Section 1: Umbrella Insurance

Chapter 1 Umbrella – Introduction

We've just spent a few sections discussing the Personal Umbrella policy, but we're about to go into greater detail as to what umbrella insurance is, who needs it and how risks are assessed.

Why would I need an umbrella insurance policy?
There are many situations where a standard liability policy is simply not enough coverage. An umbrella policy allows you to protect yourself against major lawsuits in two ways. First, the umbrella provides excess liability over underlying coverage. Second, the umbrella provides liability coverage that may be excluded by homeowners or auto policies.

Just what is a personal umbrella policy?
Often times referred to as a personal catastrophe policy, a personal umbrella policy supplements the basic personal liability coverage provided under homeowners' and auto policies. The umbrella was created to protect people from large losses.

What special protection is afforded by an umbrella policy?
Personal injury losses that may be limited or excluded under most homeowners' policies will receive broader coverage under an umbrella policy. As a rule, personal injury does not have a uniform definition. However, just about all umbrellas will refer to personal injury to include bodily injury. Most policies also include these in their definition of personal injury:

Mental anguish, false arrests, wrongful eviction, wrongful detention, malicious prosecution, invasion of privacy, assault and battery, slander, libel and defamation of character.

Are there differences in personal umbrella policies?
There is no standard personal umbrella policy. The insurance coverage, as well as the exclusions, will vary by company. It is important that you compare the costs against the coverage the policy provides. In some cases, it is more important to know what is excluded from coverage. Additionally, you need to know what coverage and limits are required on the underlying homeowners and auto policies.

Personal Umbrella Liability Insurance

A serious personal liability lawsuit can reach catastrophic levels. There have been judgments that do exceed the liability limits carried by the insured. Once these liability limits are exhausted, the insured is often forced to pay a substantial amount out of his pocket. Thus the need for protection against catastrophic lawsuits exists. Those that usually need this protection are these:

-Highly paid executives
-Physicians
-Surgeons
-Dentists
-Attorneys

Do not be mistaken in the assumption that only those listed above need this protection. Considering the increased frequency of liability lawsuits and the complexities of modern living, most people require this protection.

Nature of Personal Umbrella Liability Coverage
The umbrella package is designed to provide the insured with coverage in the event of

-A catastrophic claim
-A lawsuit
-A judgment

The amount of umbrella coverage can range from $1,000,000.00 to $10,000,000.00.

The contract usually covers the entire family worldwide. The umbrella typically covers liability losses associated with these:

-Home
-Automobile
-Boats
-Recreational Vehicles
-Sports
-Other Personal Activities

While it is true that an umbrella policy is not a standard contract, they do have some common features such as these:

-A self-insured retention must be met with certain losses covered by the umbrella policy but not covered by an underlying insurance.

-The umbrella policy provides excess coverage over basic underlying policies, such as personal auto, and homeowners' insurance.

-Coverage is broad and includes coverage for some losses not covered by underlying contracts.

Excess Liability Coverage
The umbrella policy pays only after the limits of the underlying policy are exhausted. Some umbrella policies require that the insured carry certain minimum amounts of liability on the basic underlying contracts. For example, on an automobile policy the minimum required on the basic contract could be:

-$100,000.00 per person bodily injury liability
-$300,000.00 per occurrence bodily injury liability
-$25,000.00 for property damage liability
-A combined single limit of $300,000.00

On a homeowner's policy the minimum required on the basic contract could be

-$100,000.00 of personal liability
-If a watercraft is involved, liability exposure requirements may be $500,000.00 of single limit underlying coverage

Broad Coverage

With respect to personal loss exposures, the personal umbrella policy provides broad coverage. The personal policy coverage also covers certain losses that the underlying contract may not cover after a self-insured retention of deductible is met.

These losses include:

-Personal injury
-Libel claims

-Slander
-Defamation of character
-False arrest
-False imprisonment
-Humiliation

Here are five examples of claims that may be paid by umbrella insurance companies:

-The insured slandered two police officers.

-The insured borrowed a tractor and damaged it. After a self-insured retention was met, the umbrella covered the loss.

-The mast on a rented boat broke during a race and seriously injured a crew member. Primary coverage was not available to the insured.

-The insured rents a car in England and is involved in a serious accident. The personal umbrella covers the loss since only limited underlying coverage was available.

-The insured's spouse rents a motorcycle and is involved in a serious accident. Since the underlying automobile/homeowner contracts do not cover the ensuing third-party claim, the umbrella pays.

Self-Insured Retention
When an umbrella policy, and not an underlying insurance policy, covers a loss, a self-insured retention or deductible must be met.

As you are certainly familiar with by now, a deductible is the amount the insured is responsible for paying before insurance benefits will pay out. For example, in an auto policy, the insured may be required to pay the first $500 of any repair costs before the insured's coverage will kick in – given, of course, that the damage was caused by a covered peril.

In an umbrella policy, as a rule this deductible is at least $250.00 per occurrence and can be higher. Per occurrence means the deductible must be met each time there is a loss.

Personal Umbrella Coverages

Personal Liability Injury
The insured's liability for personal injury is covered under the personal umbrella policy. Personal injury is defined to include the following:

-Bodily Injury
-Sickness
-Disease
-Disability
-Shock
-Mental Anguish
-Mental Injury

This definition can also include these:

-False Arrest
-False Imprisonment
-Wrongful Entry
-Wrongful Eviction
-Malicious Prosecution

-Humiliation
-Libel
-Slander
-Defamation of Character
-Invasion of Privacy
-Assault and Battery (not intentionally committed or directed by a covered person)

Property Damage Liability
Property damage can be defined as physical injury to tangible property and includes loss of use of the injured property.

The umbrella insurance company agrees to pay losses for which the insured is legally liable and which exceed the retained limit.

The retained limit is either one of these:

-The total of all applicable limits of all required underlying contracts and any other insurance available to a covered person
-The self-insured retention if the loss is not covered by the underlying insurance

Defense Costs
Typically, legal defense costs in addition to the policy limits are paid with the personal umbrella policy. Defense costs include these:

-Payment of attorney's fees
-Premiums on appeal bonds
-Court costs
-Interest on the judgment
-Legal costs

However, some personal umbrella policies will include the cost of defending the insured as part of the total loss. It is possible that in a catastrophic judgment the insured may have to absorb part of the loss. Most umbrella policies will provide and pay the legal defense costs of a covered loss if that loss is not covered by any underlying insurance.

Exclusions
Here are some of the more common exclusions found in personal umbrella policies:

Workers' Compensation: Any obligation the insured is legally liable for under workers' compensation, disability benefits, or similar law is not covered. This is very common of insurance policies, as they are not in the habit of covering losses that are already covered by a different policy. For example, an employer's group health plan will not pay medical costs associated with an employee's work-related injury since it is already covered by the employer's workers' compensation insurance. Remember, the purpose of insurance is to make the insured "whole" again. It is not intended to allow an insured to profit from the loss, such as being paid by two insurance companies for the same one loss.

Fellow Employee: Some personal umbrella contracts exclude coverage for any insured (other than the named insured) who injures a fellow employee in the course of employment arising out of the use of one of these:

-Automobile
-Watercraft
-Aircraft

Care, Custody or Control: Damage to property a covered person owns is excluded under all personal umbrella contracts. Most contracts also exclude damage to a non-owned aircraft and non-owned watercraft in the insured's possession. However, most umbrellas will cover damage to:

-Property rented to an insured
-Property used by an insured
-Property in the care of an insured

(Those above exclude aircraft and watercraft.)

Nuclear Energy: All personal umbrella policies have nuclear energy exclusion.

Intentional Acts: Any act directed by or committed by a covered person with the intent to cause personal injury or property damage will not be covered.

Aircraft: Any liability arising out of these will be excluded from coverage:

-Ownership
-Maintenance
-Use
-Loading
-Unloading an aircraft

Watercraft: Larger water-crafts are usually excluded such as the following:

-Inboard watercraft
-Inboard/outboard watercraft exceeding 50 horsepower
-Outboard motors of more than 25 horsepower
-Sailing vessels of more than 26 feet long

Business Pursuits: While liability arising out of business activity or business property is usually excluded, this exclusion does not apply to the insured's or a family member's use of a private automobile.

Professional Liability: While many insurance companies do not offer this coverage and virtually all umbrella policies exclude professional liability, some companies will cover certain professional liability loss with an endorsement and by charging a higher premium.

Officers and Directors: This exclusion does not apply to a non-profit corporation or organization. It does exclude coverage for an act or failure to act as

-An officer
-A trustee
-A director of a corporation or an association

Recreational Vehicles: Liability arising as a result of ownership and maintenance golf carts is excluded.

How the Policy Works

Generally, an umbrella policy pays all of the covered loss that exceeds the limits of the base or underlying policy.

If, for example, the basic policy paid $200,000 on a slip and fall injury and the claim was for $250,000, the umbrella would cover the $50,000 over the basic policy's $200,000 limit.

Deductibles
Usually umbrella liability policies have two types of deductibles. These are also referred to as retained limits. Depending on the loss, one of them pays first before the umbrella pays. If the loss is covered by the underlying policy, that policy pays first up to its maximum limit and then the umbrella policy kicks in. Another consideration is that a loss may occur and is covered by the personal umbrella but not by an underlying policy. In this case, the insured must meet a deductible that is referred as the SIR, which stands for Self-Insured Retention. For example, a $1 million umbrella usually has a $250 SIR that the insured must pay before the umbrella kicks in.

Other Exclusions
Typically, the umbrella policy will exclude losses that are better covered under other policies. Although there are differences, most umbrellas will not cover the following:

-Obligations under workers' compensation or similar laws. If a domestic employee is injured, coverage is afforded under workers' compensation and will not be duplicated under the umbrella policy.

-Damage to property owned by you. This precludes any coverage for property damage best insured under some form of property (homeowners') or inland marine (jewelry floater) insurance.

-Damage to property on which you have agreed to provide insurance. The intent is to prevent the insurance company from paying for a loss that should be insured under some form of property insurance, especially since the insured has agreed to provide coverage.

-Liability arising out of a business pursuit - unless it is covered by your homeowners' or auto insurance. If your homeowners' policy covers some business pursuits (i.e., an office at home), the umbrella will also extend coverage. Some policies also provide coverage to persons who are involved in civic activities, other than a person's regular employment, that may prompt lawsuits.

-Liability arising from your rendering (or failing to render) professional services. This typically excludes malpractice, which is better covered by malpractice insurance.

-Liability arising from the ownership, maintenance or use of any aircraft. Such potentially catastrophic losses are excluded.

-Liability arising from the ownership, maintenance or use of watercraft not covered under the homeowners' policy (subject to certain restrictions). The umbrella covers small boats that are typically afforded coverage under the homeowner's policy. However, large watercraft are excluded because of the increased liability risk.

-Liability covered by a nuclear energy policy. Nuclear energy policies contain a person's insured or "omnibus" clause that encompasses virtually everyone who may be responsible for a nuclear accident, barring only the U.S. government. If a person should become involved in a nuclear incident covered by a nuclear energy policy, such a person would be covered by that policy and would not need protection under the umbrella. Therefore, coverage is excluded under the personal umbrella policy.

The Process of Risk Management
Unfortunately, an unavoidable part of everyday life is risk. Different people handle risk in different ways. Usually past experience or personal experiences determine how you will respond to uncertainty. Before you can determine the best way to handle a risk, you must be able to identify risk probability and severity.

This is, referred to as risk management. It is the process of

-Determining what exposures to loss exist
-Determining the seriousness of exposures
-Developing a way of minimizing the effect of the loss exposure

The goal of risk management is to make the best possible arrangements ahead of time so that one will not be seriously financially affected when a loss occurs.

Risk management is intended to protect income and assets against unforeseen, unintended or accidental loss.

A risk manager follows these five basic steps in the risk management process:

-Identifying the loss
-Evaluating the exposure and eliminating the severity and frequency
-Selecting the most economical way of handling the risk
-Formulating a risk management plan
-Revising and monitoring the risk management plan

In the next sections, we'll discuss each of these in detail.

Five Basic Steps

As we discussed in the previous section, the goal of risk management is to make the best possible arrangements ahead of time so that one will not be seriously financially affected when a loss occurs. Risk management is intended to protect income and assets against unforeseen, unintended or accidental loss.

A risk manager follows these five basic steps in the risk management process:

-Identifying the loss
-Evaluating the exposure and eliminating the severity and frequency
-Selecting the most economical way of handling the risk
-Formulating a risk management plan
-Revising and monitoring the risk management plan

Identifying Loss Exposures

Before a person can "manage" risk, he or she must first identify all the possibilities of loss or the loss exposures to which he or she is subject and that can be guarded against in some way. The term loss exposure is used to describe the property or person facing a condition in which loss is possible and unpredictable. Potential property losses include direct and indirect losses. Potential liability losses are those associated with torts or, to a much lesser extent, breach of contract.

Property Loss Exposures

The individual risk manager begins the risk management process by compiling an inventory of all real and personal property that indicates the amount of property owned and its present value. Real property consists of land and, generally, whatever is erected or growing upon or affixed to it. The definition of real property included the earth's surface, the air above and the ground below, as well as all appurtenances to the land, including buildings, structures, fixtures, fences and improvements erected upon the land. Excluded are growing crops. The term also includes the interests, benefits and rights inherent in the ownership of real estate. Personal property consists of tangible, movable possessions and includes things such as furniture, jewelry, automobiles and recreational vehicles.

After the inventory is complete, the risk manager can identify the possible property loss exposures that should be addressed. The possible causes of property losses that should concern property owners are too numerous to list. However, two basic types of risk that may cause financial loss may classify these losses. These risks include the following:

-Direct physical damage to property caused by perils such as fire, wind, water and other perils that may damage or destroy the property

-Indirect loss that occurs following a direct loss to property by an insured peril and that included additional loss expenses for the extra cost of food, transportation and housing incurred by the insured.

Property may be damaged or destroyed by physical perils, such as fire, smoke, explosion, hail, etc. Deviations from expected individual conduct, such as theft, vandalism, or arson, may be termed social perils that cause property loss. Finally, certain economic perils, which occur less frequently, may result in property loss. For example, people protesting a factory layoff may cause damage to nearby property. Two or more perils, such as fire and vandalism, may be involved in a loss.

Liability Loss Exposures

The term liability may be used in a number of ways. Generally, the term is synonymous with moral or legal responsibility and involves the concept of facing a penalty when a particular responsibility is not met. In this text, we are primarily concerned with the term legal liability, which is defined as the condition of being bound in law to do (or not to do) something that may be enforced in the courts. The law does not recognize moral responsibility alone as legally enforceable, but people who do not meet their moral responsibility may also become legally obligated to pay for another's injuries.

Under our legal system, a person may be held responsible for causing injury to another person or damage to another's property. People are faced with the possibility of having to defend themselves against a lawsuit, even if the suit is groundless. The risk of being held financially responsible for judgments and legal defense and court costs, as well as the indirect expenditures of time, energy and money, is the greatest risk that most people face. Therefore, in addition to property loss exposures, risk managers must identify these two basic types of liability loss exposures:

-Casualty loss that results from perils such as robbery, burglary, vandalism or arson

-**Liability risk** where the law of negligence is used as the basis to determine whether an individual may be held responsible for the financial cost of other people's bodily injuries or for damage to their property

People may incur liability loss exposures in a number of ways. A person may be held legally responsible for injuries or damages that result from his or her ownership of an auto, recreational vehicle, watercraft or residence premises , from personal or business activities, from obligations assumed under a contract, from the employment of domestic workers, from libel, slander and other personal injury offenses, and from a number of other events.

Individuals may be held criminally or civilly liable, depending on the nature and form of their actions. Criminal liability is clearly established by statute or administrative rules. In a criminal action, a district attorney or attorney general of either the state or federal government initiates the criminal action against the accused wrongdoer. For example, a district attorney will file charges against an accused murderer. If the accused is convicted, the state or federal government imposes penalties.

On the other hand, civil liability is established by statutes, administrative rules and prior court

decisions that outline the rights of the parties as opposed to each other. One party normally brings a civil liability action against another party for the wrongs alleged. The litigants at their own expense bring these legal actions (with the court costs usually imposed on the losing party). The sources of civil liability are classified as those arising from the following:

-Contractual or similar agreements
-Torts, which are acts or omissions other than breach of contract
-Equitable actions such as fraud, errors or mistakes
-Actions that do not fall into the first three categories

Remedies based on contractual agreements and tort actions seek monetary damages: those based on equitable actions usually seek some other remedy, such as performance of a contract.

Evaluating Loss Exposures

In the second step of the risk management process, the risk manager must evaluate the loss exposures and decide which risks are intolerable, which are difficult to tolerate and which are tolerable. Intolerable risks are those that are so large that a loss from one might cause a person's bankruptcy. These risks typically include liability risk and the risk of the destruction of a home because of a natural disaster. Difficult to tolerate risks are those that would cause the individual a significant financial loss but that would not lead to bankruptcy.

An example would be the destruction of an automobile. Finally, tolerable risks include loss or damage to personal property that might be large but are not intolerable in terms of the individual finances. An example would be the replacement of a broken windshield.

Having identified the risks, the risk manager then estimates both the maximum possible loss and the maximum probable loss the property owner faces. These two estimates are useful in determining the best way or ways to handle a loss exposure. The maximum possible loss is the worst loss that could possibly happen, while the maximum probable loss is the worst loss that is likely to happen. For example, it is possible for a house located in Arizona to be completely destroyed by flood. However, it is unlikely that such a loss will occur. Therefore, if a house is not located in a flood area, it is usually unnecessary (and sometimes impossible) for the insured to purchase flood insurance.

After the risks have been classified in this way, the risk manager then evaluates the frequency and severity of each loss. Frequency is a measure of how often a particular event has occurred: severity is a measure of the damage caused by each incident. For example, counting the number of times a person's dog has bitten a neighbor is a frequency measurement, but calculating the medical and legal costs of those bites is a severity measurement. After this step has been completed, the risk manager can decide how to effectively deal with his or her property and liability loss exposures.

Handling Risk

The risk manager may select one or more risk management techniques to handle the risks he or she has identified.

These techniques include avoidance, retention, loss control, non-insurance transfer and insurance. When considering which of the risk management techniques to implement, the risk manager should remember these three general, practical rules of risk management:

-The size of the potential loss must relate favorably to the resources of the one who must bear the loss.
-The possible benefits of taking a risk must be reasonably related to the possible costs.
-The amount of potential loss can usually be reduced or prevented through effective loss control programs.

The risk manager must determine whether it is best to reduce, eliminate or transfer the risk. Let us look at how these general rules of risk management apply when selecting a risk management technique.

First, selecting a technique begins by using information gathered in the second step of the risk management process. The risk manager has approximated the total loss from one event or occurrence and has estimated how often a particular loss is likely to occur (loss frequency) and how much could be lost if a certain event should occur (loss severity). For example, if a homeowner is estimating the potential loss frequency and severity of a fire, the following losses are possible:

-Direct fire and smoke damage to the house and its contents

-Indirect damage in the form of burn injuries to a visitor in the house

-Damage to neighboring property if the fire spreads

-Loss of use of the property because the fire damage makes it necessary for the homeowner to move to another location, at least temporarily

The risk manager should determine the probability and possibility of each type of loss, as well as the loss frequency and severity of those losses.

Second, the risk manager must determine the amount of money that will be available to meet the potential loss. Obviously, this amount will vary widely by individual. To find out how much a person is worth in dollars and cents, he or she should complete a personal balance sheet. This is a financial inventory of all personal assets (that which is owned) and liabilities (that which is owed). The difference between assets and liabilities is a person's net worth.

The balance sheet provides people with a record of their financial progress and can help them with a future savings and investment program. By determining net worth on an annual or semiannual basis, people can see whether their net worth is increasing, decreasing or remaining the same, and if they are keeping pace with the rate of inflation. They can also determine what portion of their assets could easily be converted into cash if they experienced a property or liability loss and needed cash to pay for the loss.

Finally, the benefits and costs of any available alternative method of handling the risk in certain situations must be considered. In many cases, insurance is the answer. However, other risk management techniques, such as loss prevention or self-insurance, may also be viable options under various circumstances.

Implementing a Risk Management Plan

The fourth step of the risk management process is executing the plan that the risk manager has devised. Insurance coverage, which is the focal point of most individual plans, is usually purchased. The risk manager's objective is to purchase policies that will provide the most comprehensive coverage at the most reasonable cost. Insurance contracts will be one of these three types:

-**Primary** insurance required by law (e.g., automobile liability insurance) or by contract (e.g., homeowners' insurance required under a mortgage contract)

-**Desirable** insurance that provides protection against losses that could financially harm an individual but that would not completely destroy his or her savings (e.g., physical damage insurance protects against damage to the insured's auto)

-**Catastrophic** insurance that provides protection against losses that could financially destroy an individual (e.g., flood, earthquake and personal umbrella liability insurance provide protection against devastating losses)

The risk manager selects limits of liability that adequately cover the risk's probable maximum loss, as well as reasonable deductibles that help to reduce the annual premium for insurance coverage. Because some of the risks faced by the individual may not be insurable, these risks must be handled in some other way. For example, war risk is not covered by insurance so individuals must retain that risk. In other words, if property is damaged or destroyed by an act of war, property owners must pay for the loss themselves.

In the last section, we discussed the process of handling risk and developing a risk management plan. Once the plan has been developed and implemented, it must be monitored. This is the final step in the risk management process.

Monitoring the Plan

The final step in the risk management process involves a well-planned program for monitoring and updating the original plan. This consists of regularly identifying any changes in the risk manager's loss exposures, net worth, ability to personally bear financial losses and so forth. All of these are very important considerations for individuals. Risk management as a process grew out of businesses, insurance management, but insurance is hardly the sole method of treating risk. As noted earlier, there are various alternative methods available. For example, as a person's net worth increases, he or she needs more insurance to protect the possible financial costs of losses to that property, the loss of use of that property, and additional expenses that could arise from such losses. Or, on the other hand, increased wealth might mean that a person would feel comfortable retaining more losses and may, therefore, take a larger deductible to reduce the cost of his or her insurance premiums.

When an insurance agent participates in the risk management process with a client, he or she assumes important responsibilities. The client looks to the agent as a professional who can provide sound advice and, when necessary, can work with other experts in applying the principles of risk management. When insurance protection is necessary for transferring a risk, the agent will be expected to propose a practical and effective insurance plan that provides proper coverage in the correct amounts to offer adequate protection at the most reasonable cost.

Primary Insurance Policies

The average person selects insurance, with some retention in the form of a deductible, as his or her primary risk management technique. Most people will purchase homeowners' and/or a personal auto policy to cover their loss exposures. The policies are referred to as primary, basic or underlying insurance policies. Although various homeowners and personal automobile forms are in use, most follow a format similar to the programs developed by the Insurance Services Office (ISO). When we refer to any personal insurance coverage in this text, we will be referring to the standard ISO forms.

Handling Liability Loss Exposures

We will primarily be concerned with liability losses in this text. Most people handle the risk of legal liability arising out of their personal acts with personal liability insurance. Because liability losses involve a third party, the insurance company or the courts must make a determination of fault. In the event of a lawsuit involving bodily injury or property damage to another person, the insurance company will provide a legal defense and will pay those sums the insured is legally obligated to pay, up to the limits of the policy. Bodily injury refers to bodily harm, sickness or disease, including injury that results in death. Coverage also applies for any required care or loss of services of anyone whose bodily injury is negligently caused by the insured. For example, at common law, a husband may be entitled to monetary compensation if his wife is injured in an

accident and unable to provide certain duties owed to her husband under the marriage contract. These duties are collectively call consortium and the spouse may be compensated for lack of consortium. Additional coverage called property damage coverage applies to damage to or destruction of tangible property, including the loss of such property.

Personal liability insurance may be purchased as a separate policy or, more commonly, it is provided as part of a package policy, either an auto or a homeowners' package. Because these liability coverages are quite similar, we will primarily discuss the homeowners' liability coverages. The liability section of the homeowners' policy protects the insured in at least two ways:

If a claim is made or a lawsuit is brought against an insured, the policy will pay for damages for which the insured is found legally liable, up to the policy's limit of liability, typically $100,000 per occurrence. Higher limits may be obtained for an additional premium. Typically, coverage will apply for claims arising out of the ownership or use of the insured location, personal activities, such as sports or social activities on or away from the insured premises, and actions of a residence employee, such as a cook, maid, nanny or baby sitter, in the course of employment.

In addition to the limits of liability, the insurance company must defend any claim or lawsuit that is brought against the insured for bodily injury or property damage - even if the claim is false, baseless or groundless. In some cases, the policy specifies that the insurer's obligation to settle or defend claims ends when the amount the insurer pays for legal defense equals the policy's limits of liability. As a practical matter and to avoid expensive litigation, most personal liability lawsuits are settled out of court.

As mentioned earlier, individuals who own or operate automobiles may purchase liability protection in the form of an automobile policy. The Personal Auto Policy, for example, includes Part A Liability Coverage, which provides protection against economic loss to an insured for "bodily injury" or "property damage" that arises out of the operation, maintenance or use of an insured automobile. Under this policy section, the insurance company makes these two promises to the insured:

-To pay damages on behalf of the insured for which he or she becomes legally responsible because of an accident

-To settle or defend any claims under the policy, up to the policy's limit of liability

It is important to note that the insurer has no duty to defend lawsuits or to settle any claims that are not covered under a particular insurance policy. For example, an insurer who provides automobile or homeowners' insurance is not required to defend an insured who is sued by a neighbor for intentionally using a motor vehicle to damage the neighbor's lawn because intentional damage is not covered.

Handling Personal Liability Injury

The personal liability provided under the ISO homeowners' policy specifically covers these two types of liability:

-Bodily injury, meaning bodily harm, sickness or disease, including required care, loss of services and death that results
-Property damage, meaning physical injury to, destruction of or loss of use of tangible property

The policy does not mention coverage for personal injury losses, defined as any injury to another's person, rights or reputation, including torts such as libel, slander or invasion of privacy. Many insurers contend that they did not intend to provide coverage for personal injury liability under a standard homeowners; policy and coverage is often denied on that basis.

When coverage is not provided by the homeowners; policy itself, a personal injury endorsement may be added to the policy to provide coverage for certain offenses committed during the policy period.

The ISO personal injury endorsement does not provide coverage for liability in these situations:

-Arising out of disputes between insureds
-From contracts not related to the premises
-From the injured person's employment by the insured
-Involving a violation of a penal law
-Arising out of business pursuits
-Arising out of civic or public activities performed for pay

Personal injury liability protection may also be extended by a personal umbrella liability policy.

The Structure of Primary Policies

Property-casualty policies usually contain the same policy elements, regardless of what type of property or liability coverages they provide. Each policy begins with a Declarations page that contains information found on the client's application for insurance and any information that is unique to that particular policy. A Declarations page usually contains the name and mailing address of the insured(s), the name of the insurance company providing coverage, the policy number, the inception date and expiration date of the policy, the dollar amount of the applicable policy limits and deductibles, the numbers and edition dates of any forms and endorsements and the premium.

Policies usually contain a separate Definitions section that explains the meaning of certain words that are used in the insurance contract. The defined words may appear in boldface type, italics or within quotation marks. For instance, this section often explains that throughout the policy the named insured is referred to as "you," "your" and "yours" and the insurance company is referred to as "we," "us" and "our." If a word is not defined in the Definition section or in the body of the policy, rules of contract interpretation are used to determine the meaning. For example, technical words are interpreted according to their ordinary technical meaning and legal words are assigned their usual legal meaning.

The policy's Insuring Agreements provision sets forth the insurance company's promise to pay the insured (or to pay on behalf of the insured) for a covered loss. In return for the insurer's promise, the insured must pay a premium and comply with certain policy requirements which are spelled out in a section call Conditions. The Conditions section states that the insured must, in addition to paying a specified premium, report losses promptly, cooperate with the insurer in settling a loss and avoid anything that might harm an insurer's right to recover damages from a responsible third party. If the insured fails to comply with these conditions, the insurer may be relieved of its obligation to pay for the loss or defend a lawsuit.

Policies also contain a number of coverage exclusions that restrict or eliminate insurance coverage for specified loss exposures. These exclusions appear throughout the policy as well as in a separate section call Exclusions. Finally, some policies may contain various amendments or endorsements to the basic policy provisions. The insurance company or its duly appointed agent must issue these endorsements.

The Need for Umbrella Insurance

People can be held legally liable to pay damages for the bodily injury or property damage caused by their negligence. The need for liability can arise as a result of a person's personal or recreational activities as well as a person's business. Some of the higher liability claims arise when insured's are entertaining guests or permitting people to use their property.

Consider how a jury's desire to punish a negligent person could result in a judgment for damages in the following situations:

-A practical joke misfires and results in a lawsuit for defamation of character.
-A neighbor or guest falls on a person's property, resulting in permanent disability.
-A protective watchdog proves that his bite is even worse than his bark.
-A person's child accidentally breaks an expensive vase while at another person's house.
-A moment's inattention while driving results in a multi-car accident.
-A spark from burning leaves starts a fire that inadvertently burns a neighbor's roof.
-A letter to the editor triggers a libel suit.

At this point, it is important to make a distinction between two terms frequently used in liability suits: coverage and liability.

The word coverage refers to the contractual obligation imposed on the insurance company that agrees to indemnify the insured for sums he or she becomes legally responsible to pay as damages. Liability refers to the legal responsibility of the policyholder to other persons arising out of an occurrence. In some cases, a particular peril will not be covered by the policy and the insurance company is under no contractual obligation to indemnify the insured. For example, assume the insurer issued homeowners' policy covering an insured's liability arising out of the ownership of a certain property. The insurer is under no obligation to provide coverage under that homeowners' policy for an automobile accident that occurred away from the residence premises, even if the insured was at fault. In this case, there may be liability on the part of the insured, but there is no coverage provided under the policy.

On the other hand, there may be coverage under the policy but no liability on the part of the insured. For example, the Personal Auto Policy provides coverage for property damage up to the policy limits. However, if the insured vehicle is stolen and the thief uses the car to damage several lawns in the area, the insured has no liability for the damage. Even if the insured feels sorry for the neighbors and perceives some moral obligation to repair their lawns, he or she has no legal liability to do so. Likewise, the insurance company has no responsibility, either by way of settlement or as a gift, to make any payment to the neighbors. In this case, while there may be coverage under the policy, there is no liability on the part of the insured.

Insured's should be cautioned to remember that even when there is no apparent liability on the part of the insured or available insurance coverage, the insured may still be sued and found legally responsible. In a civil case, it is possible that the plaintiff, who must establish his or her claim by a preponderance of evidence, may produce evidence that is more credible and convincing than that of the defendant's. And, if the plaintiff's case is more believable, the plaintiff will win.

The settlement the plaintiff receives might be quite substantial because of these three factors:

-The public's attitude toward claims
-The application of the law of negligence
-The jury's opinion about damage awards

Identifying Gaps in Liability Coverage

Insureds routinely believe that their policies cover every possible loss exposure, but this is simply not the case. When a liability loss occurs, insureds may be surprised to learn that there are serious holes, or gaps, in their insurance coverage. As stated earlier, an insurance policy covers the insured only up to its liability limits. Beyond these limits, a liability insurance policy does not protect the insured.

The majority of policies covering liability for bodily injury have two limits: a limit of liability for one

person and another limit (usually higher) for any single occurrence, where more than one person is involved. For example, assume an insured has a Personal Auto Policy that covers him or her up to a $300,000 liability limit for bodily injury for each accident or occurrence. If the insured is involved in an accident and is held liable for $200,000 in bodily injury damages, the auto policy will pay for those damages. However, if the insured is held liable for damages in excess of $300,000, he or she will be held personally liable for the additional damages.

The underlying personal liability insurance, in addition to paying only up to certain limits of liability, excludes certain loss exposures.

For example, the liability portion of the homeowner's policy does not cover the following:

-Damage from the intentional acts of the insured
-Damage caused by the rendering or failure to render professional services
-Damage from acts of war
-Damage from communicable diseases
-Damage arising out of business activities

In addition, not all individuals on the insured's property or in the insured's auto are afforded coverage by the insured's primary liability insurance. Residence employees, defined as an employee of the insured whose duties are related to the maintenance or use of the residence premises, including household or domestic services, may not be covered under the liability section of the homeowners' policy if the insured is required to have workers' compensation coverage in force for such employees.

The basic Personal Auto Policy excludes liability coverage for the following:

-Damage caused by intentional acts of an insured
-Damage to property owned by, rented to, used by or in the care of an insured
-Bodily injuries to employees covered under workers' compensation
-Damages resulting from the ownership or operation of a vehicle while it is being used as a public or livery conveyance
-Damages incurred while a party is employed or engaged in the business of selling, repairing, servicing, storing or parking vehicles

Finally, underlying policies generally do not provide liability coverage for unusual loss exposures or for losses that occur outside the United States. For example, the Personal Auto Policy limits coverage to accidents and losses that occur within the policy territory, meaning the United States of America, its territories or possessions, Puerto Rico, Canada, or while the auto is being transported between their ports.

Purpose of Umbrella Policies

The Personal Umbrella Liability Policy was created to expand the insured's liability coverage by filling gaps in the basic liability coverage provided by underlying policies and to reduce the insured's worry, trouble and burden of facing personal litigation on his or her own. Personal umbrella liability coverage is usually sold in units of $1 million or more and may be added to a basic homeowners' or auto policy that is already written by the insurance company. Many companies also write stand alone or separate, personal umbrella policies without writing the underlying coverage. To qualify for stand-alone coverage, however, the applicant is usually required to show proof of certain underlying insurance coverage with other insurance companies. Umbrella policies provide insurance for accidents and other situations not ordinarily covered under primary insurance, subject to a deductible of between $250 and $1,000.

There is no standard personal umbrella liability policy. The policy's forms, format and coverage vary by insurer. This does not necessarily mean that because one company's policy looks more

extensive that it is superior to another policy. Rather, each contract should be reviewed to determine which offers the best coverage for a particular policyholder. Regardless of which company is providing the policy, all personal umbrella policies are designed to give insured's and their families' two types of extra liability protection.

They add to the liability of any homeowners', automobile or other liability policies currently in force. Most homeowners' policies provide basic personal liability coverage of $100,000. Auto policies typically contain a combined single limit of $300,000 per occurrence. An umbrella policy supplements these basic personal liability coverages. If, for example, the insured has a standard auto policy with liability limits of $300,000 and a personal umbrella policy with limits of $1 million, the insured is protected up to $1,300,000 if a covered auto accident occurs and the insured is found legally responsible.

These policies are designed to cover liability exposures that other policies do not cover. The personal umbrella policy is designed to cover some of the more unusual exposures, such as personal injury claims, that an insured might face but that are typically not covered under most standard liability policies.

A personal umbrella is the liability counterpart of Difference in Conditions (DIC) insurance, a property coverage that expands insurance written on a named perils basis to an open perils basis and protects the insured against risks of direct physical loss to the insured property, subject to certain exclusions and deductibles. An umbrella contract provides (subject to a deductible) liability coverage where no other liability insurance exists, and in addition provides coverage for liability when the limit of the primary or underlying insurance has been exhausted.

Special Characteristics of Umbrella Policies

The insurance company that issues the umbrella policy provides additional liability coverage over the primary policies, up to the limits listed on the Declarations page of the umbrella policy, even if the same insurer does not provide the underlying insurance. The personal umbrella policy covers any number of accidents or occurrences that occur during the policy term, regardless of how many claims are presented. However, the policy restricts payment for any one accident to the limit listed in the policy (usually up to $1 million per occurrence). In other words, even though the insurer may pay for ten claims totaling $10 million during a one-year period, it will not pay more than $1 million for any one occurrence.

To limit the insurer's liability, however, many umbrella policies are beginning to offer aggregate limits, meaning a maximum dollar amount that may be paid during the policy period or during the insured's lifetime, as specified in the policy. A policy with a $10 million aggregate limit, for example, may pay several claims for $1 million each, but it will only pay out a maximum of $10 million during a given policy period.

It is important to remember that the personal umbrella is a third party liability policy that covers only another person's claim against the insured. It does not cover damage to the insured's own property, motor vehicles, home or other valuables.

Basic Policy and Components

Personal Umbrella Liability Policies

The insurance industry has developed a number of liability contracts over the years to meet the basic liability exposures of individuals and businesses. It was not until 1960, however, that a personal catastrophe liability contract (or as it is more commonly called a personal umbrella liability policy) was developed. The contract was originally aimed at insurance buyers with the idea of providing broader insurance protection for individuals, especially professionals and wealthy members of society, who were excellent targets for liability lawsuits that could result in significant claims. Today, however, it is not unusual for liability claims to exceed the basic limits of liability

afforded by an average insured's homeowners or auto policy. These claims, which may result from personal activities or professional or business pursuits, are usually covered by a personal umbrella liability policy.

As we have said, there is no standard personal umbrella liability policy form or format. Each insurer develops its own policy based on its own preferences and/or the needs of its clients. Because coverage varies by insurer, it is important for the insurance producer and his or her client to examine each personal umbrella policy to make sure that it is not merely an ordinary excess liability contract. An excess policy provides only additional layers of coverage to the coverage already furnished by the underlying policy. The terms and conditions of an excess policy should be precisely the same as those of the underlying policy. A true umbrella policy, on the other hand, provides not only excess liability but also responds to claims that may be excluded in the underlying policy but are not excluded under its own form.

Personal umbrella liability insurance is intended for catastrophe type claims. An umbrella insurer is simply not interested in covering small claims. To support this intent, personal umbrella policies that cover loss exposures that are not covered by the underlying policies are subject to deductibles commonly referred to as a retention or self-insured retention. Most insurers offer minimum deductibles of $250 but offer higher ones for additional reductions in premium. In some cases, an insurance underwriter will require a substantial deductible when a particular risk is not otherwise insurable because of some unusual exposure to loss.

In general, the purpose of a personal umbrella policy is not only to provide million dollar-plus excess limits but also to broaden basic liability protection in several ways.

In most cases, the personal umbrella liability policy is intended to do these things:

-Apply worldwide coverage (where permitted by law), without territorial restriction as is the case with most primary insurance coverage
-Provide liability coverage for the insured who uses certain non-owned automobiles, watercraft and aircraft when this coverage is excluded under Section II of the homeowners' policy
-Include coverage for liability assumed by the insured under certain oral or written agreements
-Cover a broad range of personal injury hazards such as libel, slander, false arrest, humiliation, defamation of character, false imprisonment, wrongful eviction, wrongful detention, malicious prosecution or invasion of privacy
-Provide payment of defense costs when primary insurance does not apply

To adequately protect the insured, a personal umbrella liability policy should serve three purposes:

-It should add an additional amount of liability coverage above the limits provided by the insured's homeowners', personal auto or other underlying policies.

-It should provide insurance coverage for some exposures that are not covered (or only minimally covered) by the insured's underlying policies.

-It should provide protection for the insured against certain catastrophic liability losses that might otherwise cripple the insured financially.

Basic Policy Component Parts

Depending on the preferences of the insurance company, the actual format of the personal umbrella liability policy will vary among companies. In addition, the amounts and types of coverage may also vary.

Regardless of how it looks or exactly what it covers, however, a personal umbrella policy will usually contain six basic components or policy provisions that outline the details of the contract between the insurer and the insured.

Declarations
This part identifies the parties to the contract and defines who and what the policy insures and for what period of time. The premium and amount of insurance are also stated in the Declarations.

Definitions
The contracts commonly used words and phrases are defined in this section to reduce any misunderstandings between the parties about what the insurer intends to cover.

Insuring Agreements
An umbrella policy contains a number of promises and specific obligations assumed by the insurance company, including its duty to pay certain losses on behalf of the insured. In addition to an introductory insuring clause, there may be several additional statements within the body of the policy that must be referenced when a loss occurs to determine both the insured's and the insurer's responsibilities.

Conditions
This policy provision describes the policy requirements with which the insured must comply before the insurer is obligated to pay.

Exclusions
This provision specifically lists causes of loss for which the insurer does not intend to provide coverage.

Miscellaneous Provisions
Some policy provisions, such as the insured's duties when a loss occurs, do not neatly fit into the Declarations, Definitions, Insuring Agreement, Conditions or Exclusions headings. These provisions may be grouped together as Miscellaneous Provisions.

In the following sections, we will briefly describe each of these policy components.

Policy Components

Declarations Page
The preliminary section of each umbrella liability policy contains a Declarations page (also called a "Dec page," or the "Dec") that contains pertinent information about the insurance risk on the basis of which the policy was issued. The insurer, which draws up the insurance contract, is expected to represent clearly the intent and terms of the policy. Therefore, the purpose of the Declarations page is to provide information about who is covered (the named insured), what is covered (the property and perils listed in the policy), when it is covered (the effective dates of coverage), where it is covered (the described location) and why it is covered (a premium has been paid) so that there is no ambiguity.

The entire policy, including any endorsements or changes to the policy, is inserted into a policy jacket that serves the same function as the covers of a book. The policy jacket keeps the Declarations page and all the policy forms in one place, thereby allowing the insured to easily find, read and review his or her insurance policy.

Insuring Agreements
Every umbrella liability policy contains an insuring clause that is a general statement of the promises the insurance company makes to the insured. In addition to this general clause, the policy often contains a number of other guarantees referred to as Insuring Agreements. These

Agreements state what the company promises to do, such as agreeing to defend the insured in a liability lawsuit.

Definitions
In response to complaints from insureds and the courts that the terms used in insurance policies were not clearly defined, the insurance industry developed a section called Definitions that is now contained in every insurance policy, including a personal umbrella policy. Personal umbrella liability policy definitions are not standardized. An insurer develops its own definitions and policy wording, which may later be modified by the underwriter to meet the requirements of the applicant or to adapt to unique situations presented by different underlying forms of coverage. For example, an insurance company's definition of an insured may include the person named in the Declarations page (the "named insured"), the named insured's spouse, any relatives and persons under a specified age and in the care of any of the persons previously named - if they live in the insured residence. However, another company's definition might specifically remove coverage for any person, other than the named insured, using automobiles or watercraft while engaged in an automobile or boat-related business.

Conditions
Like other insurance contracts, the umbrella policy is a conditional contract. The insured must pay the premium indicated in the Declarations and abide with certain requirements specified in the policy. The personal umbrella policy's Conditions component describes the rights and duties of both parties to the insurance contract - the insurer and insured. Conditions are provisions inserted in the contract that qualify or place limitations on the insurer's promise to pay for losses. In addition to being contained in a separate section, a policy's conditions may also be found anywhere in the contract where the insurer intends to limit coverage.

Exclusions
A personal umbrella policy does not cover every risk that the insured faces. For example, many insurers will not provide coverage for perils that they consider being uninsurable, such as war or some other potentially catastrophic event. They also intend to deny coverage under the umbrella if coverage could be better provided by another type of insurance policy or if there are extraordinarily hazardous conditions present. Finally, insurers exclude coverage for losses that are difficult to measure or for perils that are not needed by the typical insured. Therefore, the personal umbrella policy also contains an Exclusions component that specifically lists causes of loss for which there will be no coverage. The policy may place limitations on coverage or exclude certain perils or types of losses.

Typically, personal umbrella policies exclude the following types of losses:

-Obligations under workers' compensation, unemployment compensation, disability benefits or similar laws

-Business pursuits, professional services and liability resulting from owned or rented aircraft and watercraft excluded under the homeowners' policy

-Property damage to any property owned by the insured or in the care, custody or control of the insured

-Any act committed by or at the direction of the insured with the intent to cause personal injury or property damage

-Personal injury or property damage for which the insured is covered under a nuclear energy liability policy

Although these exclusions are fairly standard, additional exclusions may be listed in the policy. In

some cases, the insurer allows the insured to "buy back" certain coverages, such as workers' compensation, for an additional premium. The agent should be familiar with each insurer's exclusions and be careful to point them out to his or her clients so that there will be fewer surprises if a loss occurs that is not covered under the umbrella liability policy.

Miscellaneous Provisions
Some umbrella policies contain provisions that cannot be strictly classified within one of the previous five policy components. These Miscellaneous Provisions might include a discussion of the insurer's production and underwriting rules, its required underlying limits or any other special company guidelines. In addition, any endorsements that add to, delete or modify the provisions in the original contract may be included in this section.

An endorsement is an attachment to an insurance policy that is used to clarify, extend or restrict coverage with regard to perils, coverage periods or premiums. It can be a standard endorsement that is used to fit a general situation, or it may be worded to fit a particular situation. These special endorsements are called manuscript forms. When an endorsement is attached to a policy, the endorsement's terms normally take precedence over any conflicting wording in the policy. However, if state law requires any provisions in the policy, an endorsement cannot be used to subvert the intention of the required legislation.

For example, the law may hold a person liable for damages if he or she is found guilty of negligently operating a motor vehicle. The personal umbrella and underlying auto policies cannot be endorsed to delete liability for negligence. If endorsements are in conflict with a state regulation or law, the laws take precedent and the policy is read and interpreted as if the conflicting endorsements had not been added. In other words, the original intent and coverage are preserved.

Chapter 2 Umbrella – Legal Contract

Requirements of Legal Contract
A contract is an agreement entered into by two or more parties under the terms of which one or more of the parties, for a consideration, undertakes to do or to refrain from doing some specified act or acts.

In order to be binding on the parties involved, a contract must meet these five basic requirements:

-Offer and acceptance
-Consideration
-Competent parties
-Legal purpose
-Legal form (in some cases)

Let's briefly review each of these requirements.

Offer and Acceptance
A contract is in essence an enforceable promise. In order for a valid contract to exist, there must be a valid offer and an unqualified acceptance of that offer, so that the seller understands the buyer's offer and the buyer understands to what the seller has agreed. In other words, a contract begins with a meeting of the minds.

The general rule is that it is the applicant for insurance who makes the offer, and it is the insurance company that accepts or rejects the offer. For example, the potential insured requests

insurance and fills out an application for personal umbrella insurance: the application constitutes the offer. The agent then accepts the offer on behalf of his or her company. Assuming that the other requirements for a valid contract are met, the property casualty agent can usually bind coverage and make it effective immediately. However, the insurer retains the right to investigate, underwrite and cancel the coverage (as described in the policy and in accordance with state law) if the risk does not meet the company's underwriting guidelines. For example, the applicant may not have disclosed several large liability losses that would have made him or her ineligible for umbrella coverage with some insurance companies. In this case, the insurance company may decline to offer coverage. In most cases, the agent cannot bind personal umbrella liability insurance.

Consideration
The second requirement of a valid contract is consideration, which is the value that each party gives to the other. In the case of an umbrella policy, the insured's consideration is the payment of the first premium (or the promise to pay) and his or her agreement to abide by the conditions specified in the policy. The insurance company's consideration is the promise to do certain things that are specified in the policy. This includes indemnifying the insured for covered losses and defending the insured in a liability lawsuit.

It should be noted that the values of the considerations exchanged are not always equal. When the insured purchases a policy, he or she usually pays a relatively small premium in exchange for a comparably large amount of insurance protection. For example, the annual premium for a $1 million umbrella policy might be less than $200, a decidedly unequal exchange of values if a large loss occurs. In fact, for the benefits the insured receives, a personal umbrella policy may be the best buy in insurance. This relatively inexpensive policy raises the insured's liability coverage to a million dollars or more, and protects him or her from personal responsibility for damages.

Competent Parties
In order to be legally enforceable, a contract must be between at least two bona fide parties. A person cannot make a legally enforceable promise to himself or herself. Thus, John Doe cannot agree to sell a piece of property to himself. However, he could agree to deed the property to himself and his wife as tenants in common.

The parties involved must be legally competent in order top enter into a valid contract. Generally speaking, competent parties are adults (usually age 18 or 21, depending on the state) who are able to understand the terms and conditions of the contract into which they are entering. In some states, however, minors as young as 14 may enter into some contracts. For example, minors have limited ability to contract, which means that the contract of a minor is valid only if the minor does not disavow a contract entered into during his or her minority or shortly after reaching majority (usually age 18 or 21). For example, a minor possesses the limited capacity to enter into a valid contract to purchase property from an adult. Such a contract would be enforceable by the minor against the adult, but would be voidable by the minor. A voidable contract is an agreement that, for a reason satisfactory to the courts, may be set aside by one of the parties to the contract. Contracts made by minors to obtain such necessities as food, clothing or shelter, however, are not voidable by the minor and will be enforced against him or her.

Some entities are excluded parties to legally binding contracts. When a person has been adjudicated insane or is an officer of a corporation who is not authorized to execute a contract on behalf of the corporation, he or she has no capacity to contract. Lack of a capacity would also cover acts of a corporation beyond its powers as defined in the articles of incorporation.

Also considered incompetent is any person who is impaired by reason physical or mental disability, drugs, alcohol, age or any other cause to the extent that he or she lacks sufficient understanding or capacity to make or communicate responsible decisions concerning himself or herself. Therefore, insane and, in certain, intoxicated people are incapable of entering into valid contracts.

An illiterate person, however, is not incompetent as long as he or she understands the nature of his or her acts.

Legal Purpose
In order to be enforceable, contracts must be made for some legal purpose. If the contract does not have a legitimate purpose, it would be contrary to public policy to enforce such a contract. For example, Robert may contract with another person to paint his house for a fee. Such a contract is considered legal and binding. However, Robert cannot legally contract with another person to kill his wife. Because murder-for-hire is not legal, it is not considered a valid contract and would not be enforceable in a court of law.

Legal Form
Unless otherwise required by laws, oral contracts can be just as valid as written contracts. Generally, however, an insurance contract must follow a specific legal form and must be in writing to be enforceable. All essential terms of the contract must be complete and certain so that the entire agreement is set forth in writing and nothing material to the contract is left to be agreed upon in the future. Once the policy is issued, changes may be made by endorsement, but only if the insurer agrees to the requested changes.

Knowing Policy Conditions
Insurance policies are conditional contracts that create a continuing relationship between the insured and the insurance company. In the policy's Insuring Agreement, the insurance company promises to pay on behalf of the insured those sums for which the insured is found legally responsible, to provide a defense for the insured or to furnish other services as stated in the policy. However, the insurer's promises are enforceable only if an insured peril occurs and if the insured has complied with certain conditions contained in the policy. Insureds understand that they must pay premiums in order to keep their insurance policies in force, but that is not the only thing they have to do. Additional duties are spelled out in the Conditions section of the policy.

As an insurance professional, you should review insurance policies before they are forwarded to your clients to assure that the policies have been issued as you requested. You should also discuss the policy with your client to assure that he/she understands what is covered and excluded. You should also be certain he/she is aware of his/her rights and obligations under the contracts so he/she will have fewer problems should a loss occur. We will discuss the important conditions that apply to most personal umbrella liability policies and explain how you can help your insureds to understand this important part of their insurance coverage.

Understanding Policy Conditions
All property-casualty insurance contracts are written subject to certain conditions or prerequisites. The duties of the insured are primarily listed in the Conditions section of the policy. However, other provisions that qualify the otherwise enforceable promise of the insurer may also be found elsewhere in policy forms or endorsements. As explained previously, insureds should fully understand their obligations under their policies because they cannot expect the insurance company to fulfill its part of the contract unless the insured fulfills all of the required policy conditions. Failure to do so may release the insurer from its obligations.

Most of the policy's conditions have to do with such matters as loss settlements, actions required at the time of a loss, cancellation of coverage and suits against the insurer. Under most umbrella contracts, insureds are obligated to report losses in a timely manner, provide any required documentation of losses to the insurer, cooperate with the insurer in investigating, negotiating and settling claims, and avoid any action that would risk the insurer's rights to recover from a responsible third party.

Common Personal Umbrella Conditions
Personal umbrella liability policies contain a number of conditions that describe the circumstances

under which the contract is to operate. Insureds should be certain that they understand how these conditions modify, suspend or rescind the original obligations. In the Conditions section of most policies, the insurer explains that the insured must meet a number of obligations before insurance coverage will apply.

For instance, the policy might state the following:

There are certain responsibilities, which you must fulfill (in addition to paying the premium) as a condition for us to provide coverage.

Policy conditions may be classified in one of these two ways:

-A Condition Precedent
-A Condition Subsequent

Condition Precedent
A Condition Precedent is a requirement or qualification that must take place before the contract exists. For example, in a contract of insurance, the insured agrees to pay the premium and the insurer agrees to provide certain insurance coverages in return. The principal duty of the insurer is to provide this coverage, but this obligation is conditioned on the insured's payment of the premium. The failure of the insured to pay the premium (condition precedent) relieves the insurance company of its principal obligation and, in fact, nullifies or voids the contract.

Condition Subsequent
A Condition Subsequent is a requirement that must be met after the contract is in force. For example, the insured must report all accidents and potential claims to the insurer as soon as possible.

A typical clause might read in this way:

In case of a claim or "occurrence" that may be covered by this policy or if a "covered person" is sued in connection with an "injury" or "damage" which may be covered under this policy, the "covered person" must do the following:

-Promptly notify us or our agent in writing
-Promptly send us copies of any notices, legal documents and any other documents that will help us with your defense
-Cooperate with us in the investigation, settlement or defense of any claim

Assume the insured is involved in an auto accident. The insured feels he or she was not at fault, so the insurance company is not notified of the accident until a year later when the other driver files a lawsuit. Because the insured breached the contract by not notifying the insurance company "promptly," the insurer may be relieved of its obligation to defend and indemnify the insured for that particular loss. The insured's failure to comply with this policy condition does not void the entire contract. The insurer will still respond to other losses during the policy term with the same obligation to defend and indemnify the insured, provided that the insured complies with the policy's terms and conditions.

The things that an insured or other covered person must do as a condition before the insurance company will provide coverage will vary by company. Generally speaking, umbrella insurers will include conditions relating to claims notification, assignment of the policy, cancellation of coverage and legal action against the insurer.

Understanding Insuring Agreements

You'll recall that an insurance contract is an agreement entered into by two parties: the insurance

company and the insured. The contract usually begins with an insuring clause (or clauses) called Insuring Agreements that outlines the insurance coverage that the company promises to provide in return for the insured's promise to pay a premium and compliance with the terms of the contract. Technically, complying with these conditions is also a part of the consideration. If a covered loss occurs but the conditions are not met by the insured, the insurer has no obligation to pay.

A rather broad Insuring Agreement might read like this:

"We will provide the insurance described in this policy if you pay the premium and comply with all the terms of the policy."

With this statement, the insurance company (one competent party) enters into a legally binding contract with the insured (a second competent party). Based on the insured's application for insurance (offer) and payment of a specified premium (consideration), the umbrella insurer agrees to provide coverage (acceptance) and issues a personal umbrella liability policy (legal form). In return for the insured's premium and promise to abide with the terms of the policy, the insurer agrees to assume many of the insured's liability loss exposures. The exact terms of the agreement are specified in the various policy provisions.

Coverage Restrictions

At first glance, Insuring Agreements like the one above might appear to cover every loss exposure. However, because it is unlikely that a company intends to provide unlimited coverage, the insurance producer should look for words or phrases in a policy's Insuring Agreements that might restrict or limit coverage. In our first example, the words insurance described in this policy are included to warn the reader to look for additional definitions, conditions, exclusions and miscellaneous provisions throughout the policy that will clarify exactly what the insurer intends to cover under the policy. The policy is not intended to cover every hazard an insured faces. Coverage applies only as described throughout the policy.

Insurance companies may include words or phrases in their Insuring Agreements that have a special meaning as used in its personal umbrella policy. This interpretation may be quite different from that normally used by the average person. As explained previously, many insurers use boldface type, italics or quotation marks throughout the policy to identify words or phrases that may be used in a special way by the insurer. An insurance producer or insured who is uncertain about what the insurer intends to cover when a loss occurs will usually find that the intended meaning of a term is explained in the Definitions section of the policy. The definitions are included to reduce confusion about what the insurer expects to cover.

For example, the following Insuring Agreements contain a number of accented words:

The company agrees to indemnity the "insured" for "ultimate net loss" in excess of the "retained limit" which the "insured" shall become legally obligated to pay as damages because of "personal liability".

In this case, the insurer wishes to alert the insured that certain words, including "insured", "ultimate net loss", " retained limit" and "personal liability" are used in a way that may be unique to this particular company. The insurance producer and the insured should use the policy's Definitions section to determine whether these terms are used in a way that is familiar to them. Let's review how most insurance companies define these highlighted terms.

Insured

An Insured (or covered person) is defined under most personal umbrella policies as the person named in the Declarations, his or her spouse and any relatives living in the named insured's household. As mentioned earlier, some companies will limit coverage to relatives under a specified

age or require that the named insured have custody of child or stepchild in order for coverage to apply. In many cases, any person insured under the named insured's basic or underlying policies is also covered under the personal umbrella.

Ultimate Net Loss and Retained Limit
The intent of an ultimate net loss provision is to limit the insurer's liability to the amount specified in the Declarations less any required retained limits, either specified underlying limits or a retained limit or self-insured retention (a form of deductible). The policy wording will usually go on to explain exactly how and when the insurer intends to make payments under the policy.

A Retained limit provision requires the insured to pay some portion of a covered loss before the umbrella policy pays. A retained limit is the larger of these:

-The total of the applicable limit(s) of all required underlying insurance required by the insurer and described in the Declarations or elsewhere in the policy and any other insurance available to a covered person

-Any deductible required by the insurer or by the state in which the insurer does business

The insured bears the risk to the extent of the uninsured amount. The retained limit or retention applies on a per loss basis to any loss covered under the umbrella policy but excluded in primary underlying policies. The retained limit does NOT apply when the umbrella is simply supplementing a primary policy that has exhausted its limits in the payment of a covered claim.

In other words, before the umbrella insurer makes any payment, the primary coverage must pay first or the insured must meet a specified deductible, such as $250 per occurrence. There is a common misunderstanding that there is a GAP or space between the primary and the umbrella coverage. No such corridor exists. In those cases where the insured has purchased the required underlying primary coverage, the protection applies right up to the top collar of the umbrella. In other words, if the insured has the required primary coverage, only that coverage and the umbrella coverage come into play. The insured is not out of pocket for any deductible.

Personal Liability

In most umbrella policies, the term personal liability means:

-Bodily injury, sickness, disease, disability, shock, mental anguish and mental injury
-False arrest, false imprisonment, wrongful entry or eviction, wrongful detention, malicious prosecution or humiliation
-Assault and battery, including death resulting therefrom

Many policies also include injury to or destruction of tangible property, including its loss of use.

To illustrate how an umbrella policy would indemnify an insured for a loss, assume an insured's umbrella policy specifies that its retained limits are the larger of either the minimum underlying comprehensive personal liability limits of $300,000 or $250. The insured's homeowners' policy has a $300,000 limit of liability. The insured is found legally responsible for covered damages of $500,000 when someone is injured. In this case, the primary coverage (the liability section of the homeowners' policy) pays the first $300,000 (the retained limit) and the umbrella policy pays the remaining $200,000. There is no corridor or gap between the primary and excess coverages and the insured pays no deductible himself or herself.

Now, assume that the insured is found legally responsible for slander in the amount of $500,000. Coverage for personal injury damages is not provided under the homeowners' policy. However, coverage is provided under the personal umbrella, up to its policy limits of $1 million. In this case, there is no underlying coverage so the insured must pay the first $250 (retained limit) before the

umbrella insurer is obligated to pay the remaining balance of $499,750.

Now, assume that the insured in these examples allows the required homeowners' policy to lapse and is subsequently found legally responsible for covered damages of $500,000 when someone is injured on his or her property. In this case, there is no primary liability coverage available. However, the personal umbrella insurer is NOT relieved of its obligation to pay even though the insured has failed to maintain the basic liability limits required as a condition of obtaining and maintaining personal umbrella liability coverage. Before the insurer pays, however, the insured, in essence, must take the place of the primary insurer and pay the amount that the primary insurer would have paid if the homeowners' coverage had been in force. The umbrella insurer then responds in the same way it would have had the primary liability insurance been in force and that is to act as the retained limit. In this case, the insured pays the first $300,000 (the retained limit) before the personal umbrella insurer pays the remaining $200,000. The insured does NOT pay an additional $250 deductible.

Excess vs. Personal Umbrella Liability

Many insurance producers use the term excess personal liability insurance and umbrella insurance interchangeably. These two insurance coverages are actually quite different and should not be confused. Unlike excess liability that provides additional coverage ONLY if the underlying policy provides coverage for a loss exposure, a typical personal umbrella policy will respond in two ways.

If the listed underlying insurance coverages, such as the homeowners' policy or personal auto policy, are exhausted in the payment of a loss, the umbrella picks up the protection and continues payment on behalf of the insured until the personal umbrella's limit of liability is also exhausted.

If a loss occurs that is NOT insured under the underlying policies, because of policy exclusion or for any other reason, the personal umbrella policy will often cover a loss subject to a deductible, RETAINED LIMIT or SELF-INSURED RETENTION payable by the insured. However, the umbrella policy does NOT cover every loss, and it should be analyzed to determine any coverage exclusions.

Required Underlying Limits

The insurer will include policy language that clearly states the types and minimum limits of liability that the insured must carry. In some policies, this provision is called MAINTENANCE OF INSURANCE OR REQUIRED UNDERLYING LIMITS.

A typical provision might read as follows:

The named insured agrees that as of the inception and for the duration of this policy (1) the following underlying insurance shall be maintained in force for at least the minimum primary limits stated hereafter, and (2) that such underlying insurance insures all residences occupied by the insured and all farms, watercraft and land motor vehicles owned, rented, hired or controlled by the named insured.

As explained earlier, an umbrella insurer does not intend to provide first-dollar coverage. Therefore, the insurer requires that certain primary insurance be in place to provide the first layer of liability coverage if a loss occurs. To illustrate how a claim involving and umbrella policy should be settled, assume the umbrella insurer requires underlying automobile liability insurance with split limits of 250/500/50 (or a combined single limit of $500,000) and homeowners' liability coverage in the amount of $300,000 before it will insure a personal umbrella policy for $2 million.

The insured purchases the required policies in the required amounts, and an umbrella policy is issued. The insured is involved in an auto accident and found legally liable for the other driver's bodily injuries. Damages of $1.3 million are awarded. The insured's auto policy pays up to $500,000 for the covered accident and the umbrella policy pays the remaining $800,000.

To guarantee that the applicant is aware of its underlying insurance requirements, insurers include questions about underlying limits on their umbrella applications. In addition, when the umbrella policy is issued, the Declarations page typically includes information about the insured's primary insurance coverage. The types of loss exposures, names(s) of the insurance carrier(s), policy numbers, and effective dates of coverage and limits of liability are shown. Finally, the policy will include some explanation of how a loss will be handled when the primary insurance required by the umbrella policy is in place.

Failure to Provide Underlying Limits
Although the insured is expected to supply certain underlying limits, these basic policies may be unavailable at the time of a loss for a number of reasons. For example, the insured may have allowed the primary policy to lapse or it may have been canceled for nonpayment of premium. The limits of coverage may be less than required by the umbrella insurer or may have been reduced by payments of losses. The primary insurance company may have become insolvent or it may refuse to pay a claim because a covered person has not complied with the terms of the primary policy.

As stated earlier, umbrella insurers intend to pay only for damages that exceed a retained limit. Therefore, insurers safeguard themselves by having certain coverage exclusions which will apply if the underlying insurance is missing.

For example, a policy might state this:

If your "primary insurance" has terminated, is uncollectable, or reduced, this will not void coverages. In these cases, we will pay the same manner as though your "primary insurance" was in force, collectable and with required limits, and you had fully complied with all conditions or agreements.

This provision explains the insurer's intention for provide defense, investigation, legal fees, court costs or any similar fees or costs. However, the insured becomes personally responsible for the amounts of coverage that would have been in effect if the policies had remained in force. For example, if the underlying insurance would have provided the first $300,000 of liability coverage, the insured must pay that amount BEFORE the umbrella insurer steps in. The insurer has no legal obligation until the retained limit has been met. It should be noted, however, that the umbrella insurer retains the right to enter the matter sooner and provide a defense. This could occur when the insurer sees the opportunity to quickly settle a lawsuit that could escalate if left uninvestigated or undefended.

SUMMARY

The Insuring Agreements contain the promises the insurer makes to the insured. Some umbrella policies have relatively simple Insuring Agreements, while others include a number of definitions, exclusions and conditions within their Insuring Agreements. Regardless of the policy wording, however, the Insuring Agreements provide a general description of the circumstances under which the policy becomes applicable.

In addition to Insuring Agreements, umbrella policies contain a separate section called CONDITIONS, which enumerates the duties of the parties to the contract and, in some cases, defines the terms being used. Many conditions found in an umbrella policy, such as notice of occurrence, assignment and the cooperation of the insured, are common to most property-casualty policies. Other conditions, such as maintenance of underlying insurance and appeals, are peculiar to umbrella policies.

It is imperative that an agent and his/her insured understand these important components of an umbrella policy (or any other policy, for that matter). Not understanding what one's

responsibilities are – or not knowing what the insurer is responsible for – can result in a rejected claim or a gap in coverage.

Knowing Policy Exclusions

The personal umbrella policy provides broader coverage than any underlying liability policy, but it is not intended to cover every risk that a person might face. Like other property and liability policies, the personal umbrella includes a number of provisions to clarify that certain perils are not to be covered. The wording of various provisions determines what is specifically excluded under the policy.

We will discuss a number of exclusions or coverage limitations that are commonly found in personal umbrella liability policies. Basically, policy exclusions are intended to prevent the insured from profiting from non-fortuitous losses, duplicate insurance coverage or unusual risks. To this end, a basic personal umbrella policy includes a number of exclusions that modify the policy's Insuring Agreements.

Understanding Policy Exclusions

Insurance policies contain a number of policy limitations or restrictions on specific perils, property, locations or losses for which the insurance company does not intend to provide coverage. The personal umbrella liability policy is no exception. Policy exclusions are usually listed and explained in a separate section of the policy called: "What is not covered;" or "Exclusions." The Exclusions section explains any exceptions to the policy's Insuring Agreements and clarifies the insurer's intentions by limiting or modifying certain aspects of coverage that the insurer plans to provide.

In theory, the policy language should clearly express an insurer's intentions as they might apply to a wide variety of loss situations. Unfortunately, the meaning of certain phrases may be debated, and it is not uncommon for the courts to find that coverage applies to losses that the insurer never intended to cover when the policy was developed.

In an attempt to be certain that an umbrella policy provides or limits certain coverages, an underwriter may issue an endorsement to amend, extend, or completely eliminate coverages in the basic contract.

It should be clear that, in order to determine what coverage a personal umbrella policy provides, one must study the entire policy including any endorsements and exclusions. In addition to those exclusions clearly outlined in the Exclusions section of the policy, other coverage limitations or exclusions may appear elsewhere in the policy.

Coverage restrictions may even begin with the Insuring Agreements that state

We will pay that portion of the damages for personal injury or property damage a covered person is legally responsible for which exceeds the retained limit.

This restrictive policy wording means that before the insurance company will make any payment for a claim under the personal umbrella, these certain elements must be in place:

> -The insurance company will pay only its share of covered losses after certain other conditions are met.
>
> -A covered person as defined in the policy (usually the named insured, a family member or a person using an auto, recreational vehicle or watercraft owned by the insured with the insured's permission) must have been involved in the event.

The covered person must have done something (or failed to do something) that resulted as follows:

-In personal injury, usually defined as bodily injury, sickness, disease, death, disability, false arrest, libel, slander and so on

-In property damage, usually defined as physical injury to tangible property, to another person

-The covered person must be held legally responsible or liable under law, as interpreted by the courts, for the action

The insured must meet a retained limit, usually the larger of the total applicable limits of all required underlying insurance or some set amount, such as $250 or more, before the umbrella policy responds to the claim.

Reasons for Exclusions

An insurance company is not required to explain its rationale for incorporating various exclusions in its policy. However, exclusions are generally used to clarify what the insurer does not intend to cover. Depending on the insurance company's underwriting philosophy, provisions that eliminate coverage for specific loss exposures are included in personal umbrella policies for at least the following five reasons:

Avoid Financial Catastrophe

Exclusions help the insurer avoid financial catastrophe. The theory of insurance is that in paying the relatively small premium, each policyholder has benefited by exchanging the uncertainty of a large future loss for the certainty of a small immediate loss (the premium paid). Pooling of losses is the essence of insurance. However, risks must fulfill certain requirements before he/she can be insured. For example, the chance of loss must be calculable, which means the loss must be determinable and measurable. In addition, the loss should not be catastrophic, so insurers exclude coverage for losses, such as from war or nuclear radiation that involves an incalculable catastrophic potential.

Limit Coverage of Non-Accidental Events

Exclusions limit coverage of non-fortuitous (non-accidental) events - The policy does not intend to provide coverage for occurrences caused by moral or morale hazards. Moral hazards are intentional acts directly attributable to the insured and caused by defects or weaknesses in human character: morale hazards include the mental attitude that may indicate a subconscious desire for a loss. The policy specifically excludes non-accidental losses that may result from these hazards. For example, if the insured intentionally runs over a pedestrian, coverage would not be provided under either the personal auto policy or the personal umbrella policy.

Insurance coverage is provided only for losses that are accidental and unintentional for two reasons. First, if intentional losses were paid, moral hazard would be increased and premiums would rise as a result. A rise in premiums could result in fewer persons purchasing insurance, thereby making prediction of future losses difficult. Second, covering intentional bodily injury or property damage is contrary to the public good.

Standardize Risk

Exclusions help to standardize the risk - If an insurance company were to assume every possible risk facing a policyholder, the insurer would soon be out of business. To prevent adverse selection, an insurance company tries to cover only those risks that meet certain company underwriting guidelines. It would be inequitable to require all insureds to share the costs of covering the significant loss exposures of a few risks. Therefore, any loss exposures that would require special rating, underwriting or loss control, such as aircraft liability coverage or professional liability coverage, are usually excluded from the umbrella policy. In addition, coverages that are not needed by the typical purchaser of a personal umbrella policy are excluded. These coverages

include workers' compensation and care, custody or control coverages. People who need these coverages may usually purchase them separately for an additional premium.

Prevention of Coverage Duplication
Insurance is a contract in which the insurer, in consideration of the payment of a premium by the insured, agrees to make good the losses suffered through the occurrence of a designated, unfavorable eventuality. Because property and liability insurance policies are essentially contracts of indemnity, the insured cannot be enriched by a loss and may only receive reimbursement for the actual damage sustained. Therefore, as discussed in previous chapters, umbrella policies are designed to dovetail with the underlying insurance policies and to pick up where the underlying policy leaves off. When the insured receives reimbursement for part or all of the loss from any other source, he or she cannot receive duplicate payment from the umbrella insurer. If two or more personal umbrella policies apply to a loss, each policy pays its share of the loss on a pro-rata basis.

Keeping Premiums Reasonable
One of the most important functions of an insurance company relates to the pricing of its policies. The insurer does not know in advance what its actual costs are going to be for the year, but it relies on the company's past loss experience and industry statistics to determine its rates. Insurance pricing must meet certain regulatory and business objectives in order to keep premiums at a reasonable level. From a regulatory standpoint, an insurer's rates must be adequate (high enough to pay all losses and expenses while earning a profit for the company), not excessive (rates should not be so high that policyholders are paying more than the value of their insurance coverage) and not unfairly discriminatory (similar exposure units should be charged the same rates).

From a business standpoint, an insurance company's rating system should be:

-Easy to understand
-Stable over short periods so consumer satisfaction can be maintained
-Responsive over time to changing loss exposures and economic conditions
-Encouraging of loss prevention activities by rewarding insured's with reduced rates for loss control measures that reduce the frequency and severity of losses

Common Personal Umbrella Exclusions

A liability insurance policy promises to pay on behalf of the insured the amount (up to the policy limit) that the insured becomes obligated to pay because of the liability imposed on him or her by law for damages caused by a covered occurrence. As explained previously, the term occurrence is defined as an accident that results in bodily injury or property damage neither expected nor intended by the insured. This definition includes continuous or repeated exposures to conditions that result in injury or damage.

Personal umbrella liability protection is quite broad, but it is possible for the insurance agent and the insured to overestimate the extent of financial protection actually afforded by a policy if they do not fully understand what is excluded from coverage.

Every peril or hazard is not covered. If, for example, a claim arises and the details of the incident show that the source of the claim is an excluded condition or incident, no coverage is afforded under the umbrella policy. The insured would be personally responsible for the expense of investigating and defending the claim. Furthermore, if the insured and the insurance company differ as to the details of the incident, it is the responsibility of the insured to convince the insurer that the incident falls within the policy coverage and should be covered.

Although personal umbrella policy exclusions will vary by insurer, most companies will usually exclude coverage for loss exposures that are better insured under another policy.

Workers' Compensation
Most personal umbrella policies exclude coverage for injuries to employees that should be covered by workers' compensation policy. Workers' compensation insurance covers loss of income, medical and rehabilitation expenses that result from work-related accidents and occupational diseases. This insurance evolved as a means of enabling employers to meet the requirements of the workers' compensation laws of the states in which they operate. Prior to the enactment of these laws, the only recourse open to any employee injured on the job was a negligence lawsuit against the employer - a process that put the employer and the employee on opposite sides of a legal argument.

Briefly, workers' compensation legislation protects workers by providing benefits to a worker or a worker's dependents for injury, disability or disease contracted by the worker in the course of his or her employment. Compensation is made without regard to fault or legal liability. Although specific workers' compensation benefits vary by state, medical and hospital expenses are generally fully reimbursed and monetary allowances are granted for various types of disability. In addition, burial expenses are paid up to a statutory limit.

Care, Custody or Control
Standard liability policies, including most personal umbrella policies, contain a Care, Custody or Control Exclusion. This provision eliminates coverage for property belonging to others that for some reason is in the insured's possession, and that the insured has agreed to assume liability for damage to the property.

The intention of this exclusion is to eliminate coverage for damage to property that:

-Should have been prevented by the insured by exercising care
-Should have been covered by some other form of insurance coverage

Unfortunately, courts do not always agree about what constitutes "care, custody or control". The courts may determine, for example, that leased machinery and equipment or property under construction is considered to be under the insured's custody. Therefore, the insured is held responsible for losses to that property.

Some umbrellas provide coverage if the insured was not obligated to provide insurance coverage for property in his or her care, custody or control and it was damaged. In addition, umbrella coverage usually applies on an excess basis if the primary policy covers the loss.

Nuclear Energy
The personal umbrella policy is not intended to cover the catastrophic risk of a nuclear disaster. In addition, loss caused by nuclear reaction or radioactive contamination, whether controlled or uncontrolled, is excluded from the underlying property and casualty policies. There are specific policies to cover nuclear risk under various pooling arrangements. Nuclear Energy Liability policies, issued by nuclear insurance pools, cover firms that own or operate nuclear reactors and provide proof of a company's financial responsibility if a nuclear accident should occur.

Policies are issued by any of the following or their successors:

-American Nuclear Insurers
-Mutual Atomic Energy Liability Underwriters
-Nuclear Insurance Association of Canada

These insurers issue policies that cover virtually everyone against liability for causing a nuclear incident. Therefore, liability coverage will not be duplicated under the personal umbrella policy.

War Risks
Insurance companies only cover risks that they consider being insurable. Generally, personal umbrella policies have specific wording to eliminate liability coverage for large loss exposures that are considered uninsurable by most insurers. For example, personal umbrella policies usually contain a War Risk Exclusion for losses from war, civil war, insurrection, rebellion or revolution. The insurer is not liable for loss by fire or other perils caused, directly or indirectly, by enemy attack by armed forces, including action taken by military, naval or air forces in resisting an actual or an immediately impending enemy attack. Likewise, damage caused by internal rebellion or other warlike acts is excluded.

Intentional Acts
Any intentional acts of the insured that can be directly attributed to the insured are considered moral hazards and are excluded under most liability contracts. However, in most cases, coverage is provided for unintentional torts caused by the insured's negligence or for the acts of others for which the insured is vicariously liable.

FOR EXAMPLE: If the insured's friend borrows a covered auto and intentionally runs over a mutual acquaintance, the insured would be vicariously liable if the driver was acting as an agent of the insured at the time of the injury.

In essence, the driver while driving the insured vehicle with the permission of the insured is also an insured. However, in this situation, if the insured were driving and the injury was caused by the intentional act of the insured, coverage would be excluded.

Aircraft
Many policies define the term aircraft as a plane, seaplane, amphibian or helicopter, including operating and navigational instruments, radio equipment and other equipment attached to or carried on the aircraft. Aircraft may also be defined as a heavier-than-air or lighter-than-air vehicle designed to transport persons or property through the air. The definition usually excludes coverage for a hovercraft, which is considered to be a recreational vehicle.

Aircraft liability insurance is similar in design to an automobile liability policy and provides coverage for losses arising out of the ownership, maintenance or use of aircraft for which the insured is liable. Under this coverage, two types of bodily injury may be covered: Bodily Injury Liability, excluding passengers, and Passenger Bodily Injury Liability. Typically, Property Damage and Medical Payments are also covered.

Although some personal umbrella policies provide aircraft liability coverage, most exclude coverage for any personal injury or property damage due to the ownership, maintenance, use, loading or unloading of aircraft owned or chartered by the insured. However, if the insured has an underlying aircraft liability policy and it is listed on the personal umbrella Declarations page, some coverage may be provided by the umbrella. In most cases, the insurer will pay the difference between what is payable under the aircraft liability policy and the total legal liability of the insured, up to the liability limit of the umbrella.

Watercraft
Many liability policies, including the Commercial General Liability policy, contain an exclusion for "bodily injury" or "property damage" that arises from the ownership, maintenance, operation, use, loading or unloading of any owned or non-owned watercraft. The personal umbrella liability policy will also typically exclude this coverage.

There is an exception, however, in that this exclusion does not apply to any injury or damage arising from owned or non-owned watercraft while they are ashore and on premises owned, rented or controlled by the insured.

It should be noted that the homeowners' policy provides some liability coverage for certain types of watercraft owned or operated by the insured. For example, liability coverage is provided for non-owned watercraft that are not sailing vessels and are powered by an inboard or inboard-outboard engine or motor power of 50 horsepower or less. When there is underlying coverage, most umbrellas provide excess coverage in the same way that the primary policy covers the insured. For example, if the primary policy covers "property damage" due to the ownership, maintenance, use, loading or unloading of any watercraft under 25 feet in overall length, the umbrella policy will normally pick up the excess liability coverage.

Recreational Vehicles
For insurance purposes, the definition of a recreational vehicle includes vehicles such as snowmobiles, mini-bikes, all-terrain vehicles (ATVs) and any similar vehicles designed principally for use off public roads, whether or not the vehicles are subject to motor vehicle registration. The definition does not include motorcycles.

Some personal umbrella policies exclude liability arising out of the ownership, maintenance or use of recreational vehicles unless the insured carries underlying limits of liability for these vehicles. For example, an insured may add snowmobile liability coverage for $100,000 to a homeowners' policy by endorsement. If the insured also purchases a personal umbrella policy, that policy typically provides excess liability protection for the insured as long as the underlying limits remain in force.

Business Pursuits
Many umbrella policies exclude coverage for liability arising out of a business activity or business property unless the liability results from the named insured's or a family member's use of a private passenger vehicle. The insurer's intention is to limit coverage for any trade, profession or occupation in which the insured is engaged and which might increase the chance of loss. The definition of business pursuits usually applies to any type of usual or ongoing business, ranging from a professional office in the home to weekly garage sales. In many cases, the umbrella insurer will provide coverage for incidental business pursuits if this loss exposure is covered by an underlying insurance policy, but coverage will be no broader than the underlying insurance coverage.

Professional Liability Insurance
Personal umbrella policies contain exclusions for all claims arising out of a professional person's errors or mistakes made in the performance of the duties of that profession. When a professional fails to meet the standards of skill and care generally accepted for that profession or occupation and causes injury or damage to a client, however, that professional may be held liable and may be required to pay money damages to the injured party. There are two types of professional liability insurance that have been developed to cover this type of legal liability. One is malpractice insurance where the negligent act causes direct injury or harm to a human being. The other is errors and omissions insurance where the negligent act causes losses involving physical things, which in turn may cause damage or injury to both people and property.

Directors and Officers Liability
The personal umbrella policy typically excludes coverage for liability due to the insured's activity as a member of a board of directors or as an officer of an organization other than a charitable, religious or civic nonprofit organization. This exclusion is in keeping with the personal umbrella policy's intention not to provide coverage for business activities that may be covered by another type of policy.

For example, Directors and Officers Liability Insurance (D & 0 Insurance) has been developed to cover the director or officer for liability claims resulting from poor judgment and wrongful acts. D & O Insurance pays on behalf of directors and officers (or reimburses their corporation if the executive receives indemnification) for claims arising out of error, neglect, breach of duty or

misleading statement. The policy also provides for legal defense. It will not cover any active or deliberate fraud.

Although the personal umbrella policy excludes liability for business activities, it typically covers liability due to the insured's civic activities. For example, assume that a teacher, for defamation of character, sues the insured and other members of a school board collectively and individually. Most personal umbrella policies would determine that service on a school board is not a "business activity" and would, therefore, provide a legal defense for the personal actions of the insured. It is also possible that the school board could provide defense for individuals in such a matter, and that the board would pay any judgment.

In addition, the personal umbrella usually provides legal defense when an insured is allegedly slandered or slanders someone else. For example, assume the insured runs for a public office and, during the course of the campaign, he or she accuses an opponent of corruption in several newspaper ads and radio spots. If the insured is later sued for libel or slander, the cost of the legal defense and any judgment against the insured will usually be paid by the personal umbrella carrier.

As part of their duties, underwriters do the following:

-Identify and evaluate loss exposures
-Price the insurance product
-Determine policy terms and conditions
-Make the final risk selection
-Monitor and service the account

The series of steps that underwriters use to select, evaluate, and approve (or reject) applicants for insurance is called the underwriting process. An underwriter who understands and observes each step in this process is likely to achieve a profitable book of business for the insurer.

Identifying and Selecting a Risk

The personal umbrella underwriting process begins with the identification and selection of a particular risk. In most cases, it is the property-casualty insurance producer who initially determines whether a risk will be acceptable to the company. In essence, the producer is a field underwriter for the company who often selects the umbrella risk from his or her existing book of business. The producer typically has had personal or business dealings with the applicant and may attest to his or her personal reputation, background and loss experience over a long period. In fact, the insured's long-term relationship with the insurance producer is often the primary reason that a personal umbrella policy is issued.

In many cases, the prospect for umbrella coverage will be an affluent client, although this is not a requirement for umbrella coverage. As we have stated, anyone who has loss exposures that could result in large liability claims is a candidate for personal umbrella coverage. However, the producer should be careful not to select applicants who present loss exposures greater than those assumed by the insurer in its rates or premiums. Risks should be in the good to above-average range to assure that they may be profitability underwritten.

Using Underwriting Information

The insured is usually asked to answer a series of questions on a detailed application for insurance. Although the producer may complete the application, the named insured is usually asked to verify the information and then sign the application. The application requests information about the risk being considered for insurance coverage and, in some cases, the completed application will be attached to and become part of the umbrella policy.

The questions on the application will vary by insurer, but most applications will ask for information

in these three specific categories:

-Personal information about the named insured and other members of the household
-Information about real and personal property owned, leased or the insured that might present a liability exposure
-General insurance information that can be used to assist the underwriter in determining a premium to be charged for the umbrella coverage

In the following sections, the information from these three categories will be used to show how to determine whether a risk is acceptable.

After the application has been completed and signed by the applicant, the insurance producer forwards the information to the line underwriter (usually located in the home office) who makes the final determination about whether the risk can be written and at what premium. The home office underwriter analyzes the information provided on the application and measures it against a theoretically ideal risk to judge whether the applicant is a good candidate for insurance.

Personal Information
The underwriter needs personal information about the insurance applicant to determine whether the risk presents any unwanted hazards for the company. The underwriter looks for specific warning signs of potential moral or morale hazard. For example, assume that during the ten years the insured has carried homeowners' and auto insurance with a particular insurer he or she has maintained extremely low limits of liability. The applicant's sudden interest in increasing the underlying limits and obtaining an umbrella may indicate that this is a poor umbrella risk. The underwriter should question what has happened to make the applicant now interested in increased limits.

The application provides the underwriter with basic information about the individual applying for insurance (the named insured) and members of the named insured's household. The information is used to give the underwriter a feeling for the loss exposures faced by the entire household.

The application typically asks for the following details:

-Name, mailing address and residence address of the applicant
-Marital status; age (or birth date) of the applicant and spouse, in states where such questions are permitted
-Occupation and employer of applicant and spouse (if any)
-Information about stability factors, such as ownership of home, years at present address, previous residence address and length of time at that address
-Information about any liability claims made against the insured during a specified period (usually three to five years)

Such information is intended to assist the underwriter in deciding whether the applicant has any unusual exposures to loss. For example, many insurers will decline coverage for people, such as actors, professional athletes and politicians, whose professions or activities expose them to extraordinary publicity and potentially large lawsuits.

Property Loss Exposures
The personal umbrella liability application asks the applicant to describe any residence or other real property owned by the insured that could generate a liability claim. The underwriter is specifically looking for clues about the property, such as inferior construction or poor housekeeping, which might increase the chance of loss.

Because the personal umbrella typically provides coverage on a worldwide basis, the underwriter needs information about all the property at risk.

The application seeks the following:

-Information about all residences occupied by the applicant, type of interest (owned or rented), description of any other buildings on the residence premises, the number of swimming pools at each location

-Information about any farms owned or rented by the applicant, including the acreage and value of any leased property

-Information about all automobiles owned or leased by the applicant, including the type and principal operator of each, where it is garaged and the rate class used for each vehicle

-Information about watercraft owned or leased by the applicant, including manufacturer, model year, type, length, horsepower, location of operation and whether any underlying policy has restrictions on water-skiing

-Information about any aircraft owned or used by the applicant with descriptions of each aircraft and additional information about the pilot

-A description of employer's liability or workers' compensation exposures, including number and type of domestic and/or farm employees

-A description of all business pursuits and business properties of the applicant

-A description of any unusual hazards, such as dangerous animals on the premises, water-skiing activities by any member of the family, child care duties (such as babysitting) by any member of the family, plans to enter a race, contest or exhibition, etc.

General Insurance Information
An underwriter needs as much general information about the risk as possible to properly quote the risk. Rating is based in part on an underwriter's experience and judgment and without fairly complete knowledge of the risk, an underwriter cannot provide a competitive quotation.

At the very least, an underwriter will request the following:

-The policy limits desired and the requested effective date

-A schedule of all applicable underlying policies: automobile, homeowners', boat, recreational vehicles, aircraft, employer's liability or workers, compensation insurance (information typically includes the name of the insurer, policy number, effective dates, limits of liability and the premium per policy)

-Information about other insurance policies in force, such as those providing coverage for business pursuits or business properties (any exclusions or limitations of liability coverage must be noted on the application for the personal umbrella policy)

-Information about any previous personal umbrella insurer, including name of the insurer, policy number, effective dates and reason for changing insurers

-An explanation of the circumstances if any insurer has ever canceled, refused, or denied renewal of a personal umbrella policy for the applicant

Accepting or Rejecting the Risk

Based on the personal, property and general information received on the application and an

analysis of that information, the underwriter will make a decision about whether to accept or reject the risk. Many underwriters will not go to great lengths to secure information other than that on an application. They assume that if another insurer willingly provided underlying insurance, the risk should be acceptable for umbrella insurance. However, some insurance companies will write umbrella coverage only if they also write the required underlying coverage. Other insurers write stand-alone policies and do not require that they issue the underlying policies but only that the coverages are in place with some insurance company.

The underwriter determines the acceptability of a particular risk by checking it against a large number of factors known to be related to loss potential. Some underwriters feel that if a property is eligible for a homeowners' policy under another insurer's underwriting guidelines, it is also eligible for umbrella coverage. Most underwriters would agree, however, that even though a risk is eligible for insurance coverage, it might be declined for any number of reasons. For example, the applicant may have an attractive nuisance, such as a swimming pool or a vicious dog, which is not properly safeguarded. Although the primary insurer may consider this an acceptable risk, the umbrella underwriter may be concerned about the likelihood of a multimillion-dollar lawsuit if a child drowns in the insured's pool or is killed by the insured's dog. It is likely that an umbrella underwriter would decline such a risk or require additional safeguards before the umbrella policy is issued. The underwriter may also charge an additional premium for certain hazardous exposure.

Most insurers refuse to issue coverage for persons who are engaged in illegal activities, who have unusual exposures to libel or slander suits, such as broadcasters and newspaper reporters, or whose activities cause them to face significant publicity, such as actors, professional athletes, public lecturers and politicians. The general feeling among insurers is that such persons offer substantial exposure to lawsuits and large liability settlements.

Pricing the Risk

One of the most important parts of a personal line underwriter's job is to determine the proper pricing for various insurance products. The policy premium is determined by multiplying an insurance rate, the dollar amount charged per a particular amount of insurance coverage, by the amount of insurance needed. Actuaries who collect data and analyze the many factors that determine the relative hazards of different risks usually accomplish the highly technical procedure of establishing rates. The costs of establishing rates would be prohibitive if each insurance company were to maintain its own rating bureaus. A practical method of solving this problem is for groups of insurers to act together to set up a central body to promulgate proper rates. In addition, the pooling of various insurers, experience makes more accurate results possible.

Strictly speaking, no two personal umbrella risks present exactly the same hazards. Even if two applicants have identical dwellings, the structures will differ as to their contents, maintenance, number of occupants and so forth. The applicants will have different types and numbers of automobiles, insurance requirements, loss histories, etc. Because these applicants have different loss exposures, an underwriter will use specific (or schedule) premium rates. The rate is determined by an analysis of the insured's application, which is compared in terms of the relative loss exposures against a theoretical average risk. Using a predetermined average price as a base, the risk being considered is given credit for superior elements, such as fire-resistive construction, loss control devices and high-level maintenance. Risks with hazardous exposures, such as swimming pools, are often surcharged if the underwriter wishes to cover those types of risk.

Issuing the Policy

After the underwriter has analyzed and priced the risk, he or she will usually forward a written premium quotation to the producer. The underwriter will note the general terms of the policy, such as the required underlying limits of liability, the amount of the self-insured retention, the proposed effective date of the policy and so forth. The producer then forwards the information to the insured that accepts or declines the quote. If the insured accepts, the underwriter proceeds with the issuance of the actual policy. In almost all cases, the producer cannot bind or issue personal

umbrella liability coverage.

Although the basic coverages do not vary greatly, the policy appearance and format will be quite different. In addition, the underwriter may change the coverages and modify the basic policy by endorsement. The underwriter may wish to amend the general policy provisions to comply with the special needs of the applicant, to cover unique situations also covered by the underlying policies or to restrict certain risks that the underwriter does not wish to cover.

Monitoring the Risk

The final step of the underwriting process is monitoring the risk throughout the policy term to confirm that the decision to write the risk was a good one. The underwriter often works with other departments, such as the accounting and claims departments, to be certain that the premiums are paid in a timely manner and that the insured's loss experience is not excessive. As part of the monitoring step, the underwriter will often follow up with the producer about three months before the umbrella's expiration date to offer a renewal policy. Although most umbrella policies are annual policies without a guaranteed renewal provision, some underwriters will send a notice of non-renewal if the company does not want to reissue the coverage. Sending a notice of non-renewal informs the producer and the insured that umbrella coverage will have to be placed with another insurer and also protects the insurer if there is some dispute about whether coverage should have been in force after a specific date. In some states, this notice may be required by statute.

Basics of Insurance

Now that we've covered the ins and outs of homeowners', auto, personal property and umbrella insurance, we might as well run through the basics of insurance to refresh your memory of the common and basic terms, definitions and concepts of insurance.

Transferring the Risk

Insurance transfers the risk of an uncertainty of a loss from an individual to an insurer. Loss is a factor of everyday life and most people handle small everyday losses on their own, but when there is a potential for an unmanageable loss, individuals and businesses look for other sources to be protected from financial ruin.

The insurance company fulfills this role and charges a fee or "premium" based on the risk of the loss. The factors that come into play in insuring the risk are

-The certainty of the loss
-The management of the risk
-The reduction of the risk

An example of certainty might be this: Is a home sitting on a mountainside where landslides are an everyday occurrence, or is the home sitting in a subdivision of leveled land where there is no potential of landslide? Another example might be to compare a home situated in a flood plain versus one that is not.

An insurance contract transfers the risk from an individual, a business, or a group of individuals to an insurance company in exchange for a premium. The premiums of many individuals are 'pooled' by the insurance company to create the funds necessary to pay the insureds that suffer the losses.

This method of transferring risk to the insurer is based on statistics showing how many potential losses can occur within a numerical quantity of people. The higher the quantity of people used in establishing the statistics the more accurate the prediction will be.

These predictions are then used by the insurer in establishing premiums to be "pooled" in covering

the losses.

Insurable Interest
Before an individual or an entity can be insured it must have insurable interest. Insurable interest is defined as any actual, lawful and substantial economic interest in the safety or preservation of the subject of the insurance from loss or destruction or financial damage or impairment.

In addition to insurability, other criteria are also used in determining if insurance can be used as a vehicle for the transference of the risk.

These other considerations include the following:

-The risk of loss must be definite and difficult to fake.
-The risk must be unexpected.
-The risk must create a financial hardship.
-The loss must be able to be assigned a financial value.
-The cost must be affordable or fractional of the value.
-The loss must be predictable by virtue of a high enough quantity of people to require the same coverage.
-The presence of the "spread of risk" must be available.
-The risk must be pure, not speculative.

Loss Frequency, Reduction and Prevention
Loss frequency, loss reduction, and loss prevention are terms that will be heard over and over again in dealing with property and casualty insurance.

For example, proper training of an employee using a blowtorch or other high-risk machinery would curtail loss frequency. Risk control techniques that diminish the loss frequency come under on the heading of loss reduction.

Installing a sprinkler system in a home, office, or factory would curtail the severity of the damage and thus serve as a risk reduction.

Types of Risk
Spread of risk is defined as the insurers' ability to spread their insured risks over a large geographical area. Pure risk is defined as a risk in which there is no chance of gain - only loss. On the other hand, a speculative risk is defined as a risk that can either result in a loss or a gain.

Peril and Hazards
In discussing property and casualty insurance, the terms peril and hazard need be defined. A peril is defined as the cause of the loss.

A hazard is anything that increases the chances of a peril occurring. An underwriter examines an insurance application to gain an understanding of the hazards in place for a particular risk, allowing him or her to better identify that risk's level. There are the following four distinct types of hazard:

Physical Hazards – Poor health, dangerous hobbies, and high-risk occupations are types of physical hazards.

Moral Hazards – Moral hazards are psychological. People who demonstrate a level of dishonesty in their lives or have been convicted of a felony or DUI may be declined coverage based on their poor morality (in insurance terms).

Morale Hazards – Careless and irresponsible people fall into this category of hazard. An example

of a morale hazard is someone who has numerous reckless driving arrests on his or her record. An individual who appears to be indifferent to loss would present a morale hazard.

Legal Hazard – People who demonstrate a tendency to sue others or file frivolous lawsuits are a clear legal hazard for an insurance company and are often declined.

Other Methods of Handling Risk

We all handle risks differently. How one handles risk affects not just the amount of insurance he or she needs, but how he or she will be viewed by an underwriter. In addition to the transfer of risk, which we have already covered, risk is handled by one or a combination of the following:

Avoidance
One of the best ways to handle risk is to avoid situations that could result in a loss. However, avoidance is not a realistic concept. Common sense tells us that avoiding driving when drunk is a good way to handle risk. An extreme example of avoidance would be to not leave home for fear of becoming injured or killed.

Control
Being in control of an area of possible loss is a way to manage risk. Homeowners can help to control the risk of their homes burning down by installing smoke detectors. Individuals can submit to annual check-ups to help control risks associated with their health.

Retention
Personal acceptance of the price of loss is called retention. People who pay their medical bills, as opposed to purchasing health insurance, or the action of selecting a deductible under an insurance policy are examples of retention.

Sharing
This method of handling risk has a group pooling together to share the costs of a loss experienced by one member. In insurance terms, a group of insurers can bank together and share losses so no one member bears the burden of cost individually.

Section 2: Ethics

Chapter 3 Ethics – General Insurance Basics

Elements of a Legal Contract

Insurance contracts are contracts of a specific nature, and are described as the following:

Aleatory Contract
An insurance policy is an "aleatory" contract, which means that performance depends on the occurrence of an uncertain event. Due to the nature of the contract, each party may not give and receive the same value. The insured who collects for a loss may receive more than the amount of premiums paid, while the insured who never has a loss receives only intangible security.

Personal Contract
Generally, insurance policies are personal contracts between the insured and insurer. Except for life insurance and some marine coverage involving transportation and cargo, insurance is not transferable to another person without the consent of the insurer. Fire insurance, for example, does not follow the property. If an owner sells an insured building and no arrangements are made for transferring coverage to the new owner, no insurance exists. The previous owner no longer has insurable interest, and the new owner has no personal coverage.

Unilateral Contract
Insurance usually involves unilateral contracts. Under a bilateral contract, a promise is exchanged for another promise, and both parties may execute the obligations in the future. Under a unilateral contract, an act is exchanged for a promise. Once the insured pays the policy premium, only the insurer makes promises about future performance.

Conditional Contract
Insurance contracts are also conditional contracts because when a loss occurs, certain conditions must be met to make the contract legally enforceable. For example, an insured might have to satisfy the test of having an insurable interest, and also satisfy the condition of submitting proof of loss.

An insurance applicant is required to exercise "utmost good faith" in providing information on which the insurer must rely. A material fact is an important fact that could change either the decision to provide insurance or the premium. Concealment or false statements about material facts may allow the insurer to declare the insurance void at a later date.

Agents also have responsibilities while forming an insurance contract. If they are not careful, or if they bend the truth, the insurer may lose certain rights, and the insured may gain rights more favorable than those spelled out in the contract provisions.

Ambiguities in a Contract of Adhesion
Any ambiguity must be interpreted in favor of the insured, because the insured has little or no control over policy content

Reasonable Expectations
The reasonable expectations doctrine can be stated as follows: The courts will honor the reasonable expectations of policy-owners and beneficiaries, even if the strict terms of the policy do not support those expectations.

The implementation of the reasonable expectations doctrine has resulted in what one author termed "judge-made insurance." The claimant's expectation of coverage, the insurer's part in creating that expectation, and the unfairness of a policy provision are factors that can influence the court to grant coverage where the policy does not provide it.

Indemnity and Subrogation
Most property and liability insurance is written on an indemnity basis - the intent being to make someone "whole" again by paying actual losses while preventing any gain. Many policies also have a subrogation clause designed to prevent an insured from collecting twice for the same loss.

Subrogation is related to the concept of indemnity. It only applies when a third party caused the loss or was primarily responsible for it through negligence. A loss victim usually has legal recourse against the party at fault. Subrogation transfers this right to the insurer when a loss is paid, but only to the extent of the insurance payment.

Utmost Good Faith
The insurance contract requires utmost good faith between the parties. This means that each party is entitled to rely upon the representations of the other, and each party should have a reasonable expectation that the other is acting in good faith without attempts to conceal or deceive.

Representations/Misrepresentations
Most of the statements contained in the insured's application for instance are representations - statements that the applicant believes are true. Under the law, a representation is not considered a matter to which the parties contract, so a policy cannot he voided on the basis of a

representation.

Misrepresentation is a written or verbal misstatement of a material fact involved in the contract on which the insurer relies. Misrepresentation will only void the policy if it concerns a material fact. A material fact is a fact that would cause an insurer to decline a risk, charge a different premium or change the provisions of the policy that was issued.

Warranties
A warranty carries greater weight than a representation because it is part of the actual contract. When an application is made part of the contract, all statements on it become warranties. Promises contained in other parts of the contract are also warranties. Under a strict interpretation, any breach of warranty (whether or not material) provides grounds for voiding the insurance.

Concealment
A failure to disclose known facts is concealment. The insurance applicant has a duty to disclose material facts that the insurer could not be expected to know. Generally, an insurer may be able to void the insurance if it can prove that the insured intentionally concealed a material fact. In reality, it is difficult to prove such intent in a court of law.

Fraud
Fraud is a deliberate misrepresentation that causes harm. An act of fraud contains these four elements:

-Someone deliberately lies.
-The intent of the lie is for someone else to rely on that lie.
-Another person relies on that lie.
-The other person suffers harm as a result of relying on that lie.

Fraud differs from misrepresentation in that misrepresentation may be either intentional or unintentional. Fraud is always intentional and involves an effort by one party to deceive and cheat the other.

Waiver and Estoppel
The legal definition of waiver is the intentional relinquishment of a known right. Sometimes an Insurer or its representative knowingly overlooks a condition or exclusion that would normally have been grounds for denying coverage, increasing the premium, reducing the benefits provided in the policy, or some other material change in the policy. When the insurer or its representative relinquishes the insurer’s right of denial or refusal, the act becomes a waiver. Though any policy provision may be waived, the requirement of an insurable interest may not he waived, nor may facts be waived.

If an insurance company representative intentionally or unintentionally creates the impression that a certain fact exists when it does not, and an innocent party relies on that impression and is damaged as a result, the insurance company will be estopped (prevented) from denying this fact. For example, if an agent states or indicates by his or her actions that a particular loss is covered, the insurance company will be estopped from denying that coverage.

Ethical Issues
No matter what line of business we are in, the subject of ethics is important to both management and agents.

It is especially critical to those handling insurance products that in some facet deal with the financial, stocks and bonds industry. It is critical that we keep in mind what is right and what is wrong.

When a person applies for insurance or files a claim, he or she must be able to trust that the insurer is ethical. This is especially true in terms of claim settlement. After all, the only time insurance really matters to the insured is when he or she actually has to use it. If that process is compromised by an unethical agent, adjuster or insurer, insurance is pointless.

Ethical Decision-Making
Making an ethical decision is made simpler when one asks the following three questions: Is it legal? Is it balanced? How will it make me feel?

If an agent or adjuster answers "no" to either of the first two questions, chances are he or she is contemplating an unethical action. A decision that results in something illegal (whether on a civil level, or in violation of company policy) is not ethical.

In terms of balance, an agent or adjuster needs to ask if the result of the decision will benefit everyone involved now, as well as later down the road. If an adjuster approves an auto claim on the condition that the policyholder will use the adjuster's brother's auto shop for repairs, he or she needs to ask whether that little business to his brother is worth the possibility of losing his or her license.

When it comes to how a decision will make the agent or adjuster feel, it is simply a matter of pride and shame. Will the individual be proud of the decision? Would he or she want his or her family to know?

There are many opportunities for unethical behavior in the insurance industry – as with many other areas of finance and protection. An agent or adjuster cannot rely on the "Everyone else is doing it" motto. Ethics and honesty always matter, and there is truth to that other motto: "What goes around comes around."

What is Considered Unethical?
Both senior management and workers closely agree that unethical behavior, although not illegal, is grounds for termination.

Some examples of behaviors considered serious ethics violations by management include the following:

-Supervisor access to employee health records
-Using resumes to discriminate
-Personal credit checks on employees
-Making misleading promises to employees or contractors

Some examples of behaviors considered serious ethics violations by employees include these:

-Using E-mail to harass co-workers
-Use of drugs at work
-Use of alcohol at work
-Circulating pornography by E-mail
-Falsifying experience on a resume
-Revealing confidential information
-Making misleading statements or promises to customers and clients

Because insurance companies and agents are in a position of trust, ethical behavior is paramount to perpetuating the industry and profession of each agent.

Both the insurer and the agent have an obligation to each other to be truthful and honest with each other through their agency relationship. In some cases, the agency relationship continues

and a level of honesty and proper representation is required with the client.

State laws further enforce this requirement of honesty and proper representation through the various state Departments of Insurance.

The Topic of Trust
What is legal is not always ethical, and what is unethical is not always a violation of state or federal laws.

The insurance industry is a business of trust, and although most consumers feel they trust their agents, studies indicate that the average consumer does not have the same concept of other agents or the industry as a whole.

An interesting fact that is presented by consumer surveys and studies is that more than 50 percent of consumers rated trust and ethics higher than professional qualification, which comes in at the bottom of the list of the nine topics surveyed.

Over the years the insurance industry has earned the trust of the consumer, and perhaps more information and public exposure of the history of the industry would serve well to strengthen the public's perception of the industry.

During the great depression and the years that followed, although many individuals lost savings as bank and savings and loans closed their doors, the insurance industry remained solvent and in many cases became a source of funds for individuals.

Through the built up assets of life insurance policies, individuals were able to borrow money to carry them through these very difficult times.

Agent Ethics at Work
Because the industry is made up in a great percentage by independent agents, workplace ethics is critical to creating sound ethical behavior by agents as they deal with customers and clients. These behaviors must come from within the agent and must be reflexive in nature in order to avoid a dereliction of this responsibility when faced with everyday work demands.

Having to meet either employer work quotas, personally set quotas, or to satisfy a personal need to be the "best" must never stand in the way of meeting the clients' needs and the need to paint an impeccable image of the insurance profession.

Although individuals in every profession are there to serve the needs of supporting themselves or their families, because insurance agents are licensed they are put in a position of trust. Their needs of self preservation must be put aside, and the interest of the client must always be put first. This is also known as "altruism."

Taking Advantage of Consumers' Lack of Knowledge on Insurance
Ethical conduct can easily be violated by selling someone more insurance than they need in order to earn more commission. Or perhaps sell someone a higher commissioned product, even though another policy would serve hiss or her needs better. Although not necessarily illegal both these actions would be unethical, not consistent with meeting the clients' needs and perhaps to a knowledgeable observer be a source of mistrust of the insurance professional and the industry.

Because insurance is a product that requires a most skilled individual to interpret its benefits, an agent's knowledge and recommendations are held to a high level of accountability.

The average consumer has neither the skill nor the ability to interpret the information in a policy accurately or to realize the additional options that may be available to him or her in order to

properly meet the needs of his or her situation. An insurance agent plays a vital role in the decision making process and this trust should never be violated.

Win-Win
Selling insurance must be a "win, win" situation for all parties involved in the transaction.

An agent can look at a situation as a one-time sale and try to maximize his or her gain from that transaction without regard for the client's needs or look at it from the point of view that it is the beginning of a long lasting professional relationship. The latter point of view will earn the agent many more transactions, future referrals and commissions, and it can only be accomplished through professional conduct and ethical behavior.

Ethical Principles

Ethical standards outlined by various groups and insurance associations set the standard for ethical behavior within the industry. In many cases these organizations were in place before even state licensing bodies and, as such, actually set the pace for legislation that now governs the industry in many states.

Organizations that have such ethical standards in place include the following:

-The National Association of Life Underwriters
-National Association of Fraternal Insurance Counselors (NAFIC)
-Code of Ethics of the Million Dollar Round Table (MDRT)
-The American College
-The American Society of Chartered Life Underwriters (CLU)
-The American Society of Chartered Financial Consultants (CHFU)
-General Agents and Management Association (GAMA)
-Independent Insurance Agents of America
-American Institute for Chartered Property and Casualty Underwriters

The National Association of Life Underwriters
The National Association of Life Underwriters prescribes to a belief that all members have a combination of professional duty to the client and company and to maintain a balance between these two as to avoid conflict that might injure either. As a result of this belief, they subscribe to a commitment of responsibility that requires the members the following:

-To hold the insurance profession in high esteem and strive to enhance its prestige
-To fulfill the needs of their clients to the best of their ability
-To maintain the confidence of their clients
-To render exemplary service to their clients and beneficiaries
-To adhere to professional standards of conduct in helping their clients
-To protect their insurable obligations and attain their financial security objectives
-To present accurately and honestly all facts essential to their client's decisions
-To perfect their skills and increase their knowledge through continuing education
-To conduct business in such a way that by example will help to raise the standards of life underwriters
-To keep informed with respect to applicable laws and regulations and observe them in the practice of their profession
-To cooperate with others whose services are constructively related to meeting the needs of their clients

The National Association of Fraternal Insurance Counselors
The National Association of Fraternal Insurance Counselors requires that its sales personnel adhere to a position of utmost professional standards to their clients and at the same time maintain a position of trust and loyalty to their society. The highest ethical standards are required

of all its members.

Its members must do the following:

-Hold the life insurance profession in high esteem and constantly strive to advance the prestige of legal reserve Fraternal Life Insurance
-Improve their ability and improve their knowledge through regular study and encourage other underwriters to do likewise
-Respect their clients' confidence and hold in trust any personal information
-Present accurately and completely all of the facts essential to have their clients make informed decisions and to always place their interests and welfare above any personal consideration
-Refuse any person or persons any part of their commissions or earnings as an inducement to purchase life insurance
-Submit complete and accurate applications for memberships and insurance on only those persons whom are believed to have the proper moral and medical requirements that conform to the Society's underwriting rules
-Cooperate with all fellow associates in all insurance organizations in furthering the best interests of the Institution of Life Insurance

The Million Dollar Round Table
The MDRT, head-quartered in Park Ridge, Illinois, represents an organization whose members are comprised of individuals who must reach certain production and persistency objectives. Its members must do the following:

-Always place the best interests of their clients above their own direct or indirect interests
-Maintain the highest standards of professional competence and give the best possible advice to clients by seeking to maintain and improve professional knowledge, skills, and competence
-Hold in the strictest confidence, and consider as privileged, all business and personal information pertaining to their clients' affairs
-Make full and adequate disclosure of all facts necessary to enable their clients to make informed decisions
-Maintain personal conduct which will reflect favorably on the life insurance industry and the MDRT
-Determine that any replacement of a life insurance or financial product must be beneficial for the client
-Abide by and conform to all provisions of the laws and regulations in the jurisdictions in which they do business

American College Code of Ethics
The American College, a fully accredited institution of higher learning, offers courses to life insurance agents across the country. These courses lead to the coveted designations of Chartered Life Underwriters (CLU) and Chartered Financial Consultants (ChFC). The American College Code of Ethics is made up of a professional pledge and Eight Cannons. The Eight Cannons consist of the following paraphrased promises:

-Honor and dignity in the conduct of business
-Avoid practices that would bring dishonor to the profession
-Publicize accomplishments only in manners that enhance the integrity of the profession
-Maintain professional competence through continuing education
-Strive toward a career of distinguished professional service
-Support the institution and organization that strive for professionalism within the industry
-Assist others in the industry striving for professionalism
-Comply with all laws and regulations

Ethical Imperatives

The following imperatives have been established by the CLU and ChFU:

Competently Advise and Serve the Client

Both organizations require that their members provide both advice and service which are in the best interest of the client.

Because insurance agents, real estate agents and other professionals have an understanding about their product which is above the knowledge of their average client, professionals must take care to avoid using this knowledge to the detriment of their client. In other words, they are in a position of trust that cannot be violated in order to serve their own interest.

In a conflict of interest situation, the client's needs must be met ahead of an agent's own needs.

The agent must make a full and concentrated effort to both explore and ascertain through that information the needs of the client.

Consideration and courtesy must be undertaken in referring to other professionals who might also be serving the client. In other words, don't knock the competition whether you're trying to get the sale or discredit them.

An agent must give due regard the principal and agent relationship that exists between himself or herself and the companies they represent.

Agent to Client Confidential Relationship

The relationship between the client and agent is that of a confidential nature and all such information should be kept within that scope.

Because, in order to properly serve the client, the agent must sometimes inquire into areas that might require the strictest of confidence. The agent must keep this information confidential and use it only for the purpose it was intended, unless released of this obligation by the client.

Continuing Education Requirement

Members of these organizations must maintain and enhance their professional skills and knowledge.

This enhancement can be formal or informal and must, not only include personal education, but also include knowledge of changing laws and legislation to properly inform clients.

Enhancement of Public Regard for Professional Designations

A member must obey all laws governing his or her business or professional activities. Business activities are defined as non-personal activities carried on outside the life insurance community. Professional activities are defined as non-personal activities carried on within the life insurance community.

Through the placement of the guide within the Code, an ethical obligation is created for a member to obey all laws applicable the agent's business or professional activities.

A member must avoid activity that detracts from the integrity and professionalism of the CLU and ChFC designation or other professional designations.

Personal, business and professional activities are encompassed within the scope of the Guide.

Things or actions that might be interpreted of a violation of the Guide include the following:

-Failure to obey a law unrelated to the member's business or professional activity
-A member harming the reputation of another practitioner
-A member unfairly competing with another practitioner
-A member performing activity that might discredit his or her own reputation
-A member discrediting life underwriting as a profession, the institution of life insurance, or the American Society of CLU & ChFC
-A member advertising the designations of the CLU or ChFC or American Society in an undignified manner or in a manner prohibited by the bylaws

Members of these organizations are encouraged to encourage others to obtain the designation.

Members cannot use the CLU & ChFC designation in a false or misleading manner. That is, members alone can use the designations and no advertising shall promote an entire organization as having the designation, when in reality the designation is individually bestowed.

The General Agents and Managers Association
The General Agents and Managers Association (GAMA) of The National Association of Life Underwriters codifies the ethical principles that general agents and agency managers should strive to maintain.

The organization encourages its members to practice the "Golden Rule" by the following:

-Using the best available techniques to select and place under contract only agents and managers that will enhance the professionalism of the profession
-Creating a sales organization made up of full time agents
-Providing adequate training and supervision to render proper service and advice to their clients
-Encouraging all associates to pursue additional and continuous education
-Encouraging all agents and contractors to participate and support the activities of the local
-Association of Life Underwriters
-Presenting fairly and honestly all facts regarding the agency to prospective agents or managers.
-Encouraging any prospective agent or manager to discuss his/her situation with his/her present manager before making a decision
-Taking a leadership role in the advocacy of the Life products as the best benefit to its policy owners

Independent Insurance Agents of America
Independent Insurance Agents of America is the nation's oldest and largest independent agent association. It is a highly regarded consumer advocacy organization and a powerful force within the insurance industry. The Independent Insurance Agents of America makes its presence known both in the media and on Capitol Hill. The association was founded in 1896 by a small group of local fire agents and now has grown to represent over 300,000 agents and their employees.

As it enters its second century of existence, the Independent Insurance Agents of America has expanded its activities to address the many challenges and opportunities that agents today have to face. Through its federation of 51 state associations, as well as its headquarters and Capitol Hill offices, the association provides advocacy, business tools and media visibility to its members.

The Independent Insurance Agents of America represents more than half of all the independent insurance agencies in the country. Its members range from small rural agencies selling personal lines to large commercial brokers handling major national accounts

Independent Insurance Agents of America strive to serve the public by promises to do the

following:

-Serve the public through the honorable occupation of insurance
-Provide the full measure of service required of an independent agent
-Recommend the best coverage to meet the needs of the client
-Provide the public with a better understanding of insurance
-Work with national, state and local authorities to heighten safety and reduce loss in a community
-Recognize civic, charitable, and philanthropic movements which contribute to the public good of the community

Independent Insurance Agents of American strive to serve the companies they serve by these things:

-Respecting the authority vested in them by the companies they serve
-Using care in the selection of risks submitted
-Expecting the same from the companies served as is rendered to them

To fellow members, Independent Insurance Agents of America pledge to maintain

-Friendly relations with other agencies, with fair and honorable competition
-Strict observance of insurance laws
-Betterment of the insurance business
-Encouragement of others to subscribe to the same high standards

The American Institute for Chartered Property and Casualty Underwriters
The American Institute for Chartered Property and Casualty Underwriters (CPCU) is an independent, nonprofit organization offering educational programs and professional certifications to people in all segments of the property and liability insurance business. To help them provide professional service to the public, the organization responds to the educational needs of people in insurance and risk management.

The CPCU offers an online counseling system to help individuals inventory their personal background and interest, making suggestions for appropriate programs of study.

The American Institute for CPCU, through its canons and rules endeavors to maintain a high degree of professionalism and ethical conduct for its membership.

-CPCU members should at all times place the public interest over their own and should encourage non member agents to do the same.
-Members should maintain and improve their knowledge, skills and competence.
-Members should obey all laws and regulations and avoid conduct that would cause unjust harm to others.
-Members should be diligent in performing their occupational duties.
-Members should assist in maintaining and raising professional standards.
-Members should strive to maintain dignified and honorable relationships with others.
-Members should strive in assisting to improve the public understanding of insurance and risk management.
-Members should honor the integrity and respect the limitations placed upon their designation.
-Members should always assist in maintaining the integrity of the Code of Professional Ethics.

Ethical Concepts

There is an entire host of terms and concepts associated with ethics to which you should commit –

and not just because you are an insurance agent. Making ethical decisions and behaving ethically is a characteristic beneficial in all areas of your life.

An Administrative Action - when a legal or ethical violation (of an unlawful nature) occurs and a Commissioner or Director takes actions. This includes investigations, hearings, censures, cease-and-desists orders, suspensions, revocations, monetary restitution, fines and referrals to other agencies for criminal prosecution.

An Agent - different from a salesperson in that an agent is regulated by a licensing body, assuming the responsibility of representing someone else, called a "principal." In doing so, an agent must put the principal's needs ahead of her or his own need.

Assumptions - factors used to illustrate values in insurance policies. It is important to understand that assumptions are not always guaranteed to re-occur and must be presented within a realistic scope in order to avoid ethical misrepresentation.

Authority - the power granted an agent to perform acts on behalf of the principal, such as in the case of an agent's ability to bind a policy or other power granted by either the insurer or the insured in an agency relationship.

Bait-and-Switch - the unethical, deceptive, and illegal act of inducing a consumer to a service or product that the salesperson has no intention or does not have the ability to deliver. The inducement is a method to get the consumer in the door in order to sell him another product.

A Buyer's Guide - a standardized disclosure designed to help consumers understand the product. Many states require agents provide this Buyer's Guide at some point during the sales process, especially in the areas of life or annuity products.

Churning - the unethical practice of inducing a client to replace an existing policy for a new one, even though the additional change is not to the benefit of the client.

Civil Liability-s the liability for monetary damages as a result of a lawsuit brought by a private party in a civil court. Individuals and corporations often use insurance to cover such exposure.

A Code of Ethics - a formal set of rules or statements of policy set by professional organizations and made part of the standards for acceptance of membership. Because ethical standards set by organizations often existed before state licensing, often these standards have been used by state regulators as guides to set the pace for legislation for a profession.

Cognosceat Emptor - the opposite of "buyer beware." Today's consumer must be "fully informed" before making a decision. An insurance agent is both ethically and legally obligated to provide both adequate and full disclosure.

A Commission i- what one collects after providing a service or sale. Under an agency relationship, such as the one that occurs in the sale of real estate and insurance, commission is also paid for advice. Therefore, it can never be put ahead of the needs of the client.

A Conflict of Interest - when an individual's self interest competes with the interest of a client or principal.

Continuing Education - a means of maintaining up to date knowledge of legal and product changes in order to best serve clients and maintain professionalism within an industry. It is required for license renewal in most states.

Degree of Care - the extent of legal duty owed by one person to another. In the case of an

insurance agent, this degree of care is maximized through the agency relation with the client or principal.

Doctrine of Reasonable Expectations - a legal concept that basically states that an insurance policy will be treated as if it includes certain coverage that an average person would reasonably expect it to include, regardless of what the policy provides.

Dual Agency - a situation created when an agent represents two clients in the same transaction who have competing interests. Dual Agency is legal in most states under outlined procedures and full disclosure to all parties.

Errors and Omissions Coverage - professional liability insurance for insurance agents and real estate agents covering liability for mistakes an agent makes in the practice of his or her profession.

Fiduciary - a term used to describe an individual who is entrusted with certain responsibilities of trust. In an agency relationship, an agent has certain fiduciary responsibilities to his or her client. Among those responsibilities include the handling of client funds and the maintaining of confidential information.

Fraud - when an individual intentionally uses deception in order to induce another party to part with something of value or to give up a legal right to his/her detriment.

A Misrepresentation - an inaccurate statement of fact or an omission of a material fact. Misrepresentations are either unintentional or intentional. Unintentional misrepresentations usually result in administrative and civil penalties. Intentional misrepresentations can result in criminal prosecution as fraud.

Multiple Company Representation - a contractual arrangement that permits an agent to represent more than one company at the same time and choose which company will receive his or her policies at any given time. Multiple company representation can result in ethical issues if an agent choosing which company to place business with does not take into account the best interest of the client.

Negligence - not taking the reasonable proper steps to protect others from unreasonable chances of harm.

Rebating - the practice of paying a party to the transaction part of an agent's commission as an inducement to purchase the insurance policy. Rebating is illegal in most states or strictly regulated with proper disclosure in the states that permit such activity.

Replacement - the practice involving the use of funds from one policy, either from an existing policy or the termination of a policy, in order to purchase other insurance. Ethical issues arise only if the use of funds to purchase the new policy is not in the best interest of the client or is motivated strictly by the agent's need for commission.

Twisting - the illegal practice of convincing a client to switch policies with no benefit to, or to the detriment of, the client.

Unfair Discrimination - the practice of applying different standards to insureds that have the same risk loss. The practice is both unethical and illegal.

Many of these key words and concepts apply to the area of ethics. A thorough comprehension of these words and concepts will help you reach a better understanding of the ethical issues that face us each day in the exercising of the insurance profession.

Applying Ethics Benefits the Industry
Knowing what ethics are or what is ethical is one thing. Actually applying ethics in your life and in your work is something entirely different. What good would ethics be if we just talked about them? They must be applied in order to affect an industry or individual.

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. Industrial workers suffered debilitating injuries due to poor work environments, and disabled workers were condemned to poverty and often starvation.

Trusts controlled some markets to the extent that prices were fixed and small businesses were choked out. Price fixing crippled normal market forces. Employees were terminated based on personalities. Influence was applied through intimidation and harassment.

Then, society reacted and demanded that businesses place high value on fairness and equal rights. Anti-trust laws were instituted. Government agencies were established. Unions were organized. Laws and regulations were established.

However, ethics and regulation ride a swinging pendulum. Today it is arguable that government agencies created to fix a problem simply expand and become a problem. Labor unions have gained so much power that they themselves have been corrupted, and bargaining agreements have crippled employers' capabilities for growth. Laws and regulations are established for a reason, but there is such a thing as over-regulation. Everyone knows that with regulation comes red-tape, and it's up to the industry being regulated to do its best to maintain effectiveness and make an effort to ward off bureaucracy if it can.

Ethics programs help maintain a moral course in turbulent times. As noted previously, attention to business ethics is critical during times of fundamental change. During times of change, there is often no clear moral compass to guide leaders through conflicts about what is right or wrong. Continuing attention to ethics in the workplace sensitizes leaders and staff to how to act — consistently.

Ethics cultivate strong teamwork and productivity. Attention to ethics aligns employee behaviors with those values preferred by leaders of the industry. Usually the small office or organization finds surprising disparity between the preferred values of the industry and the actual values in the day-to-day business transactions. Ongoing attention to values and ethics builds openness, integrity and a sense of community for the individual—critical ingredients of a strong leader in the industry.

Ethical standards support individual growth. Attention to ethics in the industry helps an agent face reality, both good and bad, in the industry and in him or herself. In this regard, an agent may feel fully confident and can admit and deal with whatever comes his or her way.

Ethics programs are an insurance policy—they help ensure that policies are legal. There are an increasing number of lawsuits in regard to the effects of services or products on the consumer. Attention to ethics ensures highly ethical policies and procedures in the workplace. Analysts believe it is far better to incur the cost of mechanisms to ensure ethical practices now than incur the costs of litigation later.

Ethical standards help avoid criminal acts of omission and can lower fines. Ethical standards, such as an insurance agent's codes 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. However, ethics guidelines adopted on an industry-wide basis potentially lower fines if an organization or individual has clearly made an effort to operate ethically.

Ethical standards help manage values associated with quality management, strategic planning and diversity management. Ethics programs identify preferred values and ensure that the individual's behavior is aligned with those values. This effort includes recording the values, developing policies and developing procedures to align behavior with preferred standards, and then training personnel about the policies and procedures. Ethics standards are highly useful for managing strategic values, such as expanding market shares, reducing costs, and managing diversity. Diversity is much more than the color of a person's skin—it is acknowledging different values and perspectives.

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 for the reason of 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 of integrity and honor. Aligning behavior with values is critical to effective marketing and public relations programs.

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

Qualities of the Highly Ethical Individual

What makes a person ethical? There are these four basic principles of a highly ethical individual (or organization):

> -The individual is at ease interacting with diverse internal and external groups, i.e., consumers. The "good of the consumer" is part of the individual's own philosophy and own good.
>
> -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.
>
> -The individual assumes personal responsibility for his actions, and he is responsible to himself first and then to his organization.
>
> -The individual sees his actions in terms of purpose. This purpose is a way of operating that members of the industry or organization highly value. Purpose ties the individual to the organization, and the organization to the environment.

Qualities of the Highly Ethical Industry

Virtually every industry on Earth has its ethical challenges. Understanding the characteristics of an ethical industry supports such industries in drafting codes of ethics and levying expectations of companies and businesses within its arena. The following are characteristics of a highly ethical organization or industry:

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

Chapter 4 Ethics – Prohibited Activities

Protecting the Consumer

Ethics must be applied to the way in which an agent conducts his day-to-day business in the insurance industry and how he handles his insurance consumers. Agents should strive to maintain business practice standards that are far above the minimum requirements set out by their states. There are serious penalties for circumventing these requirements.

There are several specific areas where the insurance industry regulates the behavior of the individual agent as well as the insurer, in the form of prohibited activities. The following list is not all-inclusive, and agents must be certain to follow the spirit, as well as the letter, of the law. There are other areas where an agent may run afoul of common practices, and it is the responsibility of each agent to maintain high standards.

Prohibited Activities

Agents are required to follow the ethical standards established in their states, and must not engage in the following prohibited activities:

-Misrepresentation
-Altering applications
-Premium theft
-Unlicensed sales
-Forgery or "Windowing"
-Misleading sales techniques
-Illegal rebates
-Discrimination
-Untruthful Policy Replacement coverage
-Untruths in advertising

Misrepresentation

In the normal course of a discussion with a potential client, an insurance agent may say something inadvertently, or make an error in representation about the insurance product that he/she is presenting. Such omissions or errors are not committed intentionally, and the insurance agent does not intend to defraud the consumer. Without malicious intent, such misrepresentations are not fraudulent, although they are still subject to penalties.

It is the responsibility of the agent to make sure he/she is well-versed about the products he/she offers. If there is any uncertainty about provisions or features, it is incumbent upon the agent to research the issue before providing erroneous information to the client.

The following are a few examples of misrepresentation:

-Advising a client that an auto policy will cover liability when it is only for collision
-Telling a prospective client that dividends are guaranteed when they are not
-An agent telling prospects that he/she represents several companies when in fact he/she represents only one
-Talking about a term life insurance policy in such a way to lead the prospective customer to believe that it will have cash value accumulation

Altering Applications

Altering applications, for any purpose, is not permitted. It is illegal and insurance agents must not engage in altering applications. In the past, applications have been altered for a number of

fraudulent reasons, including these:

-Changing underwriting information to get a more favorable premium rate
-Switching the type of coverage applied for
-Adding additional zeroes to the amount of coverage applied for

Premium Theft
Of all the prohibited activities, premium theft ranks among the worst offense an insurance agent can commit. In addition to the outright theft of the premium money, failure to turn over a premium on a policy prevents the policy from going into effect. The consumer believes he/she is insured, but in fact, his/her application was never submitted to the insurance company. These situations are quickly discovered if the prospective insured or the insurance company makes any inquiry. Every state insurance department rigorously punishes premium theft.

Unlicensed Sales
As mentioned previously, license regulations help protect the general public and allow the insurance department to maintain standards of uniformity. By licensing individual agents, the state can provide some level of assurance to the consumer that his/her needs will be met by an individual capable of offering guidance and competency. Each member of the insurance industry strives to maintain the standards established, for those who do not may tarnish the reputations of the other members of the industry.

Agents must be licensed properly to sell insurance in the jurisdictions where they do business. A resident license is required for selling within the state where the agent resides. Should an agent sell in another state, he must obtain a non-resident's license to do so. In many states, additional licenses may be required to sell variable products, such as variable annuities or variable life. The sale of products other than life insurance, such as property and casualty or investments, also requires a separate license.

It is the responsibility of every agent to comply fully with the state regulations regarding his/her licensing requirements for all activities in which he/she engages.

Forgery
Like theft of premium funds, forgery is an act that is not tolerated and which is punished severely by the insurance department. Tracing over an authentic signature on one form onto another form is known as 'windowing' and is illegal. Windowing has been used to obtain an illegal policy loan, or to obtain a change of dividend option. In addition to punishment by the insurance department, forgery is also subject to criminal penalties.

Misleading Sales Techniques
Misleading sales techniques violate the consumer's trust and harm the industry by offering a product that the agent does not actually intend to sell. Sometimes known as a 'bait and switch' tactic, a misleading sales tactic often involves offering one product that looks almost too good to be true, and then offering in its place a similar or substandard product. In most cases, the "too good to be true" product was never available in the first place.

An ethical insurance agent is always careful never to make a promise, or offer a product, which cannot be delivered.

Illegal Rebates
Rebating offers buyers of larger policies more leverage for financial incentives and harms buyers of smaller policies. The buyers of the smaller policies, in effect, end up paying more for their policies. In the two states that allow rebating, it is heavily regulated by their insurance departments.

Examples of rebating are these:

-Giving anything of value to the customer for buying insurance
-Giving back the premium, in whole or in part, to the customer
-Advising the customer of benefits or funds that will be received but which are not specified in the contract

Discrimination
It is against the law to discriminate against individuals in the same class regarding the availability, terms, benefits, premiums, rates, or dividends pertaining to any policy of life, health, or property-casualty insurance.

Untruthful Policy Replacements
Also known as twisting, this situation occurs when an agent advises a policyholder to let his current policy lapse, or to surrender it, so that a new policy can be purchased. Although this is not always a misleading situation, in some cases an unscrupulous agent may convince the policyholder to let a valid policy lapse just to purchase a new one on which the agent will reap commission.

For replacement of coverage to be legal, there must be proof that the policyholder will be better off with the new policy. To use the offer of a replacement policy just as a sales technique, however, is unethical.

There are specific procedures regarding when an agent can replace a life insurance policy. These procedures are regulated by most states. Among these procedures are the requirements that the policyholder must be provided a written explanation of exactly what the replacement means, as well as notification of the insurance company that the policy is to be replaced.

Determining the best interest of the policyholder always should be foremost in an agent's list of priorities. If a policy has been in effect for a long time, the policyholder may not be eligible for the same coverage and rate on a new policy. Policies that have been building cash value may be undermined by replacement with a new policy that will take many years to accumulate the same level of cash value.

Untruths in Advertising
An advertisement is generally defined as any printed or published material intended for the general public. Advertisements and sales materials used with the public have direct impact on an agent's sales and sales practices.

Advertising regulations differ from state to state, but the following list encompasses the rules most commonly applied by the states:

-Advertisements must be truthful, and must not have the "sin of omission," or failure to include information in an attempt to mislead the consumer.

-It must be clear that insurance is the subject of the ad.

-Ads that tout unusually high claims settlements are usually considered misleading unless the ad specifically states that the amount is unusual. Ads may not imply that claims settlements will be generous beyond the terms of the policy, or that a policy owner will receive special treatment that is not specified in the policy.

-Technical terms and illustration may not be used if their meaning is not clearly understandable to the individuals who might purchase the product. Required disclosures must be set out in plain language.

-If using statistics in an ad, they must be relevant and factual. The source of the statistics must be identified in the ad.

-Ads may not offer anything that is in violation of public policy or law.

-Ads may not offer anything of value that is outside the express terms of the policy advertised.

-It is not allowable to make unfair comparisons of policies or any of their terms.

-Testimonials from third parties must really reflect the true opinion of the third party and must relate to the exact policy that is being advertised.

-Premium amounts stated in an ad must be for the exact coverage described in the ad.

-Ads may not create the impression that the advertiser or a policy is being recommended or backed by any state or federal government agency. If an ad refers to policy approval by state authorities, it must also disclose that all legitimate insurance policies receive such approval.

Ethics are Number One Priority

The work of an insurance professional plays an important, though sometimes unrecognized, role. The insurance professional is part of the insurance industry's public relations team. The agent meets the public every day, and the way an agent conducts his business leaves a lasting impression relating to the insurance industry as a whole.

Cutting down the Competition

Insurance agents must maintain a level of professionalism in their attitudes toward their competitors. An agent must avoid criticizing other agents, as it harms the competitor, puts the critical agent in a bad light, and leaves a bad impression of the insurance industry in general with the prospective client. If unchecked, misleading or harmful criticism of another in the industry may lead to revocation of the license of the agent who is guilty.

Lofty Goals

A professional in the insurance industry must set lofty goals, and adhere to a set of high personal ethical standards, as well as comply with the minimum legal standards established by the state. These minimum legal standards create safeguards to protect the consumer, but professionalism requires more than just meeting these standards—it means exceeding these standards. An insurance professional achieves this goal by putting his clients' interests ahead of his/her own.

Trust is the Key to Success as an Agent

Maintaining high ethical standards is beneficial for the client and the agent. Put simply, people like to do business with people they trust. An agent who maintains high standards is going to have more success in business than the agent who does not maintain those same high standards. Genuine respect and concern for the client motivates the professional agent to act ethically. Agents who are tempted by an individual or find themselves in a situation in which they are pressured to act in an unethical matter must consider the long-term results of those actions, and the result it may have on the agent's career.

Some industry leaders advise that in perhaps no other industry is the element of trust as important as it is in the insurance business.

Making a Difference

-Just why that element of trust is crucial to an insurance agent's professional role is evidenced by the services an agent performs. Consider some of the following areas where an insurance agent serves the client:

-An insurance agent may provide the financial planning tools that enable a child to go to college by assisting his parents with trusts or life insurance.

-An agent may assist business partners in designing a buy-sell agreement or business continuance plan that will save the company in the event of a partner's death, or casualty to the business.

-An agent may assist a couple plan their retirement years, and give them the tools to spend a worry-free retirement.

-An agent may provide a comfortable lifestyle for survivors of a policyholder, by providing a product to the policyholder that was designed to enable them to remain in their home, and continue their normal standard of living.

-Insurance agents clearly present an essential service in our society.

Chapter 5 Insurance Fraud - Your Role in Claims

According to Progressive Insurance (2001), almost one in ten people in American would commit insurance fraud if they knew they wouldn't be caught. Three in ten people would not report insurance fraud if they knew it was occurring. One in four people believe it's okay to exaggerate claims to make up for deductibles (Insurance Research Council, 2000). Talk about a lack of ethics – and we're talking about the public!

So how does fraud affect you? It's quite simple – when it costs more for a business to provide a product or service, the business must raise its price. To the insured, this means higher premiums.

As an agent, insurance fraud represents one more thing you have to be on the lookout for as you vet risks. In terms of ethics, this means notifying the authorities if you suspect or have knowledge that fraud is taking place. It also prohibits you from participating in any type of scam, such as sending automobiles damaged in staged accidents to a particular mechanic who collects money for unnecessary service and rewards you with a kickback.

Fraud in Auto Insurance

Some of the most rampant fraud in property and casualty insurance occurs in connection to Personal Injury Protection or PIP, as it's commonly called.

PIP is an extension of car insurance available in some states that covers medical expenses and, in some cases, lost wages and other damages. PIP pays benefits regardless of who is at fault and is mandatory in some states, especially those with "no-fault" laws.

Fraud in PIP is committed by insureds, not agents, but it's something you need to be on the lookout for.

The Insurance Research Council reported in 1996 that one in three bodily injury claims involves fraud. You would think insureds would have second thoughts about those fraudulent claims if they knew the research council also reports that fraud adds $5.2-$6.3 billion to the auto premiums that policyholders pay each year.

Some people go as far as to stage fake car crashes in order to file equally fake claims. This brings PIP fraud into the realm of medical insurance fraud, as these same people go on to fake vague soft tissue injuries and consult doctors who don't conduct the most thorough of examinations because they want the business.

Dealing with fraud is a serious issue for property and casualty insurers, which paid out as much as 11 to 30 cents of each claim dollar toward "soft fraud," according to the Insurance Research Council – Insurance Services Office in 2002. Soft fraud is the term used to describe small time fraud and is of what the majority of property and casualty insurance fraud consists. Increased efforts to combat fraud at the time this survey was taken were reported to be "moderately" effective, if at all. It would probably help if these insurers actually thoroughly investigated fraud. The Insurance Research Council – ISO also reported in 2002 that less than one in four insurers investigate insiders such as employees and agents who commit premium fraud.

Fraud Motivated by National Disasters

When disaster strikes, such as a hurricane or flood, insurers experience a massive influx of claims for property damage. Unfortunately, this presents an opportunity for individuals seeking to file fraudulent claims based on the assumption that since there are so many being filed, insurers will be more interested in getting them settled than thoroughly investigating them.

On the flip side, national disasters also represent an enormous amount of benefit payouts to insurers. This leads to debates over whether damage was caused by the hurricane winds or the subsequent flooding. Consumer advocates and yes, lawyers, are always on the lookout for this type of fraud following a national disaster.

Insurers in states where hurricanes are common prepare for this, as do their respective legislatures. If you live in a state that experiences national disasters that cause extensive property damage, you are already familiar with the kinds of fraud the storm brings in.

Fraud in Homeowners Insurance

Fraudulent claims are one the reasons why adjusters are so important to insurance companies. Here is an example of insurance fraud that occurred in Texas:

Several individuals purchased two-story homes in a scheme to defraud their home insurers. In each case, furniture was removed from the house and replaced with damaged furniture. Then, with the use of garden hoses, the individuals systematically flooded the interior of the house causing excessive water and mold damage.

The insurer would be notified by the insureds who claimed that a leak from a broken pipe occurred while the owners were away. Before the insurance adjuster arrived, the leak would be repaired.

Homes in the greater Houston area, Bay City and Austin were used in this scheme. Those involved in the scheme were homeowners, independent sub-contractors, vendors and service providers in filing claims and repairing damages to the homes. They fabricated bills from repairing appliances to furnishings, clothing and electronics.

Twelve of the Texas Department of Insurance's Fraud Unit Investigators along with Federal Law Enforcement Officers were involved in this investigation, which has become the Fraud Unit's largest crackdown on fraudulent insurance claim filings. Seven individuals were convicted in U.S. District Court, Houston and sentenced to more than 31 years for their part in a scheme to defraud homeowner insurance companies out of more than $5,000,000.

The Hall of Shame

The Coalition Against Insurance Fraud takes the time to appoint spectacular cases of fraud to its "Insurance Fraud Hall of Shame."

Some of its inductees includes a teacher who paid two failing students to "steal" and destroy her car so she could file a theft claim and get a new car. She lost her job and spent a few months in jail.

Another more disturbing case involved a deeply in debt former tycoon who burned his own home down with his 90 year old mother inside, claiming she committed suicide and caused the fire. Not surprisingly, his prison sentence was a little longer than the teacher (about 189 years and nine months to be exact).

As you can see, insurance fraud ranges from the mildly humorous in a "I can't believe they thought they could get away with that" way to the morbidly criminal, such as the ungrateful son above.

Insurance Sales

Selling an insurance policy is not something an agent makes up as he or she goes along. In fact, any type of sales can be reduced to a science. There are many opinions about the best way to present a product, get the prospect's trust, and "seal the deal." In ethical terms, it's a little simpler. Your ethics may be what gets the sale, more so than your technique.

Trust

An insurance agent is much more than a suit and a selection of brochures. You are a professional and you must be perceived as one in order to gain your prospect's trust. If you arrive to an appointment with a possible applicant disheveled, unorganized or worse, uninformed, you've lost the sale before your presentation even began.

So much about sales is based on trust. People will buy from someone they trust – not someone who is impatient or fails to answer questions thoroughly. Trust and ethics are connected in that you want your professionalism, knowledge and ability to serve your prospects to be what gains their trust - not your skill in "tricking them" into trusting you.

During your sales presentation, your prospective client trusts that what you're saying is true. He expects that the benefits you claim are part of the policy you're offering are real. A misleading presentation or failure to disclose pertinent information during this phase can 1) lose you the sale or 2) void the policy because of a tainted application process.

The bottom line is to be trustworthy - not just act as though you are. Doing a good job in gaining your clients' trust will likely result in referrals, anyway, so it's a win-win situation for you (and them).

Your Role in Claims

Since so many claims filed by individual insureds are property claims, it would be very helpful for you to be able to discuss not just the things that are covered by the policy, but how claims will be handled if the insured must submit one.

Though you are the agent and not the adjuster, since the relationship between the insured and the insurer will have been forged by you in the beginning, it is common for an insured to contact you about a claim before contacting the insurer or being approached by an adjuster.

A great way to be prepared for this is to familiarize yourself with the Unfair Claims Settlement Practices Act, which was drafted by the National Association of Insurance Commissioners (NAIC) and adopted in almost every state. Here is a brief description of this Act, though it is best for you to get a copy of your own state's version.

The Unfair Claims Settlement Practices Act

The practice of settling claims is regulated closely by state insurance commissions. This is done for these two reasons:

-The very purpose of collecting money from policy owners is to pay claims.
-Claims that go unpaid, are altered, or are delayed in payment can significantly affect other areas of the insured's financial situation.

The Unfair Claims Settlement Practices Act provisions are meant to protect insureds and claimants from claims settlements that are deceptive, misleading or unfair.

These provisions are in place to guide both insurance companies and the adjusters who represent them. The following are considered unfair claims practices:

-Misrepresenting relevant facts or insurance policy provisions relating to coverage at issue
-Failing to recognize and act reasonably promptly upon communications with respect to claims arising under insurance policies
-Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies
-Refusing to pay claims without conducting a reasonable investigation based upon all available information
-Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed
-Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear
-Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds
-Attempting to settle a claim for less than the amount to which a reasonable person would have believed he or she was entitled by reference to written or principal advertising material accompanying or made part of an application
-Attempting to settle claims on the basis of an application that was altered without notice, knowledge or consent of the insured
-Making claims payments to insureds or beneficiaries not accompanied by statements setting forth the coverage under which the payments are being made
-Making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration
-Delaying the investigation or payment of claim by requiring an insured, claimant, or the physician of either, to submit preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information
-Failing to promptly settle claims where liability has become reasonably clear under one portion of the insurance policy coverage in order to influence settlement under other portions of the insurance policy coverage
-Failing to promptly provide a reasonable explanation of the basis relied on in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement

Have your state's version of the Unfair Claims Settlement Practices Act handy when the call comes from a distraught client who is dealing with a lengthy or frustrating claim process. It will help you to recognize any failures on the part of the adjuster handling the claim or by the insurer, and will further build the relationship you have with the client.

After all, being a good agent doesn't end when you deliver the policy. Being a good agent means supporting clients when they need you, even if all you can do at that point is provide information.

Section 3: Underwriting

Chapter 6 Underwriting - Objectives

Major Goals of Underwriting

Underwriting of all types is designed to accomplish these three major goals:

-It helps the company to achieve underwriting gains
-It contributes to society
-It assists in maintaining a strong, solvent industry, which can serve the public in the future

Each of these goals must be recognized and understood before changes in practices can be successfully adapted to the new regulations and pressures.

Underwriting Gains

The first goal of underwriting is to help to achieve underwriting gains. In stock companies, these gains can be called "profits." With mutual companies and reciprocals, the gains result in increased dividends or surplus. In all cases, the goal is to be able to show a modest gain after losses and expenses are paid.

Underwriting contributes to these gains by selecting applicants who fit within the parameters of the rates which have been developed. Every rate structure contemplates a certain type or class of risk.

Underwriting has the responsibility of accepting and retaining those properties and exposures which fit the expected pattern. Underwriting gains cannot be achieved by accepting applicants whose probability of loss is greater than that which is anticipated by the rates.

Applying contract provisions, which are contemplated by the rate structure, can make a further contribution. Coverage cannot be unduly broadened, exclusions cannot be removed and conditions cannot be waived without jeopardizing the expected underwriting gains.

Rates, contracts and selection are closely related. Improper use of any of them can destroy all hope of underwriting gains. If any of the three is inadequate, one or both of the others must be adjusted accordingly or underwriting losses will occur.

Total responsibility does not fall on underwriters. Those who promulgate rates and those who draft contracts carry a share of the burden. But in the final analysis, it is the underwriter who must select applicants who fit the rates and contract provisions which are designed to produce underwriting gains. If artificial restraints are imposed on underwriting, either rate must be increased or contracts restricted. Otherwise, underwriting gains cannot be realized.

Contribution to Society

Insurance contributes a great deal to society. In fact, it is difficult to imagine how this civilization could exist without insurance. Society benefits from insurance by the reduction in uncertainty which insurance provides. With this lessening of uncertainty, people can buy and furnish houses, establish manufacturing and processing firms, stock warehouses and retail establishments, and conduct the distribution of goods.

If this uncertainty was not reduced, people could not embark on these ventures. Perhaps more importantly, lending institutions would not be able to finance these enterprises, so anything

beyond a cottage-type of business would be almost impossible.

Most of the recent strides in industrial and technological fields would have been unthinkable, and most consumers would not have been able to accumulate the volume of goods which marks the affluence of society.

Insurance supplies a good share of the funds which finance long-term investments. The accumulation of capital, which is needed to guarantee the payment of future losses, can be used to promote expansion in home ownership as well as in business and industrial fields.

Another major benefit of insurance is the competition, which results from the stability and reduction of uncertainty, which is present in our economy. Small firms can compete with large enterprises because they do not need to accumulate large sums of money to help survive disasters. The protection given to insurance permits every firm to survive both heavy losses to property and claims for liabilities. Thus funds can be used for growth, and society benefits from the resulting competition.

Underwriters are the focal point through which most of the benefits of insurance are supplied to society. It is underwriters who arrange to protect almost every conceivable type of loss and in amounts of insurance which meet the needs of society. When new exposures to loss arise, underwriters develop methods of insuring those exposures.

A major contribution of underwriting is being certain that the insurance needs of society are met. This imposes a burden upon underwriters to conduct their operations in such a manner that society does benefit from insurance. Availability, affordability, capacity and solvency are some of the goals of underwriting.

Two important aims of underwriters are to support activities which will benefit society and to oppose changes which will tend to restrict these benefits. Not only underwriters must analyze the immediate results of changes but also their long-range effects.

Every underwriting action and every underwriting rule or guide should be considered in light of the ultimate effect on society as a whole.

Changes in society and in its demands are having an effect on underwriting practices. Adaptation to these pressures will be required if underwriting is to survive. The leader of a producer's organization, in a speech referring to the current mood of the "day of the consumer," said this:

"...The forces impacting on the industry will stimulate a review of its responsibilities.... some authorities believe that the insurance industry did such a great job of convincing people of the need for insurance that it is now regarded as a necessity to which the public is entitled. If insurance today is a social and economic necessity, then the industry has an obligation to society. While insurance products and services are needed, there is reason for improvement."

Maintain a Strong Insurance Industry

The greatest contribution that underwriters can make to their companies and to society is to help maintain a strong and solvent insurance industry.

Underwriting gains, as discussed in the previous section, are an essential element in maintaining this strength. Another factor is steady, solid growth. This requires an analysis of markets and a selection of applicants who represent a broad, desirable spread. Still another element is an ability to meet the needs of buyers of insurance, for only in this way can insurance companies survive.

In all of these areas, underwriting contributes best when it classifies and accepts applicants on the basis of reasonable criteria which is equitably applied. A constant objective of underwriting must

be to analyze selection standards, to change the standards and classifications when conditions require and to administer them fairly in daily activities.

Society benefits directly from the existence of strong and stable insurance companies. Only this type of insurer can meet the needs as described earlier. The future demands of a changing society will place new burdens on the insurance industry.

New energy requirements, advanced technologies, the challenges of space travel, the opportunities for increased leisure activities, the opening of markets in undeveloped lands and all of the other possibilities which will be presented by the brave new world to come—all will require even more insurance protection than is available today. A strong, solvent insurance industry is a necessity if artificial brakes are not to be applied to these many new possibilities for fortune and growth.

The future of underwriting is the analysis of characteristics of applicants in order to find meaningful factors upon which to base underwriting selection. This is the challenge of the future for underwriters. Laws and regulations will impose new rules. Pressures will cause others to lose their effectiveness. But underwriting must survive if a strong insurance industry is to exist. This will require adaptation by underwriters, through the use of revised approaches, which will achieve the established objectives.

The Chairman of the Texas Insurance Board, in speaking about the related subject of rates, made this thoughtful statement, which applies to all aspects of insurance:

"It is as important to guarantee the consumers of this state a strong, viable insurance industry as it is to guarantee equitable rates. No artificially suppressed rate can ultimately be beneficial to our state's policyholders."

Underwriting in Response to Regulation

Underwriters can react in many different ways to rules and regulations that are adopted. If they do not consider carefully the ultimate consequences, they may react in ways that will damage their reputations. In the long run, the damage will be irrevocable and will affect the entire insurance industry.

The only truly viable alternative is to underwrite with more applied intelligence and knowledge. This will include securing more facts, evaluating applicants as individuals, making objective analyses and taking prompt action in conformity with the laws and regulations.

As a starting point, underwriters must know why certain rules or guides were used in the past. For example, the applicant's occupation was not a factor because there wasn't anything wrong with people who were engaged in certain occupations.

They were not wicked, dishonest nor abhorrent. Rather, experience has shown that persons in certain occupations tended to be unstable. They moved around a great deal.

This instability can be a problem to insurers, so caution was used in accepting applicants who were engaged in certain occupations. The occupation should not have been a firm rule but just a guide (although it is likely that some underwriters used it as an unacceptable factor).

Suppose that occupation is prohibited as a factor in underwriting. The instability of the applicant may still be a problem. If this is discovered to be the case, the application may need to be rejected. The reason for the rejection is not occupation, but instability. The latter can be indicated by factors other than occupation and may need more investigation to discover.

Occupation cannot be used as a reason for underwriting action, but it can still point out the need

for more facts, which may make the application unacceptable. If unstable conditions are not found, and other factors are not present, the application should be accepted.

Obtaining Objective and Subjective Information

The key to better underwriting is to secure all relevant information. No longer will it be enough to find out a few facts, such as occupation, and then take action.

Both objective and subjective material can be secured, depending upon the circumstances and the management of the insurer.

Objective information is the most reliable data is that received from objective outside sources. Motor vehicle reports and accident information from the file is the most common for vehicle insurance. The condition of the property, photographs, a doctor's report of physical impairments and the length of driving experience are other examples for various lines.

Subjective information is purely personal and private information that may be used under some circumstances. Ordinarily, this is best if secured from the applicant, not from outside sources. After all, what a friend or neighbor says about an applicant should be accepted with a grain of salt. The application, telephone verification and a renewal questionnaire are devices which are used to get facts from applicants and policyholders.

Some insurers have used psychologically oriented self-completion questionnaires as investigative tools for new applicants, particularly for personal automobile insurance. Some of these sources may arouse antagonism from applicants or producers, but they are illustrations of the sources that are available.

Right to privacy laws and other restraints imposed by government can restrict the information which can be secured. This situation only makes the underwriter's job more difficult and requires more innovation to locate permissible data.

Analyzing Information

The first step in underwriting still requires the securing of as much relevant information as is necessary or available. The second step is analysis of the information. There are two different ways of looking at applications: by class and by individual risk.

Traditionally, personal lines have been subject to class underwriting. This means that classes or groups are identified as being problems and are not written. Underwriters recognize that some individuals in each class would be acceptable.

However, it would be more expensive to locate them, and there is usually not much information readily available upon which to make the decision. If an exception is made and a loss occurs, criticism may result. On the other hand, there will be no criticism if the applicant is rejected.

Commercial lines more commonly use individual risk underwriting. More complex factors are present, and premiums are high enough to permit more investigation. In most companies, certain groups have been identified as presenting problems, and these may be on an unacceptable list.

Still, exceptions are made for meritorious applicants based on individual characteristics. This pattern is common among larger commercial risks: smaller ones may be handled more on a class basis.

This traditional difference between class and individual risk underwriting is disappearing in today's social and regulatory climate. People no longer tolerate being handled as members of a class without regard to individual characteristics.

Many of the laws and regulations are aimed at precisely this factor. Since some physically impaired people are good drivers, it is no longer permissible to reject them simply because other physically impaired people may be problem drivers.

Rather, the rules prohibiting the use of certain characteristics require that each person be considered on the basis of individual factors alone.

The analysis of applicants, under government regulations, must include a study of individual characteristics, not just the group to which the applicant belongs. This does not necessarily involve a great deal more time and expense.

Instead, it takes only a little more effort to consider if the applicant is different, in some relevant way, from the other risks of the same type. If so, the differences must be analyzed.

This type of analysis is new for most underwriters, particularly those handling personal lines. Education, training and frequent audits will be needed.

Making a Decision

The third step in underwriting is to make a decision and take action. This can be a perilous part of the process, or it can be a golden opportunity to serve the public and the industry.

The manner in which underwriting guides are written and the way that the reasons for adverse action are stated can be very important. This is the point at which the true intentions of the companies are measured. Underwriters should avoid using words like "location," "sex," "age" and "marital status" when rejecting or canceling insurance. These may be factors to be considered in the evaluation, but they cannot be used as the primary reason for rejection. Reasons must be given, and these should be specific.

Underwriters must stop using such general terms as "condition of the property." The public insists upon knowing why adverse action is taken. The reasons must be clearly explained. Action must be taken promptly. Restrictions place a burden on underwriters to avoid procrastination. Many states prohibit cancellation of new policies after a "discovery period"—usually about 60 days.

Non-renewals are often permitted only if notice is sent to the policyholder well in advance of the expiration date. These rules require prompt and firm action, preventing the delays which previously marked the decision-making process of some underwriters.

In summary, underwriters must avoid the specific use of factors which are prohibited, although these factors may be used as indicators along the path. Applicants and policyholders must be analyzed as individuals, not as members of a class or group. Actions must be taken promptly and always in compliance with the laws. Rejection or cancellation may be taken only for relevant reasons, and never because of factors, which are prohibited. The reasons must be explained in specific terms.

The previously mentioned are the general approaches, which must be followed by underwriters under government restraints. As a first step, management of the company should outline general principles, indicating how underwriting is to be conducted.

These principles, which should be stated in broad terms, will give the necessary guidance to underwriters.

It is obvious that compliance with all laws and regulations should be the cornerstone of these principles. Then, general statements are needed as to the degree of investigation to be followed, the method of communicating decisions and the handling of complaints. Such a statement of principles will supplement the underwriters' knowledge of general approaches to be used and will

provide a broad base of guidance for future underwriting.

Specific Practices

Desk underwriters need specific instructions on practices to be followed when they encounter situations of the types described in previous sections. While general statements are helpful, they are inadequate for the day-to-day handling of individual risks.

Statements of general principles must first be developed and adopted by insurance company management. Such statements are needed before desk underwriters can make decisions which follow the wishes of management. Without such statements, underwriters can be expected to continue the old practices which have led to the current atmosphere of criticism and demands for change.

Desk underwriters, using the statement of principles, must make decisions on individual risks. This is the focal point of all of the sound and fury being heard throughout the country. This is the level at which the decisions are made on individual risks. If those decisions are in compliance with both the laws and the expectations of the public and the regulators, all will be well. If they are not, further restrictions will be imposed. Those restrictions will have an even greater impact on the ability of insurers to decide upon the types of business they wish to write.

Underwriters must learn of the laws and regulations affecting the insurance being considered. Controls must be established to be certain that both new and existing laws and regulations are communicated to all underwriters. Next, supervisors must conduct enough audits to be certain that desk underwriters are following all of the applicable laws and regulations.

Much more than this is needed, however, if underwriting is to survive as it is known today. The spirit as well as the letter of laws and regulations must be followed. Most rules have loopholes if someone looks hard enough for them. If underwriters find loopholes in laws or regulations and underwrite on that basis, further restrictions will be adopted to close the loopholes.

Complaints and criticisms must be heard. When reasonable adaptations to underwriting practices can be made to meet those objections, this should be done. Not every complaint must be met, or no underwriting could exist for long. The problem is to separate those that are reasonable and logical from those that are not. The application of these principles will not be easy. The reasons for each type of criticism must be known. The old practices must be modified in many respects.

Loss History

Underwriters considered the history of past losses to be the best predictor of future losses. A basic and very important part of underwriting is the estimation of an applicant’s future loss potential. The record of past losses was secured whenever possible, and the losses were analyzed carefully.

For vehicle insurance, the accident record was used. For other liability and property exposures, the record of past paid losses was the best source. In all cases, the underwriter analyzed both frequency and types of losses.

From these studies of past losses, many underwriters prepared rules or guides on the maximum number of losses that were permitted in order for a risk to be acceptable.

Accident Record

In auto insurance, the accident record of the driver was the most important. It affected the underwriting of many personal and commercial risks. Several statistical studies have verified what underwriters had asserted for a long time: a driver who has had accidents is more likely to have a future accident than a driver who has not had an accident. Furthermore, the more accidents a driver has had, the more likely it is that he or she will have future accidents.

The most recent three-year period was ordinarily used in statistical studies, as well as in underwriting. However, an underwriter was interested in trends and patterns and would give some consideration to a longer period of time if the information was available.

Accident Rates
Statistics demonstrate that, as a group, drivers having accidents during one time period are substantially more likely to have accidents in a future period. Underwriters, unable to determine precisely which drivers would have accidents, tended not to accept those who had shown, as a class, that they would have more accidents in the future. Accordingly, the practice was to reject a driver who had incurred prior accidents.

The actual number of past accidents that were permitted depended on the rate structure and market orientation of the company. Whatever the number, underwriters tended to make a first screening by the accident record.

Fault
One refinement sometimes used was whether the applicant had been at fault in the accident.

Studies of accidents, such as those conducted by the California Department of Motor Vehicles, include all losses, so there is no distinction between at-fault and other accidents. Actually, some people who study these factors feel that most accidents could be avoided by proper defensive driving - leading to the conclusion that even those drivers not charged with responsibility for an accident could have avoided it in many cases. The next time, they may be held to be partly at fault, or the other driver may be uninsured, so a bodily injury payment must be made under Uninsured Motorists coverage, regardless of fault.

Finally, since the Motor Vehicle Reports (MVR) do not show fault, there is no means of determining the facts short of getting a copy of the police report, which is time consuming. The only alternative is to accept without question the statement of the applicant, who is naturally biased and ordinarily unwilling to admit to fault. For these reasons, many underwriters did not consider the question of fault in an accident.

The number of past accidents over a period, such as two years, has been a fundamental guide to automobile underwriters. Often, the number of accidents was counted without regard to such refinements as severity or type because those factors did not appear to be as important a fact as accident involvement.

The MVR is the primary source of information concerning past accidents. Some information is received from questions on the application, but this was generally felt to be unreliable because people forget dates and circumstances and are inclined to minimize their own past errors.

An inherent weakness of the MVR is the fact that it reveals only accidents that are reported to the department of motor vehicles. Many accidents are never reported. An accident that results in no bodily injury and only minimal property damage does not need to be reported. Even excessive losses might not be reported if the parties so agree and no law enforcement officer is involved. An accident that occurs on private property does not need to be reported. An accident that occurred in another state may not appear on the MVR, although all states are supposed to exchange such information. Finally, some state recording of accidents is so slow or of such poor quality that the MVR reports are of questionable accuracy.

Thus, the MVR does not give all of the factual information about accidents. The underwriter, knowing the importance of complete information and predictability of future accidents based on past accidents, would try other sources. The previous insurer should have all accident data on file, so arrangements can be made to exchange such factual material. Neighbors of the applicant usually are aware of accidents, and inspection reports may elicit information from them.

Traditional underwriting practices, therefore, used all available sources to learn about past accident involvement of all drivers in order to avoid the writing of those risks which had incurred more than the allotted number of accidents during the past specified period.

Traffic Violations
The traffic violation record of drivers was almost as universally used as the record of accidents. In some instances, violations were even more important, especially for commercial risks.

Statistical evidence again supports the suspicions of underwriters that a driver who has had violations is more likely to have future accidents than a driver with no violations. The number of occurrences, as with accidents, indicates the likelihood of accidents in the future.

Two terms are used somewhat interchangeably by underwriters. "Citation" means that a motorist has been cited by a law enforcement officer for an alleged infraction.

"Conviction" means that a court has found the motorist guilty or that the motorist has forfeited bail, which is tantamount to pleading guilty. Both of these terms could be called "traffic violations."

The difference is that some people who receive citations may be found not guilty and thus receive no conviction. To the extent that this occurs, underwriters should not use citations because some of them may not result in convictions, which would imply that the person involved was not at fault in the violation.

As a matter of practice, underwriters tended to use whatever was available. If both citations and convictions could be determined, the latter were used. If only citations were available, ordinarily they were used, without the expensive process of learning if an actual conviction resulted. The daily conversation of underwriters may have used either term, without implying that one or the other was more likely to be used in underwriting.

Types of Traffic Violations
Traffic violations come in varying degrees, from very serious to harmless. Underwriters, in an effort to develop a workable arrangement, tend to divide violations into the following three groups:

Major:These are the most serious. Drunk driving is the most common. It is customarily called DWI (driving while intoxicated) or DUI (driving under the influence of intoxicating beverages). Also included are such violations as reckless driving, hit-and-run, involuntary manslaughter, driving while a license is suspended or revoked and engaging in a speed contest on public roads.

Other Moving Violations:The bulk of the remaining violations are in this group. Included among them are speeding, improper turns, improper lane changes, tailgating, failure to yield and failure to stop for a traffic control device.

Equipment Violations:These are citations issued for defective lights, improper equipment, no inspection sticker and similar violations.

Underwriters would look at the kind of violations, the frequency and the time period. For example, one major violation might have been permitted during the past five years, but none in the past three years. Not more than two other moving violations may have been permitted during the past three years.

Equipment violations seldom were included in rules, but they do give an underwriter a clue to the maintenance of the vehicle and the responsibility demonstrated by the owner.
"Accident Rates by Number of Accidents in a Prior Period"

Law enforcement activity varies among the states. Some state patrol departments are more active, and more inclined to give citations than others. An underwriter tried to learn of the practices in those states that his or her office handled, and to take this into account when judging the weight to be given to citations.

However, any frequency of citations was a cause for underwriting concern. If some states give few citations, and most drivers seldom are cited for their infractions, it was even more serious when an applicant showed a long string of citations. Some underwriters considered citations to be more important than accidents because an accident can be subject to such outside influences as weather and road conditions, while citations are issued only if the driver violates a law.

There is seldom any means of discovering a traffic violation record other than with an MVR. However, tendencies toward speeding, reckless driving, "jackrabbit starts," and other unsafe practices are usually known by neighbors. The traditional underwriter sometimes ordered an investigation report, requesting specific information on such practices from neighborhood informants. A tendency toward unsafe driving, whether it's demonstrated by citations or not, is cause for concern to the underwriter and it is considered to be good underwriting to use the complete driving record in the selection process.

Non-verifiable Record
One problem with the driving record remained. The underwriter was sometimes unable to acquire the driving record, either because it was unavailable or because the driver was newly-licensed. Judgment had to be used in these cases.

A driver who recently moved into the state should have had a record available from the previous state. The former driver's license number was usually requested, so that an MVR could be ordered from that state. But what about a driver whose record could not be secured? For instance, picture an applicant who had just returned from a three-year stay in Saudi Arabia, where he/she worked in the oil refineries. He said that he/she had no accidents or citations, but how could the underwriter verify this? Was it proper to write such a risk at the preferred rate?

Consider another applicant, one who had only recently been licensed (usually this was a youth, but sometimes older people do not learn to drive until later in life). With no record, could the underwriter assume that the record would be clean during the coming year? In cases like this, underwriters often applied a surcharge as a means of protection against the unknown exposure or used this as one factor in the selection process. Both non-verifiable driving records and newly licensed drivers were considered to be factors of concern to underwriters.

Property Losses

The record of past losses of the types for which coverage was requested was important to property underwriters. For example, on homeowners' policies, information was desired on past fires, windstorm damage, thefts, vandalism and other perils, if included in the policy.

Unfortunately, the somewhat accurate information that can be secured on accidents incurred by automobile risks is not available to underwriters for other lines. There are no studies by government bodies that indicate the average loss expectancy of dwellings and commercial risks. Also, no government body collects or disseminates information about past losses.

The claims files of an insurer could be used by an underwriter in an attempt to determine expected loss frequency and the effect of past losses on future claims. Underwriters did make such studies, although the results were seldom conclusive. The best conclusions seemed to be that a condition that caused past losses would, if not corrected, cause future losses. Inadequate wiring, a worn roof and a pattern of burglaries in the neighborhood would be cause for concern as to future loss expectancy.

The problem of how to find out about past losses still remained. An underwriter could use the company's claim records on policies that had been on the books for a period of time. On new business, there was no equivalent to an automobile insurance risk MVR. Most applicants were asked about past losses, but underwriters considered their answers unreliable.

The only solution was to secure the actual loss information from the previous insurer, and a practice developed of exchanging such information. This practice was similar to that used by automobile underwriters to secure information on losses that were not reported to a department of motor vehicles. By reciprocal arrangements, underwriters could exchange facts about losses on policyholders.

Property underwriters seldom established rules as to the number of losses which were permitted. Rather, they weighed the numbers and types of losses against other factors.

The type of loss was particularly significant. A fire from inadequate wiring probably would be repeated unless the wiring problem was corrected. A small loss from negligence, such as from a cigarette in a sofa or from a grease fire in the kitchen, might well have been a large loss under less fortunate circumstances, and the next one might be a total loss.

On the other hand, a series of unrelated or relatively uncontrollable claims might not be a cause for concern. An example is a theft of a bicycle from the yard, a hailstorm that marred the paint on one side of the house and water from a stopped-up sink, all which occurred within a period of three years.

Commercial property underwriters followed similar practices. They secured information on past losses from any available source and weighed the factors without establishing firm guide rules.

Liability Losses

Personal or commercial liability losses were handled in the same way as property losses. Again, no government source was available for analysis or as a source of information. Facts about past losses were often secured from prior insurers. The frequency and types of losses were analyzed and a decision was made, using no specific rules.

On personal lines, the degree of control and the steps taken to correct the situation were the most important. A vicious dog, an unfenced swimming pool and a broken step on the front porch are examples of hazardous conditions that an underwriter might have used as reasons to reject a risk, if uncorrected.

On commercial lines, different occupancies caused more varied hazards, but they were handled the same way as personal lines. An underwriter would be concerned about slip-and-fall claims in a market, loose carpeting in a restaurant and blind intersections in a shopping center. As with other types of losses, the aim was to find the previous loss pattern, analyze the causes, determine the corrective steps taken and compare this information with other factors before arriving at a decision.

Underwriting the Lines of Insurance

The previous discussion concerning driving records was concerned primarily with private passenger automobiles because it's an easier way to convey the use of such information in underwriting. However, the driving record of an applicant can be used in underwriting of other lines of insurance, commercial and otherwise. In this section, we'll be discussing that as well as other factors used in underwriting.

Commercial Lines

The driving record was considered to be as important on commercial vehicles as on personal vehicles. A truck driver who had several accidents or received several citations would not be

considered as good a risk compared to one whose record was clean. The most common rebuttal was that most truck drivers drove many more miles than the ordinary person and were more likely to have accidents or receive citations. This argument was refuted by the existence of many truck drivers with excellent driving records, despite the larger number of miles driven.

Not only did underwriters use the commercial driving record in reviewing commercial risks, they also used commercial accidents and citations in personal underwriting and vice versa. A driver who had problems while driving a truck for work would most likely have the same problems driving his personal automobile. Similarly, the type of driving that would cause accidents in a personal car would also cause accidents in a commercial vehicle. Many state MVRs did not show the type of vehicle, so all underwriters tended to use the complete driving record.

Boats
The driving record on a vehicle tended to demonstrate the attitude of the boat operator toward safety and the rights of others, underwriters felt. Thus, the operation of a boat would be subject to the same personality traits that affected the operation of an automobile. For this reason, the automobile driving record, as shown by the MVR and other sources, was used by boat underwriters. Another consideration was the boat's power. The more powerful the boat, the more the concern the underwriters gave to the driving record.

Dwellings
The link between the driving record and the maintenance of a home was less direct. However, underwriters felt that the attitude of a person toward owned property was demonstrated by the driving record. A person who drove with reckless abandon would tend to maintain a home in the same manner. Since maintenance of the home was an important factor in the underwriting of residential fire insurance, the driving record was one consideration used in some cases.

Condition of Property
Although the attitudes and habits of the insured were of primary importance for the underwriting of most insurance lines, the condition of property was not far behind. Almost all types of insurance involve property in one way or another, whether it is a vehicle, a building, or personal property. Underwriters were concerned when the property was not maintained in good condition because this not only led to more losses on the property, it also indicated that a person lacked responsibility.

Condition of Automobile
A vehicle that was in poor condition, perhaps with non-repaired damage, was usually unacceptable to most underwriters. You've likely seen these cars on the road – the plastic sheet window, red-tape tail light replacement, missing back bumper, or dented door are all examples of non-repaired damage that an underwriter may frown upon.

Physical damage coverages could not be written because of the difficulty of determining whether new or old damage needed repair after a loss. But liability coverages were also refused in many cases on the grounds that the car's poor maintenance showed that the owner was not interested in presenting a good appearance, which could give an unfavorable impression to a jury in case of a lawsuit. Furthermore, an owner who was not interested in the appearance of the vehicle was probably not interested in its mechanical maintenance, which could lead to accidents because of faulty brakes or steering.

The opposite of poor maintenance was also a concern to underwriters of vehicles. These were the cases when owners would paint or otherwise alter the vehicle in a manner that would either make it a show-off car, a high performance car, or both.

Many types of alterations were used: decals, "mag" wheels, wide tires, raised rear ends and other enhancements. Sports cars were the earliest and most often involved, but vans and pickup trucks

were soon altered in similar fashion.

The problem to an underwriter was that these people exhibited strong show-off tendencies, which could lead to taking unnecessary chances and careless driving. Underwriters also felt that if the power of an engine was increased, that power would be used, which could be dangerous.

Condition of Buildings
A building that was poorly maintained was unacceptable in many cases. The appearance of a building gives a good indication of the attitude of its owner or occupant. A lack of concern is indicated if a dwelling needs paint, has broken windows or has a yard littered with old tires or abandoned cars. It was felt that such an occupant would not properly maintain the electrical or heating systems of the home, and this neglect could lead to losses. The same feeling applied to commercial buildings.

"Pride of ownership" was a phrase used by underwriters to indicate a desirable situation. It indicated that the occupant or owner desired to maintain the appearance and condition of the building. Where "pride of ownership" was present, the risk was usually acceptable for fire insurance.

Even automobile insurance was affected by the condition of the building. Underwriters reasoned that the same attitude that caused a person not to care about the appearance or condition of a dwelling would be reflected in driving habits.

A person who was not concerned about the effects on other people of poorly maintained property would not be concerned about their rights on the highway. Safe driving is largely a matter of attitude, so underwriters tended to not accept automobile applicants who demonstrated a poor attitude toward their property and neighborhood. Some automobile insurance was rejected because of the poor maintenance of the dwelling in which the applicant lived.

Risk Factors

Age of Buildings
The age of a building is an important factor in its condition. After a few years, buildings can present problems from worn-out and obsolete systems. Electrical circuits deteriorate, and the addition of much new equipment such as appliances in a home can result in an overload. Heating systems wear out and controls can fail, which could lead to losses. Plumbing systems deteriorate and can cause losses under policies that insure water damage. Unless the electrical, heating and plumbing systems are modernized, underwriters may not accept older buildings.

"White elephant" is the term used to describe a building designed for an occupancy that is no longer efficient or practical. Such a building is relatively old, having seen the area around it change. One example is a dwelling in an area that is now so completely commercial or industrial that it is not suited for residential occupancy.

Another example is an old commercial building that has not been remodeled to handle current technology and really cannot be adapted economically. Every large city has examples of old manufacturing plants that cannot meet today's air pollution or energy-efficient standards and that would cost more to adapt than to build a new plant.

Underwriters were cautious in handling such risks because an extreme moral hazard could be created when a building is worthless as it stands. The owner may actually be better off financially if the property is destroyed rather than maintained. This situation created a classic moral hazard that might have made the risk unacceptable.

The age limit used by underwriters depended somewhat on the territory. As a general rule,

dwellings over 25 years of age were written cautiously, and those over 50 years were handled with extreme care. Commercial buildings were given more latitude, but the same concerns were present.

Inspection reports were ordered frequently on older buildings in order to secure information about condition and upkeep. Photographs were also common, either in conjunction with an inspection report or with the application on all buildings over a specific age. The ordinary inspection reports and photographs gave information on the general condition of buildings, but did not answer the critical questions about electrical, plumbing and heating. Only a complete engineering type of report gave good data on those items, and such a report was too expensive to use on dwellings and small commercial buildings.

For the above stated reasons, underwriting guides usually contained a specific age beyond which risks would not be written. Experience had taught underwriters that older buildings often presented abnormal hazards, and it was too expensive to secure reliable reports that would indicate if the conditions actually existed in specific risks. Many older buildings would not be acceptable, so the class was placed on an unacceptable list. Exceptions would be made only in extreme cases.

Value of Buildings
The value of a building depends upon its size, age, location and type of construction. Values can be quite low where there is a combination of great age, small size and substandard construction. On dwellings, any one of these factors can result in very low market value and actual cash value.

A good clue to the desirability of a building is its valuation. A low value may indicate an old structure with the inherent problems described above. A minimal amount of insurance may reveal that the size of the building is small, which increases the likelihood of total loss. Also, low value may be caused by construction that does not comply with current code requirements or by the use of substandard materials.

On dwelling and homeowners' policies, the replacement cost provision is included in almost all forms. A requirement of this provision is that the dwelling be insured at least 80 percent to replacement cost. An older structure usually has a substantially lower actual cash value than replacement cost. For example, a 35 year-old house may have a replacement cost of $100,000, but an actual cash value of $50,000. Even at 80 percent, the minimum to replacement cost is $80,000, which is $30,000 more than the insured might expect to receive in a sale.

It was generally accepted that such over-insurance created an invitation for arson, and the moral hazard was considered to be too great. For this reason, underwriters would not write these policies on dwellings where the disparity between replacement cost and actual cash value was too great. Sometimes the rule took the form of a blanket prohibition on homes over a certain age, as a simple means of achieving the desired result.

Valued policy laws created special problems on valuation. In states where they apply, they raise the specter of over-insurance because they require payment of the policy's face amount in case of a total loss. A moral hazard is thus created in some instances because a property owner can actually collect more than the value of the property by purchasing insurance for a higher amount. In those states, underwriters were careful about the amount of insurance, and sometimes refused to write coverage where they suspected that over-insurance might be present.

Occupancy of Buildings
The type of occupancy had a substantial effect on the desirability of a building, as it was seen by underwriters. The occupancy could substantially increase the chance of loss, so certain occupancies were on the unacceptable list.

On dwellings, owner-occupied homes were considered to be preferable. Tenant-occupied homes were underwritten very cautiously, and vacant structures were on most lists of undesirable risks. Business occupancies in a home were not accepted in many companies, and underwriters even rejected any dwelling where the hazard was increased by such hobbies as picture-frame making, furniture refinishing and antique collecting.

On commercial risks, the occupancy is obviously an important factor of desirability. Even in this class, however, underwriters often tended to list many occupancies as unacceptable, without considering that the risk could be reduced substantially by the use of fire walls, segregated operations, automatic fire extinguishers and other protective measures.

Protective devices can be used to improve almost any building. Fire alarms and burglar alarms are effective in all structures. Smoke alarms are helpful in dwellings. Burglar alarms, dead bolts, barred windows and similar measures can help to prevent theft losses in both commercial and dwelling buildings. Fences and walls can help liability exposures where there are such hazards as swimming pools.

Underwriters used inspection reports to obtain information on occupancy and protective devices. Full inspection reports were used, with information secured from neighborhood informants or from the insured. Producers were asked to secure data, and photographs were required in some cases. Even drive-by inspection reports gave some information on occupancy and other important factors.

Neighborhood

Even though the condition of property was faultless, a risk might be undesirable because of the neighborhood in which it was located or garaged. Thefts, fires and vandalism can cause damage to property, no matter how well it is maintained. The environmental hazard is important in almost every line of insurance.

A stable or improving neighborhood was desired by underwriters. A deteriorating neighborhood pointed toward so many problems that acceptability lists often specified them, either by a general description or a specific delineation of a territory.

"High-crime" and "urban core" areas were other terms used to describe deteriorating neighborhoods. In such areas, automobile theft and vandalism is high, particularly if the vehicle is not kept in a garage at night. Thefts from dwellings, vandalism to homes and even fires in residential property can be caused by the conditions in the neighborhood, regardless of the maintenance and housekeeping of the dwelling itself. Robberies in such commercial occupancies as liquor stores and gas stations generally are more common in these areas, and theft from warehouses and other occupancies is greater.

A neighborhood can be a hazard to property, even if it is not of such a nature that it could be called "deteriorating." A dwelling in a commercial neighborhood is more likely to be damaged by fire from an explosion in a nearby chemical factory or a fire in a neighboring lumber yard. If the neighborhood is a forest or brush area, a building can be exposed to serious fire losses.

These increased hazards were recognized by underwriters. Experience with risks that were exposed to such chances of loss was enough to convince an underwriter that the rate did not contemplate such exposures. Rules were adopted that prohibited the writing of risks that were garaged or located in hazardous areas. These rules applied to automobile, dwellings and commercial risks, and for most types of policies.

Age

Automobile and commercial vehicle insurance is affected by the age of drivers. Even homeowners' insurance may show different loss patterns by the age of occupants.

Youthful Drivers
Youthful drivers are involved in a substantially higher rate of accidents than are all drivers. Drivers under age 30 comprise 33.9 percent of the motoring population in the United States but are involved in over half of all accidents.

Traffic fatalities also are considerably higher for youthful drivers than for the average, according to data compiled by the National Highway Traffic Safety Administration and the Department of Health, Education and Welfare. The Highway Users Federation analyzed the data and stated this:

"...In applying U.S. Census Bureau projections...the traffic fatality rate per l00,000 population was 53.3 for 18 year olds, more than two and one-half times the national average of 21.1 for all ages. The only other age with a fatality rate greater than 50 was 19 year olds, with 51.7 per 100,000..."

Elderly Drivers
Elderly drivers have also presented problems. As a person's reflexes slow, their ability to react is reduced. As muscular flexibility drops, an elderly driver's ability to look back while changing lanes or backing out of a parking space is reduced. Probably every driver will some day be a problem, unless death intervenes before that time or the person stops driving.

One of the conclusions of the UCLA-DMV Driver Vision Research Project, was this:
"...mileage is a factor related to accidents. When the accidents are adjusted by miles driven...we find that older drivers have high accident rates per exposure unit. The adjustment of accident rates by mileage results in the younger and older drivers having the highest accident rates, where the middle-age drivers have the lowest."

Furthermore, the director of the California Department of Motor Vehicles was quoted as saying this: "Notwithstanding that older motorists drive less, and compensate for their handicaps by greater caution, the accident involvement of drivers over 75 is almost as great as that of drivers under 20. Insurance companies know this. Their reluctance to renew the auto insurance of the elderly accounts, as much as anything, for older people giving up driving."

According to the above article, the four principal handicaps of older drivers are "diminishing vision, hearing, reaction time and reduced ability to understand complex traffic situations."

Another research project on elderly drivers which concluded: "All groups in the automobile insurance industry are in agreement that senior drivers present a serious problem today. There is every indication that the problem will increase sharply, if for no other reason than the increase in the number of potential senior drivers.

"While senior citizens must be defined in terms of the commonly used chronological age bracket of 65 years or over, it is apparent that functional age would be a more accurate criterion in evaluating the physical abilities of a senior citizen. It is true that gradual deterioration of body functions begins at birth and gradually becomes more pronounced in differing degrees for each individual. At present, there is no suitable method of measuring gradual physical body breakdown. Thus, it is necessary arbitrarily to categorize the senior citizens as being 65 years of age or older."

Faced with conclusions like these, underwriters naturally tightened up the acceptability rules for senior drivers. At the same time, surcharges were imposed for operators over age 65, sometimes in steps as the age progressed.

Most automobile insurance rating plans have reduced rates for lower annual mileages. Since most elderly people drive fewer miles, they got the lower rates. However, as indicated previously, their accident rate is high when compared with mileage. Thus, the results were poorer for this age group.

Age Restrictions

Underwriters used age restrictions as a means of controlling the problems caused by age. Rate was considered inadequate to handle the exposures. Youthful driver rate classes were unprofitable for many years. Elderly drivers were eventually surcharged to compensate for the added exposure, but these surcharges were later removed under pressure.

Underwriting rules were common, as they referred to the age of the drivers. Those under age 25, (sometimes under 30), were not written alone. If the insurer handled the family's business, a youth's car may be written, but not otherwise. This was particularly true for unmarried youths. The rule often excluded drivers over age 65, 68 or 70, unless the risk had been insured with the company for a period of time prior to arriving at that age.

Commercial vehicle insurance was subject to the same factors and often used the same rules. Inexperienced, immature, youthful drivers could be a real hazard when driving the many miles required of most commercial operators and the large trucks often used. A truck fleet that hired such youthful operators was underwritten with extreme care. Some underwriters preferred to exclude all drivers under age 25. Elderly drivers were usually removed by mandatory retirement plans, but where they did continue to drive, cautious underwriting was used.

Even dwelling fire insurance was affected by the age of the insured. Elderly residents often were unable to maintain the premises properly because of lack of income and loss of mechanical ability. The property often tended to be older. Also, there was little possibility of desirable related business, such as automobile or life insurance. While age rules were seldom published as such, underwriters used caution in writing residential fire or homeowners' insurance on elderly people.

Youthful occupants of a home or apartment were more likely to have low values in personal property and less stability than middle-aged persons. Minimum value rules sometimes excluded this class. Age rules alone were seldom used, but other factors were significant. The most important of these other factors were sex and marital status.

Gender

Underwriters have long recognized that there are differences between the sexes from an insurance standpoint.

Automobile accident involvement differs considerably by the sex of the driver. Males have a higher percentage of accident involvement at every age bracket. Males have 1.7 times as many accidents as females.

Another report showed a different automobile insurance problem. The Traffic Injury Research Council of Canada related a study of the driving habits of Canadians and gave the findings in its annual conference report. It revealed that "during a random sampling of motorists over a period of months, the percentage of males discovered drinking while driving was twice that of females."

Based on such studies, plus experience, underwriters used to refuse to write youthful male drivers as a class, particularly when they were not married. Obviously, this is not the case anymore.

Marital Status

Underwriters preferred married persons living with their spouses and with one or more children. It was generally accepted that this group had stability and predictability, avoiding the increased hazards and uncertainties of other types of living arrangements.

Other relationship statuses introduced different and new risks that underwriters had to consider. Did divorce pose a moral risk? How about people who rush into serious relationships that involve moving in together, but fall apart quickly? How does a person's success or failure at love really

affect his or her risk level? Well, underwriters have learned a few things over the years, and while certain aspects may suggest discrimination, examining a person's stability in relationships that involve cohabitation is something underwriters must do.

Mingles
The term "mingles" refers to people of opposite sexes who live together as though they were married, but who actually are single.

This type of living arrangement is not new. It probably has existed during most of history. It has been called by different terms, such as "cohabitation." In many states, the continuation of this arrangement can lead to common law marriage, which can have the same impact on insurance underwriting as the more traditional type of marriage.

The problem with mingles from an insurance standpoint is the instability and lack of certainty about the future. An automobile underwriter likes to know who will be driving the car and with the temporary arrangement of mingles, this cannot be known. A homeowners' underwriter wants to know who owns and who will be using the property, and again "mingling" makes this uncertain.

The difficulty is that one who mingles may change living partners with ease. If an automobile policyholder is a young woman, her present mingling partner may be acceptable as an occasional driver, but what if he leaves and another man takes his place?

The underwriter would not know of his driving record, if indeed any notice was given of his presence in the "home." Or, worse, the other partner might have a poor driving record, but has his own car, so it is alleged that he will never drive her car. Underwriters would not accept that allegation, believing that if her car was blocking his in the driveway, or his car was in the garage for repairs, he would use her car to run down to the market.

In many states, permissive users cannot be excluded and, in others, they can be excluded only by name. Therefore, it is not a viable alternative in many cases to cover one partner and not the other. The problem remains even if the present partner is acceptable and provision is made for notification of any change of partners, since the cancellation laws could restrict an underwriting action on an existing policy if a new partner was unacceptable.

Homeowners' policies generally cover personal property "owned or used by the insured." Suppose that a policy is issued to a young woman living alone. Then a young man moves in with her under a mingling arrangement. Serious questions arise as to the extent to which her policy insures his property. If he supplies a television set and other furniture, could it be said that she does not "use" them? At best, the risk is almost certainly not insured to value. At worst, his property or his living habits might not be acceptable, but his presence may not be revealed to the underwriter. Even if it were revealed, it would be costly to investigate him, and again the law might prohibit underwriting action.

For these reasons, underwriters did not want to write insurance for people who were in this type of living arrangement. The guides to unacceptable risks often included such items as "unmarried persons living together."

Such guides did not say that unmarried persons living together were prohibited. There were situations which were acceptable. If the arrangement was quite stable, the underwriter could conclude that the inherent instability of this lifestyle was not present in this case.

At some point in time, a common law marriage was assumed by the laws of many states, or the underwriter could assume that a similar result had been attained. When the arrangement between two people had continued for five or more years, or some such period, many underwriters would accept the risk, if other factors were satisfactory.

Single, Separated, Widowed and Divorced

Builders of homes have adopted the abbreviation "SSWDs" to refer to the "single, separated, widowed and divorced" people who are buying homes in increased numbers. Members of this group have caused concern to underwriters for many years, both in homeowners' insurance and automobile insurance.

The basic problem with SSWDs is instability. In many cases, the present is filled with turmoil and the future is uncertain.

Singles of any age are generally less stable than married persons. This is reflected in their driving of automobiles. Single drivers for both sexes have more than one and one-half times as many accidents as married drivers. This problem also carries into property insurance, because these persons tend to travel more and may live with different persons of the same or the opposite sex.

Separated persons offer a special problem with instability. Being neither married-living-with-spouse nor divorced, their future is unknown. Emotional problems often exist which can adversely affect the driving. If the insured on a homeowners' policy is separated, there may be inadequate arrangements for the maintenance of the property.

Widows and widowers are the best of this group. There is more likely to be an emotional adjustment after a period of time which can be traumatic. Both associates and future living conditions may be uncertain. Many of the people in this category have adjusted well, but some have not, and underwriters needed to determine the group to which an individual applicant belonged.

Divorced persons present insurance problems, particularly during the early stages of the divorce. Emotional turmoil is common, often having an adverse effect on driving patterns. Problems arise concerning the division of property, as well as its care and future location. Some divorced persons go through a period of extreme social activity, which can affect all aspects of their lives.

All unmarried persons presented potential difficulties to underwriters. Not every individual was a problem, but it was not easy to separate them. The type of investigation which could reveal the facts was not always available or practical. Therefore, underwriters often listed unmarried applicants on caution lists, to be written only if the potential instability and emotional problems were not present.

Occupation

The occupation of an applicant has long been considered to be a good indication of the chance for future losses. Occupation was believed to demonstrate the type of exposures that could be expected, as well as the inherent hazards of some occupations.

Travel

Certain occupations seem to offer increased chances that a loss will occur because of excessive travel. Some automobiles are driven far more than average because of the requirements of the job. Sales people who use their cars in their work are a prime example. They may drive considerable distances every day. In addition, their minds may be more on the sales approach they will use with the next prospect than with the road conditions around them. The increased mileage and possible inattention were believed to present greater potential for loss than the average driver.

These same travelers also caused concern to the underwriters of homeowners' and theft policies. In this case, all occupations that involved a considerable amount of travel were suspect, even though the travel was by air. Persons who travel overnight must take clothes, toiletries and incidentals, and these are usually packed in luggage which is fairly compact. The ease of

transporting the luggage makes it easy for thefts. Many occupations involving travel will require an above-average wardrobe, whether to impress a sales prospect, to give a neat appearance before fellow employees in other branches, or to look impressive when speaking before a group or meeting.

The luggage may also contain samples, valuable articles, cameras and other targets for thieves. There have been actual cases where a diamond merchant was robbed of the display stock that he or she was taking to a sales exhibit, with the loss in the hundreds of thousands of dollars.

Coupled with this propensity for transporting expensive articles in compact containers is the fact that the property often is left unattended in exposed places. Airline terminals and hotel lobbies are places where luggage often is left for periods that are long enough for a theft to occur. Luggage is left in motel and hotel rooms, and many employees of a transient nature have keys that can provide easy access into rooms. A person who travels by car may leave both personal and business property in the car, unattended, while in a restaurant, a gas station or while checking into a hotel or motel. A traveling salesperson, conscious of his or her appearance, may have a number of expensive suits or other clothing inside the car—a tempting target for a thief.

For all of these reasons, underwriters used rules that attempted to exclude from acceptance those people who traveled extensively. Automobile underwriters used a rule like "persons who travel more than 25,000 miles in a year."

Homeowners' underwriters used such rules as "applicants who travel extensively in their work" or "applicants who are away from home on business more than 15 weeks a year." Commercial crime underwriters specified protective measures for high-valued property that might be carried in the course of business, and refused those who did not comply. The measure of actual increase in exposure in all cases was difficult, so underwriters tended to refuse those applicants whose travel exposure appeared to be above average, using cut-off points which had been determined by experience with past losses.

Transients
Some occupations are of the transient type. Requiring little training in most cases and offering few benefits by longevity, these jobs attract the "floater." Many of these people prefer to move around frequently. They do not want to be tied down to one job or to one location for a long time.

Some of these occupations are relatively unskilled, and neither require nor encourage remaining on one job for an extended period. Examples are restaurant and cocktail bar employees (dishwashers, waiters, cooks, etc.), car washers, bowling alley employees, hotel employees (maids, bellhops, desk clerks, etc.), pool hall employees, service station attendants, janitors and domestic employees.

Other occupations of the transient type may require more skill, but the nature of the work seems to encourage drifting. Examples of these are barbers, beauticians, merchant seamen, oil field and mine workers, house painters, dock workers, bartenders, commercial fishermen and taxi drivers.

Still other occupations require movement in order to follow the seasonal patterns inherent in these jobs. Some examples are circus and carnival employees, construction workers, farm laborers and race track employees.

Certain other occupations that require a transient type of living can pay large salaries, which increases exposure to drugs, alcohol and theft. This category includes professional musicians, actors and actresses, dancers, other entertainers and professional athletes. Among other hazards is the increased exposure to suit because of the prominence and income of many of these people.

All of these groups were underwritten with great care. The lack of stability was believed to

increase the chance of loss on automobile and homeowners' lines. Being transients, policyholders might be difficult to locate if testimony was needed for a court defense or if a signature on an endorsement was required. Premium collection might be more difficult. Occupations of these types were listed by underwriters on caution or unacceptable lists.

Other Types
Certain other occupations presented unique situations that concerned underwriters. Some of these might be unexpected, while others are logical even to a person not trained in underwriting. These occupations appeared on many underwriting lists and were handled with care by personal lines underwriters.

Military risks often combine many of the undesirable features of automobile insurance: youthful drivers, unidentified permissive users and frequent transfer to new locations. For years, many underwriters refused to write military risks because of these problems. Later, some exceptions were made in the rules for older members of the armed forces (over 30 years of age, for instance), for those in the higher pay grades and for commissioned officers.

Sometimes exceptions were made for those who lived with spouses off base. These exceptions were made with care because of the inherent problems associated with this group.

Students were excluded for many of the same reasons as military risks. Inexperience, lack of control over driving and a tendency toward long weekend trips were areas of concern to underwriters. Again, students who were married and living with spouses were often accepted. Otherwise, the group was rejected, unless the company also insured the family of the student.

Illegal activities were the mark of a number of occupations, all of which were excluded as completely as possible by underwriters. Drug smuggling, importation of illegal aliens and similar activities were those intended to be kept out by the general classification of "those engaged in illegal activities." Aside from the ethical questions involved in furnishing insurance to such persons, there were the increased hazards of night driving, possible shootings and unfavorable impressions as witnesses. Any occupations that appeared to fall within these categories were excluded from acceptance.

Stability
A thread running through many of the foregoing factors is the stability of the applicant. However, stability itself can be a requirement for all lines of insurance.

In personal lines, underwriters requested information on a number of areas in order to determine the degree of stability. How long has the applicant been on the present job? How many jobs has he or she held in the past few years (specified number of years)? How long at the present living location? How many addresses in the past five (or so) years? Rules often were established to determine acceptability based on these items.

The types of residence and address also were considered. An automobile applicant who lived in a hotel or motel was not accepted by many underwriters, because such living quarters ordinarily indicated a transient, unstable type of person. Likewise, if the mailing address was a post office box, the application was declined. Underwriters were concerned with possible difficulties in locating the insured in case of suit and the ability to collect premium.

Tenants, as a class, were known to change their living addresses more often than owners of homes. Every move changes the exposure to loss—on an automobile because of neighborhood crime patterns and unfamiliar traffic, and on property because of physical characteristics of the property and environmental hazards. Many times, a tenant will move and not notify the insurer, thereby causing coverage questions. The loss ratio on tenant homeowners' policies was almost always higher than on other forms, which appeared to substantiate the fears of underwriters. For

these reasons, tenants were less preferred than homeowners, and underwriting rules often reflected this feeling.

Many of the questions asked by underwriters on applications were designed to show the stability of the applicant. Combinations indicating instability were cause for rejection, along with specific rules concerning the number of jobs, the number of moves and how long one resided at the present address.

In commercial lines, stability was indicated by the length of time the applicant had been in business. Small retail stores and service establishments were particularly subject to bankruptcy after only a short time in business. Various studies have shown that only a small percentage of business ventures survive the first few years. One writer on the subject put it this way:

"About 600,000 new businesses open their doors in the United States each year. Almost an equal number quit and go out of business. Only about one in five new businesses lasts as long as 10 years—some go bankrupt and others close up shop after paying off their creditors."

For a new business, a reputation is not yet established, inexperience is common and under-capitalization is not unusual. If a business fails, the insurer may have difficulty in collecting premiums due. The moral hazard is increased if the owner sees the business starting to fail. Maintenance of equipment also suffers because of the lack of funds. Commercial underwriters often used rules to attempt to screen those risks that have not demonstrated their stability. A common requirement was that the applicant must have been engaged in the business for at least one year.

Social Maladjustment

People who have difficulty coping with today's economic system exhibit a type of instability. Those who are on welfare or who have trouble with credit collection agencies are underwritten cautiously.

Attitude

The attitude of the applicant is a major part of the concern of underwriters in personal lines. Maturity and responsibility are critical in driving a car and in maintaining property. Attitudes toward the rights of others and one's relationships with others demonstrate the type of person who is applying for insurance.

The importance of attitude is expressed in the following comments from an article on underwriting:

"As part of the 'Fatal Driver Profile' compiled by the U.S. Department of Transportation, investigators conducted a separate psychological evaluation of more than 200 fatally injured drivers who were found most responsible for fatal accidents in the Baltimore area over the past five years. To determine the attitudinal characteristics of these drivers, family, friends and colleagues were interviewed. It was found that these drivers were significantly different from the norm, displaying more belligerence, negativism, verbal expansiveness and general psychopathology, regardless of their age or alcohol involvement. Analysis of the Baltimore data indicated a slight correlation with alcohol usage, but not with age, prompting investigators to conclude that psychological factors might be more important than either age or alcohol use in causing fatal accidents."

Faced with this type of information, underwriters attempted to determine the psychological make-up of applicants. A risk was declined if the "attitudinal characteristics" were not normal.

Criminal Record

A large number of all crimes are committed by people with a prior record of criminal activity,

according to many reports.

A person who had been convicted of a crime was considered by underwriters to be more likely to commit another crime than a person who had no police record. Furthermore, the associates of a person with a criminal record were believed to be less trustworthy than average. Automobile underwriters were concerned with driving attitudes, particularly as they involved the rights of others. The possible use of the automobile in a crime or its use by unsavory associates also was considered. Court appearance in case of suit was still another factor.

Homeowners' underwriters were aware of the impact on maintenance of property if the insured had no sense of personal responsibility. Parties attended by other criminal elements might cause damage to the premises. Both moral and morale problems were felt to exist. Commercial underwriters had special problems, because employees of many firms handle money, drive expensive equipment or work on loading docks with valuable products. The opportunities for committing a crime are plentiful in most commercial establishments. Underwriters were uneasy if employees in such situations had criminal records. An extreme situation was presented to bond underwriters, where the honesty of the employee was the subject of the protection.

Every line of insurance was adversely affected if the insured, an associate or an employee was more interested in causing a loss than preventing it. A past record of crime convictions was felt to be a fairly reliable indicator that such a person might cause a future crime. For these reasons, most underwriters listed persons with a criminal record as unacceptable.

Mental Incompetence

A lack of mental competency can create all kinds of problems for insurers. Such a person can cause direct damage to persons or property. Inattention and lack of proper care of property can lead to serious consequences. Defense in a court suit is greatly hampered by evidence of mental incompetence. The very uncertainty caused by this condition may be the greatest difficulty because the entire structure of insurance is built upon the ability to predict the future from past events.

There are many degrees of mental incompetence, of course. Some such people can operate very well in society, with few associates ever learning of the impairment. Others are generally harmless but can change quickly. Some of these people are docile, while others tend to be violent. When the condition gets too severe, forcible detention in an institution is needed, although under modern treatment it is often preferable to release the patient to family members if possible. Some people have been hospitalized for treatment of mental or nervous conditions. Whether this means that the person is "mentally impaired" is a matter of judgment. There are so many factors to consider that definition is difficult.

An underwriter cannot be expected to distinguish the problem cases from the harmless. The increased chance of loss from those who might be violent or irresponsible is so great that underwriters felt that they did not dare to take a chance, trying to accept those who appeared to be "safe." Accordingly, it was common practice to exclude all persons who had given evidence of mental incompetence.

Physical Impairments

Insurance underwriters were taught that selection, classification and rating were based on the Law of Large Numbers, which operated only with a large number of relatively homogeneous risks. Individual applicants who did not fit within that pattern were a matter of concern to underwriters.

Persons with physical impairments were one of the most obvious of the groups who did not fit the normal pattern. Usually the impairment is visually observed by others, but this is not true in all cases. Allowances for the handicap may be made in some aspects of society, but the impairment may not be tolerated in other areas.

All physical impairments have the potential for difficulties to insurers. Special adaptations often are needed, which can increase the value of property in some cases and reduce it in others. Jury members who are sympathetic as individuals may be critical as jurors, tending to give the benefit of the doubt to the non-handicapped.

Many types and degrees of physical impairments exist, and underwriters try to separate them into groups to facilitate their handling.

Loss of Limb
Probably the largest group includes those with such physical handicaps as the loss of a body member or the inability to use a member. There are few difficulties on lines other than automobiles, although adaptations of a home to accommodate the handicap may affect the value for others.

Automobile underwriters are greatly concerned with these physical, or motor, impairments. Modern traffic is difficult enough for a person with full physical capabilities, as is demonstrated by the millions of accidents each year. When an arm or a leg is missing or cannot be used, new problems exist. Great strides have been made in adapting automobiles to handicaps and in training impaired persons to use these adaptations. Special equipment can be secured, often at government expense, which will permit a reasonable degree of vehicle control, given proper training. The difficulty is that underwriters cannot determine, with the sources available, which of these persons are capable of operating with these adaptations and which are not. The existence of special equipment and training in its use does not guarantee that the person will then be a good driver.

The department of motor vehicles of one large state studied its program of taking action on the licenses of "P&M" (physically and mentally impaired) drivers and thus concluded:

"To a great extent, these programs are justified from a purely traffic safety perspective. Statistics show that the accident rate of P&M drivers is substantially inflated over the population rate, even when adjustments are made for extraneous factors, and that some of the increased risk is caused by the disability. Prior to their hearings, P&M drivers were found to have two to five times as many accidents as other drivers. For the lapse, physical and mental groups, the accident involvement rate was approximately two and a half times the population rate, and for the drug, alcohol and lack of skill groups, it was substantially higher...The proportion of P&M subjects' prior accidents that involved a single motor vehicle striking a fixed object was 2.4 times greater than those for drivers without known disabilities....Virtually all medical authorities agree that certain medical and physical conditions cause increased risk...There is also a considerable body of epidemiological evidence that some P&M conditions increase the probability of accident involvement."

In order to compensate for the uncertainty, automobile underwriters tended to reject all applicants who were physically handicapped with motor disabilities.

Seizures
A completely different type of physical impairment is the "seizure." It includes diabetics, epileptics, spastics and persons with heart ailments. Again, the principal concern is with the operation of automobiles, although fire and other property losses could be caused by a seizure.

Automobile underwriters are concerned with an impairment which might interfere with the safe operation of the vehicle. A sudden seizure or blackout has been known to cause serious accidents. Injections and oral drugs can control many of these difficulties, but results are not guaranteed. Relapses or changed conditions may occur. The patient may fail to take the medication as prescribed for any one of many reasons. Even where control has been attained, this fact is hard to verify.

The usual sources of information are of little help in this area. Neighborhood informants may confirm that problems have existed, but they cannot give factual data on the degree of control attained. A doctor's statement often is the only good source available. Even this is of little help in many cases, because the statement may be couched in medical terms, obscure to an underwriter, or may be inconclusive as to the effect of the control on the patient's ability to drive. An underwriter can take little comfort from a statement which says that the impairment is capable of control with (named but unfamiliar) drugs, which may enable the subject to live a reasonably stable life. The underwriter needs to know if the ability to drive a car has been impaired.

Faced with these uncertainties, automobile underwriters usually listed as unacceptable all applicants who have been subject to any type of seizures or blackouts.

Hearing Impairments
A person with impaired hearing may possess the skills that permit the operation of a vehicle and may be able to converse with other trained people by signing. These abilities may be offset by an inability to know about emergency vehicles or other traffic problems, and to hear barking dogs or other evidence of danger to property. The latter problems can cause some difficulty when underwriting a policy, but this seldom is considered to be a problem. The major concern is with the operation of an automobile.

Persons with hearing impairments usually can use hearing aids of one type or another. While these vary in their ability to compensate for the loss, they can give warning of adverse traffic conditions, such as emergency vehicles or honking horns. Other persons with severe hearing impairments cannot be helped in this way and are greatly limited in their ability to respond to sounds. It is the latter group which is usually called "deaf" by lay persons, generally implying a hearing impairment so great that they are unable to carry out normal functions such as conversation.

Since the operation of an automobile in modern traffic requires knowledge of surrounding conditions, severe hearing impairments caused concern to underwriters. The inability of persons with relatively impaired hearing to correct their hearing problems has caused automobile underwriters to automatically reject them. "Deaf persons" or "persons with severe hearing impairments" were on the lists of unacceptable risks for most companies, in one form or another.

Alcohol and Drugs

People who use alcohol and drugs are less able than others to control their driving ability and maintain their property. This may not be true at all times, but the occasions when this occurs are unpredictable. For those who demonstrate a history of abusing such substances, a significant moral hazard is presented. This is one which cannot be ignored by underwriters – especially in terms of auto insurance when there are legal implications to consider as well.

Alcohol
People have used alcohol as a method of changing their attitudes toward circumstances since the dawn of time. Today, many people who drink are called "social drinkers." Seldom are they considered a problem by underwriters. However, such people may, on special occasions, drink too much. This can cause accidents while driving automobiles or commercial vehicles, can result in fires from carelessly discarded cigarettes, or can cause industrial accidents.

Underwriters who encounter these social drinkers who have had losses are understandably cautious. It is often difficult to draw the line between "social drinkers" and "problem drinkers." Therefore, a person who had incurred a loss while drinking was often rejected for insurance. At the very least, a substantial surcharge in rates was used to compensate for the increased hazard which could exist.

Many studies have confirmed the fears of underwriters concerning the impact of drinking upon the

ability to drive. The United States Department of Transportation conducted a series of Alcohol Safety Action Projects in four American cities, starting in 1983. As an example of the findings, the Boston study "indicated that 39 percent of fatal accidents examined involved alcohol directly, a combination of alcohol and other drugs, or other drugs alone."

The ongoing studies of the California Department of Motor Vehicles emphasize the role of drunk drivers. These strong conclusions were drawn from the latest studies.

"The drunk drivers are one of the major causes of serious accidents on the highways... drunk drivers are involved in 35.4 percent of the fatal accidents and 13.3 percent of the injury accidents. These figures apply to drivers who had been drinking any amount. These figures may be underestimates because not every instance of drinking is discovered by the investigating officer...the percentage of fatal accidents caused by drinking is estimated to be between 30 to 50 percent."

The problem of underage drinking was analyzed by the Western Insurance Information Service. The article contained the following conclusion:

"Drinking is another factor that impairs driving ability. Drivers under 18 have the worst collision involvement without alcohol. With alcohol, their collision involvement multiplies three-fold. On an even broader scope, drinking and driving is the biggest killer of people under 25. In addition, arrests for intoxication of those under the age of 19 have almost tripled in ten years."

After reading the results of such studies, it is not surprising to find that both personal lines and commercial lines underwriters are extremely careful when considering any applicant where alcohol is involved. It was difficult to separate occasional drinkers from problem drinkers, so most underwriting guides simply listed "excessive users of alcohol," or similar wording, to show unacceptable risks. The point at which drinking became "excessive" was typically a matter of judgment.

Drugs

People have used drugs for centuries; however, they have only recently become a problem for underwriters.

Definitions are difficult. Alcohol may be called a drug, but ordinarily it is handled separately. Most drugs that are used are beneficial, such as in many types of medicine. It is true that some medicines may cause insurance problems. An example is the drowsiness encountered by some people after taking medication. Obviously, extreme drowsiness could reduce reaction time and increase the chance of a traffic or industrial accident.

The term "drugs," as it is used in the news media and the insurance industry, refers to such mind-changing drugs as marijuana, heroin, cocaine and the like. These are not taken for medicinal reasons. Rather, they are used to alter one's behavior.

Various studies have shown that a majority of high school students have smoked marijuana at least once. Obviously, a one-time trial "on a dare" or "just to see what it is like" will not concern an underwriter. Beyond that point, problems can arise.

The line between an occasional drug user and a heavy drug user or addict is difficult to determine. The habit is relatively recent when compared with alcohol. The extent of continued use, and the degree to which users attempt to lead normal lives, is still unknown. A heavy drug user or addict probably is totally uninterested in buying insurance, so the underwriter has no reason to be concerned. Others, however, may own homes, drive cars and work with vehicles or machinery. The degree to which the drugs affect the judgment and abilities of the user is of great concern to the underwriter in these latter cases.

Studies have not been conducted on the effects of drug use to the extent that they have on the effects of drinking. Some studies refer to "alcohol and other drugs," such as the Boston study referred to earlier. Even the official data often fail to separate drugs from other causes of accidents.

Underwriters feel that people who use artificial means to alter their behavior can be a problem. This is particularly true if the alteration results in loss of muscular control or hallucinations. Habitual drug users, therefore, are considered unacceptable to most underwriters, both personal and commercial. The wording in the rules referred to "habitual users of drugs," or "excessive use of drugs."

Foreign Born

A particularly difficult group for underwriters to handle is composed of those who were born in foreign countries or raised in a non-English environment. Some of these people have no difficulty in handling the English language, so there are no selection problems. Others, however, cannot handle the language, and these people can be a cause for concern, particularly in automobile insurance.

People who cannot read English, or cannot read it well, will naturally find it difficult to operate in our high-powered, communication oriented society. Many highways and expressways operate at fast speeds with signs flashing by the driver. Off-ramp signs, road repair warnings and lane instructions appear quite suddenly in many cases. A driver who cannot read these signs, or who needs time to understand them, can be in serious trouble. Accidents could result.

Another problem with such people is their difficulty in understanding messages sent by the insurer. It is not uncommon for insurance companies to mail to the policyholders such items as premium notices, amendments to the contract at renewal and questionnaires that request information. Sometimes the latter must be answered, such as a selection of coverage options desired when an amendment is made to a No-Fault Law. Policyholders who cannot read these messages may cause repeated follow-ups, misclassifications or even termination of coverage.

In most lines of insurance, the policyholder may need to appear in court as a defendant. A person who cannot read or speak English well is placed at a disadvantage and usually will adversely influence the jurors.

Many of these foreign-born people do not become citizens of the United States. These factors were taken into account by most underwriters. When selection guides were published, they often contained such items as "persons unable to speak English well," "persons unable to speak or read English," or "non-citizens of the United States."

Related Business

Some classes of business, as well as individual risks in any class, are borderline for acceptance. Underwriters often included, in their analysis, any other policies insured in the company.

One reason for requiring related business was the economy of investigation that could result. A small tenant homeowners' policy supplied too little premium to be able to afford much investigation, but the underwriter might have wanted to know more about the applicant. If an automobile or two were also insured for that applicant, much of the desired information usually was secured under that coverage. Stability, occupation, attitude, drug addiction and other factors are the same for all lines.

Similarly, a small boat policy could be underwritten better if the facts about the driving record, as well as the stability and responsibility, could be obtained from automobile policies.

Some lines of insurance were more profitable than others. An underwriter who was asked to accept a less profitable line might want to "sweeten the pot," by requiring one of the more profitable lines. Thus, applications for automobile insurance on a youthful driver often would be more acceptable if the parent's cars were also insured with the same company. The addition of a homeowners' policy on the family could make the risk even more palatable.

A degree of overlapping exists between some types of policies as regards the settlement of claims. For example, a burglary of a home might involve both a personal articles floater and the unscheduled portion of contents on a homeowners' policy. If these two coverages were written in different companies, each of them would need to conduct an investigation into the loss.

It would be more efficient to have both coverages in one company. Another example is a theft of an automobile, which might also involve scheduled or unscheduled property that was in the car. Still another example is an umbrella policy, where the claims handling on liability cases is tremendously complicated by having two or more companies involved in the loss. Thus, there are advantages from a claims standpoint to writing all coverages in one company.

Coverage advantages were achieved by account underwriting because gaps could be avoided if all policies were in the same company. Competitive advantages also were gained by keeping other producers from having close contact with the insured.

"Account underwriting" is a concept practiced by many underwriters. One test book describes it in this way:

"Account underwriting refers to the concept that the profitability of a particular insured's business should be determined on an overall basis. All other things being equal, business handled as an account may receive better treatment than a single policy. A request for additional coverage or unusual coverage might be met with little resistance if the files indicate that the insured has been loyal (and profitable) over a period of years. A request for a personal umbrella, for example, might be processed without hesitation for a known account; whereas an unknown applicant would be investigated quite thoroughly before the policy was issued."

For these reasons, underwriters not only desired the related business, but sometimes required it. The acceptability rule for a youthful driver as the principal operator of an automobile might have read "Acceptable only if all cars in the household are insured in the company." An unmarried applicant for a tenant homeowners' policy might have been accepted "only if the automobiles are insured in the company."

Prior Insurance

The name of the previous insurer was usually requested by underwriters. With this information, a better picture of the risk could be obtained.

Past losses could be determined from the prior carrier. Automobile losses that were below the financial responsibility reporting requirements seldom appeared on the MVR. No central agency existed that furnished past losses on other lines. It was naive to expect the applicant to report, accurately and completely, the past losses on a voluntary basis. Investigation reports seldom developed this information. The only reliable source was the previous insurer. Obviously, the name of that insurer was needed before a request for the loss history could be requested. The importance of securing this type of information was stated this way:

"The actual record of a policyholder is much more reliable as an indicator of future performance than most other items. Underwriters depend heavily upon the principle of predicting the future by an analysis of the past. The problem, when an underwriter is considering a new applicant, is that he does not have the previous experience. It may not be available to him through any other source; even the application may contain errors or misrepresentations as to facts of previous

losses....The books of the previous insurer are sometimes made available to the underwriter, giving him access to this valuable information...the most important information that can be received from previous insurers is that concerning losses...These facts can probably be secured elsewhere but it is quicker and easier to obtain them from the previous insurer...This information can be helpful to an underwriter in determining the facts about the applicant."

Another item of interest to underwriters was the type of insurer with whom the previous insurance was carried. Many insurance companies specialize in one type of risk: preferred, standard or substandard. An underwriter looking at an application for preferred rates would be concerned if the prior insurer was a substandard company. Why was the applicant insured in such a company before? Had the risk improved so much that it was now properly assigned to a preferred category? The fact that prior insurance was with a substandard insurer did not make the risk unacceptable for preferred rates, but it did raise questions. The only way the potential difficulty could be identified was to get the name of the previous insurer.

What happened if the prior insurer was shown on the application as "none" or "unknown?" This indicated either that the applicant did not previously carry insurance or that the name of the prior insurer was being withheld for some reason. Absence of liability insurance appeared to indicate a lack of responsibility on the part of the applicant. Absence of property insurance raised the question as to why the person now has decided to secure insurance. Was there some thought of arson?

Of course, there could be a logical explanation, such as the purchase of a new car to replace an old one, or a person who had just learned to drive, or an effective sales effort on the part of the producer. Certainly, the situation raised questions in the mind of the underwriter and further information or explanation was needed. If there was a prior carrier indicated but the name was not given, the obvious reaction was to wonder what the applicant was hiding. Was it, in fact, a case of no insurance? Or did the applicant not want the underwriter to be able to verify the loss history? The underwriter would want satisfactory answers before accepting such an applicant.

A common underwriting requirement was the name of the previous insurer of the type of insurance being applied for and perhaps the policy number and expiration date. If this was not furnished, a rule was invoked that might read "unacceptable: applicants with no prior insurance during the past six months," or "one year or two years," etc.

Prior Cancellation

Underwriters reviewing an application for insurance often would ask, "Where did it come from and why?" The first part of this question was discussed previously. The second part, the "Why?" was even more critical.

The producer may have sold the applicant on the advantages of changing the insurance to this underwriter's company. The applicant may have sought out the company because of advertising, word of mouth or other reasons. No underwriting problems were presented by these reasons for changing insurers. However, some applicants were looking for insurance because they had been rejected, canceled or non-renewed by a previous insurer. These are the cases that raise warning flags for underwriters.

All insurance companies want to write business. Without it, companies cannot grow or prosper. When an insurer therefore refuses to write a policy or to continue one, there has to be a reason. Some of the reasons may be perfectly harmless as far as the succeeding underwriter is concerned. Perhaps the previous insurer is retiring from a class of business or from a territory. Perhaps it is non-renewing all of the business of a particular producer. Few, if any, of these actions would be taken if the books were profitable, but many good risks could be terminated along with the less desirable ones.

The usual reason for cancellation or non-renewal is the discovery of factors that make the risk unacceptable. The driving record is the most common, but any of the other factors used by underwriters could be the reason. In these cases, the next underwriter may not want the risk either. This conclusion is not always correct, because different companies have different requirements and aim at different segments of the market. As a general rule, it is a cause for extreme caution on the part of the next underwriter.

The trouble is that it is difficult to find out the true reason for termination in many cases. Underwriters are reluctant to share subjective information, such as an uncooperative policyholder during the settlement of a loss. To avoid possible challenges, even allegations of libel or slander, underwriters often would not share such information, even over the telephone. The result was that the next underwriter really did not know why the policy was cancelled or non-renewed.

One study emphasized the problem this way:

"...a cancellation or refusal to renew issued by an insurer, for whatever reason, has constituted a virtual condemnation to the residual market. The reason for this lies in the fact that when, after such cancellation or non-renewal, the individual applies to another insurer among the first questions on the application for insurance will be whether he has been rejected, cancelled or refused renewal by any other automobile insurer. When the answer is affirmative, the second insurer is unlikely to incur the trouble and expense of analyzing the reason and will simply reject the application."

The concern of the person who wrote the above comment was that these risks then land in the involuntary market. While this is to be regretted, it does confirm the standard practice used by underwriters for many years. Since it was difficult to find out why the other insurer rejected, cancelled or non-renewed the risk, and since the reason might also make the risk unacceptable in the next company, underwriters often rejected these risks automatically. A common rule in the non-acceptable list was something like "risks that have been rejected, cancelled or non-renewed within the past three years."

Underwriting Conclusion

As you can see, a great deal of thought goes into the underwriting of risks. A skilled underwriter must rely on his or her experience as well as understanding of the current risks people face and how certain factors, such as the ones we've discussed over the last few sections, increase or decrease risk.

Section 3: Flood Insurance

Chapter 7 The National Flood Insurance Program

The National Flood Insurance Program aims to reduce the impact of flooding on private and public structures. It does so by providing affordable insurance to property owners, renters and businesses and by encouraging communities to adopt and enforce flood plan management regulations. These efforts help mitigate the effects of flooding on new and improved structures. Overall, the program reduces the socio-economic impact of disasters by promoting the purchase and retention of general risk insurance, but also of flood insurance, specifically.

The National Flood Insurance Act of 1968 created the National Flood Insurance Plan (NFIP) as an alternative to providing direct government assistance to homeowners after floods. The Act was passed in response to Congress finding that:

- Flooding disasters required unforeseen disaster relief and placed an increased burden on the nation's resources.
- The installation of flood preventive and protective measures and other public programs designed to reduce losses caused by flood damage had not been sufficient to adequately protect against the growing exposure to flood losses as a matter of national policy. A reasonable method of slowing the risk of flood losses would be through a program of flood insurance that could complement and encourage preventive and protective measures.
- Many factors made it uneconomical for private insurance industry carriers to make flood insurance available to those in need of such protection on reasonable terms and conditions.
- A program of flood insurance with large-scale participation of the Federal Government and the maximum extent practicable by the private industry was feasible and could be initiated.

Congress stated that its goals in creating the NFIP were to:

- Authorize a flood insurance program that, over time, could be made available across the country through the cooperative effort of the Federal Government and the private insurance industry;
- Provide flexibility in the program so that such flood insurance would be based on workable methods of pooling risks, minimizing costs, and distributing burdens equitably among the general public and those who would be protected by flood insurance; and
- Encourage state and local governments to use wisely the lands under their jurisdiction by considering the hazards of flood when rendering decisions on the future use of such land in order to minimize damage.

The Federal Emergency Management Agency (FEMA), part of the Department of Homeland Security, is responsible for the oversight and management of NFIP.

The Standard Flood Insurance Policy (SFIP) consists of three forms:

Dwelling Form:

The Dwelling Form is issued to homeowner, residential renter or owner of residential building containing one to four units. In NFIP Regular Program community or Emergency Program community, provides building and/or contents coverage for:

- Single-family, non-condominium residence with incidental occupancy limited to less than 50 percent of the total floor area;
- 2- to 4-family, non-condominium building with incidental occupancy limited to less than 25 percent of the total floor area;
- dwelling unit in residential condominium building;
- residential townhouse/row-house;
- personal contents in a non-residential building.

General Property Form:

The General Property Form is issued to owner of residential building with five or more units. In

NFIP Regular Program community or Emergency Program community, provides building and/or contents coverage for these and similar "other residential" risks:

- apartment building;
- residential cooperative building;
- dormitory;
- assisted-living facility;
- hotels, motels, tourist homes, and rooming houses that have more than 4 units where the normal guest occupancy is six months or more.

The General Property Form can also be issued to the owner or lessee of non-residential building or unit. In an NFIP Regular Program community or Emergency Program community, this form provides building coverage and/or contents coverage for these and similar non-residential risks:

- hotel or motel with normal guest occupancy of less than 6 months;
- licensed bed-and-breakfast inn;
- retail shop, restaurant, or other business;
- mercantile building;
- grain bin, silo, or other farm building;
- agricultural or industrial processing facility;
- factory;
- warehouse;
- pool house, clubhouse, or other recreational building;
- house of worship;
- school;
- nursing home;
- non-residential condominium;
- condominium building with less than 75 percent of its total floor area in residential use;
- detached garage;
- tool shed;
- stock, inventory, or other commercial contents.

Residential Condominium Building Association Policy (RCBAP) Form:

Finally, the Residential Condominium Building Association Policy (RCBAP) is issued to residential condominium association on behalf of association and unit owners. In an NFIP Regular Program community only, it provides building coverage and, if desired, coverage of commonly owned contents for residential condominium building with 75 percent or more of its total floor area in residential use.

These three forms can be used as part of any of several specific "products" that are marketed by the NFIP under the broad category "Standard Flood Insurance Policy" or SFIP. These products include the following:

1. The Preferred Risk Policy (PRP) is available in moderate-risk flood zones.
2. Mortgage Portfolio Protection Program (MPPP) offers a force-placed policy available only

through a Write Your Own (WYO) Company. See more details on this Program below.

3. The Scheduled Building Policy is available to cover 2 to 10 buildings. The policy requires a specific amount of insurance to be designated for each building. To qualify, all buildings must have the same ownership and the same location. The properties on which the buildings are located must be contiguous.
4. Group Flood Insurance is issued under the NFIP Direct Program in response to a Presidential disaster declaration. Disaster assistance applicants, in exchange for a modest premium, receive a minimum amount of building and/or contents coverage for a 3-year policy period. The Group Flood Insurance Policy cannot be canceled. However, an applicant may purchase a regular SFIP through the NFIP. When this is done, the group flood certificate for the property owner is void, and premium will not be refunded.

The NFIP is the only way that most homeowners can get flood insurance - and it's an important risk management tool for companies doing business in flood-prone areas. As of late 2010, the NFIP had more than 5.6 million policyholders insured for about $1.1 trillion; and the Plan collected about $2.9 billion in annual premiums.

Amount of Insurance Available under the NFIP:

Basic Insurance Limits Add'l Ins Total Ins
Emergency Regular Limits Limits

Building Coverage

Single-Family Dwelling $ 35,000 * $ 60,000 $190,000 $250,000
2-4 Family Dwelling $ 35,000 * $ 60,000 $190,000 $250,000
Other Residential $100,000 ** $175,000 $ 75,000 $250,000
Non-Residential $100,000 ** $175,000 $325,000 $500,000

Contents Coverage

Residential $ 10,000 $ 25,000 $ 75,000 $100,000
Non-Residential $100,000 $150,000 $350,000 $500,000

* In Alaska, Guam, Hawaii, and U.S. Virgin Islands, the amount available is $50,000.
** In Alaska, Guam, Hawaii, and U.S. Virgin Islands, the amount available is $150,000.

Note: For the RCBAP, refer to the Condominiums section of this manual for basic insurance limits and maximum amount of insurance available.

Since the NFIP's inception, Congress has enacted several pieces of legislation to strengthen or expand the program:

- The Flood Disaster Protection Act of 1973 made flood insurance mandatory for owners of properties in vulnerable areas who had mortgages from federally regulated lenders-and provided other incentives for communities to join the program.
- The National Flood Insurance Reform Act of 1994 strengthened the mandatory purchase requirements for owners of properties located in special flood hazard areas (SFHA) with mortgages from federally regulated lenders.
- The Bunning-Bereuter-Blumenauer Flood Insurance Reform Act of 2004 authorized grant programs to mitigate properties that experienced repetitive flooding losses. Owners of these repetitive loss properties who do not mitigate face higher premiums.

One common theme to all of these refinements and reforms: Congress has consistently authorized the use of subsidized premiums to encourage homeowners and communities to join the NFIP. This means that the NFIP offers two types of flood insurance premiums: subsidized and full-risk. The subsidized premium rates, which usually represent about 35 to 40 percent of the cost of covering the full risk of flood damage to insured properties, accounted for about 23 percent of all NFIP policies as of the fall of 2010.

These subsidized premiums are controversial (as we will see in greater detail later). Critics say that they create market inefficiencies and distort some homeowners' notions of flood risks. For example: Approximately 36 percent of NFIP policies have the maximum coverage limits, with higher percentages in areas with higher median home values, such as coastal areas. But the percentage of policies sold at maximum coverage limits appears to be related not as much to flood losses in a particular state as it is to property values.

Case in point: the District of Columbia - which contains no coastal zone - has the highest percentage of maximum-coverage policies in the U.S.

And the most extreme effect: Property owners who are required to purchase an NFIP policy - but don't - may be automatically put in to "force-placed" insurance, primarily through private flood insurance but also through the NFIP's Mortgage Portfolio Protection Program. It is used only as a last resort and only on mortgages whose owners have failed to purchase flood insurance. According to one watchdog agency:

NFIP's rate-setting process for full-risk premiums may not ensure that those premium rates reflect the actual risk of flooding and therefore may increase NFIP's financial risk. Moreover, FEMA's rate-setting process for subsidized properties depends, in part, on the accuracy of the full-risk rates, raising concerns about how subsidized rates are calculated as well.
FEMA and the NFIP have traditionally identified flood hazard areas on maps that are provided to communities for carrying out their responsibilities. These maps assign flood zone designations based on local geography, flooding histories and risk levels. And these designations are a major factor in determining premium rates for flood insurance. (We will also examine NFIP rating formulas in greater detail later.)

However, flaws and inefficiencies in the maps and NFIP rating formulas have lead to consistent financial losses and troubles for the Plan. In the late 2000s, both the U.S. Senate and House of Representatives introduced legislation aimed at "reforming" the NFIP. While these bills differed in several particulars, they agreed about the need to improve the viability of the Plan after it had to borrow billions of dollars from the Treasury Department to pay for catastrophic losses following the 2005 hurricane season.

Total NFIP flood losses in 2005, including Hurricanes Katrina and Rita, were about $17.6 billion. In response to the magnitude and severity of the losses from the 2005 hurricanes, Congress increased NFIP's borrowing authority from the Treasury Department to $20.775 billion. And the program ended up using most of that "line of credit."

According to FEMA, despite the general economic downturn, 2010 was a good year for the NFIP.

Policy sales and retention both improved; also, collected premiums rose 24 percent over the three years leading up to June 2010. This increase, combined with a relatively low loss experience over the same period, enabled the NFIP to make nearly $600 million in payments to the Treasury Department.

Still, in the opinion of the GAO and other organizations familiar with the NFIP's finances, the Plan is unlikely to pay off the $18.8 billion debt it had with the Treasury Department in 2010.

Waiting Periods:

Most NFIP policies require some type of waiting period before taking effect-these requirements are designed to prevent insureds from buying coverage in the hours before a major storm or flood event has been predicted to occur.
With a few exceptions, the effective date of a new NFIP policy will be 12:01 a.m., local time, on the 30th calendar day after the presentment of premium.
The three main exceptions to this 30-day waiting period are:

1. There is no waiting period if the initial purchase of flood insurance on an Application requiring the Submit-for-Rate procedure is in connection with making, increasing, extending, or renewing a loan, provided that the policy is applied for and the presentment of premium is made at or prior to the loan closing. The rules provided in subsection A. Receipt Date must be used unless the premium payment was made from the escrow account (lender's check), title company, or settlement attorney. If a loss occurs during the first 30 days of the policy period, the insurer must obtain documentation, such as settlement papers, to verify the effective date of the policy before adjusting the loss.

2. The 30-day waiting period does not apply when flood insurance is required as a result of a lender determining that a loan that does not have flood insurance coverage should be protected by flood insurance, because the building securing a loan is located in an SFHA. The coverage is effective upon the completion of an Application and the presentment of premium. This exemption from the 30-day waiting period applies only to loans in SFHAs, i.e., those loans for which the statute requires flood insurance. The rules provided in subsection A. Receipt Date must be used. If a loss occurs during the first 30 days of the policy period, the insurer must obtain documentation, such as a copy of the letter requiring mandatory purchase, to verify the effective date of the policy before adjusting the loss.

3. During the 13-month period beginning on the effective date of a map revision, the effective date of a new policy shall be 12:01 a.m., local time, following the day after the date the increased amount of coverage is applied for and the presentment of additional premium is made. This rule applies only on an initial purchase of flood insurance where the FHBM or FIRM is revised to show the building to be in an SFHA when it had not been in an SFHA. The rules provided in subsection A. Receipt Date must be used. If a loss occurs during the first 30 days of the policy period, the insurer must obtain documentation, such as a copy of the previous and current map or other documentation confirming the map revision or update, to verify the effective date of the policy before adjusting the loss.

One more exception: The 30-day waiting period does not apply when an insured decides to rewrite the existing policy at the time of renewal from a standard-rated policy to a PRP, provided that the selected PRP coverage:

limit amount is no higher than the next-highest PRP amount above that which was carried on the standard-rated policy using the highest of building and contents coverage. If the standard-rated policy has only contents coverage and is rewritten as a contents-only PRP, the 30-day waiting period does not apply.

When converting a standard-rated policy to a PRP, the 30-day waiting period will not apply if the standard-rated policy has only building coverage and is rewritten as a PRP that includes contents coverage.

In addition, if the structure is no longer eligible under the PRP or the insured decides to rewrite the existing PRP at renewal time to a standard-rated policy, the 30-day waiting period does not apply provided the coverage limit amount is no more than the previous PRP coverage amount or the next-higher PRP amount above that.
Also, the 30-day waiting period does not apply when the additional amount of flood insurance is required in connection with the making, increasing, extending, or renewing of a loan, such as a second mortgage, home equity loan, or refinancing. The increased amount of flood coverage shall be effective at the time of loan closing, provided that the increased amount of coverage is applied for at or before closing. The rules provided in subsection A. Receipt Date must be used.
And certain increases in coverage requested while an NFIP policy is in place make take effect immediately or after a one-day waiting period.
Finally, in some cases, the insured can purchase an endorsement which reduces the waiting period from 30 days to one day.

NFIP Eligibility Rules

Here are the basic eligibility rules for NFIP flood insurance:

- Flood insurance may be written only in those communities that have been designated as participating in the National Flood Insurance Program (NFIP) by the Federal Emergency Management Agency (FEMA).
- The Emergency Program is the initial phase of a community's participation in the NFIP. Limited amounts of coverage are available.
- The Regular Program is the final phase of a community's participation in the NFIP. In this phase, a Flood Insurance Rate Map is in effect and full limits of coverage are available.
- Maps of participating communities indicate the degree of flood hazard so that actuarial premium rates can be assigned for insurance coverage on properties at risk. These maps include:

1. Flood Hazard Boundary Map (FHBM) - Usually the initial map of a community. Some communities entering the Regular Program will continue to use an FHBM renamed a Flood Insurance Rate Map if there is a minimum flood hazard.
2. Flood Insurance Rate Map (FIRM) - The official map of the community containing detailed actuarial risk premium zones.

- Probation, imposed by the FEMA Regional Director, occurs as a result of noncompliance with NFIP floodplain management criteria. A community is placed on probation for one year (may be extended), during which time a $50 surcharge is applied to all NFIP policies, including the Preferred Risk Policy (PRP), issued on or after the Probation Surcharge effective date. Probation is terminated if deficiencies are corrected. However, if a community does not take remedial or corrective measures while on probation, it can be suspended.
- Flood insurance may not be sold or renewed in communities that are suspended from the NFIP. When a community is suspended, coverage remains in effect until expiration. These policies cannot be renewed.
- When FEMA provides a non-participating community with an FHBM or a FIRM delineating its flood prone areas, the community is allowed one year in which to join the NFIP. If the community chooses not to participate in the NFIP, flood insurance is not available.
- Flood insurance may not be available for buildings and/or contents located in coastal barriers or otherwise protected areas. These areas are listed in a separate Coastal Barrier Resources System.

To participate in NFIP, local communities (counties, cities, towns, etc.) agree to enforce regulations for land use and new construction in high-risk flood zones - and to adopt and enforce state and community floodplain management regulations to reduce future flood damage.
In 2010, more than 20,000 communities participated in NFIP.
In return for this community participation, FEMA makes flood insurance coverage available on buildings and their contents throughout the community.
NFIP coverage is available to all owners of insurable property (a building or its contents - or both) in a community participating in NFIP. Builders of buildings in the course of construction, condominium associations and owners of residential condominium units in participating communities may also purchase flood insurance.
Specifically, NFIP coverage can be written on any of the following types of property:
Eligible Buildings. Insurance may be written only on a structure with two or more outside rigid walls and a fully secured roof that is affixed to a permanent site. Buildings must resist flotation, collapse, and lateral movement. At least 51 percent of the Actual Cash Value (ACV) of buildings, including machinery and equipment, which are a part of the buildings, must be above ground level, unless the lowest level is at or above the Base Flood Elevation (BFE) and is below ground by reason of earth having been used as insulation material in conjunction with energy-efficient building techniques.
Appurtenant Structures. The only appurtenant structure covered by the SFIP is a detached garage at the described location, which is covered under the Dwelling Form. Coverage is limited to no more than 10 percent of the limit of liability on the dwelling. Use of this insurance is at the policyholder's option but reduces the building limit of liability. Appurtenant structure coverage does not apply to any detached garage used or held for use for residential (dwelling), business, or farming purposes.
Manufactured (Mobile) Homes/Travel Trailers. A manufactured home (a "manufactured home," also known as a mobile home, is a structure built on a permanent chassis, transported to its site in one or more sections, and affixed to a permanent foundation); and a travel trailer without wheels, built on a chassis and affixed to a permanent foundation, that is regulated under the community's floodplain management and building ordinances or laws. To be insurable under the

NFIP, a mobile home must be:

- affixed to a permanent foundation: a permanent foundation for a manufactured (mobile) home may be poured masonry slab or foundation walls, or may be piers or block supports, either of which support the mobile home so that no weight is supported by the wheels and axles of the mobile home.
- anchored, if located in a Special Flood Hazard Area (SFHA): a manufactured or mobile home located within an SFHA must be anchored to a permanent foundation to resist flotation, collapse, or lateral movement by providing over-the-top or frame ties to ground anchors; or in accordance with manufacturer's specifications; or in compliance with the community's floodplain management requirements.

(All manufactured or mobile homes on a foundation continuously insured since September 30, 1982, can be renewed under the previously existing requirements if affixed to a permanent foundation.

Silos and Grain Storage Buildings

Cisterns

Buildings Entirely Over Water - Constructed or Substantially Improved before October 1, 1982. Pre-FIRM buildings constructed before October 1, 1982, are eligible for normal Pre-FIRM rates. If the building was constructed or substantially improved on or after October 1, 1982, the building is ineligible for coverage. Exception: If a building was originally constructed on land or partially over water, and later becomes entirely over water because of erosion, it is eligible for coverage only if the building has had continuous coverage:

- from the period beginning at least one year prior to the building being located entirely over water, regardless of any changes in the ownership of the building; or
- from the date of construction if less than one year.

Buildings Partially Over Water

Boathouses Located Partially Over Water. The non-boathouse parts of a building into which boats are floated are eligible for coverage if the building is partly over land and also used for residential, commercial, or municipal purposes and is eligible for flood coverage. The area above the boathouse used for purposes unrelated to the boathouse use (e.g., residential occupancy) is insurable from the floor joists to the roof, including walls. A common wall between the boathouse area and the other part of the building is insurable. The following items are not covered:

- The ceiling and roof over the boathouse portions of the building into which boats are floated;
- Floors, walkways, decking, etc., within the boathouse area, or outside the area, but pertaining to boathouse use;
- Exterior walls and doors of the boathouse area not common to the rest of the building;
- Interior walls and coverings within the boathouse area; and
- Contents located within the boathouse area, including furnishings and equipment, relating to the operation and storage of boats and other boathouse uses.

Buildings in the Course of Construction. NFIP rules allow for the issuance of an SFIP to cover a building in the course of construction before it is walled and roofed. These rules provide lenders with an option to require flood insurance coverage at the time that the development loan is made to comply with the mandatory purchase requirement outlined in the Flood Disaster Protection Act of 1973, as amended. The policy is issued and rated based on the construction designs and intended use of the building. Buildings in the course of construction that have yet to be walled and roofed are eligible for coverage except when construction has been halted for more than 90 days and/or if the lowest floor used for rating purposes is below the BFE. Materials or supplies intended for use in such construction, alteration, or repair are not insurable unless they are contained within an enclosed building on the premises or adjacent to the premises.
Severe Repetitive Loss Properties: These must be processed by the NFIP Special Direct Facility.
Single Building. To qualify as a single-building structure and be subject to the single-building limits of coverage, a building must be:

1. Separated from other buildings by intervening clear space; or
2. Separated into divisions by solid, vertical, load-bearing walls; each division may be insured as a separate building.
    - These walls must divide the building from its lowest level to its highest ceiling and have no openings.
    - If there is access through the division wall by a doorway or other opening, the structure must be insured as 1 building unless it meets all of the following criteria:
        - It is a separately titled building contiguous to the ground; and
        - It has a separate legal description; and
        - It is regarded as a separate property for other real estate purposes, meaning that it has most of its own utilities and may be deeded, conveyed, and taxed separately.

Additions and Extensions. The NFIP insures additions and extensions attached to and in contact with the building by means of a rigid exterior wall, a solid load-bearing interior wall, a stairway, an elevated walkway, or a roof. At the insured's option, additions and extensions connected by any of these methods may be separately insured. Additions and extensions attached to and in contact with the building by means of a common interior wall that is not a solid load-bearing wall are always considered part of the building and cannot be separately insured.
Eligible Contents. Contents must be located in a fully enclosed building. However, under the Dwelling Form, in a building that is not fully enclosed, contents must be secured to prevent flotation out of the building.
Vehicles and Equipment. The NFIP covers self-propelled vehicles or machines, provided they are not licensed for use on public roads and are:

1. Used mainly to service the described location; or
2. Designed and used to assist handicapped persons while the vehicles or machines are inside a building at the described location.

Silos, Grain Storage Buildings, and Cisterns. Contents located in silos, grain storage buildings, and cisterns are insurable.

Commercial Contents in a residential property must be insured on the General Property Form. Some specific examples of *ineligible* risks:

- Bailee's Customer Goods - including garment contractors, cleaners, shoe repair shops, processors of goods belonging to others, and similar risks
- Boat Repair Dock
- Boat Storage Over Water
- Camper
- Contents Located in a Building Not Fully Walled and/or Contents Not Secured Against Flotation
- Contents Located in a Structure Not Eligible for Building Coverage
- Cooperative Unit within Cooperative Building
- Decks (except for steps and landing; maximum landing area of 16 sq. Ft.)
- Drive-In Bank Teller Unit (located outside walls of building)
- Fuel Pump
- Gazebo (unless it qualifies as a building)
- Greenhouse (unless it has at least 2 rigid walls and a roof)
- Hot Tub or Spa (unless it is installed as a bathroom fixture)
- Motorized Equipment - Including dealer's stock (assembled or not)
- Non-Residential Condominium Unit
- Open Stadium
- Pavilion (unless it qualifies as a building)
- Pole Barn (unless it qualifies as a building)
- Pumping Station (unless it qualifies as a building)
- Storage Tank - Gasoline, water, chemicals, sugar, etc.
- Swimming Pool (indoor or outdoor)
- Swimming Pool Bubble
- Tennis Bubble
- Tent
- Timeshare Unit within Multi-Unit Building
- Travel Trailer (unless converted to a permanent on-site building meeting the community's floodplain management permit requirements)
- Water Treatment Plant (unless at least 51% of its ACV is above ground)

The owner of a non-residential condominium unit cannot purchase building coverage. Contents-only coverage may be purchased by the unit owner.

How the NFIP responds to catastrophes

FEMA and various Coastal Plans will determine whether a catastrophe event will necessitate a Single Adjuster Program (SAP) response. The National Weather Service declaration of a tropical storm or hurricane event will begin the watch for possible single adjuster response. When the storm is 48 hours from landfall, this will initiate FEMA's approval of the SAP response.
During that time, the NFIP Bureau and Statistical Agent's General Adjusters will be deployed to strategic areas close to where the storm is predicted to strike. At landfall, they will be able to immediately assess the damage impact from the storm. No later than 24 hours after landfall, the

WYO Companies will be advised by telephone, fax, or email through their designated Single Adjuster Liaison, as to the areas and state(s) that will be activated. At that point, the WYO Companies will be asked to immediately notify their agents/producers of the SAP procedures in reporting the claims.

The NFIP Bureau will notify the WYO Companies by telephone, fax, or email to have their agency staff submit all flood losses that are reasonably believed to involve wind and flood damage to the State Coastal Plans (i.e., Windpool, Fairplan, Beachplan, etc.).

The NFIP will notify all SAP Liaisons of the CCO's location, telephone number, fax number, and address, if the CCO does not co-locate with the State Coastal Plans.

When the CCO is operational, the WYO Companies will be notified of all assigned claims. Notice of losses reflecting the assigned adjusting firms will be faxed each day. Once the assignment is made and communicated to each company, the WYO Company will manage its own loss adjustment. However, the Catastrophe CCO will ensure that the adjuster receives a copy of the loss assignments, the name of the WYO Company, and the SAP Liaison telephone number.

Risk and NFIP

The NFIP is not an actuarially sound insurance program - Under its authorizing legislation, NFIP must offer subsidized flood insurance premiums along with its full-risk premiums. As we've noted, the subsidized premiums (which fund only about 35 to 40 percent of the cost of covering the actual risk of flood damage to the insured properties) account for almost one out of every four active residential NFIP policies.

Making matters even more difficult: the NFIP's full-risk rates are often based on outdated information and processes, so even these rates may not reflect the actual risk of flood-related loss.

So, the NFIP does not operate like most private insurance companies. From an actuarial standpoint, the biggest differences between it and conventional insurers are that the NFIP is:

1. not structured to build a capital surplus,
2. likely unable to purchase reinsurance to cover catastrophic losses,
3. unable to reject high-risk applicants, and
4. subject to statutory limits on rate increases.

That last point bears repeating: Many NFIP-insured property owners pay premium rates that do not reflect the full, long-term risk of flooding - and the law limits the NFIP's ability to correct the inefficiencies.

So, the NFIP allows some insured property owners to continue to pay rates that Plan underwriters and administrators know do not reflect reassessments of their properties' flood risk. And these aren't even what the NFIP means when it uses the term "subsidized rates," although - strictly speaking - they could be called that. (To avoid confusion, the NFIP refers to these rates as "grandfathered rates.")

FEMA documents state that properties are grandfathered in order to recognize policyholders who have complied with their original FIRM, have remained loyal NFIP customers, or both. In general, two categories of buildings may be grandfathered into the program

1. those built in compliance with the FIRM that was in effect at the time of construction and
2. those built before a FIRM was in effect or that were not in compliance at the time of construction.

For those buildings in compliance at the time of construction, property owners need to provide documentation of the date of the original FIRM and the property's flood zone, base flood elevation (BFE) and other map-related information. Properties that were not in compliance generally can be grandfathered if they have had continuous flood insurance and if the building has not been altered in certain ways.

While FEMA does not consider the premiums on these properties to be subsidized because they are based on the average risk for the whole class to which they had been assigned previously, they share two characteristics with subsidized rates:

1. rates based on new FIRMs should more accurately reflect flood risk, but grandfathered properties will not be charged those rates; and
2. the grandfathered status of a property continues indefinitely, even when the property is sold.

In most property and casualty insurance lines, state assessments are often passed through to policyholders. As a result, policyholders living in less risky locations also contribute to cover the shortfall - a scenario known as cross-subsidization.

In those states where assessments cannot be passed through in some manner, private insurers must pay the assessments while at the same time paying large claims from their own policyholders. In such instances, some companies may be reluctant to continue offering coverage in the state or may become insolvent.

FEMA officials acknowledged that property owners that obtain grandfathered rates for their homes are being cross-subsidized by other policyholders in the same zone that are paying higher rates. For example, under grandfathering, repetitive loss properties remapped into a higher-risk zone instead would pay a rate generally charged to lower-risk properties.

These are pre-FIRM properties that were built before detailed flood hazard data and flood elevations were provided to the community and usually before the community enacted comprehensive regulations on floodplain regulation.

The officials also stated that in making this decision they took into consideration several concerns:

1. potentially higher rates that could cause property owners not to buy insurance or to lose their properties,
2. adverse reactions to FEMA as the result of these higher rates,
3. the burden on insurance agents of obtaining new map determinations and information for every policyholder, and
4. the likelihood of communities resisting new maps due to the potential for large rate increase

While grandfathered rates are used to keep existing policyholders, FEMA has not taken steps to measure the impact of these rates on the program's financial condition. FEMA officials said that they currently had limited data on new or existing grandfathered properties and are just beginning to explore ways to track these properties. For example, they had not tracked the number of grandfathered properties or calculated how much lower grandfathered premiums are than the actual rates.

As a result, they did not know the effect of grandfathered properties on the program's total premium collection and the extent to which these rates deviate from fully risk-based rates. Without this information, FEMA's ability to address the financial impact of such properties on NFIP's financial health is limited.

Why can't the NFIP charge premiums high enough to build a capital surplus for years when there are unusual or catastrophic losses? Because the program was enacted to encourage property owners in vulnerable areas to join the program and maximize the number of participants. Its "primary public policy goal" is to provide flood insurance in flood-prone areas to property owners who otherwise would not be able to obtain it.

In other words, it's designed to lose money.

Which leads to its second big problem: Unlike private insurance companies, NFIP assumes all the risk for the policies it sells.

Private insurers typically retain only part of the risk that they accept from policyholders, ceding a portion of the risk to reinsurers(insurance for insurers). This mechanism is particularly important in the case of insurance for catastrophic events, because the availability of reinsurance allows an insurer to limit the possibility that it will experience losses beyond its ability to pay.

NFIP's lack of reinsurance, combined with the lack of structure to build a capital surplus, transfers much of the financial risk of catastrophic floods to the Treasury Department and - ultimately - to the American taxpayer.

A separate - but simultaneous - problem: The NFIP is required to accept virtually all applications for insurance, unlike private insurers, which can reject applicants for a variety of reasons. Because it can't deny insurance on the basis of frequent losses, the NFIP is less able to offset the effects of adverse selection; that is the phenomenon in which those people or entities most likely to purchase insurance are also the most likely to experience losses.

Adverse selection usually leads to market inefficiencies: such as concentrations of policyholders in the riskiest areas.

This problem is further compounded by the fact that those at greatest risk are required to purchase insurance from NFIP if they have a mortgage from a federally regulated lender.

Finally, by law, the Plan is prevented from raising rates on each flood zone by more than 10 percent each year. While most states regulate premium prices for private insurance companies on other lines of insurance, they generally do not set limits on premium rate increases, instead focusing on whether the resulting premium rates are justified by the projected losses and expenses.

These rates allow policyholders with structures that were built before floodplain management regulations were established in their communities to pay premiums that represent about 35 to 40 percent of the actual risk premium.

"Repetitive Loss" Properties

In reauthorizing NFIP in 2004, Congress noted that repetitive loss properties - those that have had two or more flood insurance claims payments of $1,000 or more over 10 years - constituted a significant drain on NFIP resources.

According to the NFIP's own numbers, repetitive loss properties represent only about one percent of its total number of policies - but account for 25 to 30 percent of claims.

That bears repeating: approximately one percent of NFIP policies account for between 25 and 30 percent of its claims expenses.

Various individuals and organizations have made suggestions for how the NFIP might limit its exposure to repetitive-loss property claims. For example, the Government Accountability Office (GAO) has suggested that "one option for Congress would be to substantially expand mitigation efforts and target these efforts toward the highest-risk properties."

FEMA and the NFIP have experimented with a variety of mitigation efforts for high-risk properties - including elevation, relocation and demolition. As of 2010, the NFIP had five different mitigation grant programs, each with different types of requirements, purposes and appropriations:

1. Flood Mitigation Assistance (FMA),
2. Repetitive Flood Claims (RFC),
3. Severe Repetitive Loss Pilot Program (SRL),
4. Hazard Mitigation Grant Program (HMGP), and
5. Pre-Disaster Mitigation (PDM).

Despite these efforts, the inventories of repetitive loss properties and policies with subsidized premium rates have continued to grow.

Mitigation requirements criteria could be made more stringent-for example:

- requiring all insured properties that have filed two or more flood claims (even for small amounts) to mitigate,
- denying insurance to property owners who refuse or do not respond to a mitigation offer, or
- some combination of these approaches.

While these actions would help reduce losses from flood damage and could ultimately limit costs to taxpayers by decreasing the number of subsidized properties, they would require increased funding for FEMA's mitigation programs, to elevate, relocate, or demolish the properties, would be costly to taxpayers, and could take years to com Probability of elevation plete.

Congress could also consider changes to address loopholes in mitigation and repurchase requirements that allow policyholders to avoid mitigating by simply not responding to FEMA's requests that they do so. FEMA could be required to either drop coverage for such properties or use eminent domain to seize them if owners fail to respond to FEMA's mitigation requests. Moreover, Congress could streamline the various mitigation grant programs to make them more efficient and effective.

Not all repetitive loss properties are part of the subsidized property inventory, but a high proportion receives subsidized rates, further contributing to NFIP's financial risks. While Congress has made efforts to target these properties, the number of repetitive loss properties has continued to grow, making them an ongoing challenge to NFIP's financial stability.

The NFIP'S Financial Issues

The number of policies receiving subsidized rates has grown steadily in recent years and without changes to the program will likely continue to grow, increasing the potential for future NFIP operating deficits.

FEMA estimates that properties covered by policies with subsidized rates experience as much as five times more flood damage than compliant new structures that are charged full-risk rates.

The result is predictable: As of October 2008, NFIP owed interest payments of $730 million a year to Treasury and had to borrow more from the Treasury to make these payments.

The program, "as currently designed," is not likely to generate sufficient revenue to repay this debt.

As of June 2008, NFIP's average non-catastrophic historical loss year (which excludes Hurricanes Katrina, Rita, and Wilma) is about $1.3 billion. The combined outlays for loss and loss adjustment expenses of around $1.3 billion, administrative expenses of approximately $1 billion, and interest payments of approximately $0.7 billion exceed the program's current premium collection of approximately $2.6 billion. Under current conditions, it is unlikely that NFIP will be able to meet its interest payments in most years, and the program's debt will likely grow as the program borrows to meet the interest payments.

Because of the NFIP's financial situation, the GAO has placed the program on its high-risk list - which means it's likely to cost taxpayers significantly more than its current financial reports indicate. The GAO considered the NFIP's over financial health and prospects in a 2009 report (the full text is available here:). And it didn't like what it found:

[The NFIP] likely will not generate sufficient revenues to repay the billions of dollars borrowed from the Treasury Department to cover claims from the 2005 hurricanes or future catastrophic losses.

The lack of sufficient revenues highlights structural weaknesses in how the program is funded.

Also, weaknesses in NFIP management and operations, including financial reporting processes and internal controls, and oversight of contractors place the program at risk.

The potential losses generated by NFIP create substantial financial exposure for the federal government and U.S. taxpayers. While Congress and FEMA intended that NFIP be funded with premiums collected from policyholders rather than with tax dollars, the program is, by design, not actuarially sound.

NFIP's financial condition improved slightly during the late 2000s, due to an increase in the number of policyholders and moderate flood losses. And, especially in 2009, FEMA took some steps toward improving the NFIP's financial position - including paying down its debt to Treasury by almost $850 million. However, the program was supposed to repay some $18.5 billion owed to the Treasury Department by the end of 2010. That didn't happen.

NFIP and private flood insurance

Of course, the government isn't the only place to go for flood insurance. Some private-sector insurance companies offer coverage. But the NFIP's subsidized rates have marginalized these carriers and set the tone for the overall flood insurance marketplace.

The private-sector market for residential flood insurance is small and focuses on homes with values over $1 million. The private commercial market is also relatively small, focusing on larger companies that use NFIP coverage to finance the deductibles on private policies.

A 2007 Rand Corp. study commissioned by FEMA estimated that between 180,000 to 260,000 private-sector insurance policies for both primary and excess coverage were in effect. Four large insurance companies provided almost all of this private flood insurance:

1. American International Group,
2. Chubb,
3. Fireman's Fund, and
4. Lloyds of London.

(Although AIG has effectively ceased to exist after its highly-publicized financial problems in 2008, its share of the private-sector flood insurance market has been maintained by successor companies.)

Private-sector flood insurance can be significantly more expensive than NFIP insurance for similar levels of coverage. So, most often, private flood insurance policies are purchased in conjunction with NFIP policies - with the NFIP policy paying an amount equal to the deductible on the private policy.

According to anecdotal evidence gathered by the GAO and other organizations that have analyzed the NFIP's operations and finances:

- the cost for a specified level of residential coverage could be as low as $500 from NFIP and as high as $900 from a private insurer;
- for contents insurance, the cost averages around $350 from NFIP but around $600 in the private market;
- large companies are the primary purchasers of private commercial flood insurance, and "several insurers and industry officials" say that private flood insurance for small to medium-sized businesses is prohibitively expensive;
- up to 80 percent of private policies provide excess coverage above the NFIP maximum and are purchased together with NFIP policies, and the remaining 20 percent is considered "first dollar" coverage;
- generally, the NFIP policy covers the deductible on the private policy - commercial policies often set the deductible at NFIP policy limits;
- private-sector insurers also generally determine their premium rates using NFIP rates, data and flood maps as a starting point - and adjust rates (usually upward) according to their own risk analyses.

Some private-sector insurers will write residential flood coverage on a primary basis, but it is much more expensive than excess insurance because primary coverage exposes the insurer to the first loss position and most flood-related losses are less than the NFIP coverage limits. This means that excess coverage is tapped only for losses above the NFIP coverage limit.

On the commercial lines side, private insurance can be purchased alone or included as part of a multi-peril property-casualty policy. While little aggregate data is available, most industry officials agree that private flood insurance for small and medium-size businesses is prohibitively expensive in most situations.

One type of flood insurance that private-sector carriers do offer - and that the NFIP, at least currently, does not - is business interruption coverage for commercial insureds. This coverage is expensive and, generally, only large companies can afford it.

Private-sector business interruption coverage for flood losses is usually available only if the purchaser also has a property-casualty policy that includes flood coverage. So, the insureds are already paying a lot for top-of-the-line coverage.

Underwriting flood-related business interruption coverage is complex; properly pricing the risks requires an extensive evaluation of a company's business model and cash flow - to determine the kinds of losses that a business interruption might involve.

Adjusting business interruption claims is also complex and often contentious, because the extent of a loss depends on the nature of the business and the circumstances surrounding the triggering flood event.

Some experts have suggested that an NFIP-subsidized business-interruption policy could be a way for smaller businesses to obtain such coverage; but adding business interruption coverage would further strain the NFIP's human and financial resources. (And sophisticated insureds would likely use NFIP business interruption coverage to cover deductibles on private policies, as they do with property coverage.)

More importantly: Because business interruption insurance is so complex to underwrite - and unless it were sold at a price adequate to cover the expected losses - it could increase the federal government's exposure to catastrophic flood losses.

Flooding happens every day in regions all across our country. A flood can happen even in areas that might not seem at risk. Floods do not always result from hurricanes; they can happen due to extreme conditions, such as rain, rapid spring melts, or high river conditions. It is not necessary to live in a coastal area to experience a flood. In 2004, Pennsylvania, which has no ocean coastline, received more than $175 million in flood insurance payments – second only to Florida. [3] Every property owner should consider the threat of floods when insuring their homes and businesses.

The floods we tend to read about follow such events as hurricanes or nor’easters, but more floods happen every day resulting from small, localized events. Everyone must realize that it only takes a few inches of water in a home to cause thousands of dollars in damage. In fact, flooding in the United States is the number one natural hazard.

Homeowner’s insurance will not cover flooding; it is necessary to protect their home and property by purchasing a flood insurance policy separately through their local insurance agent. As long as the individual’s hometown is an NFIP community, most people, including those who rent, can get flood insurance. The National Flood Insurance Program wants consumers to understand the flood insurance basics, including:

You can get flood insurance nationwide.

- You can get flood insurance if you live in a floodplain or high-flood-risk area.

•You can get flood insurance if you live outside a floodplain, or low to moderate flood risk area (and at a lower cost).
•You can get flood insurance if your property has experienced a past flood.
•You can get flood insurance from agents in your area.
•You can buy flood insurance even if your mortgage broker does not require such coverage.

What does this mean? It means that just about everyone should consider purchasing flood insurance. Over 25 percent of the NFIP claims were paid in low-to-moderate flood risk areas, such as zones B, C or X.

Mandatory Purchase of Flood Insurance in High Flood Risk Zones

The Flood Disaster Protection Act of 1973 placed the requirement on federally regulated lending institutions to ensure that loans secured by buildings located in high flood risk areas are protected by flood insurance. Lenders call these areas the Special Flood Hazard Areas (SFHA). They are Zone A and V. The National Flood Insurance Reform Act of 1994 further strengthened the requirements. Agents may view the Mandatory Purchase of Flood Insurance Guideline booklet online at http://www.fema.gov/nfip/mpurfi.shtm. The booklet is a guide for lending institutions, but it can help the flood insurance agent too. Agents provide important information to lenders concerning their flood insurance needs that may go beyond meeting the minimal mandatory requirements established by law.

Recommended in Moderate and Low Flood Risk Zones

Individuals may go online to determine their personal flood risk. Floodsmart.gov provides this information to anyone wishing to access it online. By entering property information, they will show the relative flood risk, links to flood insurance resources, and a list of licensed insurance agents serving the area. As we have previously stated, flood insurance is recommended even in low to moderate flood risk zones.

Why Flood Insurance is Better Than Disaster Assistance

The President must declare a major disaster before most forms of federal assistance is available. The most common form of federal disaster assistance is a Small Business Administration (SBA) low-interest disaster assistance loan, which must be repaid with interest. The average federal Individuals and Households Program (IHU) award is around $4,000. To qualify for federal Home Repair Assistance the individual's home must have eligible relatively minor damage that can be quickly repaired. Individuals cannot qualify for federal Rental Assistance unless their home has been heavily damaged or destroyed.

Disaster assistance loans from SBA are usually more costly than flood insurance premiums, so it makes sense to purchase flood policies.

Flood Loss Avoidance

What is a flood loss avoidance?

Flood loss avoidance is a protective action policyholders take to minimize flood damage and losses to their buildings and personal property before a flood occurs.

What's covered under a Standard Flood Insurance Policy?

National Flood Insurance Program flood policies will cover up to $1,000 in reasonable expenses incurred to protect policyholders' insured property, and up to $1,000 to move their insured property away from a flood or imminent danger of a flood. To be eligible for this benefit, the insured property must be located in a community where:

- A general condition of flooding in the area exists; or
- An official has issued an evacuation order or other civil order for the community requiring measures to preserve life and property from flooding.

What is eligible?

Expenses to protect your property:

- Sandbags (including the sand to fill them)
- Fill to create temporary levees
- Water pumps
- Plastic sheeting and lumber used in connection with any of these items listed above
- Labor – a policyholder may claim labor, including their own or a family member's labor, at the federal minimum wage. Labor charged by a professional may also be reimbursed.

Expenses to move your property to safety:

- Up to $1,000 for the reasonable expense to move their insured property in order to protect it rom flood, or the imminent danger of flood.

What do you need to know?

- Personal property that is moved must be placed in a fully enclosed building or otherwise protected from the elements.
- Any property removed, including a moveable home (that meets the definition of a building in the flood policy), must be placed above ground level or outside of the special flooding hazard area.
- Property removed is covered by your flood policy for 45 consecutive days from the date the move begins.
- A deductible does not apply to these limits.
- The coverage does not increase the policy limits of the liability.

Paid Receipts:

Policyholders should keep copies of all receipts and a record of the time spent performing the work.

They should be submitted to their insurance adjuster when they file a claim to be reimbursed.

Chapter 8 NFIP'S Modeling Process

As we've noted before, the NFIP's inability to manage information effectively raises many questions about it operations. Specifically: Its method for setting its full-risk rates may not ensure that the rates accurately reflect the actual risk of flood damage.

The NFIP model combines estimated flood risk with expected flood damage, but a number of factors may affect the accuracy of the rates the model generates. These factors include:

1.some data inputs are outdated or inaccurate. FEMA relies on flood probabilities from the 1980s and damage estimates that do not fully reflect recent NFIP damage experience. While FEMA has made updating its flood maps a priority, most of the maps used in rate setting have not yet been updated;

2.FEMA does not require all properties remapped into higher-risk areas to pay rates based on the new designation. This policy, known as grandfathering, erodes NFIP's ability to charge rates that reflect the risk of flooding. The policy is intended to increase participation, but FEMA does not track the number of grandfathered properties and cannot determine their financial impact on the program;

3.FEMA uses a nationwide rating system that combines flood zones across many geographic areas, so individual policies do not always reflect topographical features that affect flood risk. In fact, some patterns in historical claims and premium data suggest that NFIP's full-risk rates may not always reflect actual flood risk.

The questions raised by these problems add to concerns about the NFIP's overall financial stability.

A related issue: the NFIP's rate-setting process for subsidized properties depends in part on the accuracy of the full-risk rates-so, if the full-risk rates are wrong, the subsidized rates are likely wrong, too.

To set its subsidized rates, the NFIP first subtracts the total amount it expects to collect in full-risk premiums from the average historical loss year - that is, the minimum (target) amount that the program needs to collect from all premiums to cover at least average annual losses, as determined by historical data. The remainder becomes the aggregate target amount the program must collect in subsidized premiums.

To set individual subsidized rates, the NFIP then considers its knowledge of flood risk, previous rate increases for various locations and statutory limits on increases.

Still, the level of subsidized rates charged to policyholders depends, in part, on the full-risk premiums determined by FEMA. For example, if full-risk premiums are too low because they do not accurately reflect flood risk, the total amount FEMA will need to collect from subsidized policies will be higher, resulting in higher subsidized premiums.

So, it should be no surprise that for most of the past 10 years the annual amount collected by the NFIP in both full-risk and subsidized premiums is not enough to cover its operating costs, claim losses and principal and interest payments to the Treasury Department.

Uncertainty about these rates raises questions about all of the NFIP's rate-setting assumptions. For example:

- For a given property type, the rate per $100 of insurance on the first $50,000 of coverage for a single-family structure in the Regular Program (that is, what NFIP terms "basic" coverage) is $1.31. The rate per $100 of insurance on amounts in excess of $50,000 (that is, what NFIP terms "additional" coverage) is $0.10. But the agency has no idea whether these standard rates are valid.
- Standard rates are refined by multiplying them by factors - which range between 0.75 and 1.50 - designed to reflect specific risks related to a property's location, construction details and history.
- The "one percent annual chance flood," also known as the "100-year flood," is a statistical construct essential to NFIP rates: It is the baseline risk - a flood that has a certain discharge that produces a specific flood elevation and an estimated one percent chance of occurrence in any one year. But no one is sure that the elevations are even close to right.
- As a result, the one percent flood represents a range of discharge and elevation values because of the uncertainties and other limitations in the information available for its computation and the resulting need to use specific types of probability distributions to portray the possibilities.
- So, the SFHA flood zones on the FIRMs can reflect varying degrees of analysis, in some cases using approximate methods while in others using more detailed methods. The accuracy of the flood hazard data depicted on the FIRMs and the delineation of the SFHA are dependent on the data limitations of the computation of the one percent flood and the topographic information available for the area being mapped.

The uncertainties involved in generating flood maps render these maps less definitive and authoritative than communities frequently assume them to be - for example, many interpret the one percent flood line as an assurance that development above that elevation or outside that line is guaranteed to be safe from the one percent flood.

In the high-risk and high-risk coastal zones, the NFIP's model combines estimates of the frequency of flooding with estimates of the magnitude of damage caused by flooding, producing "pure premium" costs intended to cover the actual flood losses.

FEMA then uses factors like the elevation of the lowest floor of the building, the type of building, the number of floors, the presence of a basement, claims data and mapping information to generate loss estimates. The pure premium amount is then adjusted to capture certain program costs, compensate for underinsurance by policyholders and reflect the fact that the program has a deductible.

Property owners are underinsured when they purchase insurance coverage for less than the value of the property, either by or because of limits on the amount of available coverage. To compensate

for this possibility, FEMA increases premium rates by an "underinsurance factor" that is based on claims data going back to 1978 for different zones and types of structures. More recent experience is given a greater weight in determining the factors.

FEMA has taken this approach for pricing in high-risk flood zones because it believes the cost of obtaining the information necessary to develop detailed frequency-magnitude relationships for use in a hydrologic model would be extremely high in relation to the benefits.

For the moderate-to low-risk and other full-risk premium zones, rates have been developed based on actuarial and engineering judgments, using the rates generated by the model and the historical experience of the high-risk zones as benchmarks.

The two types of policies in the moderate- to low-risk zones are referred to as "preferred risk" and "standard" policy. The preferred risk policyholders generally pay the lowest flood rates. Preferred risk policies are available on buildings that are outside of the SFHA and have not flooded more than once.

Questions remain about the age and quality of the underlying data FEMA uses in its model to calculate full-risk premiums. The NFIP model for setting full-risk premium rates relies on flood probability estimates and expected damage data, which rely in part on outdated or potentially inaccurate information, including outdated FIRMs.

For other lines of catastrophe insurance, private insurers rely heavily on computer models of simulated damage over many possible events to price their products. But the NFIP - as well as other federal agencies and private insurers involved in flood modeling - rely instead on flood maps and proprietary data on the likelihood of flooding and damages.

And the premises underlying those maps and data may be wrong.

Waves and Flood-Proofing Affect NFIP Ratings

An agent/producer must determine whether or not the BFE on the FIRM includes wave height. With very few exceptions - mostly involving communities on the West Coast - the FIRMs published prior to January 1981 give still water levels that do not include wave height. (FIRMs published in January 1981 and later indicate whether or not wave height is included.)

If wave height is included, the following statement appears on the map legend: "Coastal base flood elevations shown on this map include the effects of wave action."

The additional elevation due to wave crest in V-Zone areas will normally vary from a minimum of 2.1 feet to 0.55 times the still water depth at the site. (BFE including wave height adjustment = still water BFE + 0.55 - [still water BFE - lowest adjacent grade elevation].)

For example, a building's site is determined to be located in Zone V8 with a BFE of 14' NGVD on the appropriate FIRM. Using the information from the Elevation Certificate, the BFE is calculated as follows:

Base Flood Elevation 14'

Lowest Adjacent Grade -6'

Difference 8'

Factor - 0.55

Wave height adjustment (2.1' minimum) 4.4'

Base Flood Elevation + 14'

BFE adjusted 18.4'

When computing a premium for a flood-proofed building, use the following procedure:

1. Determine how far above the BFE the building is flood proofed (For example, the building will be flood proofed at +1 foot, +2 feet, and so forth above BFE.)

2.Subtract 1 foot to determine the elevation to be used in determining the rate and computing the premium for the building.
3.Find the rate for the given building in the proper zone at the "adjusted" elevation.
4.Compute the premium as usual.

The building must be flood proofed to +1 foot in order to receive a rate equivalent to a building with its lowest floor elevated to the BFE.

For example, if the building is located in Zone AO and the community's flood-proofing standards have been approved to a level of 3 feet above the highest adjacent grade (HAG) for the lowest floor of a non-floodproofed building, to qualify for With Certification of Compliance rates, a building must meet the following standards:

Be flood proofed to an elevation of 4 feet above HAG (1 foot above the community's minimum standard of 3 feet above HAG).

The flood-proofing must be certified by a registered professional engineer or architect on the Flood-proofing Certificate or by a responsible local official in a letter containing the same information requested on the Flood-proofing Certificate. And the certificate or letter must accompany the NFIP Flood Insurance Application.

In order to be eligible for lower rates, the insured must have a registered professional engineer or architect certify that the floodproofing conforms to the minimum floodproofing specifications of FEMA. This means that the building must be flood proofed to at least one foot above the BFE. If flood proofed to one foot above the BFE or flood depth, it can then be treated for rating purposes as having a "0" elevation difference from the BFE.

To further illustrate: If the building is certified to be flood proofed to two feet above the BFE, flood depth or comparable community-approved floodplain management standards, whichever is highest, then it is credited for floodproofing and is to be treated for rating purposes as having a +1 foot elevation.

Flood Elevations and Public Policy

FEMA's estimates of probabilities that floods of different severities (relative to the base flood elevation) will occur in a given year, or "probability of elevation" (PELV) values, were generated in the 1970s.

Within any zone, the risk that floodwaters will reach the BFE in any year is one percent, but across zones the likelihood that floodwaters will reach a foot above or below that level varies.

PELV tables provide detailed information, by zone, about the frequency with which floods of different elevations are expected to occur. These data were generated using detailed engineering studies, available flood data, simulations, and professional judgment and were established for each flood zone to meet generally accepted scientific parameters and legal considerations of the time.

FEMA later concluded that flood probabilities were likely underestimated in some cases because of the short flood histories used in some of the studies. As a result, according to FEMA officials, some of the original PELV values were modified in the early 1980s to account for this statistical bias. They have not been revisited or updated since that time.

FEMA currently uses both the original and modified PELV values in the rate-setting process. The original PELV values contribute 80 percent to the ultimate results and the modified values 20 percent, reflecting weights set out by policies from the early 1980s, according to FEMA officials. Flood risk experts have suggested that flood probabilities (and thus flood insurance rates) are likely to change as land use (such as urban or suburban development), infrastructure (such as new bridges and culverts), and weather patterns change. FEMA could capture such changes by updating its flood probability data but has not done so.

FEMA officials also acknowledged that the weighting for the original and modified PELV values was likely out of date but said that other competing priorities, including supporting post-Katrina-related activities and other studies had been given priority.

More troubling still: One FEMA official noted that the weighting might introduce a degree of "conservatism" to the rate-setting process because it would lead to higher rather than lower premium rates. This was just the clearest example of public policy trumping good actuarial management.

And this conflict between politics and risk management is a constant issue with the NFIP. According to FEMA officials, the geographic mix of NFIP policies had become more concentrated in Florida and other communities where the PELV values were more accurate. Nevertheless, FEMA has not updated the PELV data since the 1980s or updated the weighting of the original and modified PELV data. As a result, the accuracy of the flood probability estimates and the probability of elevation values are uncertain, and we could not determine whether the rates based on such data were accurate. Moreover, FEMA was not able to provide any analysis that it had done to determine that the current weighting remained appropriate or that the probabilities had not changed in over 30 years.

FEMA relies on estimates of the percentage of the value of a structure that is expected to be damaged when a flood occurs, or the "damage by elevation" (DELV) values. DELV information is measured in one-foot increments of the flood level within the structure and is expressed as the expected percentage of the property's value that will be damaged by a flood of that elevation.

As with the PELV data, information used in establishing DELV values was obtained primarily from engineering studies. In 1973, data for DELVs were selected on the basis of studies done by the Corps and available flood claims at that time.

Currently, FEMA modifies the Army Corps of Engineers DELV values based on its NFIP claims experience. When FEMA determines that its own loss data are "credible," it uses these data rather than the original data generated by the Corps.

However, FEMA also currently uses updated Corps damage data to supplement NFIP claims data where it lacks sufficient credible loss data. According to a FEMA official, for the most common type of property insured by NFIP, the claims process has become fully credible for a wide range of water depths in the structure.

By not updating the PELV data, NFIP essentially was assuming that the difference between the 10 percent annual chance of flood (that is, the 10-year flood) and the one percent annual chance of flood has not changed since the data were published in the 1970s and 1980s.

Another problem: Claims records were often incomplete because the claims data had been collected in the field by local adjustors for purposes of processing claims.

As a result, many records did not indicate BFE or depth of flooding, clearly differentiate between wind and water losses - or capture losses above the insurance limit when damage exceeded coverage limits. In addition, Corps officials reviewed FEMA's claims between 1998 and 2000 databases and found the data to be unreliable for their purposes.

For example, according to the Corps, in some cases the claims data indicated flood damage, but flood height data were missing. FEMA's database recorded these missing height data as a flood height of zero. According to FEMA officials, zero elevation water is a depth that encompasses up to the first 5 inches of floodwater in a property.

This depth is also sometimes referred to as a "carpet soaker" flood.

The GAO's analysis of NFIP claims paid between 1978 and 2007 supported what the Corps had discovered. Specifically:

We found an increasing percentage of claims with "0" water depth until they leveled off at between 44 and 49 percent from 1998 until 2004. In 2005 when the Gulf Coast hurricanes occurred, this percentage dropped to about 13 percent, but has risen above 22 percent in the

more recent years. Thus, an erroneous data combination of positive flood damage and zero flood height was being used to develop damage curves. As a result, the Corps began to collect its own damage data, which FEMA now uses to supplement its own data.

FIRMs provide the information that determines base flood elevations, a key input in the rate-setting model. FEMA formally undertook map modernization efforts in fiscal year 2003. According to FEMA, the agency undertook map modernization for several reasons:

- Flood hazard conditions are dynamic, and many NFIP maps may not reflect recent development and/or natural changes in the environment.
- Updated NFIP maps can take advantage of revised data and improved technologies for identifying flood hazards.
- Up-to-date maps support a flood insurance program that is more closely aligned with actual risk, encourages wise community-based floodplain management, and improves citizens' flood hazard awareness.
- Local communities and various stakeholders want more timely updates of flood maps and easier access to the flood hazard data used to create the maps.

FEMA also revised its goal of having digitized maps that covered 100 percent of the population to having digitized maps for 92 percent of the population so that it could better focus its efforts and thus improve map quality.

According to FEMA, as of May 2008, approximately 4 percent of U.S. counties had maps that accurately reflect the current risk of flooding (fully updated) and were newly digitized and 2 percent had old maps that may or may not accurately reflect the actual risk of flooding but were newly digitized. For the remaining 94 percent of U.S. counties, the maps were a combination of new and old mapping data that were in production or have not yet begun the process.

However, although FEMA has been working to update FIRMs and improve their quality, a significant portion of the maps reflect data at least 15 years old, which may or may not accurately reflect actual risk of flooding.

As of April 2008:

•50 percent of the nation's approximately 105,700 flood maps were at least 15 years old,
•58 percent were more than 10 years old and
•70 percent were at least 5 years old.

To the extent that these older maps are inaccurate and the risk of flooding has changed, reliance on these older maps could lead to inaccurate flood risk assessments, which in turn could lead to inaccurate premium rates.

As floodplains are developed and more ground surfaces are paved or made impervious (nonabsorbent), the risks and expected elevations of flooding increase. When the predicted elevation of the base flood increases, SFHAs subsequently spread beyond mapped boundaries.

As a result, in rapidly developing watersheds or where characteristics change significantly due to flood control projects or other natural events, some FIRMs may become outdated shortly after their completion.

FEMA's current flood hazard mapping procedures for coastal areas incorporate storm-induced coastal erosion but not long-term erosion. While shorelines, dunes, and bluffs can retreat during a single storm, long-term erosion at a shoreline is the net result of a variety of factors such as sediment losses from storms and inundation from sea level rise, averaged over several decades.

In some cases flood insurance rates may send a false signal that understates the risk exposure faced by current policyholders or prospective development.

FEMA classifies properties according to flood risk using a single, nationwide class-rating system rather than an individual property or community-by-community rating system. That is, all

properties grouped into a class - based on structure type and elevation relative to the BFE - are assumed to have the same risk.

Further, FEMA charges the same rate for a given class in the high-risk zone (or separately, in the high-risk coastal zone) regardless of location within the zone. Thus, two properties in the same class but located on vastly different terrain - for example, one in a shallow floodplain and the other in a steep and narrow mountain valley - are charged the same rate per $100 of insurance coverage despite the fact that they may have different expected loss.

The NFIP model can incorporate specific topographic (that is, flood zone) information in rate setting. However, according to FEMA, it was determined that more averaging could be justified, because the differences in rates across flood zones were not significant enough to warrant that level of detail.

According to FEMA officials, NFIP implemented the nationwide class-rating system because of the nature of the program and the desire to make it less complex and easier for agents and customers to understand. In the early years of the program, rates were set on a community-by-community basis. But as the number of communities participating grew, this system became unwieldy and costly to maintain. FEMA analysis indicated that from a technical perspective, this system was not essential to the estimation of flood damages since, for example, flood frequency data were found to be similar across communities.

FEMA has not revisited its class-rating approach since its inception although certain program elements have changed since that time.

For example, program participation has more than doubled from just over 2 million policies to more than 5.2 million from the late 1980s to the late 2000s and increased numbers of properties have been constructed on SFHAs. As a result of the growth in the program, the rate classes may not accurately reflect the actual flood risk to individual properties and averaging may no longer accurately reflect differences in rates within zones.

Collectively, these factors raise questions about FEMA's rate-setting process and increase the risk that NFIP full-risk premiums rates may not accurately reflect the underlying risk of flood loss. As a result, the premiums collected by FEMA for full-risk policies may not be sufficient to cover the risks associated with those policies. If the premiums are not sufficient, FEMA will likely have to continue to borrow from the Treasury and could face a future of financial instability because of its ongoing inability to cover claims and expenses.

NFIP'S "Flood Mapping" System

Potentially outdated and inaccurate data about flood probabilities and damage claims, as well as outdated flood maps, raise questions about whether the NFIP's full-risk premiums reflect the actual risk of flooding.

Some of the data used to estimate the probability of flooding have not been updated since the 1980s. Similarly, the claims data used as inputs to the model may be inaccurate because of incomplete claims records and missing data.

More importantly - from a risk management perspective - some of the maps that FEMA and the NFIP use to set premium rates remain out of date despite recent modernization efforts. For instance, FEMA does not account for ongoing and planned development making some maps outdated shortly after their completion. And it does not map for long-term erosion, further increasing the likelihood that data used to set rates are inaccurate.

FEMA also sets flood insurance rates on a nationwide basis, failing to account for many topographic factors that are relevant to flood risk for particular locations and individual properties.

At the highest levels, FEMA and NFIP management understands that the NFIP flood maps are outdated and need to be replaced. But, at the frontlines, there is resistance to more accurate data and reporting.

Since the late 2000s, when the NFIP began its efforts to modernize flood maps across the country, it has faced resistance from communities and homeowners when remapping properties into higher-risk flood zones with higher rates.

(With respect to the impact of older maps on rate setting, FEMA states that older maps are not always outdated, and that in many areas the flood hazard has not changed or is possibly decreasing. While some maps may not have changed over the past 10 to 15 years, it is uncertain how many maps fall into this category and FEMA provided no analysis to support this contention.)

As a result, FEMA made a policy decision to allow certain properties remapped into riskier flood zones to keep their previous lower rates. Like subsidized rates, these "grandfathered" rates do not reflect the actual risk of flooding to the properties and do not generate sufficient premiums to cover expected losses.

FEMA officials say that the decision to grandfather rates was based on considerations of "equity, ease of administration, and goals of promoting floodplain management." But FEMA does not collect data on grandfathered properties or measure their financial impact on the program. As a result, it does not know:

- how many such properties exist,
- their exact location, or
- the volume of losses they generate.

FEMA officials have stated that, beginning in October 2010, they would indicate on all new policies whether or not they were grandfathered - but they admit that they would still be unable to identify grandfathered properties among existing policies.

This whole matter of "grandfathering" lower premiums is another example of a subsidy that warps the accurate evaluation of flood risks. And it's another example of a subsidy that the Feds fail to recognize as such - bureaucrats at FEMA and the NFIP insist that grandfathered rates are different than subsidized rates.

Strictly speaking (and extremely strictly speaking), this may be true. But no reasonable person doubts that grandfathering flood insurance policyholders into lower risk categories is a form of subsidy.

Said another way, homeowners who are remapped into high-risk areas and do not currently have flood insurance may be required to purchase it at the full risk rate.

Various individuals and groups have made suggestions about how the NFIP could make its premium rates more reflective of long-term flood risks. These suggestions include:

- eliminating, reducing or targeting premium subsidies based on need;
- improving oversight of WYO insurers and payments to them,
- updating the NFIP rate-setting process,
- fully applying internal controls, and
- strengthening oversight of contractors, among others.

But taking any of these steps would raise rates and potentially reduce participation in NFIP.

FEMA and the NFIP could also address the impact of repetitive loss properties by expanding mitigation efforts to target those properties that are at highest risk. However:

1. such an action would require congressional authorization, and
2. doing so would include actions such as elevation, relocation and demolition that would be costly to taxpayers and could take years.

Finally, congress could amend laws regarding coverage for homeowners who refuse to mitigate, and streamline the various mitigation grant programs within FEMA. But making premium rates more reflective of flood risk would require actions by FEMA and Congress. Because subsidized premium rates are required by law, addressing their associated costs would require congressional action.

Targeting subsidies based on need is an approach used by other federal programs and could help ensure that those needing the subsidy would have access to it and retain their coverage. Unlike other agencies that provide - and are allocated funds for - traditional subsidies, NFIP does not receive an appropriation to pay for shortfalls in collected premiums caused by its subsidized rates. It just borrows from the Treasury Department to make up the shortfalls.

According to the GAO:

...one option to maintain the subsidies but improve NFIP's financial stability would be to rate all policies at the full-risk rate and to appropriate subsidies for qualified policyholders. In this way, the cost of such subsidies would be more transparent, and policyholders would be better informed of their flood risk. Depending on how such a program was implemented, NFIP might be able to charge more participants rates that more accurately reflect their risk of flooding. However, raising premium rates for some participants could also decrease program participation, and low-income property owners and renters could be discouraged from participating in NFIP if they were required to prove that they met the requirements for a subsidy.

Of course, FEMA and the NFIP could end grandfathered rates - this would help ease the financial burden of the subsidized premiums. But that's also a political challenge. FEMA decided to allow grandfathering after consulting with congress, its oversight committees and other stakeholders. Groups like the GAO have recommended that the NFIP take steps to:

- ensure that information was collected on the location, number, and losses associated with existing and newly created grandfathered properties in the NFIP; and
- analyze the financial impact of these properties on the flood insurance program.

With such information, FEMA and Congress would be better informed on the extent to which these rates contribute to the NFIP's financial challenges. But these suggestions have been resisted by all sides, from congressional staffs to insureds and other "stakeholders."

Catastrophic Loss Fund

Perhaps the simplest suggestion for reforming the NFIP to achieve some level of financial solvency is that it should create a capital surplus fund - from which it could pay claims during years of heavy losses.

Building such a fund would require at least two major predicates:

1. charging premium rates that, in some cases, could be more than double or triple current rates and
2. at least several years without catastrophic losses.

And there are several other challenges to creating a catastrophic loss fund:

- unless NFIP's current debt were forgiven, even with significant premium increases NFIP probably could not collect enough to pay the $766 million in annual interest and also contribute to a loss fund;
- a catastrophic loss fund might not eliminate NFIP's need to borrow funds for larger-than-expected losses that occurred before the fund had been built up. Further borrowing would require either a longer period to rebuild the loss fund or more debt forgiveness from Congress;
- even if NFIP's debt were forgiven, building a catastrophic loss fund could require significant premium rate increases. Higher rates could reduce participation in the NFIP, but without them it could take at least 10 years to fully fund a catastrophic loss fund equal to one percent of NFIP's total loss exposure.

A loss fund equal to one percent of total NFIP exposure would require approximately $18 billion in cash.

While private insurers generally use reinsurance to hedge their risk of catastrophic losses, it is unclear whether the private reinsurance market would be willing to offer such coverage to NFIP.

In the absence of reinsurance and a surplus fund, the Treasury Department will continue to act as the effective reinsurer for the NFIP - and be the financial backstop for the program.

Counting on this backstop has created the NFIP's current $19 billion debt to the Treasury.

The GAO analyzed several loss-funding scenarios. It noted that "the potential for catastrophic losses makes estimating losses complex and difficult." It also requires making a number of assumptions. For its project, the GAO assumed that:

- the number of NFIP policies would remain at 2007 levels,
- Congress would forgive the current $19 billion in debt,
- the NFIP would earn a 4 percent annual investment yield on contributions,
- no catastrophic losses would occur before the fund was fully funded,
- the target would be a catastrophic loss fund of $18 billion no earlier than 2020.

Because no commonly agreed-upon methodology existed for incorporating losses from the 2005 hurricanes into estimates of future losses, the GAO considered two scenarios; one in which losses were not incorporated and one in which they were incorporated. It also analyzed a scenario in which the goal was to fund a catastrophic loss fund more quickly.

Here are the results the GAO found:

Under scenario one (fully-funded one-percent reserve by 2020, losses from 2005 hurricanes not included):

- From 2009 to 2020, the average subsidized premium would increase from $840 to more than $2,116, while average full-risk premium would rise from $358 to around $902.
- The fund could reach the target of approximately $18 billion in 2020 by increasing premium rates by, on average, about 8 percent annually, assuming no larger than average expected losses.
- NFIP could begin making limited contributions to the fund in 2009, but premiums would not be high enough for at least several years to make the proposed annual 7.5 percent contribution and pay expected losses.

Under scenario two (fully-funded one-percent reserve by 2020, losses from 2005 hurricanes included):

- From 2009 to 2020, the average subsidized premium would increase from around $840 to $2,696, and the average full-risk premium would rise from around $358 to $1,149.
- The fund could reach the target of approximately $18 billion in 2020 by increasing premium rates by, on average, about 15 percent in the first 3 years, 14 percent in year 4, and 8 percent thereafter, assuming no larger than average expected losses.
- As with scenario 1, NFIP could begin making limited contributions to the fund in 2011, but premiums would not be high enough for at least several years to make the proposed annual 7.5 percent contribution and pay expected losses.

Under scenario three (fully-funded one-percent reserve by 2016, losses from 2005 hurricanes included):

- Subsidized premiums would increase 25 percent annually until reaching full-risk rates, and full-risk rates would increase by 15 percent a year (the maximum allowable rate under proposed legislation).
- It would take approximately 7 years to reach the loss fund total in 2016.
- From 2009 to 2016, subsidized and full-risk rates would increase from $840 to $3,577 and $358 to $953 in 2016 respectively.

None of these options are considered solid political prospects.

Data-Management Problems at FEMA

More than any other technical matter, the NFIP has major data management problems. We've

hinted at some of these before. In this section, we'll drill down a bit into the details of these IT problems.

At FEMA, a Contracting Officer's Technical Representative (COTR) and staff (referred to as "monitors") are responsible for, respectively, ensuring compliance with contract terms and regularly monitoring and reporting on the extent to which NFIP contractors meet standards in performance areas specified in the contracts.

This compliance involves the flow of a lot of information-some involving rating and underwriting data, some involving claims data.

Internal control standards for the federal government state that records should be properly managed and maintained. But the NFIP lacked records for the majority of the monitoring reports that the GAO requested during its 2008 and 2010 examinations.

In its 2010 report, the GAO noted:

FEMA offices did not coordinate information and actions relating to contractors' deficiencies and payments, and in some cases key officials were unaware of decisions on contractors' performance. In particular, our review of monitoring reports for one contract revealed a lack of coordination between the COTR and the contracting officer.

As a result, FEMA could not ensure that the contractor had adhered to the contract's requirements and lacked information critical to effective oversight of key NFIP data collection, reporting, and insurance functions. Given NFIP's reliance on contractors, it is important that FEMA have in place adequate controls that are consistently applied to all contracts. Consistent with our findings in prior work, the DHS inspector general has also identified weaknesses in FEMA's internal controls and financial reporting related to the NFIP.

In plain English: The problem is so bad that FEMA and the NFIP can't even say how bad the problem is.

To manage flood policy and claims information that it obtains from insurance companies, the NFIP's Bureau and Statistical Agent (BSA) relies on an IT system from the 1980s that's difficult and costly to sustain and that doesn't adequately support the NFIP's mission needs. According to the GAO:

This system consists of over 70 interfaced applications that utilize monthly tape and batch submissions of policy and claims data from insurance companies. The system also provides limited access to NFIP data. Further, identifying and correcting errors in submission requires between 30 days and 6 months and the general claims processing cycle itself is 2 to 3 months.

To address the limitations of this system, NFIP launched a program in 2002 to acquire and implement a modernization and business improvement system, known as NextGen. As envisioned, NextGen was to accelerate updates to information obtained from insurance companies, identify errors before flood insurance policies went into effect, and enable FEMA to expedite business transactions and responses to NFIP claims when policyholders required urgent support. As such, the system would support the needs of a wide range of NFIP stakeholders, including FEMA headquarters and regional staff, WYO insurers, vendors, state hazard mitigation officers, and NFIP state coordinators.

...despite having invested roughly $40 million over 7 years, FEMA has yet to implement NextGen. Initial versions of NextGen were first deployed for operational use in May 2008. However, shortly thereafter system users reported major problems with the system, including significant data and processing errors. As a result, use of NextGen was halted, and the agency returned to relying exclusively on its mainframe-based legacy system while NextGen underwent additional testing. In late 2009, after this testing showed that the system did not meet user needs and was not ready to replace the legacy system, further development and deployment of NextGen was stopped, and FEMA's Chief Information Officer began an evaluation to determine what, if anything, associated with the system could be salvaged.

As this course was written, FEMA had not yet implemented NextGen or any other IT management system-and the legacy system it was using to track flood insurance information was still limping along. Inadequately.

FEMA, the NFIP and Hurricanes

The IT problems limit the NFIP's ability to identify and address financial transaction control breakdowns that occur during times of catastrophic flood losses. The clearest example of this kind of breakdown: after the 2005 hurricane - which included Hurricane Katrina - FEMA wasn't able even to estimate the NFIP's losses for several years.

And its initiatives to improve specific internal control weaknesses and the overall NFIP control environment since the 2005 hurricanes have done little to address the NFIP's financial data deficiencies.

FEMA has made some improvements, such as revising its claim re-inspection selection methodology to provide a true, random selection of statistically-representative claim files. However, the modified re-inspection methodology still doesn't include all claims. FEMA has also implemented a tracking system to monitor the number of WYO biennial audits obtained and reviewed. And it has implemented what it calls "a system modernization development and implementation effort" under way. But these efforts won't produce any measurable results for several years.

In the meantime, flood losses have imposed a significant financial burden on the federal government. Until 2004, NFIP was able to cover most of its losses. However, as we've noted, in order to pay claims arising from the 2005 hurricanes (Katrina, Rita and Wilma) congress had to authorize loans to NFIP of about $16.8 billion from the Treasury that the program used to cover the enormous number of claims.

Given this large debt and ongoing complex financial challenges created by the 2005 Gulf Coast hurricanes, the fiscal sustainability of the flood insurance program has come under scrutiny.

In March 2006, the GAO designated NFIP as a high-risk program - in part because of the program's financial uncertain condition and its near-term inability to repay borrowed funds.

The program remained on the GAO's January 2019 list of high-risk federal programs.

FloodSmart is an integrated mass marketing campaign FEMA launched in 2004 to educate the public about the risks of flooding - and to encourage the purchase of flood insurance. One of the main tools of the FloodSmart program has been a series of television ads that show nicely-appointed residential homes being flooded in dramatic fashion.

According to FEMA marketing materials:

This program was designed to educate and inform partners, stakeholders, property owners, and renters about insuring their homes and businesses against flood damage. Since the start of the FloodSmart campaign in 2004, NFIP has seen policy growth of more than 24 percent and [has] 5.6 million policies in force.

But not all observers are so optimistic. The GAO points out that flood insurance is so poorly marketed and promoted that no one can be sure which efforts really work - because the base against which the efforts are compared is to ineffective.

On a more technical note, the GAO concluded:

Most WYO insurers generally offered flood insurance when it was requested but did not strategically market the product as a primary insurance line. FEMA has set only one explicit marketing goal - to increase policy growth by 5 percent each year - and does not review the WYO insurers' marketing plans. It therefore lacks the information needed to assess the effectiveness of either the WYO insurers' efforts to increase participation or the bonus program itself. For example, FEMA does not know the extent to which sales increases may reflect external factors such as flood

events or its own FloodSmart marketing campaign rather than any effort on the part of the insurers.

Pollution Coverage under the NFIP Forms

One key issue - although a bit of a side issue - that comes up in some flood claims disputes is whether NFIP insurance covers damage from "waterborne material" and pollutants such as oil, which are often present in flood waters.

In fact, flood waters frequently contain a toxic mix of pollutants, including sewage, household, lawn care and industrial chemicals, automotive fuels and lubricants, medical waste, garbage, etc.

In the NFIP Dwelling Form, the only exclusion in Section V - Exclusions that references pollution is the following:

Exclusions. We do not pay for the testing for or monitoring of pollutants unless required by law or ordinance.

In Section III - Coverage D Increased Cost of Compliance, the following pollution-related exclusion is included, related to testing and monitoring, etc. of pollution:

Exclusions. 5.b. The cost associated with enforcement of any ordinance or law that requires any insured or others to test for, monitor, clean up, remove, contain, treat, detoxify or neutralize, or in any way respond to, or assess the effects of pollutants.

In the General Property Form, there is no pollution exclusion in Section V - Exclusions. However, in Section III - Other Coverages, there is a sublimit of $10,000 for pollution damage, as follows:

Pollution Damage

Will pay for damage caused by pollutants to covered property if the discharge, seepage, migration, release, or escape of the pollutants is caused by or results from flood. The most we will pay under this coverage is $10,000. This coverage does not increase the Coverage A or Coverage B limits of liability. Any payment under this provision when combined with all other payments for the same loss cannot exceed the replacement cost or actual cash value, as appropriate, of the covered property. This coverage does not include the testing for or the monitoring of pollutants unless required by law or ordinance.

As in the Dwelling Form, the General Property Form also has a pollution exclusion in Section III - Coverage D Increased Cost of Compliance, related to testing and monitoring, etc. of pollution that is identical to Exclusion 5.b. above.

In the Dwelling Form, damage to covered property from a flood that is otherwise covered by the flood policy is not impaired by the presence of pollutants such as oil from the oil spill in the Gulf. In addition, testing or monitoring of pollutants which is required by a law or ordinance is also covered. For claims covered under Coverage D Increased Cost of Compliance (ICC), the testing, monitoring, clean up, etc. that is required by ordinance or law is not covered. Note that ICC only has a limit of $30,000.

Under the General Property Form, there is no pollution exclusion for damage to covered property, but there is a sublimit of $10,000 for damage by a pollutant where a flood caused the discharge, seepage, migration, release, or escape of the pollutant - in this case, oil from the Gulf. It is unclear exactly how a claims-adjustment expense specifically related solely to damage by the pollutant (oil) can be determined in situations like a storm surge. However, to the degree that such costs can be isolated and assigned to the presence of a pollutant such as oil, the sublimit of $10,000 would apply.

Mortgage Portfolio Protection Program

The Mortgage Portfolio Protection Program (MPPP) was introduced in 1991, as an additional tool to assist the mortgage lending and servicing industries in bringing their mortgage portfolios into compliance with the flood insurance requirements of the Flood Disaster Protection Act of 1973.

The MPPP is not intended to act as a substitute for the need for mortgagees to review all mortgage loan applications at the time of loan origination and comply with flood insurance requirements as appropriate.

Proper implementation of the mandatory purchase requirements usually results in mortgagors, after their notification of the need for flood insurance, either showing evidence of such a policy, or contacting their insurance agent/producer or their insurer to purchase the necessary coverage. It is intended that flood insurance policies be written under the MPPP only as a last resort, and only on mortgages whose mortgagors have failed to respond to the various notifications required by the MPPP.

When a mortgagee or a mortgage-servicing company discovers, at any time following loan origination, that there is no evidence of flood insurance on a property in a Special Flood Hazard Area (SFHA), then the MPPP may be used by such lender/servicer to obtain (force-place) the required flood insurance coverage. The MPPP process can be accomplished with limited underwriting information and with special flood insurance rates.

It will be the Write Your Own (WYO) Company's responsibility to notify the mortgagor of all coverage limitations at the inception of coverage and to impose those limitations that are applicable at the time of loss adjustment.

With the implementation of the MPPP, there is no change in the method of WYO Company allowance from that which is provided in the Financial Assistance/Subsidy Arrangement for all flood insurance written.

No portion of the allowance that a WYO Company retains under the WYO Financial Assistance/Subsidy Arrangement for the MPPPmay be used to pay, reimburse, or otherwise remunerate a lending institution, mortgage servicing company, or other similar type of company that the WYO Company may work with to assist in its flood insurance compliance efforts.

The only exception to this is a situation where the lender/servicer may be actually due a commission on any flood insurance policies written on any portion of the institution's portfolio because it was written through a licensed property insurance agent/producer on their staff or through a licensed insurance agency owned by the institution or servicing company.

Any WYO Company participating in the MPPP must notify the lender or servicer, for which it is providing the MPPP capability, of the requirements of the MPPP. The WYO Company must obtain signed evidence from each such lender or servicer indicating their receipt of this information, and keep a copy in its files.

In order to participate in the MPPP, the lender (or its authorized representative, which typically will be the WYO Company providing the coverage through the MPPP) must notify the borrower of the following, at a minimum:

- the requirements of the Flood Disaster Protection Act of 1973;
- the flood zone location of the borrower's property;
- the requirement for flood insurance;
- the fact that the lender has no evidence of the borrower's having flood insurance;
- the amount of coverage being required and its cost under the MPPP; and
- the options of the borrower for obtaining conventionally underwritten flood insurance coverage and the potential cost benefits of doing so.

The MPPP will be allowed only in conjunction with mortgage portfolio reviews and the servicing of those portfolios by lenders and mortgage servicing companies. The MPPP is not allowed to be used in conjunction with any form of loan origination.

Other relevant points:

- The standard NFIP rules apply, and all types of property eligible for coverage under the NFIP will be eligible for coverage under the MPPP.
- The force-placement capability will be offered by the WYO Companies only and not by the NFIP Servicing Agent.
- The policy will be written covering the interest of both the mortgagee and the mortgagor. The name of the mortgagor must be included on the Application Form. It is not, however, necessary to include the mortgagee as a named insured because the Mortgage Clause (section VII.Q. of the Dwelling Form and the General Property Form) affords building coverage to any mortgagee named as mortgagee on the Flood Insurance Application. If contents coverage for the mortgagee is needed, the mortgagee should be included as a named insured.
- NFIP policies written under the MPPP will be for a term of 1 year only (subject to the renewal notification process).
- Both building and contents coverage will be available under the MPPP. The coverage limits available under the Regular Program will be $250,000 for building coverage and $100,000 for contents. If the WYO Company wishes to provide higher limits that are available to other occupancy types such as other residential or non-residential, it may do so only if it can indicate that occupancy type as appropriate. If the mortgaged property is in an Emergency Program community, then the coverage limits available will be $35,000 for building coverage and $10,000 for contents. Again, if the higher limits are desired for other types of property, then the building occupancy type must be provided at the inception of the policy or when that information may become available, but it must be prior to any loss.
- The current SFIP Dwelling Form and General Property Form will be used, depending upon the type of structure insured. In the absence of building occupancy information, the Dwelling Form should be used.
- The NFIP rules for the waiting period and effective dates apply to the MPPP.
- The lender or servicer (or payor) has the option to follow its usual business practices regarding premium payment, so long as the NFIP rules are followed.
- The MPPP will require less underwriting information than normally required under the standard NFIP rules and regulations. The MPPP data requirements for rating and processing are, at a minimum:
    - Name and mailing address of insured (mortgagor; also see Dual Interest);
    - Address of insured (mortgaged) property;
    - Community name, number, map panel number and suffix, and program type (Emergency and Regular);
    - Occupancy type (so statutory coverage limits are not exceeded. This information may be difficult to obtain. Also see Coverage Offered.);
    - NFIP flood zone where property is located (lender must determine, in order to determine if flood insurance requirements are necessary and to use the MPPP);
    - Amount of coverage;
    - Name and address of mortgagee; and
    - Mortgage loan number.
- In addition to the routine information, such as amounts of coverage, deductibles, and premiums, that a WYO Company may place on the policy declarations page issued to each insured under the NFIP, the following messages are required:

1. This policy is being provided for you as it is required by Federal law as has been mentioned in the previous notices sent to you on this issue. Since your mortgage company has not received proof of flood insurance coverage on your property in response to those notices, we provide this policy at their request.
2. The rates charged for this policy may be considerably higher than those that may be available to you if you contact your local insurance agent/producer (or the WYO Company).
3. The amounts of insurance coverage provided in this policy may not be sufficient to protect your full equity in the property in the event of a loss.

4.You may contact your local insurance agent/producer (or WYO Company) to replace this policy with a conventionally underwritten SFIP, at any time, and typically at a significant savings in premium.

•The WYO Company may add other messages to the declarations page and make minor editorial modifications to the language of these messages if it believes any are necessary to conform to the style or practices of that WYO Company, but any such additional messages or modifications must not change the meaning or intent of the above messages.
•Since the amount of underwriting data obtained at the time of policy inception will typically be limited, the extent of any coverage limitations (such as when replacement coverage is not available or coverage is limited because the building has a basement or is considered an elevated building with an enclosure) will be difficult to determine. It is, therefore, the responsibility of the WYO Company to notify the mortgagor/insured of all coverage limitations at the inception of coverage and impose any that are applicable at the time of the loss adjustment.
•In the event that the premium payment received is not sufficient to purchase the amounts of insurance requested, the policy shall be deemed to provide only such insurance as can be purchased for the entire term of the policy for the amount of premium received.
•There are no changes from the standard practices of the NFIP for these provisions. The coverage basis will depend on the type of occupancy of the building covered and the amount of coverage carried.
•A $1,000 deductible is applicable for policies written under the MPPP.
•The NFIP Flood Insurance Manual rules for cancellation/nullification are to be followed, when applicable.
•An MPPP policy may not be endorsed to convert it directly to a conventionally underwritten SFIP. Rather, a new policy application, with a new policy number, must be completed according to the underwriting requirements of the SFIP, as contained in the NFIP Flood Insurance Manual. The MPPP policy may be endorsed to assign it under rules of the NFIP. It may also be endorsed for other reasons such as increasing coverage.
•Current NFIP rules remain unchanged; therefore, an MPPP policy may be assigned to another mortgagor or mortgagee. Any such assignment must be through an endorsement.
•A list of the WYO Companies that participate in the MPPP is available on FEMA's website.

Flood Maps and Zone Determinations

Insurance agents, insurers, lenders, and other users make flood zone determinations by reviewing Flood Insurance Rate Maps (FIRMs) that are maintained by the community. Outside companies may be utilized that specialize in flood zone determinations. Many insurers provide flood zone determinations for their own agents to aid them in writing such policies.

Lenders and those that contract with lenders use a Standard Flood Hazard Determination Form, called a SFHDF, to document community status, the flood zone and the Base Flood Elevations. Generally, the borrower may also have a copy of the SFHDF. The elevation of the building’s lowest floor and the BFE information is not necessary for Pre-Flood Insurance Rate Map (FIRM) buildings, unless they happen to have been elevated and it is to the advantage of the property owner to use the elevated premium rating. Elevation information is not applicable in low-to-moderate flood risk zones B, C, and X.

Flood Hazard Boundary Map (FHBM)

The Flood Hazard Boundary Map (FHBM) is the initial flood map issued by FEMA. It identifies areas in the community that are considered at high risk of flooding, identified as Special Flood Hazard Areas (represented by darkly shaded areas on the map).

The “100-Year Flood” That Isn’t

Most of us have heard references to a “100-year flood.” It refers to a flood with a 1 percent or greater chance of being equaled or exceeded during any given year. Although it is commonly called the 100-year flood, the more accurate term is 'Base Flood'. Special Flood Hazard Areas

(SFHA) are subject to base floods. Many people would believe that a 100-year flood happens every 100 years, but that is not the case. In fact, Base Floods have a 26 percent chance of happening during any given 30-year period. What is the average mortgage length? Thirty years. Therefore, any individual with an average mortgage could experience what we refer to as a 100-year flood. It is not surprising that those with homes located in SFHAs are required to purchase flood insurance by their lenders. In general, a bank should not make, increase, renew, or extend any loan for property in a special hazard area unless flood insurance is in place for the term of the loan.

Flood Insurance Rate Map (FIRM)

Regular Program communities use the more detailed Flood Insurance Rate Map, called a FIRM. The primary purpose of a FIRM is to provide information needed by agents, lending institutions, community officials, flood zone determination companies, and private citizens who need to know:

1. The specific location of a building within a SFHA;
2. The flood zone assigned to a specific building location; or
3. The Base Flood Elevation of a building.

Zones beginning with the letters A and V note SFHAs on the map. The dark shading also identifies them. Zones B, C, and X are not considered to be Special Flood Hazard Areas and indicate areas of moderate to minimal hazard subject to flooding only from severe storm activity or local drainage problems. Light shading and non-shading indicates these areas on the map. Lenders do not generally require flood insurance on buildings located in the moderate to minimal hazard zones. No one should think that property located in the moderate to minimal hazard zones never flood, however, because they could. Floods happen everywhere.

Pre-FIRM/Post-FIRM Defined

Pre-FIRM means before the Flood Insurance Rate Map. It is defined as construction or substantial improvement on a building that started on or before December 31, 1974, or before the effective date of the initial FIRM of the community, whichever is later. Pre-FIRM structures were built when there was no Flood Insurance Rate Map to show the locations of floodplains or the BFE. As a result, there were no requirements for building structures to any specific elevation. Rates for Pre-FIRM buildings are based on the flood risk zone they are located in.

There can be exemptions based on circumstances that previously existed. This is called grandfathering.

Post-FIRM means after the Flood Insurance Rate Map. Post-FIRM is defined as construction or substantial improvement on a building that started on or after the effective date of the initial FIRM of the community or after December 31, 1974, whichever is later. These structures located in SFHAs are required to be built at or above BFE. Post-FIRM rates are based on the relationship of the lowest floor to the BFE.

To determine this relationship the owner would obtain an NFIP Elevation Certificate from a land surveyor, architect, or engineer. The Elevation Certificate provides the flood zone, BFE, and measurements that relate to the building and ground elevations. The insurance agent refers to these measurements when determining the lowest floor used for premium rating. More information can be obtained from the Special Certification section of the Flood Insurance Manual. An Elevation Certificate is required when rating a Post-FIRM structure located in a SFHA. An Elevation Certificate is not required for rating in unnumbered A zones.

If an agent is insuring a Pre-FIRM building where its lowest floor meets the minimum BFE requirement, the insured may opt to obtain the Elevation Certificate. It will verify that the lowest floor meets the requirements allowing the insured to benefit from the use of Post-FIRM ratings. Elevation Certificates are not used when rating buildings located in B, C, or X zones.

Even though the agent has the community status, the flood hazard zone, and whether the structure was built before or after FIRM, he or she will still need to know:

1. The building Occupancy Type;
2. The number of floors in the structure and whether or not one of them is a basement;

3. The amount of coverage;
4. The deductible amount;
5. Increased Cost of Compliance (ICC) Coverage, which is mandatory; and
6. The Community Rating System (CRS) Discount.

Special Flood Hazard Area Defined

Land areas that are at high risk for flooding are called Special Flood Hazard Areas (SFHA), or floodplains. These areas are indicated on Flood Insurance Rate Maps, called FIRMs. During a 30-year mortgage, a building has a 26 percent chance of experiencing a flood in these designated areas.

Base Flood Elevation (BFE)

We have talked about Base Flood Elevations (BFE); they are the expected water surface elevation of floodwaters during a Base Flood. These elevation measurements are typically stated in feet using the National Geodetic Vertical Datum of 1929 (NGVD). The Base Flood Elevation is shown within wavy lines. In some SFHA zones the BFE might be shown within parentheses on the flood map below its corresponding flood zone. Therefore, a listing of a zone as VE (6) would indicate that the BFE is 6 feet. That means the expected floodwater elevation would be 6 feet above mean sea level. This information is published in a Flood Insurance Study (FIS) of the community.

The Base Flood Elevation has more importance than one might imagine. It affects flood insurance rates and it affects mitigation. BFEs play an important role in any flood insurance policy. In order for a community to meet FEMA's floodplain management requirements, it must insure that substantially improved and newly constructed structures meet BFE requirements. This means a building's lowest floor must be elevated (or flood proofed if it is a commercial building) to meet the minimum BFE indicated on the map. Obviously it could exceed the BFE requirements but it could not be less than required. In the case of VE (6), the lowest floor would have to meet the requirements of 6 feet above mean sea level.

Zone Determination

SFHAs are subdivided into flood hazard zones:

Zones A, A1-A30, and AE are subject to inundation by a Base Flood. Base Flood Elevations (BFE) are shown for Zones A1-A30 and AE. BFE's are not determined in unnumbered A Zones.

- Zones V, V1-V30, and VE are areas that can be inundated by tidal floods with velocity hazard (coastal high hazard areas). BFEs are shown for Zones V1-30 and VE.
- Zones AH are those that are subject to inundation by shallow flooding, unusually involving areas that have ponds where the average depths are between 1 and 3 feet. Base Flood Elevations are provided.
- Zones AO are areas subject to inundation by shallow flooding, usually sheet flow on sloping terrain where depths are between 1 and 3 feet. BFE's are *not* provided.
- Zones A99 are areas to be protected by a flood protection system, such as dikes, dams, or levees, that are under construction where enough progress has been made to consider them complete for insurance rating purposes.
- Zones AR are SFHAs that result from the de-certification of a previously accredited flood protection system that is determined to be in the process of being restored to provide Base Flood protection.

FLOOD HAZARD MAPPING UPDATES

The Federal Emergency Management Agency (FEMA) partners with Tribal nations, States, and communities through the Risk Mapping, Assessment, and Planning (Risk MAP) program to identify flood hazards, assess flood risks, and provide accurate data to guide stakeholders in taking effective mitigation actions that result in safer and more resilient communities. This data is

incorporated into flood maps, known as Flood Insurance Rate Maps (FIRMs), that support the National Flood Insurance Program (NFIP) and provide the basis for community floodplain management regulations and flood insurance requirements.

Flood hazards are dynamic and can change frequently because of a variety of factors, including weather patterns, erosion, and new development. FEMA, through the Risk MAP program, works with communities to collect new or updated flood hazard data and periodically updates flood maps to reflect these changes.

What Happens When A Flood Map Changes?

When a new map is issued or an effective map is revised, your mapped flood hazard, as well as building or insurance requirements, may change. An effective map is one that has been through the public review and appeal process and has been adopted as a regulatory FIRM. Therefore, it is important for users to check FEMA's Map Service Center (MSC) or the local community map repository for current, effective information.

What May Affect or Change a Flood Map?

FIRM updates can occur in a variety of ways, including Flood Risk Projects, Physical Map Revisions (PMRs), and Letters of Map Revision (LOMRs). Letters of Map Amendment (LOMAs) and Letters of Map Revision Based on Fill (LOMRFs) can change flood hazard designations for specific structures or properties.

Flood Risk Project

What is it? Projects implemented under the Risk MAP program to engage with communities and provide flood risk information. Most commonly, these projects are initiated to create new or updated flood maps.
What is revised? Revises FIRM panels and FIS reports, or publishes new panels and reports for areas that were not previously mapped.
Is there an appeal period? Yes, there is a 90-day appeal period for affected communities.
What is the output? New or updated preliminary FIRM panel(s), LFD, final FIRM panel(s) and FIS report, and LOMC Revalidation Letter.
When does it become effective?
When does it become effective? Six months after the Letter of Final Determination.
Where to find it? Digital copies can be found on the MSC. Hard copies of community FIRM panels are available at the community's map repository.
What is uploaded to the MSC? Map panels, FIS report, and FIRM/NFHL database.
Where can it be found on the MSC? On http://msc.fema.gov, after a 'Search for All Products' under a jurisdiction, the paths below will provide the corresponding items. Effective and Pending Products> FIRM Panels and FIS Reports.

Physical Map Revision (PMR)

What is it? An update to the FIRM to reflect the most current flood hazard data; this results in an update to a portion of a community's map panels.
What is revised? Physically revises and supersedes at least an entire FIRM panel and the FIS report.
Is there an appeal period? Yes, there is a 90-day appeal period for affected communities.
What is the output? New or updated FIRM panel(s), FIS report, and LOMC Revalidation Letter.
When does it become effective? Six months after the Letter of Final Determination
Where to find it? Digital copies can be found on the MSC. Hard copies of community FIRM panels are available at the community's map repository.
What is uploaded to the MSC? Map panel(s), FIS report, and FIRM/NFHL database.
Where can it be found on the MSC? On http://msc.fema.gov, after a 'Search for All Products' under a jurisdiction, the paths below will provide the corresponding items. Effective and Pending Products>FIRM Panels and FIS Reports.

Letter of Map Revision (LOMR)

What is it? An official revision to a FIRM that can reflect changes to the floodplains, Base Flood Elevations (BFEs), or regulatory floodways depicted on a community's FIRM. LOMRs most frequently reflect topographic changes and/or construction projects.
What is revised? Revises (normally a portion of) an existing FIRM panel (does not supersede the panel) and possibly portions of the FIS report.
Is there an appeal period? Yes, all LOMRs are subject to a 90-day appeal period when changes to BFEs, floodplain and/or floodway boundaries occur.
What is the output? A LOMR Determination Document that includes a revised area of a FIRM panel(s) and/or revised FIS report (flood profiles).
When does it become effective? A LOMR becomes effective 120 days after the date of the second local newspaper publication is issued, unless an appeal is submitted to FEMA.
Where to find it? Digital copies can be found on the MSC. Hard copies are mailed to the applicant and the community's map repository.
What is uploaded to the MSC? A determination document, the revised portion of the map panel(s), and updated portions of the FIS report (profiles, tables, etc.) and NFHL database.
Where can it be found on the MSC? On http://msc.fema.gov, after a 'Search for All Products' under a jurisdiction, the paths below will provide the corresponding items. Effective and Pending Products> LOMC> LOMR. Effective Products>FIRM Panels>click on the LOMC Button for a specific panel.

Letter of Map Revision Based on Fill (LOMR-F)

What is it? A letter that provides an official determination on the flood zone for a property or structure that has been elevated by earthen fill to modify the SFHA.
What is revised? Flood hazard designations for properties within an SFHA on a FIRM can be changed, and an effective FIRM can be amended, but the map is not physically changed unless the area is large enough to be reflected in future updates.
Is there an appeal period? No.
What is the output? A LOMR-F Determination Document.
When does it become effective? On the date of the letter.
Where to find it? Digital copies can be found on the MSC. Hard copies are mailed to the applicant and the community's map repository.
What is uploaded to the MSC? A determination document.
Where can it be found on the MSC? On http://msc.fema.gov, after a 'Search for All Products' under a jurisdiction, the paths below will provide the corresponding items. Effective Products>LOMC>LOMA. Effective Products>FIRM Panels>click on LOMC Button for a specific panel.

Letter of Map Amendment (LOMA)

What is it? A letter that provides an official determination on the relation of a property or structure to the SFHA. LOMAs are most frequently issued when a property has inadvertently been mapped within the floodplain, but is on naturally high ground.
What is revised? Flood hazard designations for properties within an SFHA on a FIRM can be changed, and an effective FIRM can be amended, but the map is not physically changed unless the area is large enough to be reflected in future updates.
Is there an appeal period? No
What is the output? A LOMA Determination Document.
When does it become effective? On the date of the letter.
Where to find it? Digital copies can be found on the MSC. Hard copies are mailed to the applicant and the community's map repository.
What is uploaded to the MSC? A determination document.
Where can it be found on the MSC? On http://msc.fema.gov, after a 'Search for All Products' under a jurisdiction, the paths below will provide the corresponding items. Effective

Products>LOMC>LOMA. Effective Products>FIRM Panels>click on LOMC Button for a specific panel.

Mapping Terminology

Flood Insurance Rate Map (FIRM) – The official flood map that shows a community's different flood hazard areas. These may include high-hazard (Special Flood Hazard Areas), moderate- to low-hazard, and undetermined areas. Different flood insurance and building requirements apply to these flood hazard areas.

Flood Insurance Study (FIS) Report – A compilation and presentation of flood hazard data and analysis for specific watercourses, lakes, and coastal flood hazard areas within a community.

National Flood Hazard Layer (NFHL) – A digital database containing the flood hazard mapping information from FEMA's National Flood Insurance Program (NFIP).

Letter of Final Determination (LFD) – A letter FEMA sends to local officials stating that the process of establishing new flood elevations is complete, and a new or updated FIRM will become effective in 6 months.

Letter of Map Change (LOMC) – A general term used to refer to the several types of revisions and amendments to FEMA maps that can be accomplished by letter (LOMA, LOMR-F, LOMR).

Map Service Center (MSC) – FEMA's official public source for flood hazard information produced in support of the NFIP. http://msc.fema.gov Special Flood Hazard Area (SFHA) – The area where the NFIP's minimum floodplain management regulations must be enforced by the community as a condition of NFIP participation, and the area where the mandatory flood insurance purchase requirement applies. Revalidation Letter – A letter identifying the previously issued LOMCs that are still valid after the FIRM has been revised.

We have discussed how the NFIP compares to private-sector insurers. But that make create a misimpression: because NFIP coverage is implemented primarily *through* private insurance companies that participate in the Write Your Own (WYO) program.

So the more accurate comparison might be between private insurers operating within the WYO program and private insurers operating on their own.

The WYO Program, begun in 1983, is a cooperative arrangement between FEMA and the private insurance industry. The WYO Program operates within the context of the NFIP and is subject to its rules and regulations. WYO allows participating property and casualty insurance companies to write and service Federal flood insurance in their own names.

The companies receive an expense allowance for policies written and claims processed while the Federal Government retains responsibility for underwriting losses. Individual WYO Companies may, to the extent possible, and consistent with Program rules and regulations, match their flood business to their normal business practices for other lines of insurance. Many agents/producers have elected to move or place their flood policies with one or more of the WYO Companies they represent.

The goals of the WYO Program are to increase the policy base, improve services, and involve the insurance companies.

Through the WYO program, insurance companies sell and service flood insurance policies and adjust claims after flood losses. There were approximately 90 WYO companies operating during 2008.

The federal government acts as a guarantor of the flood insurance coverage policies issued under the WYO Arrangement. As a guarantor, the federal government is liable for paying NFIP claim losses should premiums collected be insufficient to cover these payments.

According to the feds:

To the extent possible, the [NFIP] is designed to pay operating expenses and flood insurance claims with premiums collected on flood insurance policies rather than by tax dollars.

That "to the extent possible" is a big qualification. As we've seen, the NFIP runs fairly constant operating losses - interrupted, occasionally, by catastrophic ones.

The WYO program isn't new; since the early 1980s, it's been the main tool that the NFIP uses to write flood coverage under what it calls the Stand Flood Insurance Policy (SFIP). As the court in *McCormick v. Travelers Ins. Co.* (Cal. App. 1st Dist. 2001) explained:

Initially, under what was originally designated as Part A of the NFIA, the [NFIP] was administered primarily through the National Flood Insurers Association, a pool of private insurance companies, under the supervision and financial support of the Department of Housing and Urban Development (HUD). Then, on April 1, 1979, [FEMA] was made principally responsible for the program's operation and administration and took full control of the payment or disallowance of all flood insurance claims. Under this arrangement, which was designated as Part B of the NFIA, the Director of FEMA was empowered by Congress to carry out the NFIP through the facilities of the federal government. In fulfilling this mandate, the Director of FEMA was authorized to utilize federal employees and/or private insurance companies and other insurers, insurance agents and brokers, and insurance adjustment organizations, who would operate specifically as fiscal agents of the while assisting the Director in implementing the NFIP. In 1983, FEMA exercised this regulatory authority by creating the [WYO] program to assist it in marketing and administration of flood insurance through the "facilities of the Federal Government."

So, WYO companies issue SFIPs in their own names as insurer and arrange for the adjustment, settlement, payment and defense of all claims arising from the policies - with the federal government acting as the guarantor and reinsurer.

While flood insurance may be issued either directly by FEMA or a WYO company, FEMA establishes the terms and conditions of the policies, which are set forth in Code of Federal Regulations and which may not be "altered, varied, or waived other than by the express written consent of the Federal Insurance Administrator."

A private insurance company becomes a WYO company by entering into an agreement with FEMA known as the Financial Assistance / Subsidy Arrangement. Under the arrangement, the private insurance company agrees to issue flood policies in its own name.

Participating WYO companies are to comply with the NFIP WYO Program Financial Control Plan Requirements and Procedures (known more simply as the "Financial Control Plan"), which outlines WYO insurance companies' responsibilities for underwriting, claims adjustments, cash management and financial reporting.

WYO companies must remit all insurance premiums collected from policyholders to be deposited into the National Flood Insurance Fund. (Premiums are kept in segregated accounts, and are considered federal funds from the moment they are collected, with interest earned belonging to the United States.)

If a WYO company depletes its premium income through the payment of claims, it may acquire additional funds to pay claims "by drawing on FEMA's letters of credit."

WYO companies receive a 3.3 percent commission on all amounts paid in satisfaction of claims under SFIPs.

SFIPs provide a dispute resolution process for aggrieved insureds, as well as a remedy for insureds and subrogation rights for insurers.

Insurance agents under contract to one or more WYO insurance companies are the main point of contact for approximately 97 percent of flood insurance policyholders. Based on information the insurance agents submit, the WYO insurance companies issue policies, collect premiums from

policyholders, deduct an allowance for expenses from the premium and remit the balance to the National Flood Insurance Fund.

The remaining 3 percent of policies are written directly by the federal government through a FEMA contractor known as the Direct Servicing Agent. The Direct Servicing Agent provides an alternative, for example, when a WYO company is unable or unwilling to write a flood insurance policy.

Adjusting WYO Policy Claims

FEMA relies heavily on WYO insurance companies to carry out NFIP financial activities such as documenting and maintaining claim files.

In turn, WYO insurance companies employ certified flood adjusters to settle NFIP claims. When flood losses occur, policyholders report them to their insurance agents, who notify the WYO insurance company. The WYO insurance company assigns a flood adjuster who is responsible for assessing damage, estimating losses and submitting required reports, work sheets and photographs to the WYO insurance company - which reviews and processes the claim, if approved, for payment.

The NFIP's claims payment policy states that the program will pay only that part of the loss that exceeds the deductible amount, subject to the applicable limit of liability (i.e., the amount of insurance coverage).

FEMA provides funds to the WYO insurance companies from the National Flood Insurance Fund for the amounts paid for approved claims and related expenses. As of December 2008, this fund was over $18 billion in debt.

About 70 FEMA Mitigation Directorate employees, assisted by approximately 105 to 110 Bureau and Statistical Agent (BSA) contractor employees, are responsible for managing and overseeing NFIP and the National Flood Insurance Fund into which premiums are deposited and from which claims and expenses are paid.

Ever few years, FEMA awards a contract for the BSA - which is responsible for:

- conducting financial and statistical reporting based upon data submissions from the WYO companies,
- developing forms and information related to NFIP and
- providing various data analyses.

Said another way, the BSA serves as the liaison between the government and insurance companies that issue federally-guaranteed WYO policies.

FEMA and the BSA are responsible for monitoring and overseeing the quality of the performance of the approximately 90 WYO insurance companies and for assuring that NFIP is administered properly. Their management responsibilities include:

- establishing and updating NFIP regulations and flood insurance rates,
- offering training to WYO company insurance agents and adjusters, and
- implementing the Financial Control Plan.

According to the NFIP Adjuster Claims Manual, the BSA maintains a database of independent adjusters who qualify to adjust flood claims. This database reflects whether the adjuster has attended FEMA-recognized flood workshops.

Problems with WYO

Payments to WYO insurers generally represent one-third to two-thirds of the premiums collected in a given year. So, these WYO insurers play a key role in NFIP operations.

However, FEMA and the NFIP have various "internal control weaknesses" when it comes to running the WYO program. Specifically, FEMA:

•does not systematically consider actual flood insurance expense information when determining payments to WYO insurers,
•has not aligned its WYO bonus and incentive structures with NFIP goals (such as increasing penetration in low-risk flood markets and among homeowners that do not have mortgages from federally regulated lenders), and
•has not implemented many of its planned financial controls for the WYO program.

Also, contractors other than WYO insurers are responsible for performing key NFIP functions - such as collecting NFIP data and marketing the program. This may be too much outsourcing. According to the GAO:

...we have also found problems with oversight of these contractors. Specifically, FEMA did not consistently follow its procedures for monitoring contractors, did not always coordinate contract monitoring responsibilities among various agency departments on some of the contracts we reviewed, lacked contract monitoring records, and did not have a system in place that would allow various departments to share information relating to contractor deficiencies.

Further, preliminary results of the GAO's ongoing review of the NFIP's operations have revealed that FEMA "continues to lack an effective system to manage flood insurance policy and claims data," despite having invested roughly seven years and $40 million in a new information-technology system (that was eventually abandoned).

The NFIP "flies blind," even though it has the means to "see" where it's going. According to the GAO:

...FEMA does not systematically consider actual flood insurance expense information when determining the amount it pays WYO insurers for selling and servicing flood insurance policies and adjusting claims. Instead, FEMA has used proxies, such as average industry operating expenses for property insurance, to determine the rates at which it pays these insurers, even though their actual flood insurance expense information has been available since 1997.

Because FEMA does not systematically consider these data when setting its payment rates, it can't effectively measure or estimate how much insurers are spending to carry out their contractual obligations. Also, because FEMA doesn't compare the WYO insurers' actual expenses to the payments they receive each year, it can't determine whether the payments are reasonable - in terms of expenses and profit.

When GAO compared payments FEMA made to six WYO insurers to their actual expenses for calendar years 2005 through 2007, it found that the payments exceeded actual expenses by 16.5 percent of total payments made. That was $327.1 million, over three years.

By considering actual expense information, FEMA could provide greater transparency and accountability over payments to the WYO insurers and potentially save taxpayers' funds.

The Financial Control Plan provides guidance for WYO insurers to help ensure compliance with the statutory requirements for NFIP; it also contains several checks and balances to help ensure that taxpayers' funds are spent appropriately. But FEMA's record for implementing this Plan is not strong. According to the GAO and other watchdog groups:

•while FEMA performs most of the biennial audits and underwriting and claims reviews required under the Plan, it rarely or never reviews state insurance department actions or marketing, litigation and customer service issues;
•FEMA does not systematically track and coordinate the outcomes of the various audits, inspections and reviews that it performs; multiple organization units have responsibility for ensuring that WYO insurers comply with each component of the Financial Control Plan but FEMA doesn't maintain a single, comprehensive monitoring system that would allow it to ensure compliance with all components of the plan;
•because FEMA does not implement all aspects of the Financial Control Plan, it cannot ensure that WYOs are fully complying with program requirements;

•weak internal controls impair FEMA's ability to maintain effective transaction-level accountability with WYO insurers; so the NFIP has limited assurance that its financial data are accurate.

The Financial Control Plan states that:

•biannual audits WYO insurance companies are intended to reduce or eliminate the need for FEMA auditors to conduct on-site visits to oversee the companies' financial activities;
•these biennial financial statement audits are a required condition of an insurance company's participation in the WYO program; and
•the audits must be conducted by an independent Certified Public Accountant and are to include an opinion on the fairness of the financial statements, the adequacy of the internal controls and the extent of compliance with laws and regulations.

According to the GAO:

In 2007, we reported that five out of 94 (about 5 percent) WYO companies had biennial audits completed for the two-year period covering fiscal years 2005 and 2006. In response to findings that FEMA had failed to consistently enforce the biennial audit requirement, FEMA officials told us that they had exempted from this requirement companies that said that they were overwhelmed with administering flood claims after the 2005 hurricane season.

Given that operational reviews are FEMA's primary method of monitoring the WYO insurance companies for the two most significant areas of the program - underwriting and claims processing - it is important for FEMA to conduct these reviews on a regular basis.

Without the timely information regarding how WYO companies sell and adjust claims gained through operation reviews, FEMA cannot be certain that the WYO companies provide appropriate financial information to NFIP program managers.

Perhaps most troubling, from an administrative or bureaucratic perspective, the GAO study concluded that the NFIP's organizational weaknesses exist at all three levels of the NFIP's "transaction accountability and financial reporting process." Specifically:

1.at the WYO level, our internal control testing of a statistical sample determined that almost 71 percent of WYO company claims loss files did not have the necessary documents to support the claims, or reports were filed late.
2.incomplete BSA-level premium data files (lacking key information such as insureds' names and addresses) prevented an assessment of the reliability of reported NFIP premium amounts. Further, BSA-level internal control activities were ineffective in verifying the accuracy of WYO-submitted data.
3.FEMA's financial reporting process uses summary data that is overly reliant on error-prone manual data entry.

To address these shortcomings, the GAO recommended that FEMA:

•Address challenges to oversight of the WYO program, specifically the lack of transparency of and accountability for the payments FEMA makes to WYO insurers, by determining in advance the amounts built into the payment rates for estimated expenses and profit, annually analyzing the amounts of actual expenses and profit in relation to the estimated amounts used in setting payment rates, and by immediately reassessing the practice of paying WYO insurers an additional 1 percent of written premiums for operating expenses.
•Take steps to better oversee WYO insurers and ensure that they are in compliance with statutory requirements for NFIP and that taxpayers' funds are spent appropriately by consistently following the Financial Control Plan and ensuring that each component is implemented; ensuring that any revised Financial Control Plan covers oversight of all functions of participating WYO insurers, including customer service and litigation expenses; systematically tracking insurance companies' compliance with and performance under each component of the Financial Control Plan; and ensuring centralized access to all audits,

reviews, and data analyses performed for each WYO insurer under the Financial Control Plan.

•Improve NFIP's transaction-level accountability and assure that financial reporting is accurate and that insurance company operations conform to program requirements by augmenting NFIP policies to require contractors to develop procedures for analyzing financial reports in relation to the transaction-level information that WYO insurers submit for statistical purposes; revising required internal control activities for contractors to provide for verifying and validating the reliability of WYO-reported financial information based on a review of a sample of the underlying transactions or events; and obtaining verification that these objectives have been met through independent audits of the WYO insurers.

Financial Reporting in the WYO Program

As those last GAO suggestions imply, the NFIP's problems go beyond organizational and management weaknesses. The Program has major financial reporting problems-the kind of problems that would create scandal and controversy in the private sector...or at a higher-profile government entity.

Some of these financial reporting problems have to do with the NFIP's heavy reliance in its outside Bureau and Statistical Agent (BSA).

The NFIP financial reporting process begins at the WYO company level when the companies provide summary-level financial data and transaction-level statistical data to the BSA.

The WYO Financial Control Plan requires the WYO companies to submit a monthly financial statement reporting package to the BSA, which is to include financial, reconciliation, and certification statements, and statistical transactions.

The BSA uses the detailed transaction-level data in the reporting package for statistical purposes that include information on claims, losses and premiums (such as claim payment and coverage amounts, data on buildings and contents, and policy effective dates). The BSA uploads the summary-level financial information to its financial system which is used for financial reporting purposes.

After the BSA receives the reporting package, it performs front-end balancing - a process intended to ensure the WYO company data are consistent with the WYO companies' reconciliation statements.

This process is intended to validate that the BSA has recorded the same information that individual WYO companies have transmitted.

After BSA personnel complete the front-end balancing process they use manual processes to upload financial data into several different software systems that generate the reports and spreadsheets that various agencies use to work with the data.

Here are some examples of resulting problems:

•Each month, the BSA sends the financial statement booklets consisting of four sets of consolidated - but unaudited - financial statements to FEMA's Office of the Chief Financial Officer (OCFO). The OCFO prepares journal vouchers based on line items from the NFIP consolidated financial vouchers into the Integrated Financial Management and Information System (IFMIS), which is NFIP's official accounting system of record.

•After the journal voucher entries are loaded into IFMIS, OCFO personnel produce trial balance data and load it into the Treasury Information Executive Repository (TIER), which is a data warehouse for DHS' components' data.

•The WYO companies did not provide complete documentation to FEMA for claims paid to insureds during fiscal years 2005 to 2007. According to NFIP policies and procedures, claim loss files are to contain adequate documentation relevant to the adjustment of a claim to support claim payments.

According to the GAO:

Our detailed testing of claim losses paid during fiscal years 2005 through 2007 showed that 20 percent (36 out of 177) of the claim files reviewed were missing adjuster-prepared preliminary reports and 20 percent (36 out of 177) did not contain adjuster-prepared final reports required by the NFIP Adjuster Claims Manual.

In addition, for the claim files we reviewed, WYO companies did not file 42 percent (74 out of 177) of the preliminary and 34 percent (61 out of 177) final reports within the required 15 and 45 days, respectively, from the date of loss in accordance with NFIP policy.

...Over 50 percent of the transactions in the NFIP databases for the insurance premium policies for fiscal years 2006 and 2007 that the BSA extracted for our testing either lacked or had incomplete insured names, addresses, or policy effective dates. Consequently, we were unable to test the accuracy of reported insurance premium amounts or whether policy premium information was complete. Officials from the BSA attributed the missing or incomplete insurance premium information to their extraction process and difficulties they encountered (programming errors) when extracting the data into a separate database specifically for our use.

The fact that BSA officials could not readily produce reliable or complete data poses questions regarding their capacity to analyze data and the NFIP program officials' ability to identify appropriate managerial actions based on what is reported to them by WYO companies through their own BSA contractor.

Again, from the GAO report:

We noted that 35 of these claim files missing preliminary and final reports are for claims adjusted by one particular WYO company. According to FEMA, this WYO company has historically taken the position that they will provide the information required but will do so in accordance with the processing of all its insurance policies as allowed by the Financial Assistance / Subsidy Arrangement. In other words, it will use its own forms that contain the information in the NFIP preliminary and final reports.

While complying with the Financial Assistance / Subsidy Arrangement, based on our review of the information in the claim files as compared to the standard preliminary and final reports, we noted that the company's forms in the files do not contain certain information such as any salvage amount and the prior condition of the building and contents. In addition, the forms are not consistently signed by the adjuster and it is not clear whether the reports were prepared timely.

The NFIP's own Financial Control Plan requires WYO companies to submit a monthly financial statement reporting package to the BSA. This package is to include financial statements, reconciliation statements, certification statements and statistical transactions.

The BSA's front-end balancing - while helping to verify that the number of records and dollar amounts agree to the reconciliation documents and the timeliness of the data submitted from WYO companies - does not verify or validate the data's accuracy.

Although WYO companies submit statistical transaction-level data for claims losses paid and premiums written, which are the primary sources of financial activity for NFIP, the BSA does not base its financial reporting on this transaction-level data, but instead compiles the financial exhibits submitted by the WYO companies, and therefore reduces assurances that activity reported to FEMA represents actual transactions between WYO companies and policyholders.

Most troubling: the process relies too heavily on manual procedures for entering data. This over-reliance increases the likelihood of errors or incomplete/inaccurate NFIP financial information.

As FEMA's NFIP financial reporting process was designed, approximately 90 WYO insurance companies submit summary financial information in emails to the BSA for consolidation and submission to FEMA. Throughout the entire process, the BSA captures and processes key financial information such as net written premiums on the financial statements prepared by the WYO companies.

For example: In 2006, FEMA officials had to correct over 100 journal vouchers totaling an estimated $260 billion.

Also: By presenting net written premium amounts, WYO companies do not show how much of earned premiums go to pay premium refunds. This limits how much even a thorough audit can show about premiums and claims costs.

Another type of audit that is supposed to help FEMA and the NFIP exert control of the WYO program is claims re-inspection. According to the Financial Control Plan, the claims re-inspection program is designed to serve as a mechanism supporting FEMA's oversight of WYO insurance companies. The objectives of the program are to:

1. keep FEMA and the BSA informed,
2. assist in the overall claims operation, and
3. provide necessary assurances and documentation for dealing with external parties.

The BSA is supposed to conduct all re-inspections and prepare a report documenting the appropriateness of WYO companies that did not have operational reviews. However, through most of the early and mid-2000s, officials selected claims to reinspect based upon judgmental criteria including, among other items, the size and location of loss and complexity of claims. Further, FEMA only required testing for a selection of claims for flood events - with over 400 claims per a single flood event for a particular WYO company.

In other words, FEMA and the NFIP did not use a statistical sampling methodology to select files for operational reviews - instead they used non-probability sampling processes. (In non-probability sampling, investigators select a sample based on their knowledge of the population's characteristics. The major limitation of this type of sampling is that the results cannot be generalized to a larger population.)

Using this flawed methodology for selecting samples for claims re-inspections, the percentage of claims reinspected by flood event for fiscal years 2005 and 2006 was 1.8 percent for Katrina, 3.6 percent for Rita and 5.0 percent for Wilma. In other words, the NFIP de-emphasized the biggest loss events that occurred during that period.

In the early 2010s, FEMA and the NFIP have taken some steps to strengthen their internal controls. However, the GAO remains unimpressed-and has recommended the following actions:

1. Augment NFIP policies to require the BSA to develop procedures to analyze financial reports in relation to the transaction-level information that WYO companies submit for statistical purposes.
2. Revise required internal control activities for the BSA to provide for verifying and validating the reliability of WYO-reported financial information based upon a review of a sample of the underlying transactions or events, or obtain verification that these objectives have been met through independent audits of the WYO companies.
3. Determine the feasibility of integrating and streamlining numerous existing NFIP financial reporting processes to reduce the risk of errors inherent in the manual recording of accounting transactions into multiple systems.
4. Establish and implement procedures to require reviewing available information such as the results of biennial audits, operational reviews, and claim re-inspections to determine whether the targeted audits for cause managerial tool should be used.
5. Establish and implement procedures to require maintaining and considering current information from an independent source regarding state audit results to gather pertinent information such as customer service issues and inform determinations about when to conduct audits for cause.
6. Establish and implement procedures to schedule and conduct all required operational reviews within the prescribed 3-year period.
7. Establish and implement procedures to select statistically representative samples of all claims as a basis for conducting re-inspections of claims by general adjusters.

The fifth recommendation - that the NFIP consider audit results from independent sources (usually, this means state regulatory agencies) - caused some controversy among FEMA and NFIP bureaucrats. FEMA officials insisted that information from an "independent source" regarding state audit results did not apply reliably to federal programs, such as NFIP.

However, the Financial Control Plan states that it is expected that audits of WYO companies by state insurance departments will include flood insurance activity. Further, FEMA and the NFIP had previously acknowledged receiving information from a source independent of the WYO companies - specifically, they'd acknowledged receiving correspondence from state insurance departments regarding issues of customer service with the WYO companies.

So, the GAO concluded:

It is important for FEMA to establish and implement procedures to require maintaining and considering all current information available from an independent source regarding state audit results. We found that FEMA rarely received or reviewed information from state insurance department audits. Consequently, we continue to reaffirm our recommendation to obtain and consider independent information on state audits of the WYO companies, rather than continuing to rely solely on the WYO company that underwrites policies and processes claims to alert FEMA of any state issues.

The NFIP Bureau and Statistical Agent operates a network of regional offices within the continental . The regional staff may be able to assist with problems and answer questions of a general nature. However, the regional offices do not handle processing, nor do they have policy files at their locations.

Chapter 9 How to make claims under NFIP Policies

In the event of loss, the insured is required to:

- give written notice of loss to the insurer, as soon as practicable, using the National Flood Insurance Program (NFIP) Notice of Loss form or similar form;
- exhibit all remains of the property, as required;
- if requested, submit to an examination under oath, as required;
- provide evidence and documentation to substantiate the loss, as required; and
- file a Proof of Loss within 60 days of the loss, unless this requirement is waived by the Federal Emergency Management Agency (FEMA).

The NFIP has a standard Proof of Loss form that the adjuster assigned to the loss may provide to the insured. The adjuster may assist in completion of the form. However, independent adjusters do not have the authority either to approve or to deny claims. Adjusters' recommendations for payment or denial are not binding on the insurer and are subject to approval and correction by the insurer staff.

The Proof of Loss form may be waived on claims for less than $7,500. In this case, the insured will be required to sign the NFIP Final Report form, which summarizes the loss and claim figures.

The following passages and tips for insureds making flood insurance claims are excerpted from the NFIP *Flood Insurance Claims Handbook*:

The NFIP provides you with a process to appeal decisions regarding your flood insurance claim. This process will help you resolve claim issues, but it cannot give you added coverage or claim limits beyond those in your NFIP policy.

In filing and completing your insurance claim, you may have questions, or need further explanations of decisions that have been made, especially with regard to coverage, dollar amount

of damages, or your Proof of Loss. Before you may appeal, your insurer must make a final determination and send you a written denial of your claim or any part of it.

Four Steps to Appealing Your Claim

Step 1

Talk with your adjuster, who has more knowledge about your claim than anyone. If you don't understand certain decisions regarding, for example, application of coverage, timing of the filing of Proof of Loss, or the damage estimate, contact your adjuster first.

Step 2

If you are not satisfied with the adjuster's answers, or do not agree with decisions, get contact information for the adjuster's supervisor.

Step 3

If the adjuster's supervisor can't resolve your issues, contact the insurance company's claim representative. Ask your insurance agent/producer or your insurance company representative for assistance. Please refer to your flood policy for more information on appeals; see General Conditions, Paragraph R.

Step 4

If you still have questions or concerns after following steps 1 through 3, contact FEMA. Write to:

Federal Emergency Management Agency

Mitigation Directorate

Federal Insurance Administrator

1800 S. Bell Street

Arlington, VA 20598-3010

This letter should be written by the Named Insured (as it appears on your NFIP policy) or by a legal representative, if necessary. The representative should clearly identify his or her relationship to the Named Insured. (For example, a son or daughter could be handling a claim for an elderly parent.) A legal representative may be asked to provide authorization from the Named Insured or other legal documents verifying the relationship.

Your letter of appeal must be submitted to FEMA within 60 days from the date of the denial letter that you receive from your flood insurer.

The following six items should be in your letter to FEMA in order to address your questions (If for some reason your policy is not available, your insurance agent/producer can provide details for the first three items.):

1. The Policy Number, as shown on your NFIP policy's declarations page.
2. The policyholder's name, as shown as the Named Insured on the declarations page.
3. The property address, as shown on the declarations page. (Not your mailing address, if it is different from the property address.)
4. How you can be contacted, if you are out of your home.
5. The details of your concern. (Please be as complete as possible.)
6. The dates of contact and contact details for the persons with whom you have spoken in steps 1 through 3 above.

Enclose documentation of everything that supports your appeal.

Provide a copy of the insurer's written denial, in whole or in part, of the claim;

Identify relevant policy and claim information and state the basis for the appeal; and

Submit relevant documentation to support the appeal, but only documentation that directly pertains to your claim.

The following are examples of the kinds of documentation that FEMA will require:

- a copy of the Proof of Loss submitted to the insurer, as required in the policy;
- a re-inspection of your property may be conducted at the discretion of FEMA to gather more information.
- adjuster's Final Report;
- adjuster's Preliminary Report;
- advance payment information;
- any assignment of interest in a claim; and
- any other pertinent information that FEMA may request in processing a claim.
- architectural plans and drawings;
- clear photographs (exterior and interior) confirming damage that resulted from direct physical loss by or from flood;
- completed Mobile Home Worksheet;
- condominium association by-laws;
- current lienholder information;
- current loss payee information;
- death certificates;
- detailed damaged personal property inventories that include the approximate ages of the items;
- detailed engineering reports specifically addressing flood-related damage and pre-existing damage;
- divorce decree;
- documentation of Flood Insurance Rate Map (FIRM) dates;
- documentation reflecting date(s) of construction and substantial improvement;
- elevation Certificate, if the building is elevated;
- emergency (911) address change information;
- engineering surveys;
- evidence of insurability as a Residential Condominium Association;
- evidence of insurance and policy information, i.e., declarations page;
- financial statements;
- franchise agreements;
- information regarding substantial improvement;
- last will and testament;
- letters of representation, i.e., attorneys and public adjusters;
- loan documents including closings;
- market values;
- mobile home title, including salvage title;
- paid receipts and invoices documenting damaged stock;
- paid receipts and invoices, including canceled checks that support an insured's out-of-pocket expenses pertaining to the claim;
- power of attorney;
- pre-loss and post-loss inventories;
- proof of other insurance, including homeowners or wind policies, and any claim information submitted to the other companies;
- proof that prior flood damage has been repaired;
- real estate appraisals that exclude land values;
- replacement cost Proofs of Loss;
- room-by-room itemized estimates from the adjuster (include contractors' estimates), detailing unit costs and quantities for the items needing repair or replacement;
- salvage information (proceeds and sales);
- tax records, lease agreements, sales contracts, settlement papers, deed, etc.;

- the community's determination concerning substantial damage;
- underwriting decisions;
- waiver, Letter of Map Revision (LOMR), or Letter of Map Amendment (LOMA) information;
- zone determinations;

A request by FEMA for additional information will include the date by which the information must be provided, which shall in no case be less than 14 calendar days. Failure to provide the requested information in full within 14 calendar days may result in dismissal of your appeal. FEMA will ensure that all information necessary to rule on the appeal has been provided prior to making an appeal decision.

The appeals process is intended to resolve claim issues and is not intended to grant coverage or limits that are not provided by the Standard Flood Insurance Policy (SFIP). Filing an appeal does not waive any of the requirements for perfecting a claim under the SFIP or extend any of the time limitations set forth in the SFIP.

1. Disputes that are or have been subject to appraisal as provided for in the SFIP cannot be appealed.
2. If you file an appeal on any issue, that issue is no longer subject to resolution by appraisal or other pre-litigation remedies.
3. If you file suit against an insurer on the flood insurance claim issue, you are prohibited from filing an appeal. All appeals submitted for decision but not resolved shall be terminated upon notice of the commencement of litigation regarding the claim.

FEMA will review the appeal documents, including any re-inspection report, if appropriate. FEMA will provide specific information on what grounds the claim was initially denied.

FEMA will provide an appeal decision in writing to the policyholder and insurer within 90 days from the date that all information has been submitted by the policyholder and will include specific information for the resolution of the appeal. No further administrative review will be provided to the insured.

If you do not agree with the final decision, please refer to your flood insurance policy. See the "GENERAL CONDITIONS" Section, Paragraph R. "Suit Against Us." The one-year period to file suit commences with the written denial from the insurer and is not extended by the appeals process.

Agents/producers may request that any NFIP Direct claim be assigned to an NFIP-approved independent adjuster. The NFIP Direct makes all NFIP Direct claim assignments, except:

- when, in major flooding disasters, the Flood Insurance Claims Office (FICO) makes all assignments;
- when an Adjuster Control Office is established;
- when a Claims Coordinating Office (CCO) is established.

Failure to indicate the assigned adjuster on the loss notice, or assignment of an adjuster who is not authorized by the NFIP, will delay the adjustment process and may result in duplicate adjuster assignments.

When it appears that a situation is serious enough that a FICO may be necessary, the NFIP will notify agents/producers and agent/producer trade associations in the affected area (using the broadcast media and press releases) as soon as possible to hold their loss notices unassigned until further instructions are received.

In the case of a WYO Company claim, the WYO Company's agent/producer will follow the established procedures when assigning an adjuster.

Disputes over NFIP Insurance Claims

The 2010 federal court decision *Florida Farm Bureau General Insurance Co. v. Voncille Jernigan* is a good example of the coverage issues common to WYO policies.

In the case, Florida Farm Bureau General sued Jernigan to recover benefits paid under a flood insurance policy.

Farm Bureau General, in its capacity as a WYO Program Carrier, issued a Standard Flood Insurance Policy ("SFIP") covering the Jernigan's property located at 645 South Garcon Point Road, Milton, Florida. As usual, the policy was effective for one year - beginning on July 24, 2004 - and covered any direct physical loss by or from a flood, as defined in the policy, to limits of $250,000 for Jernigan's dwelling and $44,041 for its contents.

On or about September 16, 2004, Hurricane Ivan struck Northwest Florida, causing extensive damage to the Jernigan's property. Following the hurricane, Jernigan notified Farm Bureau General of the loss.

Farm Bureau General assigned an adjuster, Richard Kellerman, to assist Jernigan with her claim. Kellerman inspected the property and determined it was a total loss due to flooding. Based on Kellerman's estimate of damage and the fact that the estimated actual cash value of the home exceeded $250,000, Farm Bureau General paid the policy limits for the dwelling and contents.

At the time of the hurricane, Jernigan's property was insured under a separate homeowner's policy issued by Farm Bureau Casualty Insurance Company (Farm Bureau Casualty). The homeowner's policy provided $138,500 in coverage for damage due to a covered peril, which included wind but excluded flood.

After receiving payment of the limits of the SFIP, Jernigan's husband filed a claim under the homeowner's policy seeking to recover for wind damage to the home.

Rather than pay the claim, Farm Bureau Casualty filed a Complaint in Santa Rosa County Circuit Court requesting a declaratory judgment that it was not liable for any amount under the homeowner's policy covering Jernigan's property for wind damage allegedly sustained as a result of Hurricane Ivan.

In response, Jernigan asserted a counterclaim against Farm Bureau Casualty for breach of contract based on its failure to pay.

At trial, Jernigan argued that her home was a total loss due to wind damage. Although she introduced evidence that the appraised actual cash value of her home at the time of Hurricane Ivan was $95,000, she requested policy limits under Florida's Valued Policy Law. After a two-day trial on March 9 and 10, 2009, the jury found Jernigan's property a total loss as a result of wind damage and returned a verdict in her favor for $138,500, the maximum amount allowed under her homeowner's policy. Based on the jury's verdict, Farm Bureau General filed this action, asserting a claim for unjust enrichment and seeking to recover the proceeds it paid the defendant under the SFIP.

Farm Bureau General filed a motion for summary judgment, arguing that it was required, under the NFIP and supporting regulations, to seek recovery of the amount paid to the defendant under the SFIP. Florida Farm Bureau also argued that Jernigan should be judicially estopped from denying that she was not entitled to the proceeds of the SFIP given the position she took in the state court matter, i.e., that her home was a total loss due to wind damage.

Jernigan filed a cross-motion for summary judgment, claiming there was no genuine issue of material fact because there is no recognizable cause of action for "reimbursement of overpayment of insurance proceeds" and that, even if there was, any such claim is barred by the economic loss doctrine, judicial estoppel, a prior settlement, and the doctrines of laches and unclean hands.

The court found there was no cause of action for unjust enrichment under which Farm Bureau General could recover. According to Florida insurance law:

[i]n the event of a total loss of any . . . structure . . . located in this state and insured by any insurer as to a covered peril, in the absence of any change increasing the risk without the insurer's consent and in the absence of fraudulent or criminal fault on the part of the insured or one acting in her or his behalf, the insurer's liability under the policy for such total loss, if caused by a covered peril, shall be in the amount of money for which such property was so insured as specified in the policy and for which a premium has been charged or paid.

SFIPs are not subject to Florida's Valued Policy Law.

Farm Bureau General asserted a cause of action for unjust enrichment, seeking to recoup the money it erroneously paid the defendant under her SFIP. Although it invoked the court's federal question jurisdiction, Farm Bureau General did not specify whether it is asserting a claim under state or federal law but assumed federal law because of the federal nature of the funds. In any event, because Farm Bureau General's claim arose under the NFIP, any state law claim for unjust enrichment was preempted by federal law.

As a result, in order to proceed in this matter, Farm Bureau General must provide a basis for its claim under federal law, whether statutory or common law. Neither the NFIA nor the SFIP explicitly contemplates a cause of action for unjust enrichment, and Farm Bureau General has not cited any cases recognizing such a cause of action in this context. Although an argument could be made for recognition of an implied private right of action under the SFIP, Federal Farm Bureau has not raised this argument, much less pled this cause of action in its Complaint, and the court thus need not address its viability here. In short, Farm Bureau General may proceed in this matter only if the court recognizes a federal common law claim for unjust enrichment under the circumstances of this case.

The Eleventh Circuit has not addressed whether the NFIA authorizes federal common law causes of action; it has, however, addressed whether another federal statutory scheme - ERISA - authorizes such causes of action under analogous circumstances. The court finds such decisions instructive in this matter.

In *Sanson v. General Motors Corp.* (11th Cir. 1992), the Eleventh Circuit determined that ERISA preempts a state law cause of action for fraudulent misrepresentation. The court then addressed the appellant's alternative argument that it should create a federal common law cause of action for fraud. In declining to do so, the court noted that the Supreme Court had recently "rejected such an extension of the remedies guaranteed under ERISA."

As the Eleventh Circuit observed,

As the Fifth Circuit explained in *Wright v. Allstate Ins. Co.* (5th Cir. 2007), "the reference to federal common law in the SFIP directs courts to employ standard insurance principles when deciding coverage issues under the policy. It does not confer on policyholders the right to assert extra-contractual claims against WYO insurers - which claims, if successful, would likely be paid with government funds." This construction does not change based on the WYO carrier's status as a plaintiff, as opposed to a defendant. Moreover, courts have recognized a distinction between disputes stemming from claims handling and policy procurement, finding the former, but not the latter, to be preempted by federal law.

The SFIP, as set forth in the Code of Federal Regulations, specifically provides that all disputes arising from the handling of any claim thereunder are governed exclusively by the federal flood insurance regulations, the NFIA, and federal common law. The SFIP also contains a comprehensive regulatory scheme to resolve such disputes.

Considering that Farm Bureau General is seeking to recoup funds paid under an SFIP, its claim clearly arises under an SFIP; its remedy is thus limited to those set forth by FEMA in the federal flood insurance regulations and the NFIA, as interpreted under federal common law insurance principles. Nowhere in that framework is there a provision for the relief requested by Farm Bureau General. As a result, the court cannot provide for such relief through the creation of a federal common law cause of action for unjust enrichment.

In designing NFIP, Congress required that premiums for certain properties be offered at prices below those for full-risk premiums to encourage participation in the program and to ensure that premiums were affordable for existing structures in the floodplain. However, the statute does not provide a formula or methodology for setting the subsidies, leaving it up to the program to develop one.

When the program began, NFIP administrators set the subsidized rates on the basis of what they believed would be affordable, but this process resulted in losses that had to be covered by borrowings as discussed previously. Some of the resulting deficit was later forgiven by Congress.

In 1981, NFIP administrators, after discussions with congress, started setting NFIP's subsidized premium rates based on the average historical loss year calculations.

According to FEMA, this change allowed the agency to resist external pressures in setting premium rates and provided a more objective standard for determining subsidized rates. FEMA documents from most years between 2001 and 2006 state that the average historical loss year target, which is based on losses from previous years averaged over time, generally is considered a floor for premium collection.

To account for the potential of catastrophic losses, and the additional funds required to pay such losses, FEMA sets premium rates so that the total premiums collected will be approximately 15 to 25 percent greater than the average historical loss year estimate.

However, FEMA can adjust - and has recently adjusted - the way it calculates the average historical loss year.

According to FEMA officials, including the 2005 losses in calculations of the average historical loss year would have resulted in premium increases well above the 10 percent statutory limit. As a result, FEMA officials instituted a weighting factor for the 2005 losses, and as a result the full amount of the losses was not incorporated into the rate-setting model. According to FEMA officials, they incorporated losses of $2.1 billion of the estimated $23.2 billion in losses from 2005.

In its review of the NFIP's operations, the GAO noted:

FEMA raised rates by an average of more than 9 percent on about one percent of all NFIP policies - specifically, on certain subsidized policies located in high-risk coastal zones. In contrast, FEMA raised rates by an average of around two percent on 40 percent of total policies in high-risk zones that were paying full-risk rates. Ultimately, the generally small increases will not help ensure NFIP's financial stability and may in fact decrease it by adding to its operating deficit.

The processes and policies that FEMA uses to set both full-risk and subsidized premium rates have contributed to NFIP's inability to generate enough in premiums to cover the program's operating costs, claims losses, and debt to the Treasury.

From 1978 through 2004, NFIP had a net loss of $2 billion. These years had historically low flooding, but NFIP had yearly deficits for about half of these years. Over that period, Congress retired about $1.2 billion of this total debt. However, the introduction of average historical loss year targets in the 1980s resulted in a series of rate increases that contributed to a sizeable reduction of the net loss.

The 2005 hurricanes significantly altered NFIP's financial landscape. The 2005 hurricanes, especially Katrina, left the program with debt of more than $17.4 billion as of June 2008. To service the debt to the Treasury, FEMA owes two annual interest payments of around $365 million that are generally due in April and October of each year. FEMA officials told us that they were able to make the two payments in 2007 without borrowing because, according to FEMA documents, NFIP faced unusually light flooding in 2006 and 2007. In addition, FEMA made an unscheduled principal payment of $225 million in November 2007. However, in April 2008, FEMA borrowed $50 million to pay the $364 million interest payment owed to the Treasury.

"Concurrent Causation" exclusions
The 2007 Pennsylvania Court of Common Pleas decision *Bishops, Inc., v. Penn National Insurance* dealt with several SFIP issues - including "concurrent causation," a hot topic in claims disputes that we've considered in other course texts.

The trial court granted summary judgment and awarded damages in favor of Bishops limited to the $5000 in coverage afforded by an extra-cost endorsement (the Penn Pac Endorsement) to an all-risks insurance policy that Bishops had purchased from Penn National.

Both sides appealed.

In its cross-appeal, Penn National asserts that Bishops' claim is precluded by the concurrent cause provision of the basic policy to which the Penn Pac Endorsement was added because the damage for which Bishops claimed coverage was jointly caused by flooding.

In its cross appeal, Bishops rejoins that this Court has rendered concurrent causation clauses unenforceable, declining to recognize them in the presence of an affirmative grant of coverage for which the insured paid an added premium. Bishops argues further that the Penn Pac Endorsement, which provided coverage for sewer or drain back up, changed the definition of a "covered cause of loss" in the underlying policy to provide coverage to both physical losses contemplated by the endorsement itself and losses sustained by business interruption occasioned by the events that caused the physical loss.

Upon review, we find Penn National's concurrent cause exclusion unenforceable. Moreover, we conclude that Bishops is entitled to coverage under both the Penn Pac Endorsement and the Business Income (and Extra Expense) Coverage Form of the underlying policy. Accordingly, we affirm in part, vacate in part, and remand this case for additional proceedings consistent with this disposition.

Bishops was a fabric wholesaler located in the Borough of Millvale. It was owned by Sal and Rhea Nicotra, husband and wife, who'd purchased the business from its retiring founders in the 1990s. Sal Nicotra had been, until the purchase, a long-term employee of the business. Rhea Nicotra became involved pursuant to the terms of the sale and now serves as Bishops' president.

Bishops' claim arose out of sewer and drain back-up followed by extensive flooding of its business premises on September 17, 2004, during Hurricane Ivan.

During the hurricane, Bishops suffered a total loss of inventory and office equipment when water runoff backed up through the municipal drainage system during torrential rains and nearby bodies of water overflowed their banks, inundating much of the town.

When, subsequently, Bishops filed its claim with Penn National, the insurer tendered coverage for damaged office equipment under an Electronic Data Processing Endorsement Bishops had purchased at extra cost but refused to pay any amount for the physical damage sustained by Bishops' premises and inventory.

In a first letter to Bishops' president Rhea Nicotra, dated October 8, 2004, Penn National asserted only the policy exclusions in the basic policy relating to generalized flooding and ground water.

Those exclusions, as cited by Penn National's claims representative, provide as follows:

B. EXCLUSIONS
1. We will not pay for loss or damage caused directly or indirectly by any of the following. Such loss or damage is excluded regardless of any other cause or event that contributes concurrently or in any sequence to the loss.

...g.

Water

(1) Flood, surface water, waves, tides, tidal waves, overflow of any body of water, or their spray, all whether driven by wind or not.

(2) Mudslide or mudflow;

(3) Water that backs up or overflows from a sewer, drain or sump;

(4) Water under the ground surface pressing on, or flowing or seeping through:

(a) Foundations, walls, floors or paved surfaces;

(b) Basements, whether paved or not; or

(c) Doors, windows or other openings.

In a follow-up letter dated October 13, 2004, following a telephone conversation with Mrs. Nicotra, Penn National asserted policy definitions to reinforce the surface and ground water exclusions found in the basic policy. The letter noted specifically that "Ground Water" meant:

a. water that backs up through a sewer or drain; or

b. water below the surface of the ground. This includes water that exerts pressure on or flows, seeps, or leaks through or into a building, sidewalk, driveway, foundation, swimming pool, or other structure.

Significantly, neither letter acknowledged Bishops' coverage for sewer and drain backup under the Penn Pac Endorsement or business interruption under the Business Income (and Extra Expense) Coverage Form.

In follow-up correspondence, Mrs. Nicotra informed Penn National expressly that Bishops had purchased the Penn Pac Endorsement and noted that the endorsement specifically removes from the language you cite . . . exclusion B(1)(g)(3), i.e., water that backs up from a sewer or drain.

In response, Penn National acknowledged the Penn Pac Endorsement but declined to extend coverage, asserting that the damage Bishops suffered was caused concurrently by generalized flooding, which is excluded as a covered cause of loss under the basic policy.

In support, Penn National cited the "Causes of Loss - Special Form" as quoted above.

Applying the concurrent cause limitation of that provision, Penn National asserted that the policy excludes from coverage even covered causes of loss if the damage at issue is caused concurrently by any excluded cause. Penn National then explained that although it had re-evaluated its earlier analysis of the policy provisions, it had concluded that "the coverage opinions expressed in our October 8th and October 16th, 2004 letters are correct and on point with the cause of loss occurring on September 17, 2004."

Following Penn National's final refusal, Bishops retained counsel and commenced this action, asserting that its purchase of the Penn Pac Endorsement provided an affirmative grant of coverage for the losses it suffered and rendered the concurrent cause exclusion of the basic policy unenforceable.

In its complaint, Bishops pled causes of action for breach of contract and insurance bad faith. After the parties completed discovery, Penn National filed a motion for partial summary judgment on Bishops' breach of contract claim, requesting that the court enforce the concurrent cause exclusion. In response, Bishops filed a cross-motion requesting that the court deem its losses subject to coverage under the Penn Pac Endorsement and find further that sewer and drain back-up, as a covered cause of loss, entitled Bishops to coverage under the Business Income (and Extra Expense) Coverage Form up to the policy limits of $600,000.

In preparation for argument, the parties entered an extensive set of Stipulated Facts, which appear in pertinent part as follows:

3. [Bishops'] action is based upon the interpretation of commercial insurance policy No. CX90603879 (hereafter referred to as the "Policy"), including endorsements and forms [issued to Bishops by Penn National].

...

6. On or about September 17, 2004, a substantial amount of rain fell in the Pittsburgh area, specifically in Millvale, as a consequence of Hurricane Ivan.

7. Because of the significant rainfall of September 17, 2004, the sewer system in the Millvale area generally, and specifically near the location of Plaintiff's place of business, was subject to water and sewage backup through sewers, drains and pipes, causing some degree of damage to the Plaintiff's premises.

8. Subsequent to the initial backup of sewage, the significant rainfall of September 17, 2004 also caused outside flood waters to rise and enter the Plaintiff's building through windows, doors and other openings, causing additional damage to Plaintiff's building and premises.

9. It is not possible to divide or separate the damage sustained at the time of the initial sewer backup from the damage done as a result of the subsequent flood.

...

12. The Policy provides "all risks" property damage coverage. Accordingly, all property damage to the insured premises is a "Covered Cause of Loss" unless it is specifically excluded. If an exclusion applies to a particular type of property damage, that damage is removed from the Policy's definition of "Covered Cause of Loss." The parties agree that all of the property damage suffered by Plaintiff would be covered under the Policy if there was no applicable exclusion.

13. [The primary property damage protection is set forth in a policy form entitled "Causes Of Loss - Special Form".] The "Causes of Loss - Special Form" of the Policy sets forth the following exclusions . . . :

1. We will not pay for loss or damage caused directly or indirectly by any of the following. Such loss or damage is excluded regardless of any other cause or event that contributes concurrently or in any sequence to the loss.

g. Water

Flood, surface water, waves, tides, tidal waves, overflow of any body of water, or their spray, all whether driven by wind or not;

Water that backs up or overflows from a sewer, drain or sump;

...

14. If there was no additional coverage, the exclusions in the Causes of Loss -Special Form would remove the property damage suffered by Bishops from the definition of "Covered Cause of Loss," and Bishops would not be entitled to indemnification under the Policy.

15. The parties agree that the Policy contains two endorsements that may provide such additional coverage, but dispute the effect of those endorsements. The endorsements are known as the Penn Pac Endorsement, which provides additional insurance coverage for "Backup of sewers and drains," and the Electronic Data Processing Endorsement, which provides additional insurance coverage triggered by harm to the defined terms "hardware" and/or "software."

16. The Penn Pac Endorsement includes the following provisions . . . .

II.

Additional Coverages

The following Additional Coverages are added;

f. Back Up of Sewers and Drains

We will pay for loss or damage to Covered Property caused by a back up from a sewer or drain or an overflow from a sump within the building at the described premises.

The most we will pay for each location under this Additional Coverage is $5,000 for the sum of all expenses arising from back up or overflow during each 12 month period of the policy.

Exclusion B.1.9.(3) does not apply to this Additional Coverage.

The parties agree that any damage caused solely by the backup or overflow from the sewers and drains at Plaintiff's building would be a "Covered Cause of Loss" under the Policy; provided, however, that Penn National contends this "Covered Cause of Loss" would extend only to the $5,000 limit set forth in the Penn Pac Endorsement.

Following argument, trial court judge Michael A. Della Vecchia denied Penn National's motion and entered judgment in favor of Bishops, finding that "Plaintiff is entitled to receive coverage provided by the Pennpac [sic] Endorsement up to [$]5,000."

Nevertheless, the court struck additional language that Bishops had included in the order that stated:

[t]he damage suffered by Plaintiff was a 'Covered Cause of Loss' under the Policy including without limitation the Business Income Endorsement [i.e., the Business Income (and Extra Expense) Coverage Form].

Because Della Vecchia's order had not disposed of all claims raised in the plaintiff's complaint, Bishops filed a second motion for summary judgment requesting that the court find that its claim arose out of a "covered cause of loss" as that term applies to the Business Income (and Extra Expense) Coverage Form, thereby making up to $600,000 available to satisfy Bishops' claim for business interruption under the policy.

Penn National countered with a cross-motion requesting that the court enter summary judgment limiting the insurer's exposure to $5,000 with respect to the contracts claim in Count I and entering judgment in its favor on the bad faith claim in Count II. The second trial court declined to find any further exposure under the policy and denied Bishops' motion. It granted Penn National's motion with the following direction:

> 1.This Court enters a final order with respect to the claims asserted in Count I of the Complaint, declaring that Defendants' exposure for breach of contract is limited to a maximum of $5,000 and thereby enters judgment in favor of Plaintiff and against Defendant in the amount of $5,000; and
> 2.Count II of the Complaint, seeking damages for bad faith pursuant to 42 Pa.C.S. 8371 is hereby Dismissed with prejudice.

Bishops and Penn National then filed the cross-appeals.

Consistent with its argument, Penn National emphasized the concurrent cause provision on which it relied to deny Bishops' claim. Bishops framed the issues somewhat differently, but also consistent with its argument, to emphasize the effect of the Penn Pac Endorsement in establishing sewer and drain back-up as a covered cause of loss for the purpose of property damage and business interruption coverage.

The appeals court concluded that their questions merely presented alternative facets of the same issues - i.e., whether the Penn Pac Endorsement rendered sewer and drain back-up a covered cause of loss such as to supersede or invalidate the concurrent cause exclusion in the basic policy and to make available the $600,000 coverage that Bishops sought for losses incurred by reason of the business interruption that followed its physical loss.

It concluded:

In this case, the parties' claims test the construction of the insurance policy issued to Bishops by Penn National. "Generally, the proper construction of a policy of insurance is a matter of law which may properly be resolved by a court pursuant to a motion for summary judgment."

Thus, the issue of whether a claim is within a policy's coverage or barred by an exclusion is properly determined provided that the policy's terms are clear and unambiguous so as to preclude any issue of material fact.

The appeals court cited the state supreme court decision *Collister v. Nationwide Life Ins. Co.* (Pa. 1978). In that case, the Court observed that

Because the insurer is in the business of writing insurance agreements, the recent trend in insurance cases has been away from strict contractual approaches towards a view that insurance policies (and other insurance contracts) are no longer private contracts in the traditional sense (if they ever were)." The traditional contractual approach fails to consider the true nature of the relationship between the insurer and its insureds. Only through the recognition that insurance contracts are not freely negotiated agreements entered into by parties of equal status; only by acknowledging that the conditions of an insurance contract are for the most part dictated by the insurance companies and that the insured cannot "bargain" over anything more than the monetary amount of coverage purchased, "does our analysis approach the realities of an insurance transaction."

Because the policy at issue insured for "all risks" and Penn National sought to deny coverage on the basis of an exclusion in the policy, the insurer had to bear the burden of proof to show that the exclusion is unambiguous under the circumstances so as to comport with the reasonable expectations of the insured.

In support of its decision to deny coverage under the Penn Pac Endorsement and Business Income (and Extra Expense) Coverage Form, Penn National relied on the language of the concurrent cause exclusion, which provided that Penn National "will not pay for loss or damage caused directly or indirectly" by "water," either through flooding or through back-up from a sewer or drain.

The appeals court noted that, if the content of this exclusion had remained unaltered, application of its terms to the facts of the case would exclude coverage of both of the causes of Bishops' loss - and the matter of concurrent causation language would be moot.

With Bishops' purchase of the Penn Pac Endorsement, however, loss or damage caused by sewer or drain back-up became a covered cause of loss without qualification pursuant to the following language:

We will pay for loss or damage to Covered Property caused by a back up from a sewer or drain or an overflow from a sump within the building at the described premises.

The most we will pay for each location under this Additional Coverage is $5,000 for the sum of all expenses arising from back up or overflow during each 12 month period of the policy.

Significantly, this language removed Exclusion B.1.g.(3) of the basic policy as a bar to coverage for damage caused by sewer and drain back-up and makes no effort to restate the language that bars coverage on the ground of concurrent causation by another excluded cause of loss. This omission created some ambiguity unlikely to appear until the insured files a claim, confident in the notion that the endorsement he purchased rendered all aspects of the former exclusion void only to find that the insurer interprets his coverage far more narrowly.

That ambiguity became evident upon consideration of Exclusion B.1.g.(3) in its entirety:

B. EXCLUSIONS

1. We will not pay for loss or damage caused directly or indirectly by any of the following. Such loss or damage is excluded regardless of any other cause or event that contributes concurrently or in any sequence to the loss. ...

g. Water ...

(3) Water that backs up or overflows from a sewer, drain or sump;

Based on this language, the insured might reasonably conclude that the coverage he had purchased eliminated both the specified limitation in subsection g.(3), concerning sewer and drain

back-up, as well as the preliminary language in section B.1., concerning concurrent causation. Nevertheless, the insurer might concur only as to subsection g.(3) and, as Penn National did, deny coverage on the basis of the concurrent cause language.

Yet, Penn National's interpretation was not necessarily dispositive. Both section B.1. and subsection g.(3) were component parts of "Exclusion B.1.g.(3)." Although section B.1. retained meaning so long as any specific exclusion followed it, the language of subsection g.(3) depended on section B.1. for any semblance of linguistic coherence. On its own, subsection g.(3) was meaningless.

The appeals court concluded:

Thus, we can discern no reason why an insured who purchased the Penn Pac Endorsement in reliance on the sewer and drain back-up it provided might not conclude, quite reasonably, that the elimination of "Exclusion B.1.g.(3)" should not include elimination of the concurrent cause language as it applies to sewer and drain back-up.

Accordingly, we find the intent embodied in the Penn Pac Endorsement uncertain when applied to Exclusion B.1.g.(3), and subject to more than one reasonable interpretation even if the language it uses appears clear.

Consequently, we find both the Penn Pac Endorsement and Exclusion B.1.g.(3) latently ambiguous as they relate to one another. In view of this ambiguity, the failure of the Penn Pac Endorsement to restate the concurrent cause endorsement - or to otherwise delineate a portion of the Exclusion remaining - is highly probative of the manner in which we proceed and requires that we interpret the relevant provisions in favor of the insured.

In view of what the appeals court called "the evident linguistic joust between these controlling provisions of Penn National's policy," it found a significant indicator of the parties' intent - and the insured's expectations - in the fact that the insured paid an added premium for the coverage the Penn Pac Endorsement purported to unlock because the basic policy, in which the concurrent cause language appeared, would otherwise exclude coverage.

Thus, the insured purchased additional coverage ostensibly to make up for deficiencies in the basic policy only to find its claim denied not by virtue of any limitation on the coverage it bought but because ancillary language in the basic policy barred coverage for another excluded loss. Such a result struck the appeals court as a variant of the "sleight of hand" it had rejected in earlier decisions - in which

an insurer creates the appearance of coverage using an amendatory endorsement tailored to cover a stated risk only to deny coverage when that risk comes to fruition by citing language not suggested by the endorsement.

Given that the concurrent causes of loss, flooding and sewer and drain back-up, were ineluctably linked by the effect of a hurricane on a municipal drainage system, the appeals court found this point particularly salient.

No insured would purchase extra coverage for an added premium in the expectation that its claim under that coverage would be denied because the covered cause of loss, i.e., sewer and drain back-up, was itself caused by an excluded cause of loss, i.e. flood, when the two would naturally occur together. Nevertheless, the interpretation Penn National urges would validate just such an unseemly result and in so doing undermine the reasonable expectations of the insured.

In an earlier decision, the appeals court had apportioned the burden of proof to the insurer to disprove coverage under an "all risks" policy with a concurrent cause exclusion reasoning that

[a]ny other construct would merely encourage insurers to orchestrate a shell game of exclusions and exceptions to exclusions (or "named peril coverage extensions"), ...in full recognition that the ultimate risk of loss would rest upon the insured notwithstanding his payment of an extra premium for coverage he reasonably thought he was getting.

The appeals court's analysis, based on the express language of the Penn Pac Endorsement, found little basis for the continued viability of the concurrent cause exclusion to sewer and drain back-up under the policy.

The court also noted that the decisions Penn National cited in defense of its position had involved situations in which the concurrent causation language appeared in the basic policies; in the Bishops case, the language appeared in the Endorsement. According to the court:

Given our determination that the concurrent cause language of Exclusion B.1.g.(3) is not enforceable to exclude coverage of the loss Bishops sustained, our inquiry shifts to the extent of coverage available to Bishops under both the Penn Pac Endorsement and the Business Income (and Extra Expense) Coverage Form. This issue grounds Bishops' second question on appeal. Bishops contends that "once it is [established] that sewer back-up is a 'covered cause of loss," coverage follows automatically to the limits of both the [Penn Pac] Endorsement ($5,000 for physical damage and $25,000 for extra expenses) and the Business Income (and Extra Expense) Coverage Form ($600,000)."

The court's analysis recognized that Bishops had purchased an "all risks" policy. Accordingly, the policy's definition of a "covered cause of loss" was broad, as stated in the policy's "Causes of Loss - Special Form:"

A. COVERED CAUSES OF LOSS

When Special is shown in the Declarations, Covered Causes of Loss means RISKS OF DIRECT PHYSICAL LOSS unless the loss is:

1. Excluded in Section B., Exclusions; or

2. Limited in Section C., Limitations; that follow

Although loss by "back[] up from a sewer, drain or sump" was initially excluded by "Section B., Exclusions," Bishops' purchase of the Penn Pac Endorsement rendered such an event covered subject to a limitation on the amount of "expenses" incurred which resulted from "loss or damage to Covered Property" and a further limitation on "Extra Expense."

As recognized by the parties in their Stipulations, the applicable language of the Penn Pac Endorsement specified the scope and limitations of its coverage as follows:

II. ADDITIONAL COVERAGES

The following Additional Coverages are added:

e. Back Up of Sewers and Drains

We will pay for loss or damage to Covered Property caused by a back up from a sewer or drain or an overflow from a sump within the building at the described premises.

The most we will pay for each location under this Additional Coverage is $5,000 for the sum of all expenses arising from back up or overflow during each 12 month period of the policy.

II. ADDITIONAL COVERAGES

g. Extra Expense

We will pay up to $25,000 for the actual and necessary Extra Expense you sustain due to direct physical loss or damage to property, including personal property in the open (or in a vehicle) within 100 feet, at premises which are described in the Declarations caused by or resulting from any Covered Cause of Loss.

Although the Endorsement offered no definition of "expense," as that term was used in section II.e. (Back Up of Sewers and Drains), it did provide the following definition for "Extra Expense":

g. Extra Expense

Extra Expense means necessary expenses you incur during the "period of restoration" that you would not have incurred if there had been no direct physical loss or damage to property caused by or resulting from a Covered Cause of Loss.

On the basis of this definition, the appeals court concluded that the foregoing provisions of the Endorsement address coverage for "business expenditure[s] chargeable against revenue[.]" Such expenditures must have been incurred either "due to direct physical loss or damage to [covered] property [from a covered cause of loss];" i.e. expense, or "would not have [been] incurred if there had been no direct physical loss or damage to [covered] property [from a covered cause of loss];" i.e., extra expense.

Indeed, these definitions comported seamlessly with the Endorsement's delineation of the remaining elements of "extra expense," which describe the "specific period" for which such "expenses" remain covered under the policy.

Significantly, the Endorsement's descriptions made no reference to any form of detriment suffered by the insured other than expenditures. If the endorsement's descriptions were in fact intended to address other forms of detriment, the court would expect the use of more inclusive language. On this matter, it concluded:

Therefore, we conclude that the provisions of the Endorsement at issue provide no coverage for other forms of detriment and cannot be interpreted to limit coverage of them. Thus, while the Penn Pac Endorsement covers "expenditures" as costs incurred by the insured up to $5000 as "expenses" and an additional $25,000 as "extra expenses," other forms of loss remain recoverable under other provisions or endorsements of the policy. We conclude accordingly that the trial court ruled correctly in awarding coverage for Bishops in the amount of $5000 but erred in failing to award further coverage for "extra expenses."

Bishops argued that coverage for other forms of loss, i.e., loss of revenue through business interruption occasioned by the drain and sewer back-up, were eligible for coverage under the policy's Business Income (and Extra Expense) Coverage Form. And, under this Business Income Form, the policy covered loss of business income up to $600,000 - provided that the loss arose from a "Covered Cause of Loss."

The policy defined "Business Income" as follows:

A. COVERAGE

Business Income

Business Income means the:

a. Net Income (Net Profit or Loss before income taxes) that would have been earned or incurred; and

b. Continuing normal operating expenses incurred, including payroll.

Significantly, the Business Income (and Extra Expense) Coverage Form did not define "covered cause of loss" in a way unique to this provision of the policy but incorporated the definition that appeared in the Causes of Loss - Special Form, which appeared to provide default definitions for the remainder of the policy. The court wrote:

As we discussed, supra, the Causes of Loss - Special Form defines a "covered cause of loss" to include all "risks of direct physical loss" unless the loss is excluded in "Section B., Exclusions."

Although the risk of loss by sewer and drain back-up had been excluded pursuant to Section B.1.g.(3), that exclusion ceased upon Bishops' purchase of the Penn Pac Endorsement, which, as we have discussed, deactivated the sewer and drain back-up exclusion and affirmatively granted coverage for sewer and drain back-up. Accordingly, sewer and drain back up was rendered a "risk of direct physical loss," see Causes of Loss - Special Form, not "excluded in Section B., Exclusions[,]" and therefore, a "Covered Cause of Loss" under the Causes of Loss - Special Form. As the Business Income (and Extra Expense) Coverage Form relies expressly on that Causes of

Loss - Special Form to define covered causes of loss, sewer and drain back-up was rendered covered upon Bishops' purchase of the Penn Pac Endorsement.

So, it affirmed the orders of the respective trial judges to the extent they had found a right to coverage for "expenses" under the Penn Pac Endorsement, but vacated those orders to the extent that they found no coverage for "extra expenses" under the Penn Pac Endorsement or under any provision of the Business Income (and Extra Expense) Coverage Form.

It was a big win for the insured.

The Bunning-Bereuter-Blumenauer Flood Insurance Reform Act of 2004

Authorized grant programs to mitigate properties that experienced repetitive flooding losses. Owners of these repetitive loss properties who do not mitigate face higher premiums.

Biggert–Waters Flood Insurance Reform Act of 2012

The Biggert–Waters Flood Insurance Reform Act of 2012 was "designed to allow premiums to rise to reflect the true risk of living in high-flood areas." The bill was supposed to deal with the "insolvency" of the National Flood Insurance Program by requiring the premiums to reflect real flood risks. The result was a 10 fold increase in premiums. At present, $527 billion worth of property is in the coastal floodplain. The federal government heavily underwrites the flood insurance rates for these areas. The law "ordered FEMA to stop subsidizing flood insurance for second homes and businesses, and for properties that had been swamped multiple times." These changes were to occur gradually over the course of five years. FEMA was also instructed to do a study on the affordability of this process, a study which it has failed to complete.

Homeowner Flood Insurance Affordability Act of 2014

The Homeowner Flood Insurance Affordability Act of 2014 (S. 1926) was a United States Congress bill that would have delayed the increases in flood insurance premiums that were part of the Biggert–Waters Flood Insurance Reform Act of 2012. The reforms from that law were meant to require flood insurance premiums to actually reflect the real risk of flooding, which led to an increase in premiums. At the time of the bill, the National Flood Insurance Program was $24 billion in debt.

The bill passed in the United States Senate during the 113th United States Congress, but was superseded by a similar bill which had originated in the United States House of Representatives. That bill ultimately became law as the Homeowner Flood Insurance Affordability Act of 2013.

Chapter 10 Federal Emergency Management Agency (FEMA)

The Federal Emergency Management Agency, commonly known as FEMA, was originally an independent agency that became part of the new Department of Homeland Security in March of 2003. It is the responsibility of FEMA to respond to disasters, whether it happens to be a hurricane, an earthquake, or even terrorism. Any disaster that has physical and/or financial consequences will fall under FEMA’s authority. It is FEMA’s responsibility to lead the efforts to prepare the nation for all hazards and effectively manage federal response and recovery efforts following a disaster. They also have the responsibility of managing the National Flood Insurance Program.

FEMA has statutory authority. Robert T. Stafford Disaster Relief and Emergency Assistance Act, PL 100-707, signed into law November 23, 1988 amended the Disaster Relief Act of 1974, PL 93-288. This act constitutes the statutory authority for most Federal disaster response activities, especially

as they pertain to FEMA and FEMA programs.

FEMA has more than 2,600 full time employees working at FEMA headquarters in Washington D.C., at regional and area offices, the Mount Weather Emergency Operations Center, and the National Emergency Training Center in Emmitsburg, Maryland. There are additional 4,000 or so standby assistance employees who are available for deployment following a disaster. FEMA may work in partnership with other organizations that are part of the nation's emergency management system. This would include state and local emergency management agencies and the American Red Cross. The general contact address for FEMA is 500 C Street SW in Washington D.C. 20472.

FEMA was created from the Congressional Act of 1803, which is considered the first piece of disaster legislation. It provided assistance to a New Hampshire town following an extensive fire. Successive legislation (more than 100 of them) followed in response to hurricanes, earthquakes, floods, and other natural disasters.

Eventually, a federal approach to such disasters became favored by most of the population. By the 1930s, The Reconstruction Finance Corporation was given authority to make disaster loans for repair and reconstruction of certain public facilities following an earthquake. Eventually this also covered other types of disasters. In 1934, the Bureau of Public Roads was given authority to provide funding for highways and bridges damaged by natural disasters. The Flood Control Act was passed that gave the U.S. Army Corps of Engineers greater authority to implement flood control projects, such as dams. It eventually became evident that the piecemeal approach to disaster assistance needed something to pull all pieces of legislation together, so the President was authorized to coordinate activities between federal agencies.

The 1960s and early 1970s brought massive disasters requiring major federal response and recovery operations by the Federal Disaster Assistance Administrations, established within the Department of Housing and Urban Development (HUD). There were both hurricanes and earthquakes: hurricane Carla in 1962, Hurricane Betsy in 1965, Hurricane Camille in 1969, and Hurricane Agnes in 1971. Earthquakes in 1964 in Alaska and one in San Fernando in Southern California in 1971 caused severe damage in addition to the hurricanes. In 1968, the National Flood Insurance Act gave new flood protection to homeowners. In 1974 the Disaster Relief Act established the process of Presidential disaster declarations.

Historically the Federal government has tried to control the flow of the nation's waterways by using structural methods such as dams, levees, and dikes. While there was some success with these methods they could not prevent other types of flooding disasters such as Hurricane Katrina brought. Every time a hurricane or other disaster occurred, they brought with them severe financial losses, which had to be at least partially covered by Federal disaster assistance programs.

These problems were compounded by the fact that flood insurance was not readily available to people in the private sector. The insurance industry was reluctant to provide coverage for the peril of flood since it was catastrophic in nature and it also tended to produce an adverse selection of risk. Obviously, flood insurance was likely to be purchased by those most prone to flooding rather than those who were unlikely to experience the event.

Community Participation

While community can mean many things, as it relates to flood insurance, it means a political entity that has the authority to adopt and enforce floodplain management ordinances for its jurisdiction. Therefore, community would mean a town, city or rural jurisdiction such as a county, borough, or parish.

The floodplain management requirements include the requirement of community evaluation of the building site prior to a building being erected. The evaluation would include the location of the building site in relation to the floodplain or floodway. Since there is no federal law regulating enforcement of flood building codes, enforcement of floodplain management rules are the responsibility of the different communities. Each state delegates enforcement authority to the various types of communities within its jurisdiction.

Flood insurance is not necessarily available everywhere; availability is tied to mitigation and floodplain management by the community. Once a community determines their potential for flooding and their need to make flood insurance available to those who live there, it contacts FEMA and requests admission to the NFIP. Anyone wishing to see if a particular community participates in the National Flood Insurance Program can go to http://www.fema.gov/fema/csb.shtm. Community participation determines whether buildings are eligible for Regular Program coverage limits, reduced limits if in the Emergency Program, subject to surcharge if on Probation or if the policy will be non-renewed should the community be suspended.

Emergency Program

Once a community agrees to adopt and enforce minimum floodplain management ordinances, it will likely be admitted into the NFIP Emergency Program. Acceptance is the first stage of the Program.

In the Emergency Program there is a limited amount of flood insurance available for all insurable buildings and their contents and, if appropriate, a map identifying known floodplains will be issued. Rates are broken down into either (1) Residential or (2) Non-residential.

During the Emergency phase, FEMA will perform a Flood Insurance Study. This study includes an in-depth evaluation of the community’s flood hazards. It will identify the floodway and floodplain, and establish a Base Flood Evaluation, called a BFE.

The Flood Insurance Study will provide information for a Flood Insurance Rate Map, called FIRM. This map shows greater detail regarding the floodplain and identifies the various flood risk zones. Both the Flood Insurance Study and the Flood Insurance Rate Map are presented to the community for approval. If the community agrees with the conclusions of the two, it may adopt them as they are written. Or, if the community does not completely agree with them, it may provide additional scientific data to amend them.

When FEMA and the community agree with the Flood Insurance Study and the Flood Insurance Rate Map the community must then decide if it wishes to continue participating in the NFIP. It is possible to withdraw at this time if the community wishes to. On the other hand, if the community decides to continue it must formulate and adopt more comprehensive FEMA floodplain management ordinances and agree to enforce them.

At this point, the community must establish a building permit system. No construction, including remodeling, is permitted unless the contractor or owner first obtains a building permit from a

designated floodplain administrator or community official.

Before issuing the building permit, the community official must determine if the proposed building site is inside or outside of a Special Flood Hazard Area. If the building site is outside of the area, no flood mitigation restrictions will apply. If the building site is located within a Special Flood Hazard Area, however, the community official or administrator will require the building to be elevated or flood proofed if it is a commercial building to the standards required in the community's floodplain management ordinance.

This system helps to accomplish the mitigation goals of the program. It allows the community to control construction in flood prone areas. At the very least it requires that buildings be elevated or flood proofed above the anticipated depth of water in a base flood event.

Regular Program

Once a community adopts the floodplain ordinances, it qualifies for admission into the National Flood Insurance Program (NFIP) Regular Program. The regular phase of the Program allows for increased amounts of insurance coverage.

It is necessary for the community to continue to enforce its floodplain ordinances if it wishes to remain in good standing in the NFIP. There will be periodic visits from FEMA and the state floodplain management coordinators to verity that enforcement of the ordinances is occurring. Should the community be unable or unwilling to enforce the ordinances it could be placed on probation. During the probationary period, the community is given an opportunity to correct any deficiencies that were cited. When a community is placed on probation, all new and renewal policies are subject to a $50 surcharge.

If the deficiencies have not been corrected by the end of the probation period the community could be suspended from the NFIP by FEMA. When a community is suspended, in force policies become non-renewable and new policies may not be written.

The Flood Disaster Protection Act of 1973 and the NFIRA of 1994 limits the availability of loans and disaster assistance for buildings located in Special Flood Hazard Areas (SFHA) unless the borrower purchases and maintains flood insurance coverage on the buildings for the term of the loan. If it is a disaster grant, the borrower must maintain flood insurance coverage for as long as they own the property. Flood insurance would not be available for buildings located in non-participating communities so participation is desirable. If a participating community is suspended from the NFIP, it then becomes non-participating so building owners could no longer be eligible for federal disaster assistance, federally guaranteed or federally regulated loans. It is not surprising therefore, that suspension can adversely affect the community. An individual that wishes to find out if his or her community participates may go to the Community Status Book (which lists participating and mapped non-participating communities) by state at www.fema.gov. It is available at that web address through the FEMA Map Service Center.

Community Rating System

The National Flood Insurance Program (NFIP) Community Rating System (CRS) is not mandatory; it is a voluntary incentive program that recognizes and encourages community floodplain management activities that exceed the minimum NFIP requirements. The premium for flood insurance is discounted since there is reduced flood risk as a result of community actions aimed at

meeting the Community Rating System goals of:

- Reducing flood losses;
- Facilitating accurate insurance rating; and
- Promoting the awareness of flood insurance.

An individual wishing to gain additional information concerning the community's CRS status and premium rates may go to http://fema.gov/nfip/crs.shtm.

Building Eligibility

Even when a community is participating in the National Flood Insurance Program, all buildings will not necessarily be insurable. Buildings in violation of floodplain management ordinances, new construction located in coastal barrier resource areas, buildings built over water, container type buildings, and buildings partially underground may not qualify. Buildings that are in compliance will have met specific requirements. Exact criteria may be accessed in the Flood Insurance Manual.

Many types of buildings can be eligible, including manufactured homes and travel trailers located in high flood risk areas, as long as they meet the criteria that applies to them. The eligibility or ineligibility of buildings depends upon meeting specific criteria as set down by the NFIP for flood insurance qualification. A building's status can be determined by comparing the specific building risk factors with the underwriting criteria in the General Rules Section of the Flood Insurance Manual. Additional assistance can be obtained from the underwriting department of the Write Your Own Company or Direct Side Facility, if applicable. Most buildings will be eligible if they are constructed in compliance with the community's building requirements and are located in an NFIP participating community.

Coastal Barrier Resources System and Other Protected Areas

There are specific areas where development is discouraged. The Coastal Barrier Resources Systems (CBRS) and Other Protected Area (OPA) boundaries were mapped out and established by the Department of Interior and the U.S. Fish and Wildlife Service (FWS). Flood insurance may not be available for buildings and their contents located in these locations. Such areas are designated by Congress to protect the coastline. The Coastal Barrier Resources System (CBRS) hopes to discourage development in those specially designated areas. An individual may not purchase a flood policy in the CBRS unless the structure was built prior to the area designation. These areas are shown on Flood Insurance Rate Maps (FIRMs) with backward slating diagonal lines patterns, both solid and broken, and are commonly referred to as "CoBRA Zones." Agents writing flood insurance policies must take special care for any location within these areas. Agents may consult the Community Status Book in NFIP Flood Insurance Manual's listing of communities (which have identified OPAs and CBRS areas) at htt://fema.gov/fema/csb.shtm.

These designations are not just about protecting property located in flood zones. FEMA mitigation measures, such as the elevation of buildings, can offer some protection from flood, but the damage done to fragile coastlines by development has little to do with flooding. Aquatic habitats, wetlands, marshes, estuaries, and inlets experience unavoidable damage when human

populations move in. These areas are home for wild life and ecosystems that support local fishermen and provide recreational use; they can be lost forever if they are not properly protected. Coastal barriers are unique landforms that also serve as the mainland's first line of defense against the impacts of coastal storms and erosion. While older structures may exist in such areas, it is not likely that new construction would be allowed there. In fact, by law, Federally regulated mortgage lending and Federal disaster assistance is not available in these areas. This includes federally backed flood insurance for new construction or substantial improvements in CFRS or OPAs.

There are some exceptions to the availability of federally backed flood insurance in CFRS and OPAs. Eligibility for Federal flood insurance depends upon whether the community where the building is located has Coastal Barriers Resources Act of 1982 (CBRA) or the Coastal Barrier Improvement Act of 1990 (CBIA) designated areas. Under the 1982 Act a building in a CBRS area is eligible for coverage if the following requirements are met:

1. A legally valid building permit for the construction was issued prior to October 1, 1983; and

2. The building was built (walled and roofed) prior to October 1, 1983; and

3. The building was not substantially improved or substantially damaged on or after October 1, 1983.

Eligibility under the 1990 Act for buildings in a CBRS area or Other Protected Areas requires:

For CBRS areas:

- A legally valid building permit for the construction of the building that was issued prior to November 16, 1990; and
- The actual start of construction of the building was prior to November 16, 1990; and
- The building was not substantially improved or substantially damaged on or after November 16, 1990.

For OPAs:

- A legally valid building permit for the construction of the building that was issued prior to November 16, 1991; and
- A building in the OPA was built (walled and roofed) no later than November 16, 1991; and
- The building was not substantially improved or substantially damaged after November 16, 1991.
- Or, the building is used in a manner consistent with the purpose for which the area is protected, regardless of the date of construction.

Neither of these prevents private development, financing or private flood insurance, if it is available in these areas. Of course, any development is subject to all applicable state and local laws, regulations and building codes.