("DBA") names which are intended for use. To prevent confusing the insurance

consumer, the Commissioner may deny the use of a name for any of the following **reasons:**

- The name would interfere with the business of another or is too similar to the name of another;
- The name would mislead the consumer in any way;
- The name gives the impression that the licensee is authorized to conduct a type of business which it cannot legally conduct;
- Though the terms “Chartered Property and Casualty Underwriter” and “Chartered Life Underwriter” are commonly used by those who have earned those designations, it is not acceptable to use the term “underwriter” in such a way as to give the impression that the licensee is authorized to act as such. The term “underwriter” can be used in the name of an organization of insurance producers who are individually licensed; or
- The licensee is already using 2 approved names. The exception to this is a licensee who acquires ownership of another licensee, in which case the use of a maximum of 2 names for each such entity is allowed.

In regard to the above, there is room for negotiation with the Commissioner if there are extenuating circumstances.

If a broker or agent has a contract to provide service for a corporation which holds an insurance license in its own name, or is a stockholder in a licensed corporation, or is a member of an incorporated agency, that broker or agent may use the name of such organization in printed materials as long as the broker or agent clearly identifies the relationship.

Fictitious Names

All licensees, from individuals to organizations, must file with the Commissioner their true names and any fictitious names under which they are conducting business. They must also notify the Commissioner if any of the names are changed or discontinued. The Commissioner has the right to approve and disapprove names.

Licensees may not use more than two names, real or fictitious. When licensees purchase or inherit a business, two additional names may be used for that business.

Change of Address (CIC 1729)

All licensees, on their initial license application, must provide their residence, business, and mailing addresses. It is the responsibility of the licensee to notify the Commissioner **immediately** of any changes in the *e-mail, residence, principal business, or mailing addresses* though the use of an electronic service approved by the Commissioner.

Reporting Administrative Actions and Criminal Convictions

According to the CIC 1729.2, all licensees and applicants for licenses must report any **administrative actions or criminal convictions**, and background changes to the California Department of Insurance Producer Licensing Bureau **within 30 days** of the final disposition of the matter. Background information that must be reported includes the following:

- Misdemeanor or felony convictions;
- Filing of felony criminal charges against the licensee in state or federal court;
- Administrative actions regarding an occupational license;
- Personal or organizational bankruptcy filing; or
- Any financial breach or misappropriation.

Licensees and applicants are required to submit supporting documents, such as a statement regarding the background change, certified court documents, administrative documents, or any other related documents.

To report this information to the Department, licensees may use the background change disclosure form available at www.insurance.ca.gov, Producer Background Information, under Agents & Brokers. Background changes may also be submitted electronically to the National Insurance Producer Registry (NIPR) by selecting "Reporting of Actions" under "Attachments Warehouse."

Filing License Renewal Application (CIC 1720)

Insurance licenses in this state must be renewed every **2 years.** If a licensee delays completing the renewal requirements and finds himself or herself near the license expiration date, the licensee can continue to conduct business for **60 days** past that expiration date if the licensee completes all requirements and submits the license renewal fee no later than the expiration date.

Printing License Number on Documents (CIC 1725.5)

In order to facilitate a potential client's investigation of a producer, each producer must place his/her license number on all printed materials placed before the public, including business cards, proposals, and all print advertisements in California.

To ensure that the number is not minimized and would not be missed by a prospective insurance purchaser, the license number must be printed *at least as large as the smallest address or telephone number on the same document*. For licensees with more than one license, a single license number will suffice. Solicitors must use the license number of their employer.

A first offense will be punished by a fine of $200, a second by a fine of $500, and a third by a fine of $1,000. However, a separate penalty cannot be imposed for each piece of illegal material used. There is a process for explaining violations, and the Commissioner has the option to consider extenuating circumstances and relieve the licensee of the penalty.

The one exception to the license number requirement is motor club (A.A.A., etc.) advertisements which include insurance in a general list of services provided without giving details regarding the insurance products.

Internet Advertisements

A California agent or broker who advertises his or her services over the internet, regardless of whether the agent/broker created the ad or someone created it on his or her behalf, must include all of the following information in the ad:

- His or her name as it appears on the insurance license, as well as any fictitious name approved by the Commissioner;
- The state of his or her domicile and principal place of business; and
- His or her license number.

A person is deemed to be transacting insurance when the person advertises on the Internet, regardless of whether the agent or broker maintains the Internet presence or if it is maintained on his or her behalf, and does any of the following:

- Provides an insurance premium quote to a California resident;
- Accepts an application for coverage from a California resident; or
- Communicates with a California resident regarding one or more terms of an agreement to provide insurance or an insurance policy.

Records

One of the challenges facing new agents and brokers is to accept the responsibility to obtain and maintain accurate, legible records which can be available within 30 days after a request to the insurer from the Department of Insurance. Each admitted insurer must maintain certain records pertaining to the activities of its life, life and disability, and disability agents for a period of **5 years.** Life, life and disability, and disability insurance agents must also maintain all applicable records at their principal place of business for a minimum of 5 years. The records must be maintained in orderly manner and be available for Commissioner's review at all times.

The records may be in the form of originals, copies, or electronic data-processing records and must include the following:

- Name of insured;
- Name of insurer;
- Policy number;
- Date insurance is effective and any date it ceases to be effective;
- Renewals;
- Coverage changes;
- All information regarding binders;
- Proposals, including comparisons with existing coverage;
- Copy of the application or other request for insurance;
- All correspondence or other written records which describe the transaction, except printed materials in general usage;
- All correspondence regarding cessation of coverage; and
- Legally required outline of coverage or disclosure statement.

The following records must be kept regarding policies, premium payments and commissions:

- The original policy application;
- Amount of premiums received by the insurer;
- Production records showing policies sold by each agent;
- Itemization of the premium received;
- All written communications send by the insurer or its agents to a prospect, applicant or insured;
- A copy of outline of coverage or disclosure statements.

Disclosure of Effective Date of Coverage to Insureds/Applicants (CIC 1730.5)

When a person applies for an insurance policy or pays the initial premium, a producer must disclose the effective date of coverage (if known), or the circumstances under which coverage will be effective as soon as specific conditions are met. This regulation applies only to coverage for personal lines of insurance.

Fiduciary

The term *fiduciary* describes both the responsibility inherent in handling another person's financial affairs, and the individual with such responsibility. Insurance licensees commonly act as a conduit, receiving and transferring funds from client to insurer, and, eventually, from insurer to client. Any person who diverts or appropriates fiduciary funds to his or her own use is guilty of **theft** and punishable for theft as provided by law.

If fiduciary funds are received by a licensed producer, he or she must ensure the following:

- Remit and return premiums received to the insurer (minus commissions due);
- Maintain fiduciary funds at all times in a trustee bank account separate from any other accounts, in the amount at least equal to the premium and return premiums received by the producer and unpaid to the person entitled to those funds.

Managing General Agent (MGA) is any person, firm, association, partnership or corporation that negotiates ceding reinsurance contracts on behalf of an insurer or manages the insurance business for that insurer and acts as its agent.

The following would not be considered MGAs:

- An employee of the insurer;
- A U.S. manager of the United States branch of an alien insurer;
- An underwriting manager of the insurer who manages the insurance operations and whose compensation is not based on the volume of the premiums written by the insurer;
- The attorney-in-fact authorized by and acting on the behalf of the subscribers of a reciprocal insurer.

MGAs usually have the authority to transfer the funds to the appropriate party; therefore, their fiduciary capacity includes the following:

- Have a written management contract and an appointment with one or more admitted insurers that cover a substantial portion of the insurance business in the state of California;
- Manage transactions of either all or some classes of insurance for those insurers;
- Appoint, supervise and terminate the appointments of local agents;
- Accept and decline risks;
- Collect premium funds from producing broker-agents and remit the funds to the insurers.

The responsibility of the licensee is to, as soon as practicable, transfer the funds to the appropriate party. If authorized by written agreement of all involved parties, the licensee may place the funds in U.S. government instruments, certificates of deposit, or government bonds which meet specified guidelines

until such time as they are to be transferred. Any losses resulting from such investments are the responsibility of the licensee and in no way reduces the amount of funds they must transfer.

Appointment Regulations

In order to validate and legitimatize the agency relationship and the insurance contract, the insurer must submit a notice of appointment within **14 days** to the Commissioner. The licensee will be legal to conduct business, and the insurer will become responsible for the acts of the licensee, as of the date the appointment is signed by the insurer.

An appointment will cease and the licensee will become unable to conduct business for the insurer when any of the following conditions exist:

- The licensee loses his/her license; or
- The licensee is terminated or resigns his/her appointment.

Life Insurance (CIC 1704, 1705)

Upon signing and submitting an appointment for an original license, an insurer is inherently confirming to the Department of Insurance that the applicant has a good reputation and is worthy to be issued the license. This includes confirmation that the applicant has sufficient experience or education or will soon (within 30 days) receive sufficient education to meet the requirements of the license. All of this is true for the entity and each of its natural persons if the applicant is a business entity.

When a licensed business entity adds a person to its license, the declarations discussed above are presumed to have been made about that person.

A life or accident and health agent is allowed to present a coverage proposal to a client for an insurer with whom the agent is not appointed. If the proposal results in an application to the insurer and a policy is issued, which the insurer is under no obligation to do, it is assumed that the insurer is appointing the agent. **Within 14 days**, the insurer must file the notice of appointment with the Department. All payments from the client in regard to such a policy must be made payable to the insurer. The following are exceptions to this rule:

- An unappointed agent may not present a proposal or accept an application for an insurer which uses only “career” agents, agents which exclusively represent only a single company or group of companies; and
- The insurer requires that it be the first insurer to whom its agents present policy applications.

Disability Insurance (CIC 1673, 1704-1705)

A person licensed as a property and casualty broker-agent, a life-only agent, or an accident and health agent may transact disability insurance on behalf of any insurer which is authorized to transact disability insurance if he/she has filed a **notice of appointment** for the purpose of transacting disability insurance. The authority to transact disability insurance becomes effective the day the notice of appointment is signed by the insurer. This authority will apply to transactions

occurring after that date and for the purpose of determining the insurer's liability for acts of appointed agents.

Inactive License (CIC 1704a)

When a licensee has no active appointments, he or she does not lose his or her license. The insurance license is the result of a relationship the licensee has with the Department of Insurance, and a lack of appointments does not change that relationship. A licensee with no appointments has a license which is designated as **inactive**. Upon being appointed by any insurer, the license becomes *active* again.

Cancellation of a License by the Licensee (CIC 1708)

A licensee may surrender his/her license for cancellation at any time. If the license is in the possession of the licensee, he/she may surrender the license by delivering it to the Commissioner. If the license is in the possession of the insurer or the licensee's employer, the licensee may still surrender the license by delivering a written notice of surrender to the Commissioner.

Application and License Related Laws (CIC 1666, 1668-1669, 1738)
Producer Application Investigation (CIC 1666)

The Commissioner is obligated to the consumers of California to assure that all insurance licensees are qualified in regard to their knowledge and character. To this end, the Commissioner is authorized to require the provision of any information or documents necessary to make such a determination. After the investigation is complete, the applicant may be authorized to conduct business.

Denial of Applications (CIC 1668-1669)

There are many possible causes given in the Insurance Code for denying an insurance license. Keep in mind that these causes apply to legal “persons” which include individuals and business entities such as agencies and corporations. The applicant can be denied licensure if the applicant is unqualified or if licensing the applicant would be against the public’s best interest.

An applicant's license could be denied if the applicant has committed any of the following:

- Has no intention of selling the insurance permitted by the license
- Does not have a good business reputation
- Lacks integrity
- Was denied or lost another state license within the past 5 years for a reason which would also cause an insurance license to be denied
- Wants the license to avoid the consequences of insurance law
- Has lied on his/her application
- Previously acted dishonestly in business
- Exposed the public to loss as a result of incompetence or lack of trustworthiness
- Lied about an insurance policy
- Has either not done something required by, or has done something forbidden by the Insurance Code
- Has been convicted of (not charged with) any felony or a misdemeanor violation of insurance law

- Has helped someone else commit a crime which would make that other person lose or be denied a license
- Has allowed an employee to violate the Insurance Code
- Has acted as a licensed person prior to issuing of a license
- Has submitted a fraudulent educational certificate.

The applicant may be denied a license without the right to a hearing if the applicant has a history of any of the following conditions:

- Felony convictions;
- Misdemeanor violations of insurance law;
- Denial of an insurance license within the past 5 years; or
- Insurance license suspension or revocation within the past 5 years.

Note that any person **caught willfully cheating** on the licensing examination will be barred from taking any license examination and from holding an active license for a period of **5 years**.

In regards to what may constitute a *conviction*: any applicant for licensure in the state of California will be considered convicted of a misdemeanor or felony if he or she was found guilty or convicted after entering a plea of "nolo contendere," or "no contest."

It is important to remember that **all convictions**, at *any time* in an applicant's past, must be disclosed on the license application. This also applies to convictions for which the charges were later dismissed or expunged, or for which a person was placed on probation or received a suspended sentence. If an applicant fails to **disclose** all convictions, the application for a producer license will be denied (CIC 1729.2).

Suspension or Revocation of License

A permanent license may be revoked for any of the reasons given for which a license could be denied. A hearing would not be allowed if one of the four conditions mentioned above exists.

Termination of a License/Dissolving Partnerships (CIC 1708-1714)

I.C2.17 (Life)/I.C2.16 (Health). Be able to identify the scope and effect of the Code regarding termination of a (producer's) license, including when producers dissolve a partnership (CIC 1708-1712.5).

A licensee can surrender his/her insurance license at any time, either by returning the license to the Commissioner or, if not in possession of the license, sending a notice of resignation.

An insurance license automatically terminates when the licensee dies. If the licensee is an organization, the license will terminate if its partnership, association or corporation is dissolved. Also, a partnership will lose its license if it changes the persons serving as partners. When new partners join, a partnership can continue its license if it files notice within 30 days with the Department and the changes are approved.

When any of the above organizations cease, they may continue to conduct business under another name if the same people remain involved and the necessary paperwork is completed within **30 days**.

Continuing Education Requirements

Continuing education rules are established to protect the public by maintaining high standards of professional competence in the insurance industry, and to maintain and improve the insurance skills and knowledge of licensed producers. The State of California has implemented prelicensing and continuing education requirements for initial applicants and license renewals that apply equally to life-only agents, accident and health agents, property broker-agents and casualty broker-agents (formerly fire and casualty broker-agents).

Any licensee must complete **24 hours** of continuing education (CE), including **3 hours of ethics**, per each 2-year license renewal term for the type of license held. This regulation applies to the following licenses:

- Life-only agent;
- Accident and health agent;
- Property broker-agent;
- Casualty broker-agent.

These hours can be completed at any time before the license renewal date. The CE courses and programs must be approved by the Commissioner.

If an agent holds 2 types of licenses (for example, a life agent and a property broker-agent), the agent may satisfy CE requirement by completing for any of the license types held.

It may not be practical to complete precisely the minimum number of CE units during a license period. While it is not possible to renew a license without the required number of credits, those credits in excess of the required number will be carried over into the next licensing period; they are not “lost.”

Note, however, that only those hours that were completed during the second year of the licensing period may be carried over. The number of hours that can be carried over cannot exceed the number of hours that are required to renew the license.

Continuing education is available in a variety of settings. Courses are available with a live instructor, known as a “contact” setting, via mail order as a “self-study” course, and even by computer over the Internet, also a “self-study” method. Agents should be certain, however, that the courses they pay for are approved by the Department of Insurance for California continuing education. A student may gain valuable knowledge by taking any course, but only approved courses will satisfy license renewal requirements.

Life-only agents, accident and health agents, or property and casualty broker-agents may only receive credit for CE courses approved for their respective licenses. **Agents who hold licenses in more than one line of authority must satisfy the continuing education requirements by completion of the approved courses or programs of instruction for any of the license types**.

Licensees who have been in good standing for 30 continuous years in this state and who are 70 years of age or older are not required to comply with the requirements for continuing education.

Agents Writing Long-Term Care Insurance (CIC 10234.93)

Each agent authorized to solicit long-term care insurance **must satisfy the training and continuing education requirements**. The training requirements are as follows:

- 8 hours of LTC training annually for the first 4 years after the original license is issued; and
- 8 hours of training during each licensing period thereafter.

The required LTC training is **included** in the hours required for overall continuing education, not added to them. Note that long-term care training is **not required** when an agent is transacting accelerated death benefit provisions or riders that do not require services.

Agents Writing California Partnership Coverage

Accident and health agents who intend to sell California Partnership for Long-Term Care (CPLTC) insurance must also satisfy the continuing education requirement for those courses. These agents are required to complete one specifically designated long-term care training course, and one specifically designated 8-hour California Partnership for Long-Term Care classroom course. Once the initial training requirement has been met, the agents are required to complete an 8-hour classroom CE course on the Partnership every 2-year licensing period.

Life-only agents may be authorized to solicit long-term care riders to a life insurance policy after meeting the proper training requirements.

Note that the total number of CE hours required for the accident and health agent is **not increased** by CE requirement for LTC or CPLTC.

Ethics

I.C2.23 (Life)/I.C2.21 (Health). The following points are derived from the ethical codes of major industry organizations and may be the basis of Ethics-related test questions on the licensing exam.
I.C2.24 (Life)/I.C2.22 (Health). Be able to identify that the CIC and the California Code of Regulations (CCR) identify many unethical and/or illegal practices, but they are not a complete guide to ethical behavior.

You should be able to **identify and apply** the meaning of the following:

- Place the customer's interest first;
- Know your job and continue to increase your level of competence;
- Identify the customer's needs and recommend products and services that meet those needs;
- Accurately and truthfully represent products and services;
- Use simple language that insurance consumers can understand;
- Stay in touch with customers and conduct periodic coverage reviews;

- Protect your confidential relationship with your client;
- Keep informed of and obey all insurance laws and regulations;
- Provide exemplary service to your clients; and
- Avoid unfair or inaccurate remarks about the competition.

Note that the California Insurance Code (CIC) and the California Code of Regulations identify many unethical and/or illegal practices. It is impossible, however, to write legislation for every possible unethical act.

An agent's role in the insurance industry is one of great responsibility toward others. The Insurance Code articulates in many different ways the legal and ethical aspects of the client-agent relationship. Fiduciary responsibilities are very high on the list – the contact an agent has with the money or premiums of insureds, or the advice and recommendations given to others which have implications for their money or financial security.

An insurance agent must practice and demonstrate the highest level of ethics, integrity, and morals. Failures or lapses in any of these areas can result in great financial harm to others. Misrepresentation, twisting, concealment, diverting client money to personal use, commingling client money with general business funds (even if there was no bad intent), and other practices are ethical, integrity, and moral issues and are prohibited in various ways by the Code. Failing to answer, or giving an intentional wrong answer to questions that insureds or prospects ask is also an ethical problem, because it can lead a client to make a choice that might not be in their best interest. Unethical conduct can lead to suspension or loss of license, monetary penalties, and even time in jail or prison.

Agents must make recommendations to clients based on the clients' best interests. For an agent to recommend products or services to a person that he or she would not recommend for himself or herself in the same circumstances is an ethical dilemma. This is often described as conflict of interest. The normal conduct of business, especially in the insurance industry, can present agents with many opportunities for conflicts of interest.

Agents are typically paid on a commission basis. Commissions are usually calculated on the basis of annual premium submitted, even though the client may have paid just the first monthly installment with their application. For an agent, then, the higher the premium collected, the higher their commission check. If the higher premium, and the higher commission, is the result of an inappropriate recommendation for the client, that is a conflict of interest and an unethical act.

The opportunity an agent may have to represent multiple insurers can be in the best interest of the client, but it can also lead to conflicts of interest, especially if a decision to place business with a particular company is made on the basis of which company is offering the best “perk” to its agents. Incentives such as commission bonuses, trips or cruises, computers, or other sales-based contests all present opportunities to do what’s right for the agent, but not what’s right for the client.

Ethics demands that the other person and his or her family are of primary importance. An agent who demonstrates the highest respect for others will

have the most successful career. Agents who neglect this respect for others may have success initially, but they rarely have long-term success. The responsibility for ethical behavior is squarely on the agent.

Special Ethical Concerns Regarding Senior Citizens

Seniors are among the least likely to report financial crimes or abuses against them because they might be embarrassed at having “been taken,” or because they do not wish to appear to be losing the ability to manage their lives or personal finances.

Unethical agents have been caught selling multiple, duplicative policies to seniors, proposing one type of insurance policy or annuity contract but delivering another *(bait and switch),* and misleading senior consumers into believing that an annuity product is actually a long-term care contract (or vice-versa).

The California's Medicare supplement and long-term care insurance regulations address unethical practices such as inaccurate or misleading comparisons of existing and proposed replacement contracts, selling a person a third long term care policy within 12 months, or a second Medicare supplement policy. California enacted the **Financial Elder Abuse statutes** in 2002, which, in part, specifically addresses insurance agent abuses of persons age 65 or older.

Under most circumstances, insurance institutions, agents, and insurance-support organizations are not allowed to use **pretext interviews** to obtain information that relates to an insurance transaction.

A **pretext interview** is conducted when any person, in an attempt to gain information about another natural person, does one or more of any of the following:

- Pretends to be someone he or she is not;
- Pretends to represent someone he or she is not actually representing;
- Misrepresents the purpose of the interview; or
- Refuses to identify himself or herself upon request.

Pretext interviews are prohibited during any phase of the transaction process of insurance. This includes information gathering during underwriting. Obviously, the use of a pretext interview could reveal information that is privileged and would not normally be available to the insurer or agent. It could result in an **adverse underwriting decision**. However, in the investigation of a claim, particularly when fraud is suspected, as an investigative technique, pretext interviews are permitted.

It is further required that the reason of the interview must be to investigate a claim where there is a reasonable basis for suspecting criminal activity, fraud, material misrepresentation, or material nondisclosure in connection with a claim.

3. Insurers

Qualifications to Be an Insurer (CIC 150, 19)

According to California Insurance Code 150, any person capable of making a contract may be an insurer, subject to the Code restrictions. In order to become an admitted insurer (legally entitled to transact insurance in this state), there are many financial, technical, and legal qualifications that a company must meet. The Code regulation is in place to prevent unqualified persons from offering insurance to the public.

The term *person* is used in the law to refer to any entity which is legally capable of performing legal acts, such as making contracts, on its own behalf. In California, a person may, therefore, be either a natural person **at least age 18** who is legally competent, or any of the following entities:

- Association
- Organization
- Partnership
- Business trust
- Limited liability company
- Corporation.

Any person may be an insurer by meeting the following guidelines of the California Insurance Code:

- Submitting all forms, products, premiums, and advertising for approval prior to use;
- Using only licensed agents and brokers;
- Using acceptable D.B.A. ("Doing Business As") names; and
- Maintaining required financial reserves.

Insurance is available from both private companies and the government. The major difference between government and private insurance is that the government programs are funded with taxes and serve national and state social purposes, while private policies are funded by premiums.

Private insurance companies can be classified in a variety of ways:

- Ownership;
- Authority to transact business;
- Location (domicile);
- Marketing and distribution systems; or
- Rating (financial strength).

As you read about different classifications of insurers, keep in mind that these categories are not mutually exclusive, and the same company can be described based on where it is located and allowed to transact the business of insurance, who owns it, and what type of agents it appoints.

Admitted vs. Nonadmitted Insurers (CIC 24-25)

Before insurers may transact business in a specific state, they must apply for and be granted a license or **Certificate of Authority** from the state department of insurance and meet any financial (capital and surplus) requirements set by the state. Insurers who meet the state's financial requirements and are approved to transact business in the state are considered **authorized or admitted** into the state as a legal insurer. Those insurers who have not been approved to do business in the state are considered **unauthorized or**

nonadmitted. Most states have laws that prohibit unauthorized insurers to conduct business in the state, except through licensed excess and surplus lines brokers.

Before an insurance company can legally transact insurance, it must first obtain a **certificate of authority** from the Commissioner. This certificate indicates that the Commissioner has examined the business and found it to be financially stable and organized in accordance with the Insurance Code.

Penalty for Acting as an Insurer without a Certificate of Authority

Transaction of insurance business in this state without a certificate of authority is considered a **public offense punishable** by:

- Imprisonment according to the Penal Code; or
- Imprisonment in a county jail for up to 1 year; or
- Fine up $100,000; or
- Both that fine and imprisonment.

Domestic, Foreign, and Alien Insurers (CIC 26-27, 1580)

Insurance companies are classified according to the **location of incorporation** (domicile). Regardless of where an insurance company is incorporated, it must obtain a Certificate of Authority before transacting insurance within the state.

A **domestic** insurer is an insurance company that is incorporated in this state. In most cases, the company's home office is in the state in which it was formed - the company's domicile. *For instance,* a company chartered in Pennsylvania would be considered a Pennsylvania domestic company.

A **foreign** insurer is an insurance company that is incorporated in another state or territorial possession (such as Puerto Rico, Guam or American Samoa). *For example,* a company chartered in California would be a foreign company within the state of New York.

An **alien** insurer is an insurance company that is incorporated outside the United States.

Major Types of Private Insurers

The following are the most common types of ownership.

Stock Insurance Companies

Stock companies are owned by the stockholders who provide the capital necessary to establish and operate the insurance company and who share in any profits or losses. Officers are elected by the stockholders and manage stock insurance companies. Traditionally, stock companies issue **nonparticipating** policies, in which policyowners do not share in profits or losses.

A nonparticipating (stock) policy does not pay dividends to policyowners; however, taxable dividends are paid to stockholders.

Mutual Insurance Companies

Mutual companies are owned by the policyowners and issue **participating** policies. With participating policies, policyowners are entitled to dividends, which, in the case of mutual companies, are a return of excess premiums and are therefore **nontaxable**. Dividends are generated when the premiums and the earnings combined exceed the actual costs of providing coverage, creating a surplus. Dividends are not guaranteed.

De-mutualization is the process in which a mutual insurer becomes a stock company.

Fraternal Organizations

A **fraternal benefit society** is an organization formed to provide insurance benefits for members of an affiliated lodge, religious organization, or fraternal organization with a representative form of government. Fraternals sell only to their members and are considered charitable institutions, and *not insurers.* They are not subject to all of the regulations that apply to the insurers that offer coverage to the public at large.

4. Market Regulation - General

California Insurance Code (CIC) and Code of Regulations (CCR)

The **California Insurance Code (CIC)** is the primary body of laws established by the state legislature, which regulates the business of insurance in California. The present form of the Code, as amended, was enacted in 1935, as a restatement and expansion of previously established law. It is a dynamic, fluid device, constantly being reviewed, amended, added to, and even having outdated sections repealed, all consistent with current issues and practices in the marketplace.

How the Code May Be Changed

In order to change the Insurance Code in any way, **legislative** action is required. A bill amending or repealing an existing section or desiring to add something new is introduced into either the Assembly or the Senate, where it undergoes a variety of committee hearings and revisions before it is presented to the full body for a vote. If approved, it goes to the other body for the same sort of process. If more changes are made before the bill is approved, it must be returned to the first body for re-approval. Once approved by both houses, the bill goes to the Governor for approval or veto, or it may also become law without action, positive or negative, by the Governor.

California Code of Regulations

The **California Code of Regulations (CCR)**, also known as the California **Administrative Code**, is the set of regulations issued by the Department of Insurance that identifies the standards for the Insurance Code, and how it is to be administered. The CCR contains the regulations that have been issued by the Insurance Commissioner for clarification and administration of the Code.

Definitions
Shall and May (CIC 16)

Certain concepts or terms have special relevance to insurance, but they do not have different legal interpretations in insurance law than elsewhere. *For example*, the words **shall** and **may** always have the same implications, whether they appear in the Insurance Code or any other law.

Shall is a word that compels action; it normally indicates that a specific action or response is mandatory. Where the Code states that a person "shall" or "shall not" do something, there is usually no room for misunderstanding what that means. The word **may**, on the other hand, is normally a word of options or permission; it leaves room to act or not act and still remain in compliance with the law. However, the Code leaves open the possibility that, in context, even the word **may** could be interpreted the same as the word **shall**.

Person (CIC 19)

Even the word **person** is expansive. A *person* does not simply mean a living, breathing human being – a natural person. *Person* also refers to associations, organizations, partnerships, trusts, limited liability companies, and even corporations – all are non-natural persons. Whether natural or non-natural, all persons are distinguished by their ability to contract, sue, or be sued. Non-natural persons simply have to designate a natural person to represent them or act as their agent.

The Commissioner
Selection of Commissioner (CIC 12900)

The Commissioner of Insurance is an **elected** officer in California. The Commissioner may be elected to serve not more than **two consecutive 4-year terms**.

The Commissioner is expected to be a person knowledgeable in the business of insurance, but cannot be an active agent, officer, director, or employee of an insurance company. If a licensed person is elected Commissioner, he or she must surrender his/her license within 10 days of taking office. At the conclusion of his/her term of office, he/she may have his/her license reinstated for the balance of his/her license term without penalties or fees.

Responsibilities (CIC 12921)

The Commissioner of Insurance has **no power or authority to write or change the law** but **has the authority to enforce the law**. The Commissioner's duty is to issue regulations which establish how the Department of Insurance intends to interpret and enforce the law. The regulations proposed by the Commissioner must undergo a public hearing process to determine their fairness or applicability before they may actually go into effect.

The Commissioner has the responsibility to oversee the California Department of Insurance (CDI) and direct all of the CDI's affairs and staff.

The Commissioner can appoint persons to act on his or her behalf. These representatives can negotiate settlements with agents or insurers who have violated the Code. However, it is the Commissioner's responsibility to make the final approval of a sanction.

The Commissioner is responsible for a procedure to investigate complaints and respond to inquiries and, when warranted, to bring enforcement actions against insurers. The system for managing complaints must include the following:

- A toll-free number published in telephone books throughout the state, dedicated to the handling of complaints and inquiries;
- Public service announcements to inform consumers of the toll-free telephone number and how to register a complaint or make an inquiry to the department;
- A simple, standardized complaint form designed to assure that complaints will be properly registered and tracked;
- Retention of records on complaints for at least 3 years;
- Guidelines to disseminate complaint and enforcement information to the public that includes license status, number and type of complaints filed within the last calendar year, number and type of violations found, and enforcement actions taken. Also included is the ratio of complaints received to total policies in force, or premium dollars paid in a given line, or both.

The Commissioner's duty is to provide to the insurer a description of any complaint against the insurer that the Commissioner received and deemed to be justified at least **30 days** prior to public release of a report summarizing the information required. This description includes the name of the complainant, the date it was filed, a description of facts and a statement of the DOI's rationale for determining whether the complaint is valid.

The Commissioner must prepare a written report, to be made available by the DOI to
interested individuals upon written request, that details complaint and enforcement information on individual insurers in accordance with the CIC. The report must be made available by mail, telephone, internet and email.

All public records of the Department and the Commissioner must be available for inspection and copying.

The Commissioner receives complaints and inquiries, investigate complaints, prosecute insurers according to guidelines determined by the CIC, and must respond to complaints and inquiries concerning alleged misconduct. The Commissioner must notify the complainant of receipt within **10 working days**. The complainant will be notified of final order within 30 days of judgment.

The Commissioner has the authority to issue a **cease and desist order** against any person acting as an insurance agent or broker without being licensed, and against any person transacting insurance without having been issued a certificate of authority. The Commissioner may issue a cease and desist order without holding a hearing prior to issuance of the order, and may also impose a fine of up to $5,000 for each day the order is violated. A person to whom a cease and desist order is issued may request a hearing by filing a request with the Commissioner within 7 days after service of the order.

Unfair Trade Practices (CIC 790-790.10)

Subsequent to passage of the McCarran-Ferguson Act in 1945, affirming the role of state regulation of insurance, California adopted regulations pertaining to “unfair practices.” Section 790 of the Code, together with its subparts, contain the several different practices that the Code has specifically identified as unfair, as well as the penalties and other regulations related to unfair practices. The Code is also clear that any other undefined act or practice which the Commissioner determines to be unfair to consumers or unfair to insurers, even though it is not mentioned in particular, may still be a violation of the Code.

General Prohibitions

Many of the most common or prevalent practices which are problems include things such as misrepresentations in sales illustrations or advertised policy terms, or in the financial condition of an insurer, including its reserves, policy titles which could mislead a person into believing that the contract performs differently, or other misrepresentations which could lead a person to lapse, forfeit, or surrender a policy. Additionally, acts such as filing false financial documents, unfairly discriminating against classes of insureds, or simply making false statements which should be known as untrue by using "reasonable care" are identified as unfair practices.

Unfair claims settlement practices include the following:

- Misrepresenting facts or provisions of policy coverage;
- Failure to determine within a reasonable amount of time following submission of proof of loss forms whether or not a claim is payable;
- Not making a fair and equitable settlement of a claim after the insurer’s liability has been made clear;
- Compelling insureds to sue the insurer in order to obtain a judgment to enforce a claim by offering substantially less than the insured receives following a trial, only to collect an amount the same or nearly the same as the insured hoped to receive; and
- Advertising insurance that the insurer will not sell;
- Providing untrue or deceptive information about a person or entity engaged in insurance.

Also included in this subpart are other offenses, such as the following:

- An insurer attempting to appeal arbitration awards in an effort to get the insured to accept a settlement or compromise for less than the arbitration award;
- Requiring insureds to submit preliminary claim reports followed later by a request to submit essentially the same information in order to either deny or accept a claim;
- Advising an insured not to retain or seek an attorney;
- Delaying payment in regard to hospital, medical, or surgical claims for persons with AIDS or HIV, for more than 60 days after filing a claim for the purpose of attempting to invoke a pre-existing condition exclusion
- Filing false financial statements;
- Unfair discrimination;
- Advertising membership in the State's Guarantee Association;
- Boycott, coercion, intimidation.

Specific Unfair Trade Practices Defined
False Advertising

Advertising covers a wide scope of communication, from publishing an ad in a newspaper or magazine, to broadcasting a commercial on television or the Internet. Advertisements cannot include any untrue, deceptive, or misleading statements that apply to the business of insurance or anyone who conducts it. The violation of this rule is called **false advertising.**

It is prohibited to advertise or circulate any materials that are untrue, deceptive, or misleading. False or deceptive advertising specifically includes **misrepresenting** any of the following:

- Terms, benefits, conditions, or advantages of any insurance policy;
- Any dividends to be received from the policy, or previously paid out;
- Financial condition of any person or the insurance company; or
- The true purpose of an assignment or loan against a policy.

Representing an insurance policy as a share of stock, or using names or titles that may misrepresent the true nature of a policy also will be considered false advertising. In addition, a person or an entity cannot use a name that deceptively suggests it is an insurer.

Misrepresentation

It is illegal to issue, publish, or circulate any illustration or sales material that is false, misleading, or deceptive as to policy benefits or terms, the payment of dividends, etc. This also refers to oral statements. Committing this illegal act is called **misrepresentation**.

Rebating

Rebating is defined as any inducement offered to the insured in the sale of insurance products that is not specified in the policy. Both the offer and acceptance of a rebate are illegal. Rebates may include, but are not limited to, the following:

- Rebates of premiums payable on the policy;
- Special favors or services;
- Advantages in the dividends or other benefits; and
- Stocks, bonds, securities, and their dividends or profits.

Twisting

Twisting is a misrepresentation, or incomplete or fraudulent comparison of insurance policies that persuades an insured/owner, to his or her detriment, to cancel, lapse, switch policies, or take out a policy **with another insurer**. Twisting is prohibited.

Unfair Discrimination

Discrimination in rates, premiums, or policy benefits for persons within the **same class** or with the same life expectancy is illegal. No discrimination may be made on the basis of an individual's marital status, race, national origin, gender identity, sexual orientation, creed, or ancestry unless the distinction is made for a business purpose or required by law.

Defamation

Defamation occurs when an oral or written statement is made that is intended to injure a person engaged in the insurance business. This also applies to statements that are **maliciously critical** of the *financial condition* of any person or a company.

Boycott, Coercion and Intimidation

It is illegal to be involved in any activity of **boycott, coercion, or intimidation** that is intended to restrict fair trade or to create a monopoly. This would include unfair behavior that influences not only clients, but competing agents and brokers.

Penalties

Whenever the Commissioner has reason to believe that a person has been engaged or is engaging in any unfair trade practices, the Commissioner must issue a cease and desist order to show cause, the person's liability, and the notice of a hearing, which must be at least **30 days** from the date of the order. At the hearing, if the charges are found to be justified, the Commissioner may issue a penalty.

The **civil penalties** which may be assessed for violations of unfair trade practices are $5,000 for each act in violation of the Code, whether intentional or not. However, if the act or practice is determined to be a willful violation or a general business practice, the penalty increases to a maximum of $10,000 per violation. In addition to this, the Commissioner may also take action against the license of a person found to have been engaged in any unfair practice.

If the Commissioner has reason to believe that a person has **violated a cease and desist order** after the order has become final, the Commissioner may, after a hearing at which it is determined that the violation was committed, order that person to pay a sum not to exceed $5,000 which may be recovered in a civil action. If the violation is found to be willful, the amount of the penalty may be a sum not to exceed $55,000. These fines are in addition to civil penalties for violation of insurance code ($5,000 for each act) and intentional violation of insurance code ($10,000 for each act).

The Gramm-Leach-Bliley Act

The Gramm-Leach-Bliley Act stipulates that in general, an insurance company may not disclose nonpublic personal information to a nonaffiliated third party except for the following reasons:

- The insurance company clearly and conspicuously discloses to the consumer in writing that information may be disclosed to a third party.
- The consumer is given the opportunity, before the time that information is initially disclosed, to direct that information not be disclosed to the third party.
- The consumer is given an explanation of how the consumer can exercise a nondisclosure option.

The Gramm-Leach-Bliley Act requires **2 disclosures** to a customer (a consumer who has an ongoing financial relationship with a financial institution):

1. When the customer relationship is established (i.e. a policy is purchased); and
2. Before disclosing protected information.

The customer must also receive an annual privacy disclosure, and have the right to opt out, or choose not have their private information shared with other parties.

Insurance Information and Privacy Act (CIC 791-791.26) Practices

Section 791 of the Insurance Code is concerned with access to, or collection and distribution of, a person's private or privileged information which may be necessary to obtain in connection with an application for insurance. The law is sensitive to a consumer's desire to keep certain information private, but it also recognizes that in the absence of that information, an insurer might approve a person for insurance that it could lawfully decline coverage to if it knew that same information.

Section 791 tries to strike a balance of fairness for both applicants and insurers in the process of gathering and using information. The law is intended to apply to natural persons who are residents of the state and are seeking life or disability insurance. It also applies to any person seeking property or casualty insurance for policies that will be issued or delivered in this state.

The information necessary for proper underwriting may be both personal and highly sensitive in nature. Because of this, there is great potential for harm to an individual if their personal information is disclosed to others who have no legitimate reason for receiving it. How, and from whom, that information is obtained, collected, held, and when or how it will or may be disseminated to others must be disclosed in advance to applicants for insurance.

In some cases, insurers may decide to conduct an **investigative consumer report** in connection with an application. An investigative consumer report goes beyond simply gathering information from the credit reporting bureaus or the Medical Information Bureau (MIB). It can include interviews with applicants, their relatives, employers, or neighbors, or any other person who may have personal or other information about the person's character, general reputation, personal characteristics, and lifestyle. The Insurance Code allows people to request that they be interviewed personally. It also requires that the person must be given a copy of the report upon request and provides them with a mechanism to protest and request correction of inaccurate information about them. The person has a right to know to whom the information has been given and those who were the source or sources of information about them.

In the event of an "adverse underwriting decision," which could mean being declined, rated, or in any way deemed less than a standard risk, or even being issued coverage by a company other than the one the applicant originally intended to apply for coverage, the person must be given the reason for the decision. That information must be given to them in writing, or the person must

be advised that they may request in writing the reason for the action be furnished to them.

If the information is medically-related, and supplied by a medical care institution or medical professional, it must be disclosed, upon request, to the individual directly or to a medical professional of that person's choosing who is licensed to treat the person for the condition to which the information relates. If the information is related to a person's mental health, it may only be disclosed with the consent of the professional who is responsible for the treatment related to that information.

Prohibitions

The Insurance Code also addresses the issue of pretext interviews. A **pretext interview** is conducted when any person, in an attempt to gain information about another natural person, does one or more of any of the following:

- Pretends to be someone he or she is not;
- Pretends to represent someone he or she is not actually representing;
- Misrepresents the purpose of the interview; or
- Refuses to identify himself or herself upon request.

Pretext interviews are prohibited during any phase of the transaction process of insurance. This includes information gathering during underwriting. Obviously, the use of a pretext interview could reveal information that is privileged and would not normally be available to the insurer or agent. It could result in an **adverse underwriting decision**. However, in the investigation of a claim, particularly when fraud is suspected, as an investigative technique, pretext interviews are permitted.

Penalties

Section 791 also details under what circumstances and how the Commissioner may examine insurers, agents, and others engaged in the information gathering processes, and how they maintain or distribute the information obtained. There are a variety of penalties which can be applied to the various violations that could be committed. The following are some of the penalties:

- Suspension or loss of license; and
- Civil fines for violating cease and desist orders of up to $10,000 for each violation; or
- Up to $50,000 if the violations are found to be committed with a frequency indicating they are a general business practice.

Insurers or agents can also be liable for civil damages and legal fees that arise for the unlawful collection or distribution of personal, private, or privileged information about a person that causes him/her harm. Certain acts could also violate other criminal laws and subject a person to prosecution, resulting in fines or imprisonment.

California Financial Information Privacy Act

The California Financial Information Privacy Act, in effect since July 1, 2004, enacted the most stringent financial privacy protections in the country.

The act, which gives consumers the final say in the sharing of their information, also restricts financial profiling of consumers and makes consumers aware of their rights through a clearly written and easy-to-understand notice.

The "opt-in" rule means that financial institutions must get a consumer's permission before sharing information with outside companies.

Cal-GLBA

The California Financial Information Privacy Act provides standards for financial institutions regarding sharing or selling of nonpublic personal information about consumers. California Legislature, known as **Cal-GLBA**, provides greater privacy protection to consumers than the federal Gramm-Leach-Bliley Act. Cal-GLBA outlines consumer privacy choices and rights, and allows California consumers to have greater control over the disclosure of nonpublic personal information.

As defined by the California Financial Code, *nonpublic personal information* means any financial information that is

- Provided by a consumer to a financial institution;
- Obtained as a result from a transaction with the consumer; or
- Obtained by a financial institution by any other means.

The Health Insurance Portability and Accountability Act (HIPAA)

Legislation that took effect in July 1997 ensures "portability" of group insurance coverage and includes various required benefits that affect small employers, the self-employed, pregnant women, and the mentally ill. HIPAA (Health Insurance Portability and Accountability Act) regulates protection for both **group health plans** (for employers with 2 or more employees) and for **individual insurance policies** sold by insurance companies.

HIPAA includes the following protection for coverage:

Group Health Plans

- Prohibiting discrimination against employees and dependents based on their health condition;
- Allowing opportunities to enroll in a new plan to individuals in special circumstances.

Individual Policies

- Guaranteeing access to individual policies for qualifying individuals;
- Guaranteeing renewability of individual policies.

Eligibility

HIPAA has regulations regarding eligibility for employer-sponsored group health plans. These plans cannot establish eligibility rules for enrollment under the plan

that discriminate based on any health factor relating to an eligible individual or the individual's dependents. A **health factor** includes any of the following:

- Health status;
- Medical conditions (both physical and mental);
- Claims experience;
- Receipt of health care;
- Medical history;
- Genetic information;
- Disability; or
- Evidence of insurability, which includes conditions arising out of acts of domestic violence and participation in such activities as motorcycling, skiing, snowmobiling, etc.

Employer-sponsored group health plans may apply waiting periods prior to enrollment as long as they are applied uniformly to all participants.

To be eligible under HIPAA regulations to convert health insurance coverage from a **group plan** to an **individual policy**, an individual must meet the following criteria:

- Have 18 months of continuous creditable health coverage;
- Have been covered under a group plan in most recent insurance;
- Have used up any COBRA or state continuation coverage;
- Not be eligible for Medicare or Medicaid;
- Not have any other health insurance;
- Apply for individual health insurance within 63 days of losing prior coverage.

Such HIPAA-eligible individuals are guaranteed the right to purchase individual coverage.

Pre-existing Conditions

Under HIPAA, a *pre-existing condition* is a condition for which the employee has sought medical advice, diagnosis, or treatment within a specified period of time prior to the policy issue.

Creditable Coverage

The concept of **creditable coverage** means that an insured must be given day-for-day credit for previous health coverage against the application of pre-existing condition exclusion period when moving from one group health plan to another, or from a group health plan to an individual plan.

Prior to the enactment of the Affordable Care Act (ACA), individual insureds were entitled to receive credit for previous creditable coverage that occurred without a break of 63 (or more) consecutive days.

The ACA has prohibited pre-existing condition exclusions and eliminated waiting period in excess of 90 days; it also eliminated the requirement to issue HIPAA group health plans certificates of creditable coverage after December 31, 2014.

Renewability

At the plan sponsor's option, the issuer offering group health coverage must renew or continue in force the current coverage. However, the group health coverage may be discontinued or nonrenewed because of nonpayment of premium, fraud, violation of participation or contribution rules, discontinuation of that particular coverage, or movement outside the service area or association membership cessation.

Conservation Proceedings (CIC 1011, 1013, 1016)

Insurance companies are specifically exempted under federal bankruptcy laws, which means that any **liquidation** of an insolvent insurer is strictly a matter for the state to pursue. To accomplish this, California has adopted the **Uniform Insurers Rehabilitation Act**. This Act describes the steps that the Commissioner must take when attempting to either rehabilitate an **insolvent** or **delinquent** insurer to sound financial condition or liquidate an insurer that cannot be rehabilitated. The Code also describes the mandatory action the superior court is required to take when the Commissioner presents a petition for either a **conservation** or **liquidation** order.

Each year, on or before March 1, every insurer doing business in California is required to report its financial condition to the Commissioner. At that time, or at any other time, if an insurer's legal reserve funds are less than the minimum required by law, the company is **impaired** in its ability to pay claims, and is technically **insolvent**. The Commissioner has authority under the Code to take control of the insurance company, and the superior court *must* grant the Commissioner's petition for conservation. There is no long, drawn-out legal battle – the insurer has no power to prevent the act of conservation.

The court order gives the Commissioner absolute control over the assets and operations of the company. The Commissioners first responsibility is to attempt to rehabilitate the company, if at all possible. Initially, all new business transactions are terminated. Existing and new claims are paid, and ways to return the company to solvency are explored. If it becomes clear that there is no possibility of rehabilitating the company, the Commissioner's final move will be to liquidate the company, selling assets to continue to pay claims, and if all claims have been satisfied, any remaining assets will be used to satisfy the claims of other creditors.

If the company cannot pay any or all of its claims, the two Guarantee Associations in California are prepared to pay a portion of the claims, depending on the type of policy. If either or both of the Guarantee Associations have paid claims due to the inability of the company to pay, they become creditors of the company and can seek repayment through the liquidation process.

In a conservation or liquidation effort, the Commissioner also has the power to sue officers, directors, or others who may bear responsibility for the company's condition, including managing general agents, auditors and accountants, or actuaries in order to add to the "estate" of the company in order to pay claims of insureds or creditors. Even the industry rating companies have been held responsible for their published inaccuracies!

Additionally, in a liquidation, other parties not normally associated with the claims-paying responsibility of the company may have their assets seized. If the insolvent insurer was a substantial owner of another business or partnership, those assets may be taken to satisfy the obligations of the insurer, regardless of whether that business was involved in the business of insurance.

When the Commissioner is engaged in liquidating an insurer, there is a legal requirement to publish the notice of liquidation for 4 consecutive weeks, and, in most cases, to also mail notices to known potential claimants against the estate of the company. Once the notices have been published or mailed, claimants have no more than 6 months to file their claims. The Insurance Code establishes the priority of claims, and only when the claims of a class or group have been fully satisfied will the next in order be entitled to pursue their claims.

Insolvent Insurers (CIC 36, 985, 1013)

Insolvency means either of the following:

- Any impairment of minimum paid-in capital" required of an insurer by the provisions of the Insurance Code for the class, or classes, of insurance that it transacts anywhere; or
- An inability of the insurer to meet its financial obligations when they are due.

Even if the insurer is able to provide for all its liabilities and for reinsurance of all outstanding risks, it cannot escape the condition of insolvency unless it has additional assets equivalent to the aggregate paid-in capital as established by the state regulation.

Paid-in Capital (CIC 36 & 985)

Paid-in capital or **capital paid-in** means the following:

1. In the case of a **foreign mutual** insurer not issuing or having outstanding capital stock, the value of its assets in excess of the sum of its liabilities for losses reported, expenses, taxes, and all other indebtedness and reinsurance of outstanding risks as provided by law. Foreign mutual insurers cannot be admitted, however, unless their paid-in capital is composed of available cash assets amounting to at least $200,000.
2. In the case of a foreign joint stock and mutual insurer, its paid-in capital is computed, according to its desire, based on the standards for either 1 or 3. If paid-in capital is computed pursuant in accordance with 1, then its admission is subject to the same qualifications.
3. In the case of **all other insurers**, the lesser of the following amounts:
    - The value of its assets in excess of the sum of its liabilities for losses reported, expenses, taxes, and all other indebtedness and reinsurance of outstanding risks as provided by law; or
    - The aggregate par value of its issued shares of stock, including treasury shares. For the purpose of computing paid-in capital or capital paid-in, shares of stock are not taken as liabilities.

Refusal to Issue Information (CIC 1013)

Whenever it appears to the Commissioner that irreparable loss and injury to the property and business of a person has occurred or may occur unless the Commissioner takes action, the Commissioner, without notice and before applying to the court for any order, can take possession of the property,

business, books, records, and accounts of the person and the person's office. The Commissioner can continue to retain possession after receiving a court order.

Any person against whom a seizure order has been issued and who refuses to deliver pertinent books, records, or assets will be guilty of a **misdemeanor** and could be punishable by a maximum fine of $1,000, imprisonment for no longer than 1 year, or both.

Fraud

Insurance fraud is a significant problem for insurance companies and insureds alike. Premiums for most forms of insurance have risen in recent years because of the increasing number of fraudulent claims that are being presented to insurers for payment. The most common forms of insurance fraud include claims in the following areas:

- Staged automobile accidents;
- Fraudulent healthcare billings (including HMO and Medi-Cal);
- False and/or inflated property loss claims;
- Phony Workers Compensation claims;
- Fraudulent denial of Workers Compensation benefits;
- Arson for profit;
- Fake life insurance claims; and
- Workers Compensation premium fraud by employers.

The California Department of Insurance reported in 2002 that up to 50% of all automobile insurance claims may be fraudulent, many of them being “staged” on paper instead of actually occurring, and that automobile insurance fraud is estimated to cost California consumers as much as $500,000,000 per year. Due in large part to the high cost of medical claims, but also to the large number of fraudulent claims, California also has the highest rates for Workers Compensation insurance, even though the actual compensation benefits are among the lowest in the nation.

Efforts to Combat Fraud (CIC 1872, 1874.6, 1875.8, 1875.14, 1875.20, 1877.3b1)

Federal, state, and local law enforcement officials work together, aided by insurance companies and industry support organizations to combat all forms of insurance fraud. The California Department of Insurance has created **the Fraud Division** to enforce the provisions of the Penal Code and to administer the fraud reporting provisions. *(CIC 1872)*

Among other agencies and systems put in place to help combat fraud is the Arson Information Reporting System that allows for cooperation between insurers, law enforcement agencies, fire investigating agencies, and district attorneys. This system allows all parties to deposit arson case information in a common data base within the Department of Justice. *(CIC 1875.8)*

To prevent auto insurance related fraud, every insurer must report covered private passenger vehicles involved in theft, including the vehicle identification number and any other pertinent information, to the National Automobile Theft Bureau or a similar central organization engaged in automobile loss prevention

approved by the Commissioner. Prior to the payment of theft losses, insurer must comply with verification procedures according to the regulations adopted by the Commissioner. *(CIC 1874.6)*

Insurance companies, agents and brokers also have a legal responsibility to report suspected fraud. Whenever an insurer or licensed rating organization knows or reasonably believes that it knows the identify of a person or entity that has committed a fraudulent act relating to a workers compensation insurance claim or policy, they insurer must notify the local district attorney's office and the Fraud Division of the Department of Insurance, and may notify any other authorized governmental agency of that suspected fraud and provide any additional information. *(CIC 1877.3)*

The Commissioner may license an organization as an **Insurance Claims Analysis Bureau** if is a nonprofit corporation organized for the purposes of fraud prevention with at least 2 years of relevant experience. An Insurance Claims Analysis Bureau is required to perform the following functions:

- Collect and compile information and data from members concerning insurance claims;
- Disseminate claims-related information to members for the purpose of preventing and suppressing insurance fraud;
- Promote training and education related to investigation, suppression, and prosecution of insurance fraud; and
- Provide to the Commissioner (without fee or charge) all state data and information contained in the records of the Bureau to further prevent and prosecute insurance fraud.

Every insurer admitted to do business in this state must provide for the continuous operation of a unit or division to investigate possible fraudulent claims by insureds or by persons making claims for services or repairs against policies held by insureds *(CIC 1875.20)*.

Insurers, agents, and brokers have legal immunity from civil suits claiming libel or slander that might result from giving statements, filing reports, or furnishing any other information, as long as the information is offered *"in good faith and without malice."*

Fraudulent Claim Forms

If a claimant signs a fraudulent claim form, the claimant may be found guilty of **perjury**.

False and Fraudulent Claims Article (CIC 1871-1872.5)

Chapter 12 of the Insurance Code is devoted exclusively to the **Insurance Fraud Prevention Act**. The Insurance Code describes the basic responsibilities that the Insurance Commissioner, law enforcement agencies, insurers, agents, brokers, and others have when "confronting aggressively the problem of insurance fraud in this state."

State insurance claim forms are required to carry a notice informing claimants of their liability in the event of a fraudulent claim. The notice now reads: "*For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.*"

Every person who **commits insurance fraud** may be punished as follows:

- Imprisonment in the county jail for 1 year, or in the state prison, for up to 5 years;
- Fine up to $150,000 or double the value of the fraud, whichever is greater; or
- Both imprisonment and fine.

The court will determine the amount of restitution, and where the restitution must be paid. A person convicted may be charged for the costs of investigation at the discretion of the court.

A person who commits insurance fraud and who has a prior felony conviction will receive a **2-year enhancement** for each prior conviction in addition to the sentence provided.

Rates
Requirements for Rates to be Approved or Remain in Effect (CIC 1861.05a)

Insurance rates cannot be approved or remain in effect if they are excessive, inadequate, unfairly discriminatory or otherwise in violation of the California Insurance Code. In considering whether a rate is excessive, inadequate or unfairly discriminatory, no consideration can be given to the degree of competition, and the Commissioner must consider whether the rate mathematically reflects the insurance company's investment income.

Types of Rating Laws
Prior Approval

Under this plan, insurers must file proposed policy rate information with the state department of insurance. Upon filing, the insurer must deliver supporting evidence that such rates are justified and do not charge excessive, inadequate, or unfairly discriminatory premiums. The Commissioner has a predetermined number of days, generally 30 to 60, to approve or reject the submitted rate plan; however, the Commissioners failure to reject the plan is deemed as approval to adopt and market such plan.

File and Use

File-and-use laws require that the rate plan be filed **prior to marketing the plan**; however, such laws provide that once the plan is filed, the insurer does not have to wait for the Commissioner's approval to begin marketing the plan.

Use and File

Use-and-file laws require that rate plans be filed within a specified period, generally 15-30 days, **after they are first used** with the public.

Open Competition

The open competition rating method, also known as no-file laws, allow insurers to compete with one another by quickly changing rates without review by the state regulators. Under such a plan, market forces rather than administrative action determine what rates will be charged for a given risk.

State Regulation of Rates (CIC 1861.05c)

The Commissioner must notify the public of any application by an insurer for a rate change. The application will be deemed approved **60 days** after public notice unless:

- A consumer requests a hearing within 45 days of public notice and the Commissioner grants the hearing, or determines not to grant the hearing and issues written findings in support of that decision;
- The Commissioner on his or her own motion determines to hold a hearing;
- The proposed rate adjustment exceeds 7% of the then applicable rate for personal lines or 15% for commercial lines, in which case the Commissioner must hold a hearing upon a timely request.

In any event, a rate change application will be **deemed approved 180 days** after the Commissioner receives the rate application unless that application has been disapproved by a final order of the Commissioner.

Notice by Mail (CIC 38)

I.C4.11 (Life)/I.C4.12 (Health). Be able to identify the requirements for notice by mail and by electronic transmission (CIC 38 and 38.5).

Since there is always the possibility that a party to a policy may attempt to avoid responsibility under the policy by falsely claiming that he or she sent a notice or that the other party never sent an important notice, the law explains what is considered to be sufficient proof of mailing.

If the notice had postage applied and was put in the hands of the U.S. Postal Service with the last known address of the recipient on it, then an affidavit by the sender, stating such facts, is proof of the mailing. Any notice provided by electronic transmission must be treated as if mailed or given for the purposes of any provision of the Insurance Code. A valid electronic signature will be sufficient for any provision of law requiring a written signature.

The insurance company must **retain a copy of the confirmation** and electronic signature, when either is required, with the policy information so that they are retrievable upon request by the Department of Insurance while the policy is in force and for **5 years** thereafter.

Fair Claims Settlement Practices Regulations
Definitions

Claimant - any person who asserts a right of recovery under a surety bond, an attorney, any person authorized by operation of law to represent the claimant, or an insurance adjuster, a public adjuster, or any member of the claimant's family as designated by the person.

Notice of legal action - notice of an action commenced against the insurer with respect to a claim, or notice of action against the insured received by the insurer, or notice of action against the principal under a bond, and includes any arbitration proceeding.

Proof of claim - any evidence or documentation in the possession of the insurer that reasonably supports the magnitude or the amount of the claimed loss. The documentation could have been submitted by the claimant or obtained by the insurer in the course of its investigation.

File and Record Documentation

I.C5.2. Be able to identify File and Record Documentation (CCR 2695.3).

The Commissioner reserves the right to examine every licensee's claim files, including all documents, notes and work papers (including copies of all correspondence). The files should be in such detail that events and the dates of events can be reconstructed; and the licensee's actions can be determined.

Insurers must do the following:

- Maintain claim records that are accessible, legible and retrievable.
- Record the dates the licensee received, processed and transmitted or mailed relevant documents in the file.
- Maintain hard copy files. If the files aren't hard copies, they must be in a format that is accessible, legible and capable of being duplicated to hard copy.

If the licensee cannot construct complete records, he or she must document for the Commissioner the inability or difficulty to obtain data due to catastrophic losses or other unusual circumstances.

In this case, the licensee must submit to the Commissioner a plan for file and record documentation to be used while the circumstances that keep the licensee from compiling a complete record persist.

Standards for Prompt, Fair and Equitable Settlements

I.C5.4. Be able to identify Standards for Prompt, Fair and Equitable Settlements (CCR 2695.7(a)(b)(c)(g) and (h).

Insurers cannot discriminate in their claims settlements practices based on a claimant’s age, race, gender, income, religion, language, sexual orientation, ancestry, national origin, or physical disability, or the territory of the property or person insured.

Once the claim is received, insurers must either accept or deny it within **40 calendar days**. The amounts accepted or denied must be clearly documented unless the claim has been denied in its entirety. (The time frame doesn’t apply to claims arising from disability insurance and disability income insurance policies, or to automobile repair bills arising from policies of automobile collision and comprehensive insurance.)

If an insurer rejects a first party claim, that must be done in writing and state the basis for the rejection. Insurers are protected from disclosing information that could alert a claimant that a claim is being investigated as a suspected fraudulent claim.

Written notification must include a statement that a claimant may have a claim reviewed by the California Department of Insurance if he or she suspects the claim has been wrongfully denied or rejected. The notice will include the address and telephone number of the unit of the Department which reviews claims practices.

If an insurer needs more time to determine if a claim should be accepted or denied, the insurer must, within the 40-day acceptance period, notify the claimant in writing of the need for more time and any additional information the insurer requires and any continuing reasons for the insurer's inability to make a determination. Thereafter, the written notice must be provided every 30 calendar days until a determination is made or notice of legal action is served.

An insurer cannot attempt to settle a claim by making a settlement offer that is unreasonably low. Upon acceptance of the claim, insurers are required to provide payment within **30 days.**