7 – Insurance Policy Fundamentals

**1 - Ideally Insurable Loss Exposures**

**Objective**: describe the characteristics of an ideally insurable loss exposure.

Although insurers insure any loss exposures, not all loss exposures are ideally insurable. To be insurable, a loss exposure should have certain characteristics.

Most insured loss exposures do not completely embody all of the characteristics of an ideally insurable loss exposure. However, the criteria are useful to an insurer when deciding to offer new coverages or to continue offering existing coverages.

Six Characteristics of an ideally insurable loss exposure:

1.) Pure Risk – involves pure risk, not speculative risk

2.) Fortuitous losses – subject to fortuitous loss from the insured’s standpoint

3.) definite and measurable – subject to losses that are definite in time, cause, and location that are measurable.

4.) Large number of similar exposure units – one of a large number of similar exposure units

5.) Independent and not catastrophic – not subject to a loss that would simultaneously affect many other similar loss exposures; not catastrophic

6.) Affordable – premiums are economically feasible

**Pure Risk**

**The first characteristic of an ideally insurable loss exposure is that it should be associated with pure risk, not speculative risk. Pure risk entails a change of loss or no loss, but no chance of gain**. Conversely, a speculative risk presents the possibility of loss, or gain. A purpose of insurance is to indemnify the insured for a loss, not to enable the insured to profit from the loss. Indemnification is the process of restoring the insured to a pre-loss financial condition. Limiting insurance coverage only to pure risk reduces the complexity of the loss exposures insured by the policy in two situations. Having a loss or not having a loss.

**Fortuitous Losses**

The second characteristic of an ideally insurable loss is that the loss associated with the loss exposure should be fortuitous (occurring by chance) from the insured’s standpoint.

Some causes of loss may be fortuitous from one point of view only. For example, vandalism and theft are intentional (and therefore not fortuitous) from the perspective of the individual or organization committing the acts. However, vandalism and theft are fortuitous (and insurable) from the victim’s standpoint because the victim did not intend or expect these acts to occur. Other causes of loss are fortuitous regardless of the perspective from which they are examined, such as naturally occurring events, windstorms, hail or lightning.

**For a loss to be fortuitous, the insured cannot have control over whether or when a loss will occur**. If the insured has control, the insured might have an incentive to cause a loss. This is known as moral hazard. Arson committed by an insured is not a fortuitous act. Ideally, insurance is suitable for situation in which there is reasonable uncertainty about the probability or timing of a loss without the threat of a moral hazard. If insureds were compensated for losses they cause, they might be encouraged to generate losses for property they no longer wish to own. This practice could undermine the pricing structure for insurance and increase insurance premiums for all policyholders.

**Definite and Measurable**

The third characteristic of an ideally insurable loss exposure is that it is definite and measurable.

**Three components are required for a loss exposure to be definite: time, cause, and location. The insurer must be able to determine the event (or series of events) that led to the loss, when the loss occurred, and where the loss occurred**. Example, you left your car parked in a parking lot and upon returning to the vehicle you discover that the driver’s side door is badly damaged. You can state that this happened on this date, and this location, and the damage and transfer of paint chips, you can determine another vehicle hit your car.

All insurance policies have a policy period that specifies the precise dates and times of coverage. A typical property-casualty policy has a policy period ranting from 6-month to 1-year. After receiving notice of a claim, the insurer usually needs to determine that the event occurred during the policy period. For some events, this may be a difficult process; insurers are reluctant to insure such events. Example, an insurer considering insuring a gas station against environmental pollution. A definite environmental pollution loss would be a fire that ruptured an underground gas tank and caused gas to leak into the surrounding soul. However, had no fire occurred and had the tank been slowly leaking for an indeterminate number of years, it would be impossible to pinpoint the exact date or cause of the pollution. Therefore, it may be impossible to determine whether the event occurring during the policy period. Because they are not definite, these types of loss exposures are not ideally insurable.

*A loss exposure also needs to be measurable to be ideally insurable. Insurers cannot determine an appropriate premium if they cannon measure the frequency or severity of the potential losses*. A house fire is a measurable loss exposure. Underwriters can analyze data from past fire losses to single-dwelling, wood-frame homes within a set geographic area. From the analysis, frequency and severity patterns are used to determine potential fire losses and the premium needed. In addition, the cost to repair or replace a house damaged by fire can be objectively measured before a loss, and coverage can be priced accordingly.

Conversely, contagious diseases are an example of a potential exposure that is difficult to measure. Flu viruses mutate constantly. The strength of the virus, as well as the group susceptible, may vary from one flu season to the next. Also, the geographic territory where the virus strikes can vary from year to year. All of these factors make it difficult for an underwriter to measure future losses*. Insurers are reluctant to insure losses that are highly uncertain without substantial compensation (high premiums)*.

**Large Number of Similar Exposure Units**

**The fourth characteristic of an ideally insurable loss exposure is that the loss exposure is one of a large number of similar exposure units. Some common loss exposures that satisfy this requirement include homes, offices, and automobiles. Each exposure unit has a value that can be at risk when exposed to loss**. ***A unique vehicle***

Joe purchases a single-family home for $300,000. He faces loss exposures of fire, theft, burglary, windstorm, hail, collapse, and so forth. His exposure is the value of his home. If the home were destroyed by fire, he could not afford to replace it. This risk is transferred with the purchase of a homeowner’s insurance policy. **The insurer does not want to insure only Joe’s home, but rather thousands of single-family homes that face similar exposures. Based on past losses, the insurer knows that although all homes have a fire exposure, only a small percentage will experience a fire loss. The insurer can therefore spread the risk of fire loss over its entire pool of insured homes and thereby maintain manageable premium levels**.

**Independent and Not Catastrophic**

**The fifth characteristic of an ideally insurable loss exposure is that it is independent and not catastrophic. Independent means that a loss suffered by one insured does not affect any other insured or group of insureds**. Example, Joe’s home is located in a large subdivision of 1,000 homes and is surrounded by a wooded area. Joe’s insurer would not want to insure all the homes in that subdivision because the forest fire loss exposure would put all the homes at risk of fire. The risk would not be independent for each home.

A catastrophic loss is severe; it involves numerous exposure units suffering the same type of loss simultaneously, with significant financial consequences for the insurer. Insurance operates economically because many insureds pay premiums that are small relative to the cost of the potential losses they could each incur. The cost can stay relatively small because insurers project that they will incur far fewer losses than the loss exposures they have. However, if a large number of insureds who are covered for the same type of loss were to incur losses simultaneously, the insurance mechanism would not operate economically and losses to the insurer could be catastrophic. Such as all the homes in a flood zone area, the loss would not be independent because all of the homes are exposed.

Example, to avoid catastrophic hurricane loss, an insurer will diversify the homes and businesses it insurers and will not have a large concentration in any one geographic area. Single events or a series of events can also present catastrophic risk to an insurer. Similarly, a small insurer should not insure a multimillion-dollar property, such as an oil refinery. Although the loss exposure may be independent of the other properties the insurer has chosen to insure, a loss at such a single location may cause the insurer severe financial difficulty.

**Affordable**

**The final characteristic of an ideally insurable loss exposure is that the insurer is able to charge an economically feasible premium – one that the insured can afford to pay. Because of this constraint, loss exposures involving only small losses, as well as those involving a high probability of loss, are generally considered uninsurable.**

Writing insurance to cover small losses may not make sense when the expense of providing the insurance probably exceeds the amount of potential losses. Insurance covering the disappearance of office supplies, for example, could require the insurer to spend more to investigate and issue claim checks than it would for the insured to simply absorb the cost of replacing the supplies.

It also may not make sense to write insurance to cover losses that are almost certain to occur. The premiums would probably be as high as or higher than the potential amount of the loss, such a wear and tear on an automobile. Homes in a flood zone, only those who believe they are at risk for a flood loss would purchase the flood endorsement, the insurer will not be able to offer an economically feasible premium.

**2 - Distinguishing Characteristics of Insurance Policies**

**Objective:** Describe the following characteristics of insurance policies including common exceptions to these characteristics: Indemnity; Utmost Good Faith; Fortuitous Losses; Contract of Adhesion; Exchange of Unequal Amounts; Conditional; Nontransferable.

An insurance policy is a formal written contract by which an insurer provides protection if an insured suffers specified losses. Insurance policies display certain distinguishing characteristics not often found in other types of contracts. Some distinguishing characteristics that apply to insurance policies are also called insurance principles because they adhere to the economic theory behind the business of insurance.

**The distinguishing characteristics of insurance policies are these:**

* **Indemnity**
* **Utmost good faith**
* **Fortuitous losses**
* **Contract of adhesion**
* **Exchange of unequal amounts**
* **Conditional**
* **Nontransferable**.

Although these characteristics are unique to insurance policies, not all insurance policies exhibit ever one of these characteristics.

**Indemnity**

The goal of an insurance policy is to indemnify (make whole) the insured who has suffered a covered loss. An insurance policy adheres to the principle of indemnity (insurance should provide a benefit not greater than the loss suffered by an insured); the policyholder should not profit from insurance*. This adherence of the principle of indemnity means that an insurance policy is a contract of indemnity (The insurer agrees in the event of a covered loss to pay an amount directly related to the amount of the loss).*

**In practice, an insurance policy does not necessarily pay the full amount necessary to restore an insured who has suffered a covered loss. Most insurance policies contain a dollar limit, a deductible, or other provisions or limitations that result in the insured’s being paid less than the entire loss amount.** Furthermore, insurance policies do not always indemnify the insured for the inconvenience, time and other nonfinancial expenses involved in recovering from an insured loss. The valuation method used to value the loss is also a major factor in determining the level of indemnity the insured receives from the policy.

**Some insurance policies violate the principle of indemnity. For example, certain policies are valued policies, not contracts of indemnity. Under the terms of a valued policy, the insurer agrees to pay a pre-established dollar amount in the event of an insured total loss. That dollar amount may be more or less than the value of the insured loss**, **which may over indemnify or over indemnify the insured**. Such as rare objects of art. Despite the fact that some policies do not adhere to the principle of indemnity**, in order to reduce or avoid moral hazards, insurance policies should not do either of these:**

* **Over indemnify the insured**
* **Indemnify insured more than once per loss**

**Insurance should Not Over Indemnify**

Insureds should be compensated, but not overcompensated (over indemnified), for a loss. Ideally the insured should be restored to approximately the same financial position that he or she was in before the loss. The principle of indemnity implies that an insured should not profit from an insured loss.

The potential for over indemnification can constitute a moral hazard. Insurers can reduce moral hazard (and thereby reduce the potential for over indemnification) by clearly defining the extent of a covered loss in the policy provisions and by carefully setting policy limits.

**Insureds Should Not Be Indemnified More than Once Per Loss**

Ideally, a loss exposure should be the subject on only one insurance policy and only one portion of that insurance policy. Multiple sources of recovery (payment from many policies or more than one portion of the same policy) could result in the insured’s over indemnification. To limit this, most policies contain clauses called “other insurance provisions” that limit source of recovery.

However, sometimes duplicate recovery is both available and justifiable. For example, people can be insureds under more than one policy when they carry multiple polices, such as auto and health insurance. If an insured who has overlapping coverage has been charged an actuarially fair premium for the duplicate portion of coverage, it may be unfair for an insurer to deny coverage simply because the insured has more than one policy. In some instances, prohibiting duplicate recovery for an insured could unfairly absolve the responsible parties from bearing the financial consequences of the loss.

Collateral source Rule – A legal doctrine that provides that the damages owed to a victim should not be reduced because the victim is entitled to recover money from other sources, such as an insurance policy. Example: if a person (the plaintiff) sue another (the defendant) for injuries suffered as a result of the defendant’s negligence and the court finds in favor of the plaintiff, it is not acceptable for the negligent party to avoid paying some or all of those damages because the plaintiff can also recover money under his or her own insurance policies.

**Utmost Good Faith**

**An insurance policy is generally more vulnerable to abuses such as misrepresentation or opportunism than other contracts, for two reasons; information asymmetry and costly verification.**

**Information asymmetry exists when one party to a contract has information important to the contract that the other party does not**. Example; a homeowner may know that an insured home is in a state of disrepair that makes a loss more likely.

To reduce information asymmetry, the insurer attempts to gather as much relevant information as possible during the underwriting process. Such as conducting and inspection to verify the condition of the property, if it is in a state of disrepair, the insurer may charge a high premium. However**, verification of information is often time consuming and expensive (costly verification). The more difficult or more costly it is to verify information provided by the insured, the less likely it is that the insurer will expend the resources to verify information**, and the information asymmetry will remain.

**Information asymmetry can lead to adverse selection**; that is, the insurer may improperly price insurance policies by charging a high-risk insured a lower than actuarially fair premium. Similarly, it may lead to the insurer’s issuing a policy on a loss exposure that it may not want to insure at all. Such situations can be prevented if all parties exercise the utmost good faith in the insurance transaction.

**Utmost good faith is an obligation to act with complete honesty and to disclose all relevant facts.** The characteristic of utmost good faith has its roots in early marine insurance transactions, when underwriters could not verify the condition of ships and their cargoes. Therefore, **insurance policies became agreements founded in the utmost good faith that the statements made by both the insured and the insurer could be relied upon as accurate fact**. Although the principle of utmost good faith has been eroded somewhat by court decisions, the doctrines of misrepresentation, fraud, and concealment inf insurance policies are based on utmost good faith.

The most common violations of the concept of utmost good faith in insurance policies involve fraud and/or buildup insurance claims filed by insureds. Fraud is the misrepresentation of key facts of a claim, and buildup is the intentional inflation of an otherwise legitimate claim.

**Fortuitous Losses**

**Fortuitous Losses are losses that happen accidentally or unexpectedly. For a loss to be fortuitous, reasonable uncertainty must exist about its probability or timing. For insurance purposes, the loss must be fortuitous from the insured’s standpoint.**

**In an insured knows in advance that a loss will occur and the insurer does not, the insured has information advantage over the insurer. This information asymmetry, is acted on by the insured (the insured purchases an insurance policy covering the known loss), promotes adverse selection, thereby changing the loss distribution in the pool the insurer insures. Therefore, the premium the insurer charges the pool is no longer actuarially fair, because the loss distribution on which the premium was based has changed**. Underwriting is designed to minimize the effect that adverse selection can have on the insurer’s loss distribution. One method of avoiding adverse selection is precluding coverages for losses that are not fortuitous.

Fortuitous losses are not necessarily covered by insurance. Many losses happen fortuitously but are not covered; Example, earthquake. It is fortuitous cause of loss that is excluded by most property insurance policies.

Many finite risk insurance contracts cover losses that have occurred but have not been settled. In such cases, some uncertainty remains about the final settlement values. For example, an auto manufacturer may have recalled a model because of a faulty part that was responsible for 50 accidents. Although the accidents have been reported, none of the claim have been settled. Both the auto manufacturer and insurer would have an estimate of the ultimate claims settlement amounts; however, there is still some uncertainty regarding both the timing and the amounts of the settlements. The insurer may be willing to provide liability insurance coverage to the auto manufacturer for these 50 accident after the fact for a very high premium because the insurer believes that it will be able to negotiate settlements that would make the transaction profitable.

**Contract of Adhesion**

The amount of negotiation required to formulate a contract varies widely. Some contracts are the result of extensive negotiation between parties, in which every clause is discussed before agreement is reached. Other contracts involve little or not negotiation. Between these two extremes are contract that contain some standard clauses, leaving the remainder of the contract to be negotiated.

Insurance policies typically involve little or no negotiation (except for unique loss exposures that require special underwriting consideration, such as highly valued property). An insurer generally chooses the exact working in the policies it offers (or uses the wording developed by an insurance advisory organization), and the insured generally has little choice but to accept it.

A basic insurance policy might be altered by endorsements, but the insurer or advisory organization also typically develops these endorsements. Consequently, a party who wants to purchase an insurance policy usually has to accept and adhere to the standard policy forms the insurer or advisory organization drafts. This typical insurance policy is, therefore, a contract of adhesion.

Courts have ruled that any ambiguities or uncertainties in contract are to be construed against the party who drafted the agreement because that party had the opportunity to express its intent clearly and unequivocally in the agreement. Therefore, unless the insured drafted the policy (which is rare), ambiguities in an insurance policy are interpreted in the insured’s favor. The insurer has a good-faith obligation to draft a policy that clearly expresses what it intends to cover. Any policy provision that can reasonably be interpreted more than one way can be considered ambiguous.

Some insurance policies are sometimes constructed with acceptable ambiguities. If an insurance policy can be interpreted in two different ways and the insurer is satisfied with either interpretation, no expansion of the policy is necessary to make it more precise.

**An important consideration affecting the interpretation of a contract’s ambiguity is the level of sophistication of the parties to the contract**. In cases concerning insurance policies, the level of sophistication of the insured has had these affects on court decisions:

* Unsophisticated insured – usually, the insurer has drafted a ready-made policy, and the insured has little or no control over the policy’s wording. This is true of most homeowners and personal auto insurance policies. Ambiguities in these cases are typically interpreted against the insurer. This is the case for most personal insurance consumers.
* Sophisticated insured – in a minority of cases, the insured (or its representatives) draft all or part of the insurance policy. Alternatively, the insurer and a sophisticated insured negotiate the policy wording. In these cases, the contract of adhesion doctrine may not apply. Courts do not necessarily interpret any ambiguity in the insured’s favor if the insured had some understanding and ability to alter the policy wording before entering the agreement. Sophisticated insureds include many medium to large organizations with dedicated risk management functions.

**The courts consider several factors when determining whether an insured can be considered sophisticated. These factors include:**

* **Size of the insured organization**
* **The size of the insured organization’s risk management department**
* **Use of an Insurance broker or legal counsel with expertise in insurance policies**
* **The relative bargaining power of the insured in relation to the insurer**

The most common examples of insurance policies that are not contracts of adhesion are manuscript policies or policies that contain manuscript forms. When the insured contributes to the precise wording of the contract, courts generally do not apply the standards that are common under contracts of adhesion.

*An extension of the contract of adhesion doctrine is the reasonable expectations doctrine, which is a legal doctrine that provides for ambiguous insurance policy clause to be interpreted in the way that an insured would reasonable expect. Such as the reasonable expectations doctrine is sometimes applied to the renewal of insurance policies* that contain a change from the original policy. Unless an oral or a written notification and explanation accompanies the renewal policy, the insured can reasonably expect that the renewal policy is the same as the expiring policy.

*The reasonable expectations doctrine is an important extension of the contract of adhesion doctrine because it accounts for the fact that most insureds are not practiced in policy interpretation.*  However, insureds should not rely on the reasonable expectations doctrine because not all courts recognize it.

**Exchange of Unequal Amounts**

Consideration is an element of any enforceable contract. For insurance policies, the consideration offered by the insured is the premium; the consideration offered by the insurer is the promise to indemnify the insured in the event of a covered loss. There is not requirement that the amounts exchanged be equal in value. In most insurance policies, the tangible amounts exchanged, the premium form the insured, and any payments made by the insurer, will be unequal

It is difficult to explicitly value the reduction in volatility of losses and the reduction in the maximum amount at risk that insurance policies provide for an insured because they vary baes on the insured’s level of risk aversion. However, when both the tangible and intangible values are jointly considered, the values exchanged between the insurer and insured are closer in value.

**An insurer makes sure that the tangible consideration exchanged by the insured for an insurance contract is equitable by charging a premium that is directly proportional to the insured’s expected losses on an actuarially sound basis.** This is often called the equitable distribution of risk costs. That is, the insured’s premium should be commensurate with the risk it presents to the insurer. By charging the appropriate premium, the insurer can ensure that the tangible consideration offered by the insured is equitable compared with the intangible consideration offered by the insurer.

*Finite risk insurance policies involve an exchange of amounts closer in value than other types of policies, because their premiums are often close to the present value of the limit stated on the policy*. Finite risk involves little or no actual risk transfer and often functions as a loan.

**Conditional**

**Insurance policies are conditional contracts because the insurer is obligated to pay for losses incurred by the insured only if the insured has fulfilled all of the policy conditions.** The insurer is not obligated to fulfill the insurance policy (pay for any covered losses) unless the insured meets this condition.

The most common exception to “the conditional nature of an insurance policy” occurs when the insurer is willing to waive some of the conditions of the insurance policy. This often occurs in practice. Example; an insurer may be willing to pay a claim without making an inspection, thereby waiving the condition that the insured make damaged property available for inspection.

**Nontransferable**

Insurance policies are sometimes referred to as “personal contracts” to indicate their nontransferable or non-assignable nature. An insurance policy is a contract between two parties; most property and liability policies contain a condition stating that the insured cannot assign (transfer) the policy to a third party without the insurer’s written consent.

Insurers sometimes transfer policies to other insurers. Insureds are notified of the transfer or assignment, but their approval is not required. For example, if an insured is getting out of a geographic area. Alternatively, an insurer can transfer all of its business if it is acquired by another insurer, or a state regulator can assign insurance policies from an insolvent insurer to other insurers that are licensed in that state.

Insurance policies typically do not contain any condition prohibiting the insurer from transferring or assigning the policy to a third party without the insured’s written consent. If insureds are not receptive to the transfer or assignment, they have 2 choices. They can cancel their policies and purchase from other insurers, or they may pursue claims through the courts based on the notion that the consideration offered by the transferee (new insurer) is lower than the consideration offered by the transferor (original insurer)

In essence, the insured would be claiming that the transferee’s claim-paying ability is not equal to the transferor’s. However, typically the consideration offered by the new insurer is equal to or greater than that of the original insured, improving the insured’s position. When a policy is transferred from an insolvent insurer, insureds’ coverage is more secure.

Some policies contain exceptions to the usual assignment condition in order to help insureds manage situations that arise in normal commercial operations. Example, ocean marine hull insurance policies typically contain a change of ownership clause, which states that the policy will terminate automatically with a change in the insured vessel’s ownership. However, this clause usually has an exception stating that the policy does not terminate if a change in ownership occurs while the vessel is at sea.

**3 – Structure of Insurance Policies**

**Objective:** Describe these approaches to insurance policy structure and how they can affect policy analysis: Self-contained and modular policies; Preprinted and manuscript polices; Standard and nonstandard forms; endorsements and other related documents

Understanding the various ways in which insurance policies can be structured helps insurance and risk management professionals analyze and interpret any particular policy.

The structure of an insurance policy can be either self-contained or modular. The form or forms used to make up a policy can be either preprinted or manuscript and either standard or nonstandard. In addition to forms, related documents of various types can be incorporated in a policy.

**Self-Contained and Modular Policies**

The basic structure of every property-casualty insurance policy can be classified as either self-contained or modular.

*A self-contained policy contains, within one document, all the provisions needed to make up a complete insurance policy*. Endorsements can be added to a self-contained policy to provide additional, optional coverages or to exclude unnecessary coverages. An endorsement is a document that amends an insurance policy.

A self-contained policy is appropriate for insuring loss exposures that are similar among many insureds. Private auto insurance, is typically provided in a self-contained policy (such as ISO Personal Auto Policy), it can be written for each insured in that state and potentially several different states. Endorsements such as towing and labor costs or customizing equipment coverage can be added.

A self-contained policy can be either a monoline policy or a package policy. A self-contained monoline policy is an insurance agent’s E&O liability policy. A self-contained package policy is a homeowners policy, in which provides both property and liability coverages.

A modular policy is created by combining a set of individual components, such as one or more coverage forms, one or more causes of loss form, and one or more conditions forms. The modular approach is often used in commercial insurance because the insured’s loss exposures are typically unique and require more customization of the insurance policy than is the case with other lines of insurance.

A modular policy can be either a monoline policy or a package policy. An example of a modular monoline policy is a commercial property policy that consists of a commercial property coverage form, a causes of loss form, a commercial property conditions form, and a common policy conditions form. An example of a modular package policy is a commercial package policy that consists of multiple forms for providing commercial property coverage, commercial general liability coverage, commercial auto coverage, and commercial crime coverage.

**The insured has the option of purchasing multiple standalone policies or a single package policy to cover the same loss exposures. However, relative to self-contained policies, modular polices have these advantages:**

* **Carefully designed and coordinated provisions in the various forms minimize the possibility of gaps and overlaps that might exist when several monoline policies are used**
* **Consistent terminology, definitions, and policy language makes coverage interpretation easier for the insured**
* **Fewer forms are required to meet a wide range of needs**
* **Underwriting is simplified because much of the basic information that must be analyzed applies to all lines of insurance**
* **Adverse selection problems can be reduced when the same insurer provides several lines of insurance for an individual insured**
* **Insurers often give a package discount when several coverages are included in the same policy**

**Insurance and risk management professionals might find policy analysis more difficult with multiple self-contained policies than with a single modular policy for these reasons:**

* **Multiple self-contained policies often use inconsistent terminology and have gaps and overlaps in coverage.**
* **Modular policies offer a better framework for policy analysis**

**Preprinted and Manuscript Forms**

The forms used to make up insurance policies can be classified as either preprinted forms or manuscript forms.

**Most insurance policies are assembled from one or more preprinted forms and endorsements. Preprinted forms are developed for use with many different insureds. Therefore, they refer to the insured in general terms (such as “the insured” or “you”) so that forms can be used in multiple insurance policies without customization. The declarations page then adds the specific information about the insured that customized the insurance policy**.

Using preprinted forms significantly reduces the paperwork necessary for an insurance policy. When the policy is issued, insurers send the insured the generic preprinted policy and the customized declarations page. The declaration page indicates the form number or numbers and edition dates of the insurer’s form or forms that apply to the insurance policy. When the insured update (for example, change deductibles) or renew their policies, the insurer can simply send the insured the new declarations pages without having to resend entire new policies.

Furthermore, if they are using preprinted forms, the insurer and its producer do not have to keep a complete duplicate of each insured’s entire policy in their files.

**Preprinted forms typically are interpreted as contracts of adhesion. The** wording of preprinted forms and endorsements is carefully chosen by the insurer (or developed by an advisory organization then adopted by the insurer). Courts tend to interpret any ambiguities in policy language in favor of the insured, because the insured did not have an opportunity to choose the policy wording.

**Manuscript forms are custom forms developed for one specific insured - or for a small group of insureds – with unique coverage needs.**

**If an insurance policy includes a manuscript form, it is often referred to as a manuscript policy. A manuscript policy can be specifically drafted or selected to cover a unique loss exposure or to customize regular coverage to meet an insured’s particular specifications.**

**Because the insurer and the insured develop policy language together, manuscript policies are not generally considered to be contracts of adhesion. Therefore, courts do not automatically interpret ambiguous policy provisions in the insured’s favor. Manuscript forms are the most difficult to interpret during policy analysis. These forms, because they often contain unique wording, can vary widely in their interpretation**.

Manuscript forms do not have the same history of court interpretations for insurance and risk management professionals to rely on during policy analysis. This fact can lead to differences between how an insurance risk management professional interprets a manuscript form and how the insured or courts will interpret the same form. Consequently, substantial delays in claim adjusting or strained relations between the insurer and the insured can occur. To reduce the likelihood of such problems, most manuscript forms are not individually composed but are adapted from wording of previously developed and used in standard form or other insurance policies.

**Standard and Nonstandard Forms**

*An insurer may use the standard forms that are also used by other insurer, or it may develop its own nonstandard forms.* A nonstandard form drafted or adapted by one insurer is sometimes called a company-specific or proprietary form.

*Insurance series and advisory organizations, such as ISO and the American Association of Insurance Services, have developed standard insurance forms for use by individual insurers. These standard forms are accompanied by portfolios of coordinated endorsements that apply necessary state variations or customize coverage. because they are widely used, standard forms provide benchmarks against which nonstandard forms ca be evaluated*.

Standardized forms are typically easier than nonstandard forms for insurance and risk management professionals to evaluate during policy analysis. Standard forms are widely used and usually have been more consistently interpreted by the courts than other forms. Furthermore, most professionals have more experience working with standard forms than nonstandard forms.

Many insurers have developed their own company-specific preprinted forms, especially for high volume lines of insurance (such as auto or homeowners) or for coverages in which the insurer specializes (such as recreational vehicle insurance). Other insurers use manuscript forms to provide nonstandard policy wordings for either individual customers or small groups of customers. *By their very nature, all manuscript forms are nonstandard forms. Nonstandard forms (whether preprinted or manuscript) include provisions that vary from standard-form provisions and often contain coverage enhancements not found in standard forms.*

Similar to preprinted standard forms, preprinted nonstandard forms are typically easier than manuscript forms for insurance or risk management professionals to evaluate during policy analysis. Although these preprinted forms are referred to as nonstandard, many of them are widely used by some of the largest insurers.

**Endorsements and Other Related Documents**

Documents other than insurance forms can become part of an insurance policy, either by being physically attached to or by being referenced within the policy. Subject to statutory and regulatory constraints, an insurance policy may incorporate a wide range of documents in addition to policy forms.

Endorsements, if added to the policy, form part of the policy. An endorsement may be a preprinted, computer printed, typewritten, or handwritten line, sentence, paragraph, or set of paragraphs on one or more pages attached to the policy. In rare cases, and endorsement may take the form of a handwritten note in the margin of the policy and e dated and initialed by an insured and the insurer’s authorized representative.

**Because endorsements are intended to modify a basic policy form, the endorsement provisions often differ from basic policy provisions. This difference can lead to questions of policy interpretations. These two general rules of policy interpretation apply to endorsements:**

* **An endorsement takes precedence over any conflicting terms in the policy to which it is attached**
* **A handwritten endorsement supersedes a computer-printed or typewritten one. Handwritten alterations tend to reflect true intent more accurately than do preprinted policy terms**

**In several lines of business, policies are issued with what many practitioners call “standard” endorsement included in the policy. These endorsements that are included with most of the policies written in that line. Because they are so common, they essentially become part of the basic policy form. In addition, certain states require state specific endorsements be included with every policy sold in that state.**

**An insurance application is the documented request for coverage, whether given orally, in writing, or electronically (over the internet). The application contains information about the insured and the loss exposures presented to the insurer**. Underwriters use the information provided on the application to decide whether to provide the requested insurance and, is so, to price the policy. Although the declarations page often contains much of the same information as the application, the insurer usually keeps the application to preserve the representations made by the insured. This application can be used, if necessary, to provide evidence of misleading or false material information supplied by the insured**. In some jurisdictions, statutes explicitly require that any written application be made par to the policy for certain lines of insurance**.

**In certain circumstances, the insurer’s bylaws are incorporated into an insurance policy. The policyholders of mutual and reciprocal insurers typically have some rights and duties associated with managing the insurer’s operations, and theses rights and duties are specified in the policy**.

**Insurance policies sometimes incorporate the insurer’s rating manual (or the insurer’s rules and rates, whether found in the manual or elsewhere) by referencing to it in the policy language**. Although the rules and rates themselves do not appear in the policy, reference to them makes them part of the policy.

**Other documents incorporated in insurance policies include premium notes (promissory notes that are accepted by the insurer in lieu of cash premium payment), inspection reports, and specification sheets or operating manuals relating to safety equipment or procedures**.

Any of these related documents can alter the forms that are included in a policy. Therefore, related documents make policy analysis more difficult for insurance professionals because they add to the volume and complexity of forms that must be evaluated. As the number of related documents grows, so does the likelihood that one or more of the documents may contradict, exclude or expand provisions in basic forms.

**4 – Policy Provisions**

**Objective:** Describe the purpose(s) and characteristics of each of these types of policy provisions in a property-casualty insurance policy: Declarations; Definitions; Insuring Agreement; Exclusions; Conditions; Miscellaneous Provisions

Every insurance policy is composed of numerous policy provisions. A policy provision is a contractual term included in an insurance policy that specifies requirements or clarifies intended meaning. Despite wide variation in property-casualty insurance policy provisions, each provision can typically be placed into one of 6 categories, depending on the purpose it serves. Comprehending the purpose(s) and characteristics of each of these categories of policy provisions assists insurance and risk management professionals in analyzing and interpreting insurance policies.

|  |  |  |
| --- | --- | --- |
| **Policy Provision Category** | **Description** | **Effect on Coverage** |
| **Declarations** | Unique information on the insured; list of forms included in the policy | **Outline who or what is covered, and where and when coverage applies** |
| **Definitions** | Words with special meanings in policy | **May limit or expand coverage based on definition of terms** |
| **Insuring Agreements** | Promise to make payment | **Outline circumstances under which the insurer agrees to pay** |
| **Conditions** | Qualifications on promise to make payment | **Outlines steps insured needs to take to enforce policy** |
| **Exclusions** | Limitation on promise to make payment | **Limit insurer’s payments based on excluded persons, places, things, or actions** |
| **Miscellaneous Provisions** | Wide variety of provisions that may alter policy | **Deal with the relationship between the insured and the insurer or establish procedures for implementing the policy** |

**Declarations**

Insurance policy declarations typically contain not only the standard information that has been “declared” by both the insured and the insurer but also information unique to the particular policy. The declarations may be only one page or several pages in length and typically appear in the front of an insurance policy. The declarations state important facts about the particular policy such as: Policy number, inception date; name of insurer; name of agent; name of insured(s); names of persons or organizations whose additional interests are covered; mailing address of insured; physical address and description of covered property or operations; numbers and edition dates of all forms and endorsements; dollar amounts of applicable policy limits; dollar amounts of applicable deductibles; rating information and the policy premium.

Sometimes endorsements also contain information similar to that contained in the declarations. Example, an endorsement to a homeowners policy may contain a “schedule” listing descriptions and limits of coverage for valuable pieces of personal property that need special insurance treatment.

**Definitions**

Most insurance policies or forms include a section that contains definitions of certain terms used throughout the entire policy or form. Boldface type or quotation marks are typically used in the body of the policy to distinguish words and phrases that are defined in the definitions section.

Many of the definitions that appear in insurance policies are there because of real or perceived ambiguity that has arisen regarding the use of those terms in previous policies.

Words and phrases defined within an insurance policy are interpreted according to their definitions in the policy. Undefined words and phrases are interpreted according to these rules of policy interpretation:

* Everyday words are given their ordinary meanings
* Technical words are given their technical meanings
* Words with established legal meaning are given their legal meanings
* Consideration is also given to the local, cultural, and trade usage meanings of words, if applicable

**Insuring Agreements**

Following the declarations, and possibly preceded by a section containing definitions, the body of most insurance policies begins with an insuring agreement which is a statement in an insurance policy that the insurer will, under described circumstances, make loss payment or provide a service.

Policies typically contain an insuring agreement for each coverage they provide. Consequently, package policies contain multiple insuring agreements. For example, the Personal Auto Policy of ISO contains a separate insuring agreement for each of the 4 parts of the policy. Part A – Liability; Part B – Medical Payments; Part C – Uninsured Motorists; Part D – Coverage for Damage to your auto.

The term insuring agreement is usually applied to statements that introduce a policy’s coverage section. However, “insuring agreement” can also be used to describe statements introducing coverage extensions, additional coverages, supplementary payments, and so on.

Comprehensive insuring agreements provide an extremely broad grant of unrestricted coverage that is both clarifies and narrowed by exclusions, definitions, and other policy provisions.

In commercial property insurance, a comprehensive insuring agreement is called special-form (or open perils coverage), and a limited insuring agreement is called either basic-form or broad-form coverage (or named perils coverage).

**The special-form coverage provides protection against causes of loss that are not specifically excluded. This comprehensive approach covers all the named causes of loss included in the basic- or broad-form coverage, as well as additional causes of loss that are not otherwise excluded**.

Limited insuring agreements restrict coverage to certain causes of loss or to certain situations. Exclusions, definitions, and other policy provisions serve to clarify and narrow coverage but may also broaden the coverage. **The limited insuring agreements in commercial property insurance are the named perils, specified perils, or specified causes of loss coverage, referred to as the basic-form or broad-form coverages. The basic form coverage protects against a list of named causes of loss,** and the broad-form coverage protects against the named causes of loss in the basic form plus some additional named causes of loss.

In liability insurance, a limited or single-purpose insuring agreement (which uses specific policy language to define the policy terms) applies to a limited number of incidents. In contrast, comprehensive liability insuring agreements are much broader and do no limit coverage to a particular location, operation, or activity. Additionally, policy provisions, such as exclusions, limit the coverage of these policies.

Many insurance policies include secondary or supplemental coverages in addition to the main coverage in the insuring agreement. These coverages are described by terms such as “coverage extensions”, “additional coverages”, or “supplementary payments”. The terms “coverage extensions” and “additional coverages” are often used in property coverages. “supplementary payments” clarify the extent of coverage for certain expenses in liability insurance. The provisions that express these secondary or supplemental coverages are considered insuring agreements.

**Exclusions**

Exclusions state what the insurer does not intend to cover. The word “intend” here is important; the primary function of exclusions is not only to limit coverage but also to clarify the coverages granted by the insurer. Specifying what the insurer does not intend to cover is a way of clarifying what aspects the insurer does not intend to cover. An exclusion can serve one or more of six basic purposes:

* **Eliminate Coverage for Uninsurable Loss Exposures** – Some loss exposures possess few, if any, of the ideal characteristics of an insurable loss exposure. The first purpose of exclusions is to eliminate coverage for loss exposures that are considered uninsurable by private insurers.
  + **War**
  + **Criminal acts committed by the insured**
  + **Normal wear and tear**
* **Assist in Managing Moral and Moral Hazards** – Both moral and morale hazards can cause individuals and organization to behave differently when they are insured because they do not have to assume the entire cost of a loss. These exclusions help insurers minimize theses hazards because they ensure that the individual or organization remains responsible for certain types of loss. ISO HO-3 Special Form excludes “any loss arising out of an act an “insured” commits or conspires to commit with the intent to cause a loss”, this exclusion reduces moral hazard incentives by eliminating coverage for intentional loss caused by an insured. Some exclusions assist in managing morale hazards by making insureds themselves bear the losses that result from their own carelessness; such as ISO HO eliminates coverage for property loss caused by “neglect of an insured” to use all reasonable means to save and preserve property at and after a loss”
* **Reduce Likelihood of Coverage Duplications** – Having two insurance policies coverage the same loss is usually unnecessary and inefficient. It is unnecessary because coverage under one policy is all that is needed to indemnify the insured (unless policy restrictions or limits of insurance preclude full recovery). It is inefficient because, at least in theory, each policy providing coverage for certain types of losses includes a related premium charge. Therefore, an insured with duplicated coverage is paying higher premiums than is necessary. Exclusions ensure that multiple policies can work together to provide complementary, not duplicate coverage and that insureds are not paying duplicate premiums.
* **Eliminate Coverages Not Needed by the Typical Insured** – Elimination of such coverages avoids the situation of all insureds having to share the costs of covering loss exposures that relatively few insureds have. Example; a typical auto owner or home owner do not operate private aircraft or rent portions of the family home for storage of others; business property. Therefore, homeowners ‘policies typically exclude coverage for such loss exposures. People who do have these loss exposures may be able to obtain coverage separately through endorsement to their policies or separate insurance policies. Insurers are not always permitted to exclude coverage for loss exposures not faced by the typical insurance purchaser. Example, insurers may want to exclude auto liability coverage for drivers who have accidents while driving under the influence. However, state insurance regulators are unlikely to approve such an exclusion because it tends to eliminate a source of recovery for the victims of drunken drivers. The effect is that auto policyholders who never drink and drive are required to share the costs of accidents caused by those that do.
* **Eliminate Coverage Requiring Special Treatment –** Such special treatment may entail underwriting, risk control, or reinsurance that is substantially different from what is normally required for the policy containing the exclusion. For example, commercial general liability policies issued to professionals are usually endorsed to exclude their professional liability exposures. These insureds can purchase separate professional liability insurance to cover claims alleging that they made errors or omissions in providing their professional services.
* **Assist in Keeping Premiums Reasonable –** Assist in keeping premiums at a level that a sufficiently large number of insurance buyers will consider reasonable. All exclusions serve this purpose to some extent. However, for some exclusions it is the primary or sole purpose. Excluded losses are not necessarily uninsurable. In many cases, few people are willing to pay the premiums necessary to include coverage for losses that ordinarily are excluded. Such as mechanical breakdown; this is an insurable loss exposure. In fact, may auto dealers, tire shops, and other various organizations offer insurance-like service warranties covering such loss exposures. The additional premium for this type of coverage might exceed the typical costs associated with these losses.

**Conditions**

Some policy conditions are found in a section of the policy titled “Conditions”, while others are found in other sections of the forms, endorsements, or other documents that constitute the policy.

In a policy’s insuring agreement, the insurer promises to pay to the insured, to pay on behalf of the insured, to defend the insured, and/or to provide various additional services. However, the insurer’s promises are enforceable only if an insured event occurs and only if the insured has fulfilled its contractual duties as specified in the policy conditions.

Examples of policy conditions include the insured’s obligation to pay premium, report losses promptly, provide appropriate documentation for losses, cooperate with the insurer in any legal proceedings, and refrain from jeopardizing an insurer’s rights to recover from third parties responsible for causing covered losses. If the insured does not comply with these conditions, then the insurer may be released from any obligation to perform some or all of its otherwise enforceable promises.

**Miscellaneous Provisions**

In addition to declarations, definitions, insuring agreements, exclusions and conditions, insurance policies often contain miscellaneous provisions that deal with the relationship between the insured and the insurer to help to establish working procedures for implementing the policy. However, such provisions do not have the force of conditions. Consequently, even if the insured does not follow the procedures specified in the miscellaneous provisions, the insurer may still be required to fulfill its contractual promises.

Miscellaneous provisions often are unique to particular types of insurers.

* A policy issued by a mutual insurer is likely to describe each insured’s right to vote in the election of the board of directors
* A policy issued by a reciprocal insurer is likely to specify the attorney-in-fact’s authority to implement its power on the insured’s behalf

**5 – Policy Analysis**

**Objective**: Describe to primary methods of insurance policy analysis

Each pre-loss question posed or post-loss claim filed by an insured is a unique situation that may require a review of policy provisions.

Insurance professionals should conduct a pre-loss policy analysis to prepare themselves to answer and insured’s coverage question and to ensure that the policy being sold is appropriate for the insured’s loss exposures. Insureds should conduct per-loss policy analysis to verify that the policy they’re purchasing adequately addresses their loss exposures. After a loss, the insurer must analyze the policy to determine whether it covers the loss and, if necessary, the extent of coverage the policy provides.

**Pre-Loss Policy Analysis**

Pre-loss policy analysis almost exclusively relies on scenario analysis to determine the extent of coverage (if any) the policy provides for the losses generated by a given scenario. **For insureds, the primary source of information for generating loss scenarios for analysis is their past loss experience. If the insured has never suffered a loss that triggered insurance coverage, friends, neighbors, co-workers, and family members can also provide information about their experience with losses and the claims process.**

**Another source of information for the insured’s scenario analysis is the insurance producer or customer service representative consulted in the insurance transaction**. Such insurance professionals need to be able to accurately interpret coverage questions raised. Producers may have specialized knowledge of the loss exposures covered under the policy. They also understand the alternative ways insurance policies may describe the same coverage and may be aware of any policy provisions that depart from customary wording.

**One of the limitations of scenario analysis is that, because the number of possible loss scenarios is theoretically infinite, it is impossible to account for every possibility**. Example, most insurance professionals would not have envisioned the terrorist attacks of 9/11. Alternatively, the insured or insurance professional may recognize the possibility of an event but underestimate the extent of potential loss. Example; extend of damage caused by Hurricane Andrew, or Katrina.

**Post-Loss Policy Analysis**

When an insured reports a loss, the insurer must determine whether the loss triggers coverage, and if so, the extent of that coverage**. The primary method of post-loss policy analysis is the DICE (Declarations, Insuring agreements, Conditions and Exclusions) method, which is a systematic review of all the categories of property-casualty policy provisions**.

The Dice method entails following 4 steps to determine whether a policy provides coverage. **The first step is an examination of the Declarations page to determine whether the information provided by the insured precludes coverage.**

**If nothing in the declarations precludes coverage, the insurance professional would move to the second step in the DICE method, an analysis of the insuring agreement**. The insuring agreement – the insurer agrees to provide coverage in exchange for the insured’s payment of the premium (has premium been paid). The insuring agreement or agreements often contain policy provisions regarding covered property or events, covered causes of loss, and coverage territories. If these provisions contain specially defined terms, those definitions should be analyzed. If a provision in the insuring agreement precludes cover, the claim will be denied.

**If nothing in the insuring agreement precludes coverage, the insurance professional proceeds to the third step of the DICE method, analyzing conditions**. Policy conditions specify the duties of the insurer and the insured. Examples; the insured’s obligation to report losses promptly, provide appropriate documentation for losses and cooperate with the insurer in any legal proceedings. Violating a condition can change the coverage on an otherwise-covered claim. Examining the policy conditions can help the insurance professional clarify these important points:

* Whether fulfillment of certain conditions, such a premium payment, is required for there to be an enforceable policy
* Whether coverage will be denied if an insured party breaches a policy condition
* Whether coverage triggers and coverage territory restrictions affect the loss
* Whether conditions concerning the rights and duties of both parties to maintain the insurance policy apply (example, the insurer’s right to inspect covered premises, the rights of either or both parties to cancel the policy, and the insurer’s right to make coverage modifications)
* Whether the post-loss duties of the insured and the insurer affect coverage disputes
* Whether subrogation and salvage rights and conditions must be considered

One breach of a condition that can occur under a homeowners policy is the concealment of a material fact. For example, assume an insured has a primary business running a furniture refinishing operation in his home. If he fails to disclose this fact when obtaining his homeowners covered, in violation of one of the policy’s coverage conditions, the policy would not cover a fire caused by flammable rags sued to polish furniture.

**If the insured has complied with all of the policy conditions, the insurance professional performs the final step of the DICE method, analyzing policy exclusions and other policy provisions not already analyzed, including endorsement and miscellaneous provisions**. This is the fourth and final step of the DICE method. Exclusions, which can appear anywhere in the policy, state what the insurer does not intend to cover. The primary function of exclusions is not only to limit coverage but also to clarify the coverages granted by the insurer. They also eliminate coverage for uninsurable loss exposures and can be used to reduce the likelihood of coverage duplications, eliminate coverages not needed by the typical insured, eliminate coverage requiring special treatment, or assist in keeping premiums reasonable.

**After using the DICE method to determine whether the claim is covered, the insurer must then determine how much is payable under that insurance policy**. The amount payable under a given insurance policy can be affected not only by the value of the loss but also by policy limits and deductibles, or self-insured retentions. For property insurance, the amount payable is affected by several factors. The valuation provision indicates how the property will be valued for claims purposes, which could be on the basis of replacement cost, its depreciated actual cash value, or some other valuation method. The amount payable is also affected by applicable policy limits and can be limited by a coinsurance provision or other insurance to value provisions. Some policies designate a deductible to be subtracted from the amount otherwise payable. For liability, the valuation of a covered loss is established by the courts or, more commonly, by a negotiated settlement. The amounts payable for both property and liability insurance losses can also be affected by other insurance.