

Regulations And Ethics - Supplementary Reading

A. Insurance Business In North Carolina

The information in this section will provide you with a greater understanding of important topics; however, it will not appear on the state exam.

1. North Carolina Department of Insurance

The North Carolina Department of Insurance was created by the General Assembly in 1899. Before that, the licensing and supervision of insurance companies was the responsibility of the Secretary of State's office. However, a group of insurance agents determined that the insurance industry needed a state agency specifically dedicated to overseeing it. It was established by North Carolina General Statute 58-2-1, which reads, "The Department is hereby established as a separate and distinct department, which is charged with the execution of laws relating to insurance and other subjects placed under the Department."

According to North Carolina Administrative Code, the primary location of the North Carolina Department of Insurance is the Dobbs Building, 430 North Salisbury Street, Raleigh, North Carolina. The mailing address for the North Carolina Department of Insurance is 1201 Mail Service Center, Raleigh, NC 27699-1201. The Department must have normal working hours between 8 a.m. and 5 p.m., Monday through Friday.

Departmental records that are properly deemed to be public information may be reproduced upon request. The request must be made in writing and directed to the head of the appropriate division. Reproduction of departmental records will be permitted on a discretionary basis depending on the volume of the request and the availability of personnel to make the reproductions. Fees will be charged in accordance with the applicable General Statutes of North Carolina.

All rules for the Department and all codes, standards and rules adopted by reference are located in the Hearings Office of the Department of Insurance. Any person desiring to inspect the rules of the Department shall so notify the Deputy Commissioner of the North Carolina Department of Insurance in charge of the Hearings Office.

The North Carolina Department of Insurance does more than merely regulate the insurance, including licensing insurance professionals, educating insurance consumers about the different types available to them, and handling complaints from insurance consumers regarding the industry. The office of the state fire marshal is also under the North Carolina Department of Insurance.

The North Carolina Department of Insurance also provides a host of other services that are not related directly to insurance. These services include:

- Licensing bail bondsmen;
- Overseeing motor clubs and collection agencies;
- Protecting consumers from fraud and illegal behavior with a staff of sworn law enforcement officers in our Investigations Division;
- Educating North Carolinians about safety issues such as child safety seats, fire protection, natural disaster preparation and other family safety issues;
- Interpreting the state's building codes and suggesting new and improved codes to further protect citizens;
- Obtaining and maintaining insurance coverage for all state-owned buildings, including such items as the Battleship North Carolina in Wilmington and the campuses of the state university system; and
- Assisting the elderly and others with Medicare and Medicaid questions through the nationally recognized Seniors' Health Insurance Information Program.

Divisions

According to the North Carolina Department of Insurance website (www.ncdoi.com), the North Carolina Department of Insurance encompasses a variety of divisions, including

- **Services for Consumers:**
- **The Seniors' Health Insurance Information Program (SHIIP)**, created in 1986, answers questions and counsels Medicare beneficiaries and caregivers about Medicare, Medicare supplements, Medicare Advantage, Medicare prescription drug plans, long-term care insurance and other health insurance concerns;
- **Agent Services**, which regulates all licensed agents, brokers, limited representatives, appraisers, adjusters, premium finance companies, collection agencies, motor clubs, bail bondsman, surety bondsman, and bail bond runners authorized to do business in North Carolina. This includes pre-licensing education, continuing education, agency examinations and administrative actions;
- **Criminal Investigations**, the investigative personnel of which are sworn, state law enforcement officers who have statewide jurisdiction;
- **External Review Program**; the Healthcare Review (HCR) Unit provides independent medical review of health plan coverage denials that North Carolina law grants to citizens. It primarily receives and processes requests for external review and assigns accepted cases to contracted independent review organizations;
- **The Property & Casualty Division** is responsible for reviewing rates, forms and rules for all kinds of insurance authorized in North Carolina General Statute 58-7-15.
- **Life & Health Division (Forms and Rates)** is responsible for
 - Reviewing and approving all filings for life, health and credit insurance policy forms, long term care forms, Medicare Supplement forms, and rates; managed care provider network contract forms and health care provider contract forms;
 - Licensing of Third Party Administrators;
 - Licensing Viatical Settlement Providers;
 - Licensing of Multiple Employer Welfare Arrangements (MEWA);
 - Coordinating Health Maintenance Organizations (HMO) licensure and license modifications, review for compliance non-financial operational policies and procedures;
 - Reviewing Preferred Provider Organization (PPO) plans for compliance of non-financial operational policies and procedures;
 - Regulating non-financial operations of HMOs, PPOs, and MEWAs;
 - Reviewing Medicare Select plans and operations filings;
 - Receiving required notifications related to Charitable Gift Annuities; and

- Reviewing Assumption Reinsurance transactions and related forms involving life or health insurance, or annuity business.
- **Market Regulation Division** is responsible for monitoring market conduct activity on domestic and foreign Property and Casualty (P&C) insurance companies, Life and Health (L&H) insurance companies, Premium Finance companies, Health Maintenance Organizations (HMO), Preferred Provider Organizations (PPO), Multiple Employer Welfare Arrangement (MEWA) and more as required by North Carolina General Statute, Chapter 58. The purpose of the examination is to monitor compliance with statutes and regulations in the following areas: Policyholder Treatment, Sales, Marketing, Underwriting and Rating, Agent Appointments and Terminations, Nonforfeitures, Provider Relations, Utilization Management, Quality Management, Provider Credentialing, and claims.
- **Financial Evaluation Division** is part of the Company Services Group and is comprised of the Company Admissions, Financial Analysis, Financial Examinations, and Special Entities sections. The Financial Evaluation Division regulates all authorized insurers, entities that self-insure for workers compensation, certain third party administrators, managing general agents, accredited reinsurers, professional employer organizations and continuing care retirement communities, for compliance with the solvency laws of this state. The ultimate objective of this regulation is to reduce the likelihood of any of these entities failing or to mitigate the effect of any of these entities' insolvency on the insurance consumers of this state.
- **Regulatory Actions Division** is responsible for
 - The monitoring of troubled insurance entities, including supervisions and work-outs; and
 - Administering the estates of all insurance entities placed into rehabilitation or liquidation in North Carolina.
- **Actuarial Services Division (ASD)** assists the Insurance Department in its mission to protect consumers in insurance matters. Among the ways it does this are as follows:
 - by providing technical assistance to the Property and Casualty Division and the Life and Health Division in reviewing filings made by insurance companies that seek to make changes in premium rates. By law, an insurer must submit a filing with actuarial data to support the proposed changes to its premium rates. By statute, rates must not be inadequate, excessive, or unfairly discriminatory. The ASD is typically asked to review filings when they are complex, involve a large insurer, or an unusual change.
 - by assisting the Legal Division when there are rate hearings scheduled. These frequently occur in the automobile, homeowners, and workers compensation lines of business.
 - by assisting the Financial Division in fulfilling its responsibility to ensure that insurance companies that are headquartered in North Carolina, or licensed to do business in the state, are financially secure enough to be able to pay all claims they are obligated to pay. This financial analysis commonly requires the expertise that actuaries are trained to provide.
 - by assisting the Consumer Services Division when it receives consumer complaints, especially with regard to insurance pricing.
 - by responding to requests from State Legislators in regard to proposed legislation affecting the various types of insurance such as auto, home, life, health, workers compensation, and medical malpractice.
- **The Legislative Services Office** acts on behalf of the Commissioner in the General Assembly with respect to all legislative matters. The Office serves as liaison to the members of the General Assembly on insurance-related issues, and provides oversight in rule-making procedures for the Department;
- **The Media Relations** department oversees any media requests; coordinate all public records requests and any contacts related to insurance, including:
 - Questions about various types of insurance -- health, auto, homeowners, etc.
 - Questions about the rate making process or about rate hearings, settlements, etc.
 - Information regarding criminal investigations, fraud, arrests involving agents, companies, bail bondsmen or other licensed entities

- Company financials and examinations
 - Inquiries about licensure status for agents, adjusters, companies
 - State property insurance
- **North Carolina Department of Insurance Controller's Office.** The purpose of the Controller's Office is to provide assistance to the Department's Divisions with Preparing and adjusting budgets; monitor divisional budget needs; process cash receipts; prepare cash disbursements; manage cash, special funds, and investments; control fixed assets; employee payroll; leave record accounting; contract approval; financial statement preparation; insure proper internal accounting controls and procedures are in place; maintain E-Procurement accounting system; departmental purchasing; process and deliver all mail and supplies.
- **North Carolina Department of Insurance Regional Offices.** The purpose of the Regional Offices is to serve the citizens and governmental officials and staff of the Eastern and Westernmost part of the state in any and all matters related to any and all divisions of the Department of Insurance. This includes the fielding and handling of questions or inquiries regarding Manufactured Building, Risk Management, Agent Services Division, Consumer Services Division, Investigations Division, Bail Bondsmen, Premium Finance Companies, Building Codes, SHIIP, and the Office of the State Fire Marshal. The Regional Offices also provide staffing facilities for field personnel within the Department including Investigations, Agent Services, Manufactured Housing, SHIIP, OSFM and others while also providing a facility for all consumers utilizing the services of the Department. The Eastern Regional Office, which serves to 32 easternmost counties in North Carolina, is located at 1316 Unit A Commerce Drive in New Bern, 28562. It is run by Deputy Commissioner Joan Buck and Office Manager/Communications Specialist Michele Amos. The Western Regional Office, which serves the 29 westernmost counties, is located at 537 College Street in Asheville, 28801. It is run by Deputy Commissioner Joan Creasman, Deputy Director Mike Harkey, and Communications Specialist Kirby Rhash.

The North Carolina Department of Insurance Commissioner

The current commissioner for the North Carolina Department of Insurance is Wayne Goodwin. He also serves as the state's fire marshal. He was first elected to the post in 2008. Before being elected to that post, he was the assistance insurance commissioner for almost 4 years.

According to North Carolina General Statutes, the Commissioner's term of office begins on the first day of January next after his election, and is for four years or until his successor is elected and qualified. If a vacancy occurs during the term, it is to be filled by the Governor for the unexpired term.

The Commissioner, with the approval of the Governor, must devise a seal, with suitable inscription, for his office, a description of which, with the certificate of approval by the Governor, must be filed in the office of the Secretary of State, with an impression thereof, which seal will become the seal of office of the Commissioner of the Department. The seal may be renewed whenever necessary.

The salary of the Commissioner is set by the General Assembly in the Current Operations Appropriations Act. In addition to the salary set by the General Assembly in the Current Operations Appropriations Act, longevity pay must be paid on the same basis as is provided to employees of the State who are subject to the State Personnel Act.

The Commissioner may appoint and remove at his discretion a chief deputy commissioner, who, in the event of the absence, death, resignation, disability or disqualification of the Commissioner, or in case the office of Commissioner has for any reason become vacant, will have and exercise all the powers and duties vested by law in the Commissioner. He will receive such compensation as fixed and provided by the Department of Administration.

The Commissioner may appoint or remove at his discretion a chief actuary, who will receive such compensation as fixed and provided by the Department of Administration.

The Commissioner must appoint or employ such other deputies, actuaries, economists, financial analysts, financial examiners, licensed attorneys, rate and policy analysts, accountants, fire and rescue training instructors, market conduct analysts, insurance complaint analysts, investigators, engineers, building inspectors, risk managers, clerks and other employees that the Commissioner considers to be necessary for the proper execution of the work of the Department, at the compensation that is fixed and provided by the Department of Administration.

The minimum education requirements for these financial analysts and examiners are a bachelor's degree, with the appropriate courses in accounting, and other courses that are required to qualify the applicant as a candidate for the uniform certified public accountant examination, based on the examination requirements in effect at the time of graduation by the analyst or examiner from an accredited college or university.

If the Commissioner is authorized to grant any approval, authorization or permission or to make any other order affecting any insurer, insurance agent, insurance broker or other person or persons, the order will not go into effect unless made in writing and signed by the Commissioner or by his authority.

In Cases of Emergencies

North Carolina General Statute 58-2-46 establishes regulations for whenever a state of disaster is proclaimed for the State or for an area within the State or whenever the President of the United States has issued a major disaster declaration for the State or for an area within the State.

The application of any provision in an insurance policy insuring real property and its contents that are located within the geographic area designated in the proclamation or declaration, which provision requires an insured to file a proof of loss within a certain period of time after the occurrence of the loss, will be stayed for the time period not exceeding the expiration of the disaster proclamation or declaration and all renewals of the proclamation or 45 days, whichever is later.

All insurance companies, premium finance companies, collection agencies, and other persons subject to this Chapter shall give their customers who reside within the geographic area designated in the proclamation or declaration the option of deferring premium or debt payments that are due during the time period covered by the proclamation or declaration. This deferral period shall be 30 days from the last day the premium or debt payment may be made under the terms of the policy

or contract. This deferral period shall also apply to any statute, rule, or other policy or contract provision that imposes a time limit on an insurer, insured, claimant, or customer to perform any act during the time period covered by the proclamation or declaration, including the transmittal of information, with respect to insurance policies or contracts, premium finance agreements, or debt instruments when the insurer, insured, claimant, or customer resides or is located in the geographic area designated in the proclamation or declaration. Likewise, the deferral period shall apply to any time limitations imposed on insurers under the terms of a policy or contract or provisions of law related to individuals who reside within the geographic area designated in the proclamation or declaration. Likewise, the deferral period shall apply to any time limitations imposed on insurers under the terms of a policy or contract or provisions of law related to individuals who reside within the geographic area designated in the proclamation or declaration. The Commissioner may extend any deferral period in this subdivision, depending on the nature and severity of the proclaimed or declared disaster. No additional rate or contract filing will be necessary to effect any deferral period.

With respect to health benefit plans, after a deferral period has expired, all premiums in arrears will be payable to the insurer. If premiums in arrears are not paid, coverage will lapse as of the date premiums were paid up, and preexisting conditions will apply as permitted; and the insured will be responsible for all medical expenses incurred since the effective date of the lapse in coverage.

Incidents Affecting Operations of the Department

Regardless of whether a state of disaster has been proclaimed or declared under the Stafford Act, whenever an incident beyond the Department's reasonable control, including an act of God, insurrection, strike, fire, power outage, or systematic technological failure, substantially affects the daily business operations of the Department, the Commissioner may issue an order, effective immediately, to stay the application of any deadlines and deemer provisions imposed by law or rule upon the Commissioner or Department or upon persons subject to the Commissioner's jurisdiction, which deadlines and deemer provisions would otherwise operate during the time period for which the operations of the Department have been substantially affected. The order will remain in effect for a period not exceeding 30 days. The order may be renewed by the Commissioner for successive periods not exceeding 30 days each for as long as the operations of the Department remain substantially affected, up to a period of one year from the effective date of the initial order.

Consumer Services Division

Complaints regarding insurance transactions in the state of North Carolina will be processed in the following manner:

- Analyst will request explanation from company, agent or adjuster;
- If he finds that the complaint has been improperly handled, then he will recommend that proper action be taken;
- If the issue is not resolved, the deputy commissioner may arrange a conference with company representatives to resolve the problem.

If a conference does not resolve a disputed issue, the deputy commissioner may recommend to the commissioner that appropriate legal action be taken to insure compliance with the statutes, rules and regulations administered by the department. Such legal action may include the convening of a public hearing to review, in light of the conduct which occasioned the complaint, the necessity of entering an order against the party complained of.

The Division will not investigate a complaint which is also the subject matter of a pending lawsuit filed by an attorney representing the complainant. If a lawsuit has not been filed but the complainant has retained an attorney, the Division will investigate the complaint according to its normal procedures provided it has first obtained the attorney's consent.

The Division maintains facilities and personnel to receive inquiries and complaints by telephone, letter or personal visit. The telephone number of the Division is (919) 733-2032. The mailing address of the Division is: North Carolina Department of Insurance, Post Office Box 26387, Raleigh, North Carolina 27611, (Attention: Consumer Services Division). The street address of the Division is: Room 3040, Dobbs Building, 430 North Salisbury Street, Raleigh, North Carolina.

When an insurer denies a claim after receiving written notice thereof from the claimant sufficiently informative to enable the insurer to identify the specific coverage involved, the insurer's denial must be in writing and cite specific policy provisions or legal basis relied upon in denying the claim.

When an insurer offers to settle a claim after receiving written notice thereof from the claimant sufficiently informative to enable the insurer to identify the specific coverage involved, the insurer's offer of compromise settlement, when requested by the consumer, must confirm in writing the offer of compromise settlement and cite the specific policy provision or legal basis relied upon in support of the compromise.

Insurance Carriers as Lenders

Any lender who offers an insurance product to a consumer either directly or indirectly through a subsidiary or affiliate in conjunction with an extension of credit must inform the consumer of the protections afforded by the North Carolina general statutes. Nothing in this Regulation limits the right of the lender, for purposes of protecting the interest of the lender, to require insurance in connection with a loan. This Regulation will not apply where the extension of credit arises out of a life insurance contract itself or where the extension of credit is subject to the provisions of Regulation Z (12 CFR 226), or other federal statutes or regulations requiring comparable disclosures.

Use of Specific Company Names in Responses

When an insurer makes a written response to an inquiry or complaint made by a consumer or the Department, the insurer shall identify on its response its mailing address, official corporate name, and on its response to the Department, the NAIC company code; or its mailing address, specific corporate name, and on its response to the Department, the NAIC company code if the insurer is part of a group of companies.

Every insurer must provide the Department's Consumer Services Division with the name, title, address, and telephone number, including a toll free number, of a designated person to whom any person may send a complaint or inquiry. Every insurer must also provide the Division with the company president's name, address, and telephone number for the Division's use. Forms will be provided by the Division, which must be completed and returned to the Division by every insurer. Every insurer must complete, have signed by a corporate officer, and file with the Division a new form within 15 business days after any change in the information on the form.

2. Consumer Protection Fund

A special fund known as the Department of Insurance Consumer Protection Fund is part of the Office of the State Treasurer. The money in the fund will be placed in an interest-bearing account and any interest or other income derived from those funds will be credited back to the fund. Money in the fund will be spent solely pursuant to warrants drawn by the Commissioner on the Fund through the State Treasurer. The Fund will be subject to the provisions of the Executive Budget Act.

All money in the fund will be used only to pay the following expenses incurred by the Department:

- For the purpose of retaining outside actuarial and economic consultants, legal counsel, and court reporting services in the review and analysis of rate filings and any other insurance regulatory matters, in conducting all hearings, and through any final adjudication.
- In connection with any delinquency proceeding under Article 30 of this Chapter, for the purpose of locating and recovering the assets of or any other obligations or liabilities owed to or due an insurer that has been placed under such proceeding.
- In connection with any civil litigation, other than under Chapter 150B of the General Statutes or any appeal from an order of the Commissioner or his deputies, that is commenced against the Commissioner or his deputies and that arises out of the performance of their official duties, for the purpose of retaining outside consultants, legal counsel, and court reporting services to defend such litigation.

Money appropriated by the General Assembly will be deposited in the fund and become a part of the continuation budget of the Department of Insurance. The continuation budget amount will equal the actual expenditures drawn from the Fund during the prior fiscal year plus the official inflation rate designated by the Director of the Budget in the preparation of the State Budget for each ensuing fiscal year. However, if interest income on the fund exceeds the amount yielded by the application of the official inflation rate, the continuation budget amount will be the actual expenditures drawn from the Fund.

3. Readable Insurance Policies Act

If you've had any experience at all with the insurance world, whether selling or buying it, you have probably noticed that policies tend to be long-winded and in tiny print. In short, they can be very confusing for the average consumer to read.

The state of North Carolina has a law that specifically targets this potential confusion.

The purpose of the Readable Insurance Policies Act is to ensure that insurance policies and contracts are readable by a person of average intelligence, experience, and education. All insurers are required by the Readable Insurance Policies Act to use policy and contract forms and, where applicable, benefit booklets that are written in simple and commonly used language, that are logically and clearly arranged, and that are printed in a legible format.

Applicability

The provisions of the Readable Insurance Policies Act apply to all policies and contracts of direct insurance. It does not, however, apply to any of the following:

- Any policy that is a security subject to federal jurisdiction;
- Any group policy covering a group of 1,000 or more lives at date of issue, other than a group credit life insurance policy, nor any group policy delivered or issued for delivery outside of this State; however, this does not exempt any certificate issued pursuant to a group policy delivered or issued for delivery in this State;
- Any group annuity contract that serves as a funding vehicle for pension, profit sharing, or deferred compensation plans;
- Any form used in connection with, as a conversion from, as an addition to, or in exchange pursuant to a contractual provision for, a policy delivered or issued for delivery on a form approved or permitted to be issued prior to the dates such forms must be approved under this Article;
- The renewal of a policy delivered or issued for delivery prior to the date such policy must be approved under this Article; nor
- Insurers who issue benefit booklets on group and nongroup bases. In these cases, the provisions of this Article apply to the benefit booklets furnished to the persons insured.
- Insurance on farm buildings (other than farm dwellings and their appurtenant structures); farm personal property; travel or camper trailers designed to be pulled by private passenger motor vehicles unless insured under policies covering nonfleet private passenger motor vehicles; nonfleet private passenger motor vehicles insured under a commercial motor vehicle insurance policy when combined with a commercial risk; residential real and personal property insured in multiple line insurance policies covering business activities as the primary insurable interest; and marine, general liability, burglary and theft, glass, and animal collision insurance except when such coverages are written as an integral part of a multiple line insurance policy for which there is an indivisible premium.

No other provision of the General Statutes setting language simplification standards applies to any policy forms covered by this Article.

Any non-English language policy delivered or issued for delivery in North Carolina will be deemed to be in compliance with the Readable Insurance Policies Act if the insurer certifies that such policy is translated from an English language policy which complies with this law.

Definitions

As used in this Article, unless the context clearly indicates otherwise, the following definitions apply to the Readable Insurance Policies Act:

- **Benefit booklet** means any written explanation of insurance coverages or benefits issued by an insurer and which is supplemental to and not a part of an insurance policy or contract.
- **Flesch scale analysis readability score** means a measurement of the ease of readability of an insurance policy or contract.

- **Insurance policy or contract or policy** means an agreement.
- **Insurer** means every person entering insurance policies or contracts as a principal.
- **Person** means any individual, corporation, partnership, association, business trust, or voluntary organization.

Format Requirements

All insurance policies and contracts must be printed in a typeface at least as large as 10 point modern type, one point leaded, be written in a logical and clear order and form, and contain the following items:

- On the cover, first, or insert page of the policy a statement that the policy is a legal contract between the policy owner and the insurer and the statement, printed in larger or other contrasting type or color, "Read your policy carefully"
- An index of the major provisions of the policy, which may include the following items:
 - The person or persons insured by the policy;
 - The applicable events, occurrences, conditions, losses, or damages covered by the policy;
 - The limitations or conditions on the coverage of the policy;
 - Definitional sections of the policy;
 - Provisions governing the procedure for filing a claim under the policy;
 - Provisions governing cancellation, renewal, or amendment of the policy by either the insurer or the policyholder;
 - Any options under the policy; and
 - Provisions governing the insurer's duties and powers in the event that suit is filed against the insured.

In determining whether or not a policy is written in a logical and clear order and form the Commissioner must consider the following factors:

- The extent to which sections or provisions are set off and clearly identified by titles, headings, or margin notations;
- The use of a more readable format, such as narrative or outline forms;
- Margin size and the amount and use of space to separate sections of the policy; and
- Contrast and legibility of the colors of the ink and paper and the use of contrasting titles or headings for sections.

Flesch Scale Analysis Readability Score

A Flesch scale analysis readability score will be measured as provided in this section.

For policies containing 10,000 words or less of text, the entire policy must be analyzed. For policies containing more than 10,000 words, the readability of two 200 word samples per page may be analyzed in lieu of the entire policy. The samples must be separated by at least 20 printed lines. For the purposes of this subsection a word will be counted as five printed characters or spaces between characters.

The number of words and sentences in the text must be counted and the total number of words divided by the total number of sentences. The figure obtained must be multiplied by a factor of 1.015. The total number of syllables must be counted and divided by the total number of words. The figure obtained must be multiplied by a factor of 84.6. The sum of the figures computed under this

subsection subtracted from 206.835 equals the Flesch scale analysis readability score for the policy.

For the purposes of determining the number of words and sentences, the following procedures must be used:

- A contraction, hyphenated word, or numbers and letters, when separated by spaces, will be counted as one word;
- A unit of words ending with a period, semicolon, or colon, but excluding headings and captions, will be counted as a sentence; and
- A syllable means a unit of spoken language consisting of one or more letters of a word as divided by an accepted dictionary. Where the dictionary shows two or more equally acceptable pronunciations of a word, the pronunciation containing fewer syllables may be used.

The term "text" as used in this section includes all printed matter except the following:

- The name and address of the insurer; the name, number or title of the policy; the table of contents or index; captions and subcaptions; specification pages, schedules or tables; and
- Any policy language that is drafted to conform to the requirements of any law, regulation, or agency interpretation of any state or the federal government; any policy language required by any collectively bargained agreement; any medical terminology; and any words that are defined in the policy; however, this means that the insurer must submit a certified document identifying the language or terminology that is entitled to be excepted by this subdivision.

Construction

The provisions of the Readable Insurance Policies Act will not operate to relieve any insurer from any provision of law regulating the contents or provisions of insurance policies or contracts nor operate to reduce an insured's or beneficiary's rights or protection granted under any statute or provision of law.

The provisions of the Readable Insurance Policies Act cannot be construed to mandate, require, or allow alteration of the legal effect of any provision of any insurance policy or contract.

In any action brought by a policyholder or claimant arising out of a policy approved according to the Readable Insurance Policies Act, the policyholder or claimant may base such an action on either or both

- The substantive language prescribed by such other statute or provision of law; or
- The wording of the approved policy.

4. Transacting Life Insurance Business in North Carolina

The following rules and regulations apply specifically to the transaction of life insurance in the state of North Carolina:

- Individual life policies may be terminated by the insurance company when the following conditions occur:
 - All like policies issued to employees of an employer are terminated; and
 - When the employee terminates his employment with that employer.

- Applications to be used with the sale of life insurance in which the first year's premium is financed must comply with all laws regarding these types of policies. This includes laws regarding the minimum down payment, the financing device and how it must be explained, and the disclosure of extended obligations. The information required may be attached to the application instead of printed on it. A rubber stamp must not be used.
- In regards to total and permanent disability benefits, the following provisions or those more favorable to the insured are prescribed:
 - Language defining total disability shall be included in the policy;
 - That total disability which has been continuous for a period specified in the provisions (not less than four months nor more than one year) must be presumed permanent;
 - That written notice of claim must be given to the company
 - During the lifetime of the insured; and
 - During the period of disability; failure to give notice within the time provided in the policy will not invalidate any claim if it will be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible;
 - That if total and permanent disability is established pursuant to this Rule, any premium or installment thereof which fell due during such total continuous disability and during a period specified in the provision of the policy contract (not less than six months) immediately preceding notice of claim shall be waived;
 - That if total and permanent disability is established pursuant to this Rule, which began after the due date of a premium or installment thereof in default, but not later than the last day of grace, provided such due date was within a period specified in the provision (not less than six months) immediately preceding notice of claim, disability benefits shall be allowed as if the default has not occurred, but the insured shall be liable for the premium in default with interest thereon, if any;
 - That any dividends which would otherwise have become payable during disability shall be allowed as though the disability has not occurred, unless an annuity is provided as permitted by Subsection (3)(d) of this Rule;
 - That upon recovery of the insured from total disability, disability benefits will cease and premiums or installments thereof becoming due after such recovery will be payable.
- In regards to group life insurance,
 - No insurance company licensed in North Carolina will be permitted to pay a collection fee to any person for the collection of premiums under group life insurance contracts, salary savings plans, or any other plan of group life insurance who does not devote a majority of his or her time to the life insurance business and who is not licensed by this department.
 - Dependent life insurance may be written in connection with group life insurance in amounts as allowed by an insurer's underwriting practices.
- After a life insurance company has been granted the authority to write variable annuities the company must submit its variable annuity contract forms to the department for approval. The same requirements which are applicable under existing statutes and rules with respect to the filing and approval of individual and group life insurance and annuity contract forms shall apply to variable annuity contracts. No company may submit variable annuity contracts for approval until its license has been amended to include the authority to write such variable annuity contracts.
- A company submitting variable annuity contracts to the Department for approval shall furnish the following information with each variable annuity contract filing:
 - Evidence that a copy of all appropriate information has been registered with the Securities and Exchange Commission,
 - A copy of all sales promotion material to be used in North Carolina,
 - A copy of the variable annuity application form,
 - A copy of the "Suitability Questionnaire" form (this may be a separate form or a part of the policy application and shall contain questions designed to

- determine whether the proposed variable annuity contract meets the reasonable objectives and needs of the applicant), and
- A copy of all proposed riders to be used with the variable annuity contract.

B. Ethics

1. Insurance Marketplace

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.

Producers Legal Relationships

By definition, **an agent/producer** is a person who acts for another person or entity, known as the principal, with regard to contractual arrangements with third parties.

Insurer as Principal

In applying the law of agency, the acts of an agent/producer, while acting within the scope of their authority, are the acts of the insurer.

Producer and Insurer Relationships

An agent (or producer) will always be deemed to represent the insurer, not the insured. With regards to an insurance contract, any knowledge of the agent is presumed to be knowledge of the insurer. **If the agent is working within the conditions of his/her contract, the company is fully responsible.**

The agent is responsible to the insurer when completing applications for insurance, submitting the application to the insurer for underwriting, and when issued, delivering the policy to the policyowner and explaining the contract. Also, if the insured submits payment to the agent, it is the same as submitting a payment to the insurer.

Underwriting Producer's Responsibilities

Underwriting is the risk selection and classification process. It involves the careful analysis of many different factors to determine the acceptability of applicants for insurance. In other words, underwriting is the process in which an insurance company determines whether or not a particular applicant is insurable, and if so, what premium to charge.

The agent is the company's front-line. He or she is often referred to as a **field underwriter** because the agent is usually the one that has solicited the potential insured. As a field underwriter, the agent has many important responsibilities, including the following:

- Helping prevent adverse selection;
- The proper solicitation of applicants;
- Completing the application;
- Obtaining the required signatures;

- Collecting the initial premium and issuing the receipt, if applicable; and
- Delivering the policy.

Limitations on Pre-selection and Post-selection

Pre-Selection - The agent or broker is able to accomplish good pre-selection by a complete, accurate and thorough completion of the insurance application. The application will ask for all of the legally allowed information which an insurer may gather in order to do effective **post-selection** underwriting.

During the application process, the agent is in a position to terminate at any time if he finds that the client poses an untenable risk to the insurance company or to explain to the clients why their risk may be higher than normal. Forewarning clients of a possible premium rating can help them overcome "sticker shock" later. *For example*, if an applicant is morbidly obese, the application could still be submitted but the producer could warn him/her that since his/her height/weight ratio is out of the standard range, he/she can expect to pay a significantly higher premium. The same applies to smokers, extreme sports enthusiasts, pilots, skin divers, etc.

The producer is not allowed to collect information which is not asked for on the application, but can seek details for those items which do appear. This can include dosages and frequency of use of medications, extent of involvement in hazardous activities, specifics regarding employment duties, etc. It is also necessary to emphasize the responsibility of the producer to not withhold any information which may be negative in regard to the client's risk.

Post-Selection - Once the producer has elected to complete and submit an application, the in-house underwriters begin the "post-selection" process.

Using the application as a springboard, the underwriter begins an investigation of the client's complete risk profile. Federal and state law delineates the types and extent of information which can be acquired and considered, which we will see below. After considering all of the information legally available, the underwriter will label the client as **Standard, Sub-Standard or Uninsurable**.

If the client is sub-standard, she will be offered the opportunity to obtain coverage under a higher than standard premium. The client can, of course, decline to be insured under the stated conditions.

After the agent receives a signed authorization for disclosure of information, the underwriter can begin an investigation using the following sources of information:

- **MIB** -- The Medical Information Bureau is a centralized information center into which insurers pour information gleaned from applications and claims. Subscribing insurers are then able to search the MIB database for information regarding any client who submits an application. The clients may be surprised when they "forget" to include information regarding past cancer treatment on their application and the insurer comes back with dates, treatments and doctors' names.
- **Department of Motor Vehicles** -- Since half of all "accidental" deaths in the United States occur as the result of traffic collisions, insurers are very interested in the driving records of their applicants. A poor driving record can result in a rating or even a declination.

- **Physician/medical facility records** -- The APS (attending physician statement) enables the insurer to receive the complete medical treatment history of the client.
- **Current physical** --The insurer can request that the client be examined by a physician and the results submitted for consideration. It is also common to require examination by a paramedical company and the use of blood, urine or saliva samples to check for nicotine or other drug use and the presence of HIV. An EKG may be required.
- **Financial reports** -- Using financial inspection reports and/or information from major credit reporting agencies, the insurer can detect whether the client has a history of financial malfeasance.
- **Personal interviews** -- The underwriter may contact persons with information about the applicant by telephone. These may include coworkers, neighbors, relatives or other acquaintances.

Interstate Commerce

If a person transacts insurance in a way that affects interstate commerce and knowingly makes a false material statement/report, alters records with an intention to deceive, or intentionally overvalues any land, property, or security, in an attempt to deceive an insurance regulatory official or agency, the person could be fined and/or imprisoned for a period of up to 10 years (or 15 years if the safety or soundness of the insurer was jeopardized).

It is also illegal for those who transact insurance in a way that affects interstate commerce to willfully embezzle, abstract, purloin, or misappropriate any of the moneys, funds, premiums, credits, or other property. The punishment for this offense is a fine or imprisonment for up to 10 years (or 15 years if the safety or soundness of the insurer was jeopardized). If the amount of misappropriated money does not exceed \$5,000, the term of imprisonment could be reduced to a 1-year sentence.

If an individual who transacts insurance in a way that affects interstate commerce has been convicted of a criminal felony involving dishonesty or a breach of trust or has been convicted of an offense under the laws of this section, a fine could be imposed and/or the individual could be imprisoned for a maximum of 5 years. It is possible for a person with this criminal history to transact insurance again, but he or she would need to first obtain written consent from an insurance regulatory official.

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.

Life Settlement Brokers Disclosure to Owners and Insureds, and Privacy

According to the disclosure regulations for life settlement brokers and providers, no later than the date the life settlement contract is signed, brokers and providers must give the owner a separate document which *clearly* lists all the required disclosures. This document must be signed by the owner and the life settlement provider. The required disclosures are explained below.

Owners Disclosures:

To help the owner understand the benefits and consequences of a life settlement transaction, at a minimum, the following information must be included in the disclosure:

- An explanation of possible alternatives, including accelerated benefits offered by the insurer;
- That some or all of the proceeds of a life settlement contract may be taxable;
- The proceeds of a life settlement contract may be subject to the claims of creditors;
- Receipt of the proceeds may adversely affect the recipient's eligibility for public assistance;
- That the proceeds will be sent to the owner within 3 business days after the life settlement provider has received acknowledgement that ownership of the policy has been transferred and the beneficiary has been designated according to the terms of the life settlement contract;
- That entering into a life settlement contract may cause other benefits under the policy, such as conversion or waiver of premium, to be forfeited by the owner;
- The total amount paid by the life settlement provider, as well as the net amount to be paid to the owner;
- The date by which the funds will be available;
- That the life settlement provider is required to furnish to the owner a consumer information booklet;
- The life settlement provider's name, business and email address, and phone number.

Brokers' Commissions and Other Compensations Disclosures:

The following information needs to be disclosed regarding brokers' commissions:

- The name of each broker, intermediary, producer or consultant that will be compensated by the life settlement provider
- The amount of compensation.

Life settlement brokers may NOT receive a commission if they have acted as a consultant with regard to the transaction during the prior 12 months and received a fee for such services.

Records of the disclosure must be kept by the licensed broker for at least 3 years after the services were performed.

Broker Disclosure of Offers, Counteroffers, Acceptances & Rejections:

The broker must provide to the insured a complete and accurate description of all offers, counteroffers, acceptances and rejections relating to the proposed life settlement contract.

Insured Disclosures:

The life settlement broker or provider must disclose to the insured that the insured may be contacted by the provider, the broker, or another authorized representative for information regarding the insured's health status or for address verification. The provider or broker must also disclose that the contact will be limited to once every 3 months if the insured's life expectancy is more than one year, and no more than once a month if the insured is expected to live one year or less.

Right of Rescission Disclosure:

The life settlement provider or broker must disclose that the owner has the right to change his or her mind. In other words, the owner may rescind a life settlement contract **within 15 days** after the receipt of the life settlement proceeds by the owner.

Remember that the separate document which conspicuously displays the above disclosures must be signed by the owner and life settlement provider no later than the date the life settlement contract is signed by all parties.

If the insured dies during the rescission period, the life settlement contract will be deemed to have been rescinded, subject to repayment of the listed items.

Life settlement brokers, intermediaries, or providers may not share information regarding the insured, except as necessary to conduct the business of the transaction, unless permitted or required by law. All parties to the transaction must comply with privacy protections required by federal law (HIPAA). Should the laws of the state provide for greater confidentiality than public health law requires, the regulations of the state will govern.

Prohibited Practices

The following are considered prohibited practices in the business of life settlements:

- Entering into a life settlement contract if the person is aware of any deception;
- Engaging in any transaction while knowing the intent was to avoid disclosure of material information relating to life settlements;
- Engaging in any fraudulent acts in connection with any life settlement;
- Entering into a premium finance loan arrangement where any consideration is paid other than normal commissions, or fees charged other than normal loan fees;
- Acting as a life settlement broker or intermediary while having an interest in that policy;
- Receiving any compensation for acting as a life settlement broker or intermediary without being properly licensed;
- Transferring the ownership of a policy that is subject to a premium finance arrangement and not remitting any proceeds or consideration paid (other than normal commissions or loan fees) to the original owner;
- Paying finder's fees or any other compensation to any owner's physician, attorney, accountant, insurance producer or consultant, or other person acting in these capacities;
- Paying life settlement broker's fees before they have been fully disclosed; and
- Paying life settlement payments in installments.

Advertising

A licensed life settlement provider, intermediary, or broker may advertise, but must comply with all advertising and marketing laws, rules, and regulations set forth by the Commissioner. Advertisements must be truthful, accurate and not be misleading in **any** way.

Errors and Omissions

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

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 usually written with "per claim" deductibles of at least \$500 or \$1,000, and will 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.

Needs to 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.

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. If a licensee takes it upon himself to use such funds for his own needs, the law sees such an act as a **theft**. The licensee will be prosecuted as a thief.

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.

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.

A licensee with the authority to transfer the funds to the appropriate party is usually a **managing general agent** whose fiduciary capacity includes the following:

- To 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;
- To 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.

Ethics

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. 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. Talk the layman's language when possible;
- 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.

As an agent, a person'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 often have success, initially, but they rarely have long-term success. The responsibility for ethical behavior is squarely on the agent.

Special Ethics 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. The 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. Some states have enacted the Financial Elder Abuse statutes, which, in part, specifically address 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. However, a pretext interview is acceptable when the purpose is to obtain information from a person or institution that does not have a generally or statutorily-recognized privileged relationship with the person to whom the information relates. Also, 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.

Insurers Operating Divisions

Insurance companies operate with many different departments and divisions. Among them are four principal departments responsible for the major functions: Marketing or Sales, Underwriting, Claims, and Actuarial. These departments each have a specific purpose within the structure of an insurer, and each can have an impact, positive or negative, on the profitability of the company.

Marketing and Sales

The **marketing department** is responsible for advertising, promoting, and distributing an insurer's products to the public. This department also sells the products, trains the producers, and develops any materials related to the marketing process. Agents are field representatives of the marketing department, responsible for putting the company's products and services in the hands of clients. Monitoring compliance with the various laws relating to the conduct of agents and the transacting of contracts may also be handled within the marketing department. The marketing department is also responsible for watching consumer trends and then researching and developing or modifying products and services to meet the needs or demands of the marketplace.

Underwriting

The **underwriting department** is responsible for receiving applications for insurance and then evaluating them according to established guidelines. Applications are either approved or declined. Those that are declined do not meet the company's guidelines, but not all approved applicants are equal either. Many present risks that, although the company is willing to insure them, are greater than average risks the company expects to insure, and will be classified as **substandard**. There will also be some applicants whose risks are more favorable than average, and those will classified as **preferred**.

The underwriting department's main objective is to prevent **adverse selection**, which is an imbalance of risks or the selection of poor risks--too many substandard compared to preferred and standard risks. If the underwriting department approves too many poor risks, the statistical predictions of the actuaries may not hold up, and the company will not have the level of profit it expected, or could even suffer a loss.

Claims

The **claims department** is responsible for receiving claim requests, evaluating them in light of the actual contract, paying those claims which are covered by the terms of the contract, and rejecting those which are not. The claims department may employ or contract with adjusters or other investigators to assist in the evaluation of claims, or to seek evidence of false or fraudulent claims. If the claims department does not settle claims promptly or fairly, or makes payments for claims that are not actually covered by the contract, the profitability of the company can be affected.

Actuarial

The **actuarial department** is where the science of statistics is put into practice. Insurance company actuaries are persons who study mortality and morbidity statistics, the nature of claims and actual claims experience, even factoring in the potential for fraudulent claims and the financial impact of those claims--including investigating fraudulent claims and payments. The actuaries must also account for the ordinary expenses of doing business, including the payment of claims, as well as make a conservative estimate of earnings from invested reserves--premiums received by the company but not currently needed to pay expenses.

After all the analyses and calculations have been made, the actuaries publish the rates that must be charged for each line of business the company insures, with the intent of achieving profitability.

Primary Insurer in Reinsurance

Reinsurance is insurance purchased by a primary insurer to protect itself against the catastrophe of a comparatively large single loss or a large number of small losses caused by a single occurrence. The reinsurance contract is between two parties.

1. **Reinsurer:** the company that, in consideration of the premium paid, assumes a part of the risk over an amount retained by the primary insurer, known as the **net line**.
2. **Primary insurer:** the insurer covering losses on a first dollar basis (sometimes subject to a deductible), who issues the policy over which reinsurance is purchased. In the reinsurance contract, the primary insurer may also be called the **ceding company**.

The contract between the reinsurer and the primary insurer is called a **treaty**. There are two types of reinsurance treaties:

1. **Automatic treaty:** The reinsurer agrees, in advance, to accept a portion of the gross line of the primary company's risks that meet the reinsurer's underwriting rules.
2. **Facultative treaty:** Each risk is considered individually by both parties. A risk is submitted to the reinsurer for acceptance or rejection. If the risk is accepted, the primary insurer may accept or reject the rates and terms of the offer.

When a reinsurance company reinsures risks with other reinsurance companies, this is known as **retrocession**.

Post-claims Underwriting

In the area of health insurance (also called disability insurance, which includes policies covering hospital, medical and surgical expenses), it is expected that, prior to issuing a policy or certificate of insurance, an insurer will do the necessary investigation and underwriting to determine whether an insured is an acceptable risk.

Once an insurer issues coverage, it becomes responsible for fulfilling the promises of that coverage. The only exception would be if the applicant had engaged in fraud, in which case the insurer would have the right to rescind the coverage.

It is **illegal** for an insurer to attempt to rescind, cancel, or reduce the coverage of a client after a claim has been filed by then doing the underwriting which was not done when it should have been. Attempting to do underwriting after issuing a policy and receiving a claim is called **post-claims underwriting** and is illegal.

Fair Claims Settlement Practices Definitions

A **claimant** is 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

any of the following persons properly designated by the claimant:

- Insurance adjuster;
- Public adjuster; or
- Any member of the claimant's family.

A **notice of legal action** is one that is 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. This includes any arbitration proceeding.

A **proof of claim** is any documentation in the claimant's possession submitted to the insurer which provides evidence of the claim and supports the magnitude or the amount of the claimed loss.

Standards for Prompt, Fair and Equitable Settlements

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 a specified number of 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 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 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. 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 (usually within **30 days**).

Consider the following examples: Albert buys a house that has faulty wiring, which starts a small fire in the kitchen and causes \$2,500 in damages. Two weeks later, a thunder storm starts a fire in the attic, causing another \$10,000 worth of damage. Albert submits a claim for \$12,500 to his insurance company. Thirty days later, the insurance company sends Albert a notice detailing that it will accept \$10,000 of the claim for the storm damage, but will deny the \$2,500 caused by a non-related incident.

Mary buys a used car with a crumpled bumper. After a minor fender bender, Mary submits a claim for the damages from the accident including the damage to the bumper. Her insurance company sends her a letter denying the claim. The letter must also alert Mary that she has the right to have the Department of Insurance review her claim, and include the contact information for the department that reviews claims.

2. Insurance Ethics

Ethics in the 21st Century Ethics: Principles and Practices

The purpose of this part of the course is to provide the foundation of knowledge and understanding that an individual needs to function ethically in his or her role as an insurance professional. Our concentration will be on the social, professional, and legal aspects of ethics.

It seems that in many news reports that a person reads or listens to these days, some insurance company or insurance agent is receiving negative publicity as a result of bad professional judgment or poor ethical conduct. Bad news usually attracts far more attention than that paid to the legions of insurance agents who perform their daily sales and service tasks in a thoughtful, fair, and ethical manner. Their exemplary work will be discussed in detail.

As you will discover, ethics can be studied on two levels:

1. **Philosophically**, where a code of personal ethics helps you gain personal and professional satisfaction: and
2. **Practically**, where a code of personal ethics helps you avoid controversy and misunderstandings, which increases your personal efficiency as an agent.

Understanding Ethics

At some time in your life, you've been exposed to the Golden Rule that states: "Do unto others as you would have them do unto you." Either taught by a parent, a teacher, or a religious leader, this golden rule not only promises spiritual satisfaction and fulfillment, but it also serves as a practical guide to an insurance agent's everyday business life.

To a certain extent, ethics is a set of instructions on how to deal daily with a group and a community. These instructions revolve around a single theme: "social behavior that favors the group over the individual." Antisocial behavior usually stems from individual selfishness and greed -- characteristics that are against the common good and disruptive to overall balance and harmony. Because ethical behavior on the part of the individual resulted in group harmony, communities turned to such ethics as the basis for common law, which in turn became the basis for our own civil and criminal codes of conduct.

Today, we live in a fast-paced society. Unfortunately, this pace does not always give us the necessary time to consider different choices of action or reflect upon the consequences of our words and deeds. This can create ethical problems. Moreover, some people tend to focus on practical and expedient solutions to their problems when their main consideration should be the ethical answer. In these

situations, the practical solution may not be correct, and the cure could result in a condition worse than before.

Ethics Defined

Ethics is a derivative of the Greek word *ethikos*, meaning "moral" and *ethos*, meaning "character." By textbook definition, ethics is "a branch of philosophy that deals with the values of human life in a coherent, systematic, and scientific manner." The Oxford English Dictionary defines ethics as "the department of study concerned with the principles of human duty" and the "rules of conduct recognized in certain associations or departments of human life."

You won't find universal agreement among philosophers as to what, exactly, is ethically right. Immanuel Kant, a German philosopher, believed what is right is based on pure reason. On the other hand, Jeremy Bentham, early 19th-century British philosopher, believed *right* to be that which will produce the greatest good. Religious philosophers, like St. Thomas Aquinas, say that *right* is determined by the will of God, and *wrong* is anything contrary to God's will.

For the purpose of our work, we will use Albert Schweitzer's definition of ethics:

Ethics is the name we give to our concern for good behavior. We feel an obligation to consider not only our own personal well-being but also that of others and of human society as a whole.

Dr. Schweitzer, who was a French medical missionary and philosopher, applied this idea of "duty beyond the group" to all humanity. He believes that the ultimate goal of ethics is the fullest measure of justice for all. If we were to distill the philosophy of Dr. Schweitzer into three words, they would be "regard for others."

The Golden Rule

The Chinese philosopher Confucius said that ethics is the foundation of peace in a society. He believed that a body politic of "good brothers" living in moral harmony would result in an orderly and peaceful nation. The golden rule, in fact, comes from Confucius, who said, "What you do not want others to do to you, do not do to others."

The golden rule provides us with the most basic test concerning ethical conduct. You can easily determine whether a course of conduct is ethical simply by asking, "Would I want someone else to act in this manner toward me?"

It is interesting to note that this same test is a guidepost of the Chartered Life Underwriter: proposing a life insurance solution (to a client's problem) that you yourself would purchase.

Failure to apply the golden rule will result in two separate standards of ethics. One standard is how you treat others; the second is how you expect others to treat you.

Ethics—A Way of Life

When we discuss ethics, we are not dealing with a set of hard-and-fast scientific rules--but rather with attitudes, ideas, and beliefs. Ethics is really a set of instructions for a way of life. Ethics presents an individual with a way to live harmoniously with others.

Ethics, like religion, favors the group over the individual. Quite simply, if the individual is completely self-seeking, then the group will most likely suffer. The phrase "Love thy neighbor as thyself" is pure ethics -- it serves as a brake on antisocial behavior.

Ethical business practices, in turn, can help foster satisfied customers, as well as a stable economy. In this context, ethics is about social justice -- making sure that people receive benefits from every decision made.

How Do We Define Success?

Unfortunately, our society isn't always critical of wrongdoing. For example, many people are impressed with the wealth accumulated by some individuals and ignore the means by which it was gained.

This tendency to emphasize personal financial gain is a common way many businesses -- including the insurance industry -- motivate their employees. Financial gain is often held out as the primary measure of success. This is not to say that pursuit of financial gain is wrong; however, consider how incentives such as "Top Agents of the Month" rosters have the tendency to spotlight financial achievement while ignoring professionalism and public service. What about an agency atmosphere that stresses results by any means? Shouldn't those who have achieved ethical success -- those who have best served the needs of their insurers and the public -- be honored, too? An overemphasis on financial rewards can lead to looking at prospects and clients on the basis of "What can I get from them?" as opposed to "What I can do for them?"

Certainly, insurance agents should expect to be adequately rewarded for success, and production figures are vital to the well-being of any agency or insurance company. However, no less important is meeting the needs of clients and the public in a proper and ethical manner. Self-interest is fine, but not when maintained at any cost -- not at the cost of your self-respect and not at the cost of others.

The Ethical Balance Sheet

Ethics does not have to be incompatible with capitalism. "Profit" is not a dirty word. In the long run, good ethics is indeed good business. Hard but fair competition cannot help but benefit the public.

Selling life insurance is an aggressive profession accustomed to vigorous competition. In fact, that vigorous competition leads to a better serving of the public's needs. Applying the golden rule does not mean that you should allow someone else to make the sale, hoping that he or she might let you make the next one. If someone asked you to sign a written agreement after telling you what the document contained, it would not be unethical to read the document anyway before signing. Ethics is personal in nature and does not demand that you trust

others implicitly. You have no control over the conduct of others — only over your own.

Ethics as a Legal Force

For some, there is a conflict because ethics deals with the way things ought to be -- which is not necessarily practical in our society. These individuals get wrapped up in differences between ethical and legal -- two completely separate concepts. Ethics is right for rights sake, while the law represents a set of minimum standards that society demands.

Ethics usually precedes the law. While many ethical standards of conduct have been codified, many have not. So something can be legal but not ethical. For example, it is legal to sell a prospect more life insurance than he or she can afford, but this is not ethical. Ethics goes beyond the letter of the law and entails not only what a person "must do" but also what a person "should do."

However, it should be noted that the law does not provide a very specific ethical direction for everyone through civil and criminal statutes. Under the law, ethical conduct is generally defined as that which a reasonable person is expected to do under any circumstances. Also defined in the law are illegal and improper conduct and the penalties for such conduct.

In spite of this merger of the legal and ethical, there is still a distinction between the two. How often have you heard people ask, "Well, were my actions illegal?" And when they were told that their actions were perfectly legal, they assumed that their actions were also acceptable.

The integrity and truthfulness of a company's policies are subject to scrutiny by the general public. Public pressure may force a business to revise its practices. All of this means that what is legal today--but unethical--could become illegal tomorrow, depending on changes by the community to bring reform.

However, relying on legalities alone can become the easy way out. Paying attention to "have-to" rules and regulations at the expense of "choose-to" ethical standards can keep the individual out of legal trouble but can also result in a delusion of success. Ethics has more to do with approval from the man or woman in the mirror than it does with approval from one's manager or the insurance company that one represents.

Honesty

In our modern society, it may not be possible for an individual to live in an absolutely honest manner. Completely honest people who refused to tell white lies to protect the feelings of others would have few friends. However, there is a big difference between telling your Aunt Betty that you love her atrocious new hairstyle and telling a client that he/she needs more life insurance than is actually necessary.

Ethics for Insurance Agents

Consider these questions:

- Is it ethical for an insurance agent to use for a prospect list the names of individuals who registered for a new home in a supermarket drawing?
- Is it ethical for an insurance agent to call himself or herself a financial planner or an estate planning specialist without the proper training, experience, or qualifications?
- Is it ethical for an insurance agent to show a prospect a policy illustration without explaining the difference between guaranteed and nonguaranteed benefits?

Of course, the answer to all of these questions is "**NO.**" None of these situations shows proper ethical behavior by an insurance agent. No matter how extreme these examples might seem, they represent ethical responsibilities that an insurance agent is expected to fulfill. An agents four primary ethical responsibilities are to the following:

1. Insurer;
2. Policyowners;
3. General public; and
4. State.

Each of these areas will be discussed in detail in the following sections, but let's take a brief look at them now.

Ethical Responsibilities to the Insurer

The duties of an insurance agent to his or her insurer are established by the concept of agency. This concept is tangibly represented by the agency contract, which both parties agree to and sign. Within the scope of that contract, the insurance agent owes to his or her insurer the duties of honesty, good faith, and loyalty. He or she also is obligated to reveal to the insurer all material facts concerning the agency.

In carrying out his or her duties, the insurance agent is the direct representative of the insurer. His or her day-to-day activities are a direct reflection on the insurers image within the community. Should the agent behave unethically, everyone in that community is given to believe that the insurer is also unethical.

Ethical Responsibilities to Policyowners

The professional agent can meet his or her ethical responsibilities to an insured policyowner by filling needs and providing quality service. Service is a primary function of the insurance industry. The way that service is provided often determines the agent's future, since clients are a good source for future sales and references.

In addition to quality service, the agent also owes the policyowner the same degree of loyalty that he or she provides to the insurer. The agent is also charged with the ethical responsibilities of full disclosure, confidentially, timely submission of all applications, and prompt policy delivery.

Ethical Responsibilities to the Public

The insurance agent has more control over the public's attitude toward insurance than sales representatives for most other consumer products. This is because the insurance agent initiates contact with a prospect, determines a prospects need for insurance, recommends a certain product or solution, makes the sales

presentation, and finally develops a long-term relationship with after-sale service. In many cases, the prospect has little or no direct contact with the insurance company.

Because this special relationship involves a great deal of contract between the consumer and agent (and because the public generally understands very little about insurance), public perceptions of the industry itself are based on how well -- or how poorly -- an agent does his or her job. Thus, the professional insurance agent has two main ethical responsibilities to the public:

1. To inform the public about insurance with the highest level of professional integrity; and
2. To strive for an equally high level of professionalism in all public contacts in order to maintain a strong, positive image of the industry.

Ethical Responsibilities to the State

The responsibility to regulate the insurance industry is shared by the federal and state governments. However, the states carry the burden of regulating insurance affairs, including the ethical conduct of licensed insurance agents. In some states, the regulation of ethical conduct falls under the category of "marketing practices," while other states refer to it in the context of "unfair trade practices."

Whatever it is called, all states have established a code of ethical standards for insurance agents by defining -- through laws and regulations -- what an agent can and cannot do. Although these laws differ from state to state, there are enough similarities to discuss them in general terms. This will be the subject of the next section, in which ethical standards for financial planning and the Investment Advisers Act will also be discussed.

Ethical Issue Number One

Good Intentions Don't Replace Experience

John and Sue were members of the same agency. John had been with the agency for many years and was experienced in developing employee benefit packages for start-up companies. Linda was new to the insurance business.

John was going out of town to make a service call on one of his cases. While he was packing his briefcase, he noticed that Sue was sitting at her desk, and she appeared to be totally overwhelmed. "What's wrong?" he asked, noticing Sue's confusion.

"I've made 40 calls this morning--and so far no appointments," she said. "What am I doing wrong?"

John grinned. "Maybe you should have made 50 calls. Tell you what," he said, reaching for his appointment book. "Today's your lucky day. Al Brewster over at Top-Notch Tools needs to talk to someone about a 401(k) plan for his hourly, salaried, and executive groups. You might try for an appointment."

At their sales appointment, Al Brewster said to Sue, "Tell me what kind of tax advantages I can gain if I move my current pension plan over to a 401(k) plan."

Sue remembered a part in the company manual that covered that question. "Mr. Brewester, if you're currently administering a defined benefit pension plan for all your employees, you're paying far too much out of your company treasure for a limited tax break. I can promise you that you will not only be able to cut your annual contribution with a 401(k), but you'll also be able to customize a retirement plan for all three of your employee groups -- hourly, salaried, and executive."

Al Brewester was really impressed. "My fiscal year starts in two weeks. Can you get something worked up for the accounting department by next Tuesday? If you can, you've got a sale. If you can't, tell me now and I'll go somewhere else."

Sue didn't hesitate. "I will handle this case myself, Mr. Brewester. I specialize in 401(k) plans. What time on Tuesday do you want to meet?" She knew that with the help of the manual, she could get the job done for Al Brewester.

Ethical Responsibilities to the Insurer

A potential source of ethical conflict for insurance agents can be a lack of understanding of the contractual relationship that they have with their companies. Understandably, an individual new to the business or one joining a new company will be concerned with the day-to-day matters of insurance sales -- matters such as quotas, territories, commissions, products, training, support, service, underwriting practices, premium rates, and competition -- and may have little time to contemplate the other duties and responsibilities that he or she has accepted by signing the agency contract. In this section, we will examine the ethical responsibilities that an agent owes to his or her insurer.

The Concept of Agency

The relationship between an insurance agent and his or her company is governed by the concept of agency. **Agency** is a legal term that describes the relationship between two parties, in which one the principal has authorized the other the agent to perform certain legally binding acts on the principals behalf. In most agency relationships (including that of an insurance company and its agents), these acts involve making contracts between the principal and outside parties. In carrying out these duties, the agent, in effect, "becomes" the principal and assumes the party's identity when performing the authorized acts. When an agent acts within the scope of his or her authority, the law takes the position that the actions of the agent are also those of the principal.

Power

The essence of an agency relationship is power. Before an individual can act as an agent and establish contracts between the principal and outside parties, he or she must have the power to do so. In the case of an insurer and an agent, this power is granted through an agency contract, which is how an insurer appoints an individual to act on its behalf.

Authority

The concept of authority is related to the concept of power. Although the two words are often used interchangeably, their definitions are distinct. The agency

contract gives the agent the power to act on behalf of the principal and, at the same time, describes the actions that the agent is authorized to take. Technically, only the authorized acts of an agent can bind a principal; practically and legally, however, an agent's authority can be quite broad.

For example, an agent is given the power to sell and service an insurer's policies, but he or she is authorized to do so only within a certain geographical area. One of the important implications of an agency relationship — and occasionally a source of conflict — is that an agent has the power to take actions that he or she may not be authorized to take.

In essence, there are three types of agency authority: express, implied, and apparent.

Expressed Authority

Express authority is the authority that a principal intends to -- and actually does, in fact -- give to its agents, either orally or in writing. Usually written, express authority spells out the actions that the agent can and cannot perform for the principal. For example, through the agency agreement, a life insurance agent is given the express authority to solicit applications for life insurance and collect the initial premiums for those policies.

Implied Authority

Implied authority is authority that is not expressly granted--but which the agent is assumed to have in order to transact the business of the principal. It includes those acts that are incidental to the accomplishment of the expressly authorized acts. For instance, when an insurer has expressly authorized an agent to solicit an application and accept premium payments, it also implicitly authorizes the agent to issue a conditional receipt that is binding on the insurer.

Apparent Authority

Apparent authority is the appearance of--or the assumption of--authority based on the actions, words, or deeds of the principal or because of circumstances that the principal created. In effect, the principal creates the "appearance" of authority. If a third party in good faith relies upon the principal's intentional or negligent permissiveness in regard to the agent's acts, the principal will be bound by the acts of the agent because the agent possessed apparent authority.

However, the apparent authority of an agent must be derived from the actions of the principal. For example, if an agent's agreement with an insurer authorizes him or her to solicit applications only within a specified geographical area, but the company accepts an application and issues a policy outside that area, the apparent authority of the agent to operate outside of that area has been established (or ratified) by the insurer. Statements or actions of an agent alone are not sufficient to create apparent authority.

Limitations on Authority

Rarely is an agent's authority to act for a principal unlimited. In most agency relationships, an agent's activity is restricted to some extent. For example, while

an insurance agent is authorized to solicit applications, he or she cannot accept or reject a risk. An insurance agent cannot modify a contract or waive exclusions. An insurance agent cannot adjust premium rates. These acts are reserved for the company. Typically, the limits to an agent's authority are spelled out in the agency agreement, and it is within those powers that an agent must act. To step beyond those limits is to invite problems.

Beyond the Contract

This section will provide a brief overview of the agency concept in order to provide a basis for understanding the contractual relationship that an insurance agent has with his or her company. Obviously, the ethical significance is that an agent must, first and foremost, serve the insurer. The agent must live up to the contract and operate within the scope of his or her authority. But actually, an agent's duty to the insurer goes far beyond the wording of the contract. By entering into this contractual relationship, an agent has also entered into a fiduciary relationship.

The Agent as a Fiduciary

A **fiduciary** is an individual whose position and responsibilities involve a high degree of trust and confidence. Trustees, guardians, and executors, by virtue of their responsibilities, are fiduciaries. So are insurance agents.

An insurer places a great deal of trust and confidence in its agents; consequently, an agent must exercise a corresponding high degree of fairness and good faith, acting in the best interests of the insurer.

Through his or her appointment, an insurance agent is generally given the power and express authority to act for the insurer by:

- Soliciting applications for coverage;
- Describing coverage and policies to prospects and applicants and explaining how the policies can be purchased;
- Collecting premiums (or in some cases, only initial premiums); and
- Providing service to prospects and the insurer's policyholders.

Thus, while the provisions of the agency contract tell agents what acts they are authorized to perform, how they go about those tasks is usually left to their own judgment and discretion. But keep in mind that both actions and judgments are held to fiduciary standards.

Serving a fiduciary role demands high ethical standards and performance. In fact, those who depend on fiduciaries expect of them a higher standard of conduct than is required in the usual course of events. *For example*, assume that a customer at a grocery store is mistakenly given more change than is owed. Ethically, the customer should return the difference -- that would be the right thing to do. However, other than the motive or desire to do what is right, there's nothing else compelling the customer to give back the additional money. By comparison, a fiduciary acts in accordance with ethical standards not only because it's the right thing to do, but because he or she must. That is the essence of a fiduciary's role.

So, let's look beyond what an agent is expressly authorized to do and examine the ethics of the fiduciary relationship that he or she has with the insurer.

Loyalty to the Insurer

The primary ethical responsibility that an agent owes to the insurer is loyalty. This means that he or she must, at all times, act in the insurers best interest in every matter involving the insurer's business. Thus, by extension, an agent cannot act for himself or herself if personal objectives run counter to the insurers interest.

For instance, while it is common for independent insurance agents and brokers to represent several insurers with the full knowledge and consent of the other insurers, in many agency relationships, unless the agent is specifically authorized to do so, he or she cannot represent competing principals.

An agent is also charged with conforming to the limits of his or her authority and staying within the guidelines of the agency contract.

Care and Skill

An agent has a duty to carry out his or her actions with utmost care and skill. As the insurers authorized agent, the agent represents the company to the public and must act accordingly. In some cases, this means that the agent must refer the business to others who are more qualified if the agent is not qualified to handle it.

Full Disclosure

An agent is obligated to fully disclose all information that may affect the insurer and its ability to conduct business. Practically speaking, full disclosure is most significant during the application and claims-handling processes. An agent must complete all application and claim forms as accurately as possible. Failure to do so could lead the insurer to follow a course of action that it would not otherwise take (such as issuing a policy to an applicant whose bad health had been concealed).

Therefore, it is the agents or brokers responsibility to see that the answers to questions on the application are recorded fully and accurately. Anything less than full disclosure may prompt the insurer to act in a way that is contrary to its own interest.

Prompt Action and Follow-Up

An agent has the obligation to act promptly in all matters regarding the insurers business, but most significant is the responsibility to transmit completed applications and notice of premium receipts as quickly as possible. The insurer cannot begin the process of issuing insurance until it has received an application. Unless the applicant has been given a binding receipt, he or she remains at risk until the policy is issued. On the other hand, if an applicant is given a binding receipt at the time of application, the insurer is obligated to provide coverage, until and unless the applicant is formally rejected. In either event, a delay by the agent in turning over an application or notice of premium receipt may place the applicant or the insurer in jeopardy.

Handling of Premiums

Most agents are authorized to collect initial premiums from applicants; some are also allowed to collect renewal premiums. By law, payment to an agent is considered to be payment to the insurer. The agent has the fiduciary duty to account for all funds that he or she receives in connection with the insurers business and to turn these funds over promptly. Even if there is no legal intent, it is unethical to delay or withhold premium payments. In many states, it is illegal to combine premium monies with personal funds. Rarely would it be ethical to do so anyway, regardless of whether a specific law exists.

Avoiding Conflicts of Interest

Ethically, an insurance agent who has signed an exclusive contract with his or her insurer cannot serve two principals at the same time. As a "captive" agent, he or she owes a singular loyalty to that insurer. It would be unethical for that agent to represent two insurance companies selling the same policies. In addition, an agent has the ethical obligation to inform his or her company about any other related services that he or she provides and receives payment for. An agent who does part-time preparation and filing, for example, or who serves as a consultant to a local business, should inform his or her company of this activity. The insurer can then determine if there is a conflict of interest.

Independent agents also face this issue when they attempt to serve their clients while being contracted to an insurer. Conflicts can be avoided if independent agents follow these guidelines for dual-agency:

- The agent represents the insurance company when insurance is being applied for and when it is in the process of being underwritten, in recordkeeping and in claim settlement or other insurer-related activities.
- The agent "represents" his or her client only during the process of helping the client select the insurance plan best suited to the client's needs.

Careful Solicitation

An agent has the ethical duty to protect the insurers interest by soliciting business that appears to be good and profitable for the insurer. Although at some point every agent will submit an application that is rejected or will write business that quickly lapses, the obligation to exercise reasonable care in soliciting quality business is constant.

At the same time, once an agent has taken an application, he or she has the duty to submit it, even if it appears that the applicant may be a poor or uninsurable risk. Whether or not an individual is issued coverage is a decision for the insurers underwriters.

Competitive Integrity

The insurance industry is highly competitive. For an agent, there exists ample opportunity to conduct business inappropriately at the expense of a competitor. Misrepresentation or defamation of a competitor casts a dark reflection on the entire industry. As a duty to his or her insurer and to the industry itself, an agent must resist this temptation. Ethics requires that an agent acknowledge the worth of other agents and their policies and compete only on the basis of the value of the products and service that he or she can provide.

Duties of the Principal to the Agent

The relationship between the agent and the principal is a two-way street. The principal also owes certain duties to the agent. A rule of agency law is that the principal is responsible for all of an agent's acts when he or she is acting within the scope of his or her authority. This responsibility includes fraudulent acts, omissions, and misrepresentations.

The principal, then, must carefully select honest, loyal, and hard-working agents to protect itself from potential liability. In return, the principal gives the agent:

- Compensation, or payment, for the business that the agent has given to the principal;
- Employment (The principal must specify a reasonable period of time during which the agent is expected to produce a certain amount of business.); and
- Indemnity. The principal is obligated to reimburse the agent for any damages or expenses incurred in defending against claims that the agent may be held liable for in the course of fulfilling his or her agency obligations.

Who is an Agent of the Insurer?

Up to now, this course has focused on the relationship between the insurer and the insurance agent. The preceding explanation of legal and ethical principles has been based on the assumption that the agent works singularly for one insurer.

But what is the relationship of a broker to an insurer? How do these principles apply to those who represent more than one insurer? Let's take a look.

Is a Broker an Agent?

An **insurance broker** is one who places business with more than one company and has no exclusive contract requiring that his or her business first be offered to a single company. Legally, a broker obtains insurance for anyone who requests him or her to do so and represents the customer. For this reason, the insurance broker is an agent of the applicant. "Broker" and "brokerage" are not interchangeable terms. In insurance, **brokerage** is often used to describe business placed by persons who are not regular members of the insurers agency force.

A full-time career agent of one insurer may also have a broker's license and submit occasional applications to another insurer. This can happen when coverage is available through the second insurer that is not offered by the first.

Any life insurance agent may represent the insurer for some purposes and the applicant for others. This occurs frequently in the brokerage business.

There is an exception to the general rule that an insurance broker represents the client. This occurs when an insurer gives a policy to a broker for delivery to an insured. During the delivery process, the broker becomes the agent of the insurer. Should collection of premium be involved, payment to the broker would be considered as payment to the insurance company.

A Broker's Responsibilities to the Insurer

The insurance broker represents the buyer of insurance in most parts of the insurance transaction and, therefore, owes all of the duties of an agency relationship to the client. However, even though a broker technically represents the clients, the ethical and fiduciary standards that apply to an agent also apply to a broker.

For example, a broker has the duty to fully disclose all information that he or she has regarding an application for insurance. A broker is charged with carrying out his or her actions with utmost skill and care. A broker should seek quality business and provide prompt, exacting service. A broker must complete fairly and ethically, relying on his or her abilities, and not operate at the expense of other agents.

Actually, it makes little difference whether an individual represents one insurer or works with a number of insurers; the ethics and fiduciary standards are virtually identical.

Ethics Responsibilities to Policyowners

Some people believe that an insurance agent's greatest single obligation is to his or her policyowners. Yet, if you are an agent of the insurer, how can this be? How can an insurance sales representative serve the best interests of both the insurer and policyowner? The answer lies in knowing that these interests are not really in conflict. By promoting the concepts that insurers stand for and by selling the appropriate products in the appropriate situations, in a competent, professional manner, the agent meets the needs of both the insurer and the insured. In this section, we discuss how agents can fulfill their ethical responsibilities to policyowners through needs selling and quality service.

Selling to Needs

Before an individual becomes a policyowner, he or she is a prospect. The transition from prospect to policyowner—and ultimately from policyowner to client—comes about when an agent follows two basic rules:

1. Sell to needs.
2. Service the sale.

In doing so, the agent will also live up to the ethical duties that he or she has to policyowners.

An insurance agent has one principal reason for calling on a prospect: to offer a product or service that will benefit the prospect in some way. An agent must sell the kinds of policies that will best fit the prospect's needs and in amounts that he or she can afford to pay. No one profits—not the insurer, not the agent, and especially not the policyowner—if an individual is coerced or misled into buying too much insurance or purchasing coverage that doesn't suit specific needs.

Fortunately, most agents recognize that selling to fit needs is the best approach to the products and services that they represent. They know that specific types of insurance policies are designed to meet specific needs and that matching policies to needs produces the maximum effect, to the benefit of the policyowner. They also know that needs selling involves problem analysis, action planning, product

recommendation, and plan implementation. This requires two important commitments on the agents part:

1. A commitment to obtain and maintain the knowledge and skills necessary to carry out those tasks; and
2. A commitment to educating the prospect or client about the products and plans that may be implemented.

Commitment to Knowledge and Skills

The relationship between the professional insurance agent and the policyowner is usually built upon the policyowner's trust in the agent's knowledge and skills. The policyowner must rely on the agent to provide informed options and trusts that the recommendations for insurance are in the client's best interest.

An agent thus has an obligation to ensure that this trust is justified. This means that an agent has the ethical responsibility to obtain the necessary knowledge and skills needed to evaluate and service the insurance needs of clients. Indeed, the term "professional" implies knowledge and skill. If the agent feels that he or she is not properly trained to perform the needed service, then another professional should be called in to assist.

An agent must also keep his or her base of knowledge and skills current. To this end, the agent must be committed to a program of continuing education. He or she must also stay informed of the latest developments affecting a client's interests. In recent years, there has been an increasing trend toward insurance professionalism. Agents should be competent professionals with a high degree of technical knowledge so that they can match a prospect's need with the appropriate solution.

Commitment to Educating the Client

Client trust must be earned, nurtured, and constantly reinforced. The agent who remembers this basic rule is the agent who communicates to his or her client the reasons why a particular insurance policy or program is being recommended and how it will serve the client.

Individuals who understand what a particular insurance plan or policy will do for them are more likely to buy, more likely to be satisfied with their insurance, and more likely to keep their business on the books. This communication and education continues long after the particular policy or program is sold and becomes part of the overall insurance program designed for that client. As noted earlier, the professional agent has established his or her client's insurance program based on needs. These needs should be reviewed annually, supported by explanation and communication of the programs put in place to meet those needs.

Service the Sale

Selling to needs is only part of what an agent must do to meet the ethical responsibilities that he or she owes to a policyholder. Service -- during and after the sale -- is just as important. Quality and productivity experts such as W. Edwards Deming and Joseph M. Juran see service as a process in which the

customer's wants and needs are anticipated and then satisfied. Most companies today are committed to giving their customers quality service.

In fact, the quality of a company's level of service is perceived as the most important single factor affecting a business unit's performance in the long run. Since 1972, the Strategic Planning Institute (SPI) of Cambridge, Massachusetts, has collected data to determine what corporate strategies influence performance. SPI's studies consistently show that successful companies stress quality service over their competitors.

What Role Does Ethics Play When it Comes to Service?

Perhaps one of the most important aspects of business ethics is that the characteristics one associates with an ethical person — fairness, honesty, and personal responsiveness — affects the level of service that a company provides. For example, an insurance agent who doesn't promptly return a client's telephone calls or procrastinates in giving a client important information about a policy will only hurt his or her reputation as a responsible professional. Therefore, treating clients with ethical principles will result in a high level of quality service.

Keep in mind that the term "service" means many things, and no two people would define all that it entails in precisely the same manner. However, for the purpose of this discussion, we will cover the elements of service in the context of ethical selling and professional responsibility. Thus, we will define "service" to mean:

- Educating the client before, during, and after the sale;
- Ensuring that the client fully understands the application and underwriting processes, the policy purchased, and any attached riders;
- Treating with confidentiality the client's financial and personal affairs;
- Disclosing all information needed by the policyholder or applicant so that he or she can make an informed decision; and
- Showing loyalty to the client, which includes providing the full range of services offered by the insurer.

Service Begins with the Application

In securing coverage for your client, your main responsibility as an agent is to act reasonably under the circumstances. This means that you must also adhere to your ethical responsibilities to the insurer and see that the prospect completes the application accurately and completely.

At this point, your primary responsibility is to the insurer because you are acting as its agent during the application process. Remember that the insurer is relying upon you for full disclosure of all pertinent information regarding the applicant. However, you also have an ethical responsibility to educate your prospective insured to make sure that he or she fully understands the nature of the application process:

- Why the information is required;
- How it will be evaluated;
- The need for accuracy and honesty in answering all questions; and
- The meaning of terms such as "waiver of premium", "automatic premium loan", "nonforfeiture options", and "conditional receipt."

The Conditional Receipt

Because the conditional receipt is occasionally a source of misunderstanding with applicants, let's clarify what is and how insurance agents should explain it.

A conditional receipt is normally given when the applicant pays the initial premium at the time the application for a policy is signed. This means that the applicant and the company have formed what might be called a "conditional contract," one contingent upon conditions that existed at the time of application or when a later medical examination is completed. In other words, a conditional receipt provides that the applicant is covered immediately from the date of application, as long as he or she passes the insurer's underwriting requirements. If a medical examination or blood profile is subsequently required, the date of coverage begins once the applicant passes the medical examination.

This information regarding the conditional receipt should be made clear to the applicant. Many applicants accustomed to homeowners or automobile insurance —where coverage is available immediately upon issuance of the binding receipt—assume that their life insurance coverage is also effective upon submitting the application and premium. It is your ethical responsibility to explain that the applicant is covered on the condition that he or she proves to be insurable and passes the medical exam, if required.

Explaining the Underwriting Process

Another ethical responsibility that you owe your applicant is to briefly explain the underwriting process that the application will undergo. Although many insurance policies are issued on the basis of the application alone, others require additional information. No prospect should ever be surprised that he or she could be subjected to further underwriting. Therefore, the explanation of the underwriting process should include a description of the checks and balances that apply to underwriting a risk, such as the Medical Information Bureau, the inspection report, and the credit report.

The Medical Information Bureau (MIB)

The **Medical Information Bureau (MIB)** serves as a clearinghouse of medical information concerning applicants and helps to disclose cases where an applicant conceals or submits misleading medical information. A life underwriter can check the MIB for information on an applicant's past medical history. This possibility should be explained to your applicant when you ask for a signature on the MIB form.

The Inspection Report

An **inspection report** provides details on an applicant's lifestyle, finances, and exposure to abnormal hazards. An inspection report is usually ordered on applicants who apply for large amounts of insurance. It's conceivable that the prospects friends and/or employer may be contacted for purposes of an inspection report. The purpose of this report is to provide a picture of an applicant's general character and mode of living.

The Credit Report

A **credit report** is ordered when there is reason to question the applicants ability to pay the premiums and to determine whether he or she may be a poor credit risk. Applicants who have questionable credit ratings can cause an insurance company to lose money. Applicants with poor credit standing are likely to allow their policies to lapse within a short time, perhaps even before a second premium is paid. Again, the purpose of this report should be explained when you ask the applicant to sign the authorization form.

The Importance of the Application to the Applicant

All of the information submitted on an insurance application has a direct bearing on whether the policy will be issued as requested, whether the application will be rejected, or whether another policy will be offered by the insurer. An agent who knowingly or unknowingly fails to provide all the necessary information about a prospect is not serving anyone's best interest.

Consider, for example, that you visit a prospective client in his home. You ask if he has any dangerous hobbies, and he says that his most dangerous activity is serving as an armchair quarterback for his favorite football team. As your client is filling out the application, you notice a picture on the wall--your client with a group of five other people on a mountain hiking expedition. When you mention this, your client remarks that as a hobby, he is a mountain climber and leads people on tours up Mount Everest. This is definitely more dangerous than serving as an armchair quarterback.

Because you are afraid that your client will not be issued an affordable policy if this detail is mentioned, you advise him to omit it from the application. The policy is later issued, and all is well.

But, what happens if, a year later, the insured is killed in a mountain-climbing accident? It's quite likely that the insurer will contest or deny the claim, citing concealment. Rather than getting the policy proceeds, the family receives a return of premiums paid. What benefit did this policy provide? What kind of service did you render?

This example illustrates why precision and accuracy in completing the application are in the best interest of both the insurer and the prospective insured. It is vital that an agent understands this and explains the need for full disclosure to an applicant.

Confidentiality

In the course of qualifying a prospect, completing a financial questionnaire, analyzing needs, or working on an estate or business plan, insurance agents are privy to a client's personal and financial information. Ethics require that the agent respect the sensitive nature of this information and keep it confidential. Personal information about a client should never be released without proper approval from the client.

Full Disclosure to the Applicant

As has been emphasized throughout the text, insurance agents have a duty to fully disclose to the insurer all material facts concerning an applicant, policyowner, or situations involving both, to aid in any decision that the insurer has to make regarding a particular case. At the same time, an agent has the ethical responsibility of full disclosure to a prospect or client.

In this context, full disclosure means informing the prospect or client of all facts involving a specific policy or plan, so an informed decision can be made. Full disclosure allows the insurance agent to help the client:

- Select the most appropriate policy to meet his or her needs;
- Understand the basic features of life insurance; and
- Evaluate the relative costs of similar plans offered by a competitor.

To assist agents with disclosure, there are published documents available to help the consumer understand the intricacies of a life insurance policy. Many agents use the forms not only as an educational tool, but also to help them in their sales presentations. These forms include the NAIC Buyers Guide and Policy Summary.

The NAIC Buyer's Guide

The Buyers Guide was developed by the National Association of Insurance Commissioners (NAIC) as an aid to consumers who are contemplating the purchase of life insurance. Most states require that agents make the Buyers Guide (or similar document) available when they solicit insurance sales. This guide explains life insurance in a way that the average consumer can understand. It speaks of the concept in general and does not address the specific product or policy being considered. Included in the Buyers Guide is an explanation of the surrender cost indexes used in the Policy Summary.

The Policy Summary

The Policy Summary includes two types of cost indexes:

1. The life insurance surrender cost index; and
2. The life insurance net payment cost index.

The surrender cost index is useful to applicants who want to compare the death benefits of policies.

The Buyer's Guide and Policy Summary are especially helpful to agents who want to explain the features and benefits of the life insurance policy that they are presenting. These forms also provided needed guidelines for the comparison of two or more policies.

Keeping the Applicant Informed

The underwriting process for an insurance application can be time-consuming. Most insurance companies strive to complete the process within a 21-day period, assuming that there are no delays. Delays can occur whenever an underwriter needs additional information from the applicant and relays that request through the agent, or when a counteroffer, different policy, or different rate is made to the applicant (again through the agent).

An agent's ethical responsibilities to his or her client during the underwriting process center around promptness and policy delivery.

Promptness

An insurance agent needs to ensure that there are no unnecessary delays in the underwriting process. This does not mean that the agent has to rush from an applicant's home to the nearest post office to mail an application. It does mean, however, checking the application for accuracy and giving careful thought to it before the application is actually submitted. Many underwriting delays occur simply because the application is not complete or is not clear.

Applications should be submitted as soon as possible. The time frame will vary, of course, depending on the plan of insurance and the complexity of the case. An agent must take these factors into account to act in an efficient manner. If it appears that the underwriting process may take longer than anticipated, the agent should notify the applicant of the delay.

Policy Delivery

Most policies are issued as applied for. In such cases, the agent owes his or her new policyowner prompt delivery of the policy and a review of its features and benefits. Not only does this help solidify the sale, it also represents a step toward making the policyowner a lasting client.

On the other hand, some policies will be rated or rejected. When this happens, the agent has two responsibilities:

1. He or she personally reviews the rating or rejection. Was it medical? Was there an unfavorable medical report? Was something overlooked or not made known to the underwriter? Should additional information be submitted? Is the rating or rejection proper? Should the application be reconsidered? In any event, the agent should have as much information as possible and be able to explain the rating or rejection to the applicant.
2. Assuming that the rating or rejection was valid, the agent has the responsibility to notify the applicant promptly. To withhold this information is a breach of ethics and could actually harm the applicant and his or her family.

Special Situations

In most cases, an insurance agent needs only common sense to avoid an unethical situation with a policyholder. However, there are some specialized areas where the agents ethical conduct is specifically detailed.

These specific ethical responsibilities are spelled out for agents active in estate and professional business planning. In these areas, the ethical guidelines are clearly defined by professional organizations chartered to monitor the activities of their practitioners.

Estate or Business Planning Insurance

An insurance agent who works in estate or business planning knows that the valuable plans and programs that he or she helps implement for a client are often the result of a joint effort with other professionals, such as attorneys and

accountants. Typically, an insurance agent is the catalyst who, through analysis and planning, evaluates the client's needs, proposes a solution, and then brings together the professional estate or business planning team.

Unfortunately, the zealous activities of some agents have triggered serious disagreements with members of the legal profession. The American Bar Association has issued opinions regarding the ethical conduct of insurance agents and their advertising and sales presentations to prospects and clients in these areas.

The following is a summary of the American Bar Associations position regarding the legal role of an insurance agent:

Persons who are not lawyers can be active in areas of analysis of facts, the orderly arrangement of assets to provide for a client's needs while living, and for the economic needs of dependents after the clients death. Persons who are not lawyers may also provide general information as to the laws governing the disposition of these assets. Persons who are not lawyers but who do legal research, give specific legal advice, draft legal documents, or apply legal principles to a clients specific situation are engaged in the unauthorized practice of law. A producer should never dissuade a client from seeking the advice of legal counsel. It is improper for a producer to attempt to divert legal business from one attorney to another. A producer must never share or participate in an attorneys fee. A producer must not pay directly or indirectly any part of his or her commission to an attorney or any other person who is not a producer.

The professional insurance agent understands that each member of the estate or business planning team serves a specific function. The attorney drafts the documents necessary to accomplish the client's objectives and advises the client of any legal consequences, while the accountant determines the accounting and tax implications and procedures. On the other hand, the agent recommends specific insurance policies or plans in an appropriate amount and ensures that ownership and beneficiary designations conform to the legal agreements prepared by the attorney.

The insurance agent understands that his or her ability to help meet the client's objectives depends on the involvement of these other professionals and encourages their participation.

Once the policy is issued and an applicant becomes a policyowner and client, service becomes more than ethical responsibility -- service now forms the foundation in which the agent and client form a lasting relationship. All policyowners should receive periodic reviews to ensure that their insurance programs are in step with their plans and objectives. Service after the sale is more than a responsibility; it is part of a life insurance industry tradition. Agents through the years have helped build that tradition, and your future success as an agent depends on your continuing that tradition.

Ethical Responsibilities to the Public

The insurance professional has a great degree of control over the public's attitude toward insurance. This is because the agent initiates contact with a prospect,

determines a prospects need for insurance, recommends and implements an appropriate plan, and continues a long-term relationship with after-sale service.

Because the agent has significant contact with the public and represents a primary source of insurance information, public perceptions of the insurance industry can be severely damaged by unethical agents. The professional insurance agent has two ethical responsibilities to the public:

1. To inform the public about insurance with the highest level of professional integrity; and
2. To strive for an equally high level of professionalism in all public contacts to create and maintain a strong positive image of the industry.

Public Obligation

Insurance plays a major role in the lives of most people in the United States. Property insurance protects homes and businesses from losses resulting from fire and natural disasters. Liability coverage protects individuals from losses resulting from accidents. Medical insurance not only provides a cushion against economic disaster, but in many instances it also helps to speed recovery because the patient does not have to worry about paying the bills. Lastly, life insurance benefits and cash values represent a substantial part of the financial holding and retirement plans of many people.

Considering how important insurance is and how it benefits our lives, it's surprising how many people just do not understand even the fundamentals of insurance. Given that some consumers remain ignorant about insurance, it's possible for unscrupulous agents to take advantage of these people by inducing them to buy policies that are unnecessary or do not live up to the promised benefits.

Many consumers feel that insurance is one area in which a wrong purchase is easy to make. The terminology is confusing, and the conditions and exclusions seem complicated. Further, it may not always appear that the agent is working in the consumer's best interest.

To combat this perception, the professional insurance agent must offer the public an honest and fair explanation of the policies and services that he or she represents. In addition, the insurance agent has to be dedicated to the principle of needs selling.

This means that the agent must clearly explain policy features and benefits without misleading the consumer or misrepresenting the policy and its benefits. And the professional insurance agent must be ready to back up his or her promises with solid performance, and encourage other agents to do the same.

A View from the Top

In 1990, the Ethics Resource Center conducted a survey of key ethical issues in the American insurance industry. Participating in the survey were the chief executive officers of top property-casualty companies (in terms of premiums written) and the top life insurance companies (in terms of insurance issued). Each CEO was asked to rate the key ethical issues facing their particular industry. In

this "view from the top," these executives indicated that two of the most significant ethics problems are deceptive use of advertising material and deceptive sales presentations, both of which do great damage to the public's perception of the insurance industry.

Deceptive Use of Advertising Material

There are two indisputable facts about insurance and the buying public:

1. The average insurance buyer knows very little about insurance and relies on the advice and recommendations of the insurance agent; and
2. By the time a consumer finds that a particular policy does not meet his or her needs or does not live up to the agent's promises, it may be too late to purchase another policy.

The potential for deceptive advertising or promotion by companies and agents alike is significant, and the consequences to the consumer can be quite grave. Accordingly, all states have enacted laws regulating insurance advertising. The basis for many of these state statutes is the NAIC's model Unfair Trade Practices Act, which expressly cites false advertising as an unfair trade practice and prohibits it. In this context, the term "advertising" is quite broad. It includes print and radio material, descriptive literature, sales aids, slide shows, prepared group talks, brochures, sales illustrations, policy illustrations, and TV commercials—in short, almost any kind of communication or presentation used to promote the sale of an insurance policy.

The purpose of the NAIC model act is to establish guidelines to ensure that insurance companies and their agents promote their products properly and accurately, without exaggerating the benefits or minimizing the drawbacks. For example, the act forbids any misrepresentations of the benefits, terms, conditions, or features of any insurance policy, including dividends. The act also bars any misrepresentation of an insurer's financial condition or its legal reserve system, and it prohibits names or titles of insurance that do not represent their true character.

Some states have enacted regulations that separately address life insurance and health insurance advertising. Life insurance advertising, for instance, cannot use the terms "investment", "savings", or "profit" in a misleading way. Health insurance advertising must disclose provisions regarding renewability, cancellability, termination, or modification of benefits.

Generally speaking, the burden of complying with state insurance advertising law rests on insurance companies because most advertisements or promotional pieces, regardless of the writer or presenter, are considered to be the responsibility of the insurer whose policies are being advertised. In practice, most of the advertising and sales literature that an agent uses is prepared by the insurer under the careful eye of its legal staff. For an agent, then, the ethical issue isn't necessarily the material itself but instead how the material is used -- and the deceptive sales presentation that may result.

Deceptive Sales Presentations

Deceptive sales presentations have probably generated more complaints of unethical agent behavior than any other activity. In addition to the life insurance CEOs in the United States, concern over this activity is shared by the National Association of Life Underwriters (NALU) and the American Society of CLU & ChFC, as well as by the Independent Insurance Agents of America. The topic has also been addressed by the U.S. Congress in committees studying insurance company activity.

What constitutes a deceptive sale? Any presentation that gives a prospect or client the wrong impression about any aspect of an insurance policy or plan is deceptive. Any presentation that does not provide complete disclosure to a prospect or client is deceptive. Any presentation that includes misleading or inconclusive product comparisons is deceptive. Even if the deception is unintentional, the agent has done the consumer a great disservice.

Deceptive sales presentations can be blatant. For example, a comparison of a term policy and a whole life policy based only on premium rates is obviously misleading and incomplete. Yet, deception does not have to be so apparent to be unethical. What about describing a personal life insurance policy as a "tax shelter" but failing to mention that premiums are not deductible and that surrendered cash values may be subject to tax? What about recommending a certain kind of health policy without explaining the conditions under which it could be canceled or the premiums increased? While any of these ploys might help make the sale, they are all misleading and unethical.

Policy Illustrations

Of all the companies surrounding the marketing and the sales of life insurance, none resonate so loudly as those over the use -- and misuse -- of policy illustrations. As insurance policies changed over the years, with the emphasis on the growth, return, and investment aspects of permanent plans; the "unbundling" of a policy's accumulation and protection elements; and the flexibility of premium payments, insurers and agents discovered that one of the best ways to demonstrate the complex mechanics of a policy was through the use of the computerized policy illustration.

Unfortunately, these illustrations have also been used to "predict" a policy's potential and its future performance based on assumptions that may or may not be realized. Vanishing premiums, huge cash values, in-force lifetime benefits -- all of these things have been extolled to sell a life insurance policy, without the explanation that they are based on nonguaranteed numbers projected into the future. What did not accompany these illustrations was an understanding on the part of the consumer that the values they were being shown would materialize only if the underlying assumptions came true.

Along with the changing dimensions and features of today's life insurance products comes a subtle shift in risk back to the buyer. The more flexible the policy, the more aggressive the assumptions and the more sensitive the product will be to changes in mortality, expense, and interest rates. However, this fact has been buried, ignored, or glossed over — intentionally and unintentionally — in too many sales presentations. Current and illustrative values have been spotlighted, and guaranteed values have been pushed backstage. In many sales situations, the

policy illustration became the focus of the presentation (i.e., the illustration became the product).

The consequences of illustration-based selling became apparent in the early 1990s. Individuals who purchased life insurance policies in the mid-1980s (when interest rates were high) with the expectation that they would pay premiums for only seven or eight years found out that their policy's accumulated values were sufficient to "vanish" but were charged against the policy's value. Others who bought plans with the idea that premiums of a few hundred dollars a year would produce values of a million dollars by the time they were ready to retire discovered that they were far from their goals.

The experiences described above gave momentum to the charge that the misuse of policy illustrations has created a "crisis" situation in the insurance industry. Consumer groups, politicians, and journalists have declared that life insurance buyers are being misled by many in the insurance industry who abuse the use of policy illustrations and don't distinguish between values and benefits that are guaranteed and those that are not. For some agents and some companies, the allegations have led to lawsuits.

The problems associated with policy illustrations have compelled the industry to respond. Insurance companies are redesigning their disclosures to promote better understanding by consumers as to policy pricing, company and product performance, and illustration assumptions. They're instructing their agents to show illustrations based on a variety of assumptions, not merely those in which current assumptions prevail against the guarantees. However, perhaps the most significant initiatives, given their combined impact and reach, come from the NAIC and the American Society of CLU & ChFC. The NAIC has draft model legislation on policy illustrations, and the American Society has developed an illustration questionnaire to help agents understand the assumption that is used to design and create sales illustrations.

The Role of Ethics

The term "professional status" implies long-term success, and with good reason. The qualities that make you a professional will also make you successful in your career over the long run.

The following are qualities of a successful professional:

- Performance of an essential service to society;
- Command of specialized knowledge;
- Possession of a tolerant attitude toward competition; and
- Adherence to high ethical standards.

Let's look at each of these qualities.

Essential Service

Our society depends on insurance increasingly as a means of protection from financial disaster. Life insurance purchases continue to increase each year. There is a growing concern over health insurance coverage. Property insurance coverage forms part of every mortgage contract, lease agreement, and is often

found in construction, service, and maintenance agreements. In some cases, Casualty coverages, such as auto liability and workers compensation, are required by law.

Insurance is an essential service in our society, and insurance professionals are instrumental in causing one or more of the following to happen, now or at some point in the future:

1. A policyholder dies, and his or her survivors are able to remain financially comfortable in their own home because life insurance provided the funds that were needed for both mortgage liquidation and living expenses.
2. A couple enjoys a worry-free retirement because a fund begun years before by a timely life insurance policy or annuity made the money available at the right time.
3. A young person is able to attend college or vocational school because someone made the timely purchase of a policy designed to provide the necessary funding in the event of the premature death of the family provider.
4. The physical assets of a business are destroyed by fire or other peril but are quickly replaced, and people are soon put back to work earning their incomes because insurance against the occurrence of the event had been secured.
5. The financial ruin of a policyowner following an automobile accident for which he or she may have had some legal responsibility is averted because he or she had adequate insurance to cover such occurrences.

Specialized Knowledge

The insurance professional must have a thorough understanding of how the product works and how it meets the needs of the public. Agents must be able to analyze needs and recommend proper solutions. They must also be able to motivate people to take action. Home office personnel need to know how companies operate and how to provide necessary support to agents, policyowners, and management. Claims representatives need to understand the obligations of the parties to the insurance contract, as well as how to deal with people.

Tolerant Attitude Toward Competition

Agents should avoid criticizing other agents; such activity is detrimental to everyone in the business. Any criticism of other companies' policies should be avoided. An incomplete comparison is misleading and harmful to the public, and it can even result in the revocation of the license of the guilty party.

If you are asked to evaluate an insurance company's reputation, you should refer your questioners to one of the widely-respected insurance company rating systems. These evaluate each insurance company's financial status and look at reserves, underwriting, investments, and management, and rate the companies accordingly. Some of the most widely-known and respected are AM Best Company, Standards and Poor's, and Weiss Rating, Inc.

In addition, some situations, such as the handling of death claims or a national disaster, call for insurance professionals to lay aside all thoughts of competition and join hands to provide the best possible service for the people involved.

High Ethical Standards

The most distinguishing characteristic of a professional is an adherence to high ethical standards. There are minimum legal standards that must be complied with in order to engage in the insurance business. However, professionalism implies more than just meeting these minimum standards. To be a professional, you must put your client's interest ahead of your own. Taking ethical shortcuts will impair not only your status as a professional but also your long-term success. In perhaps no other industry is the element of trust more important than in the insurance business. In the Journal of Insurance Regulation, "Ethics and Compliance in the Business of Life Industry: Reflections of an Ethicists," author Ronald Duska has this to say:

Massive changes in the insurance industry are encouraging enlightened leaders, particularly those in the compliance field, to become more ethically attuned to the needs of clients, agents, and other stakeholders. Compliance officers need to convey that their office does more than worry about the law, but rather is seen as driven by the overriding ethical concern for the good of the customer. An ethical perspective must overlay the compliance perspective, addressing three basic rules: fulfilling ones responsibilities, being fair, and doing no unnecessary harm. Attitudes reflected in the statements "If it's legal, it's moral" and "You can't legislate morality" mitigate against this goal, and reflect outmoded ways of thinking. To advance the theme that "Good ethics is good business," compliance officers can use reward systems, behavioral controls (external force), and ethical attitudes, reflected in the Golden Rule, "Do unto others as you would have them do unto you."

People like to do business with people you trust. Trust is built by ethical behavior. When people find a business person who has high ethical behavior, when people find a business person who has high ethical standards, they tend to do more business with that person. On the other hand, when they observe a business person acting unethically, they'll be reluctant to do more business with that person.

How to Incorporate Ethical Values in Life

While properly defining professionalism requires accuracy, everyone agrees that a high ethical standard is an integral part of the definition. What is required in order to live a more ethical life and develop a more ethically-based career?

Experts agree there are three fundamental elements:

1. Commitment: The desire to do the right thing;
2. Sensitivity: An awareness of the ethical implications of situations that you face; and
3. Ethical Competency: Applying a decision-making process that has ethical principles as its foundation.

While some people are committed to doing the right thing, others are committed to maximizing their income, increasing their pleasure, or avoiding difficult situations. There is often a price to pay for doing the right thing, especially in the short term. Leading an ethical lifestyle requires a strong commitment to doing the right thing

Every day, most of us walk past opportunities to improve the quality of our own lives and those of others with whom we come in contact. We often respond to situations automatically, the way we always have, or the way we see others respond. We fail to recognize the opportunities to "take the high road."

We all need help in leading a more ethical life. If we are to build a quality life, we need some guidelines and practice in doing the right thing. That said, rules of thumb are not enough in a difficult ethical dilemma.

Major Themes in Ethical Philosophy

Philosophers consider ethics to be the science of conduct -- the fundamental ground rules by which all people live their lives. Philosophers have been discussing ethics for at least 2,500 years, since the time of Socrates and Plato. Many ethicists consider emerging ethical beliefs to be state-of-the-art legal matters. What becomes an ethical guideline today is often translated into a law, regulation, or rule tomorrow.

The following major themes run through all ethical philosophies. By reviewing these four themes, we soon realize that there may be another perspective to any position.

1. Concern for Self versus Concern for Others
2. Intuition versus Rationalism
3. Religious Teaching versus Individual Authority
4. Absolutism versus Relativism

Because people have different belief systems, none of us is in the position to judge another's motives. Some people take others into consideration when making decisions, believing that the decision should reflect the greatest good for the greatest number of people. Other people make their decisions based purely on their own happiness, welfare, or enjoyment. Their philosophy is "You take care of yourself, and I will take care of myself."

Some people adhere to religious doctrines that present what is right and what is wrong. They reference holy writings, revelations, or tradition to establish good behavior. According to that religion, each person should attempt to follow those traditions. Other thinkers, like Jean Paul Sartre (1905-1980), believe that there are no absolute values, that each person creates his or her own values and projects them onto the world.

Some people believe that certain actions are always right or good, without exception. Other people hold that "goodness" or "rightness" of actions depends on the circumstances.

The Challenges in Ethics

Sometimes taking the most ethical path means that you will lose something else that is important to you. If we are to live an ethically-based life, we must be willing to lose for the right reasons. The probability of losing is a test of your ethical courage. The willingness to lose for the right reasons is the price you pay factor (PTP Factor) for leading an ethically-based life. People in positions of power, motivated to "win at all costs," often have great difficulty with this challenge.

There is often a price to pay for leading a more ethically-based life; fortunately, in the long run, the rewards are also greater.

Is a Code of Ethics Effective?

Many people believe that codes of ethics, or lists of ethical values to which the organization aspires, are rather superfluous because they represent values to which everyone should naturally aspire. However, the value of a code of ethics to an organization is its priority and focus regarding certain ethical values in that workplace.

For example, it is obvious that it is desirable for all people to be honest. However, if an organization is struggling around continuing occasions of deceit in its industry, placing a priority on honesty is very timely, and honesty should be listed in that organization's code of ethics.

A code of ethics is an organic instrument, so it often changes with the needs of society and the organization.

Ethics vs. Values

Ethics is the rightness of what you do. Values are what you believe in—what you hold important. Values that represent how an individual should behave are considered to be moral values, such as respect, honesty, fairness, and responsibility. Statements around how these values are applied are sometimes called moral or ethical principles.

Many people do not realize the connection between values and ethics. They live each day without recognizing the cumulative impact of their individual actions. Leading an ethical life requires that we establish our values carefully and then work every day to live up to those values.

Core Ethical Principles

We build more a principled life with the small choices that we make each day. If we are to lead more ethically-based lives, we must all develop the ability to recognize ethical considerations. We must all become better at recognizing these opportunities to elevate our existence.

These core ethical values can serve as a tool to identify ethical considerations. Whenever honesty, integrity, promise-keeping, fidelity, loyalty, fairness, caring, compassion, respect for others, and personal responsibility come into play, it always involves the consideration of ethics.

Ethical decision-making is a process of evaluating and choosing among alternatives. The goal is to eliminate unethical options and select the best ethical alternative. To consistently make ethical decisions, one must accomplish two fundamental things:

1. Evaluate alternative courses of conduct on the basis of core ethical principles; and
2. Choose the action that best advances those principles.

There are many definitions of ethics, but it is generally accepted that any definition would include the following core ethical values, and the long-term commitment to their implementation:

1. **Honesty:** Is truthful, straightforward, sincere, and candid. It is not deceptive, tricky, or misleading.
2. **Integrity:** Is honorable. It has courage of conviction; it stands up for beliefs and puts principle over expediency. It is not hypocritical, weak, or dishonorable.
3. **Promise-keeping:** Always strives to keep commitments.
4. **Fidelity/Loyalty:** Commits to being reliable and dependable.
5. **Fairness:** Strives to be equitable, open, just, and unprejudiced. It does not discriminate on an improper basis. It is not arbitrary or self-serving.
6. **Caring/Compassion:** Is considerate, kind, sharing, and charitable. It is not selfish, manipulative, or controlling.
7. **Respects for Others:** Respects freedom, dignity, and rights of others.
8. **Personal Responsibility:** Considers consequences and accepts responsibility for actions and inaction. It doesn't shift blame or make excuses.

Rationalization as a Tool

There are a variety of reasons why we do not take the actions necessary to earn the high ethical ratings that we give ourselves. To make ourselves more comfortable with our actions, we often revert to rationalizations. Have you ever heard yourself say any of the following?

- "I'm simply fighting fire with fire."
- "If it is legal, it must be okay."
- "I was just doing it for you."
- "We all do it; it's just how you play the game."
- "If it doesn't hurt anyone, it's okay."
- "It's necessary to get the order."
- "Business is business. I'll be as ethical as the competition allows."
- "I deserve it: I have it coming."

Rationalizations make it easier to live with ourselves when we do the things that we want to do, rather than the things that we know we should be doing.

The Bottom Line

History is made and lives are changed not by those who follow the crowd, but by those who are prepared to take the ultimate risk and stand up for what is right.

It is always a challenge to do the right thing in a competitive environment. But each time we make a decision to stand for what is right, even if it costs us something, we reinforce our own moral character and influence others.

We do not develop that ability overnight. It is developed in small steps as we do the right thing each day. Unfortunately, many of us do not even recognize the opportunities that exist.

There are four basic principles of a highly-ethical individual:

1. The individual is at ease when interacting with diverse customers.
2. The individual is obsessed with fairness. The individual's ground rules emphasize that the other person's interests count as much as his/her own.
3. The individual assumes personal responsibility for his/her actions, and he/she is responsible for himself/herself first and then to his/her organization.

4. The individual sees his/her activities in terms of purpose. This method of viewing an individual's activities is highly valued by the members of the industry or organization. Purpose ties the individual to the organization--and the organization to the environment.

The following are characteristics of a highly-ethical organization or industry:

1. There exists a clear vision and picture of integrity throughout the industry.
2. The vision is owned and embodied by top management in the industry, over time.
3. The reward system is aligned with the vision of integrity.
4. Policies and practices of the industry are aligned with the vision; no mixed messages.
5. It is understood that every significant decision has ethical value dimensions.
6. Everyone in the industry is expected to work through conflicting value perspectives.

The Benefit of Applying Ethics

There are many obvious moral benefits to adhering to ethical standards, but there are other benefits of ensuring that ethics are followed in the industry and in the workplace:

Attention to business ethics has substantially improved society.

A number of decades ago, children in our country worked 16-hour days. Workers limbs were literally torn off, and disabled workers were condemned to poverty and often starvation. Conglomerates controlled some markets to ensure that prices were fixed and small businesses were choked out. Price-fixing crippled normal market forces. Employees were terminated based upon personalities. Influence was applied through intimidation and harassment.

Then society reacted and demanded that businesses place a higher value on fairness and equal rights. Antitrust laws were instituted. Government agencies were established. Unions were organized. Laws and regulations were established. Ethics programs help to maintain a moral course in turbulent times.

Attention to business ethics is critical during times of fundamental change. At such times, there is often no clear moral compass to guide leaders through complex conflicts about what is right or wrong.

Continuing attention to ethics in the workplace sensitizes leaders and staff to acting consistently.

Ethical standards support individual growth.

Attention to ethics in the industry helps an agent to face realities -- both good and bad -- in the industry and within himself. In this regard, an agent may feel full of confidence and can admit and deal with whatever comes his way.

Ethics programs are a form of insurance; they help to ensure that policies and practices are legal and can stand the test of public or shareholder scrutiny.

There are an increasing number of lawsuits in regard to the effects of products and services on the consumer. Attention to ethics ensures highly ethical policies

and procedures in the workplace. Analysts believe that it is far better to incur the cost of mechanisms to ensure ethical practices now, rather than to incur the costs of litigation later.

Ethical standards help to avoid criminal acts of omission and can lower fines.

Ethics standards, such as an insurance agents code of ethics, tend to detect ethical issues and violations early on, so they can be addressed. In some cases, when an organization is aware of an actual or potential violation and does not report it to the appropriate authorities, it can be considered a criminal act.

Ethical guidelines adopted on an industry-wide basis potentially decrease fines if an organization or individual has clearly made an effort to operate ethically.

Ethical standards help to manage values.

Ethics programs identify preferred values and ensure that the individuals behavior is aligned with those values. This effort includes recording the values, developing policies and procedures to align behavior with preferred standards, and then training personnel about the policies and procedures. Ethical standards are highly useful for managing strategies, such as expanding market shares, reducing costs, and managing diversity.

Ethical standards promote a strong public image.

Attention to ethics is also a strong public relations tool. Admittedly, managing ethics should not be done primarily to enhance public relations. But the fact that an organization regularly gives attention to ethics can portray a strong, positive image to the public.

People see those organizations as valuing people more than profit, as striving to operate with the utmost integrity and honor. Aligning behavior with values is critical to effective marketing and public relations programs.

Here's the bottom line: Applying ethical standards legitimizes managerial actions, strengthens the coherence and balance of the industry, improves trust in the relationship between individuals and groups, and supports greater consistency in the standards and qualities of products.

Ethics and its Fundamentals

Ethics is defined as principles of moral conduct. For the insurance industry, as in many others, the basis of a business relationship is the ethical dispensation of the terms of the contract. In view of the special **agent-client relationship**, the following aspects of ethics are the following:

- Honesty
- Integrity
- Fairness
- Fidelity and loyalty
- Compassion
- Personal responsibility and accountability

Where there are moral considerations for employing the highest ethical standards in business dealings, there are also other considerations that reflect on the well-being and reputation of the agent. A few of them are itemized as follows:

- Social responsibility towards the community at large, including carriers
- Avoidance of public criticism. This has a direct bearing upon the volume and type of business that can be generated.
- Avoidance of government regulations.
- Minimization of errors and omissions exposures.

Legal Responsibility and its Basis

Ethical and professional responsibility is the basis for laws, and this creates the basis for legal responsibilities. Legal duties are based on the following:

- Peer Standards;
- Oral or written agreements; and
- Statutes.

Duties of an Agent to the Insurer

The legal duties of an agent, which are born out of ethical and professional responsibilities to his or her insurance company, follow the four segments as outlined below:

1. Act within authority
2. Provide full disclosure
3. Account for property and money
4. Follow instructions

Duties of an Agent to the Client

The following are the duties of an agent to his or her client:

- Provide adequate coverage.
- Provide proper legal notification.
- Place business on the best possible terms for the client.
- Investigate carrier stability.
- Give correct coverage options related to the insurance.
- Other—as determined by the courts

You might have a system of notifying direct-bill clients of cancellation notices for nonpayment of premiums. This is acceptable—but expensive—and may give rise to a potential E&O problem if the agency misses calling a customer. To safely cease this practice once it is established, notify all insureds that you will no longer be following up on cancellation notices for nonpayment of premium.

Agency Ethical Considerations

The following are an agency's ethical considerations:

1. Fiduciary duties;
2. Commingling of funds – trust account;
3. Payment and acceptance of commissions and fees;
4. Unfair claims practices;
5. Conflict of Interest; and
6. Unfair methods of competition and deceptive practices.

