Ethics in Insurance – SELF DIRECTED

Contents

Chapter 1: Ethical Foundations

Introduction

Our society is founded on principles promoting behavior that is good instead of bad and virtuous rather than evil. For thousands of years, civilization has formed its opinion about how individuals and businesses should conduct themselves and it imposes consequences for acts and practices that do not meet society's standards.

Over time, those standards change in light of events and circumstances that affect the members of society. For instance, Prohibition, the Industrial Revolution, and the Civil Rights Movement all significantly influenced the laws and ethical mores adopted by Americans during those time periods after public outcry.

In the latter half of the 20th Century, scandals involving a number of large corporations brought to light financial transgressions and other ethical concerns involving the behavior of their corporate officers, accountants, and attorneys. Some of those individuals were also indicted and punished for criminal wrongdoing. These types of misdeeds continue today.

The proper application of ethics in any business setting tends to avoid or diminish the harm to individuals and entities whose interests were ignored or exploited by unethical individuals and their behavior. ***When ethics are abandoned, the overlooked parties are usually those who suffer the most*** and are the least equipped to cope with the consequences.

In this course, the philosophy of ethics is addressed from the perspective of how it applies to the insurance industry in this country today. Upon completion of this course, students will:

- Understand how ethical foundations are formed and how they apply to the insurance industry
- Be able to identify and carry out their ethical responsibilities based on certain legal principles actively at work within the insurance industry
- Have the tools to apply their newfound knowledge in various lines of insurance, during sales and customer service transactions, in the process of loss and claim settlement, and when marketing and advertising

Ethical Theories

Before applying ethical concepts to the business of insurance, it is important to have a complete understanding of what "ethics" is and how an ethical mindset is created. When asked, most people respond to the question *What is ethics?* by answering:

- Doing the right thing
- Being good instead of bad
- Following the rules

- Being honest
- Putting the interests of other people first

Ethics can be defined as: "Morals and values that guide decisions and behavior." But what are "morals" and "values?" How do we acquire and recognize them?

Morals are rules developed by society. They tell us how to behave and help us distinguish between good behavior and bad behavior.

Values also encompass rules but are established more to aid us in the decision-making process and teach us how to rank the importance of different types of conduct. Essentially, values help us figure out the differences between right and wrong, and good and bad--along with ranking degrees of rightness, wrongness, goodness, and badness.

The Golden Rule vs The Ends Justifies the Means

In our society, two ethical principles seem to guide the majority of the population: The Golden Rule or The Ends Justifies the Means. Most individuals and businesses tend to follow one theory most of the time. Others use both, applying them mainly based on their personal morals and values.

The Golden Rule is the concept of people treating others as they wish to be treated themselves – "Do Unto Others As You Would Like Them To Do Unto You." This ethical philosophy is thousands of years old and has prevailed in many societies over time, regardless of religious and other beliefs. ***Inherent in the Golden Rule is the precept of "doing no harm" … to anyone***. For instance, if embracing the Golden Rule, a person who doesn't want to be lied to wouldn't tell untruths to another.

Looking at the ***Golden Rule*** from a different perspective would be to think about the intentions of any individual's conduct or behavior. If the intention is kind, fair, good, and/or right, a person's conduct is considered ethical, even if the outcome is not what was intended.

> Mrs. A called her agent to make an appointment to purchase auto insurance for a vehicle she was buying the following day. During the phone call, the agent completed the application online, saved the transaction, and the two agreed Mrs. A would visit the insurance agency the following morning. At that time, Mrs. A would sign the application and make the premium payment before heading to the car dealership to complete the purchase and pick up her car.
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> During his meeting with Mrs. A the following morning, and after submitting and printing the application, the agent noticed the premium was $150 higher than quoted. After comparing the application with the electronic confirmation of coverage, the agent noted the policy included a surcharge for an at-fault accident appearing on the driving record of Mrs. A's boyfriend--an accident Mrs. A hadn't known about.

> Rather than pay the higher premium, Mrs. A instructed the agent to remove her boyfriend as a listed driver on the policy. The agent explained he couldn't do that because Mrs. A had already informed him that her boyfriend would be driving the vehicle and they'd completed and submitted the application. A disagreement ensued. Mrs. A withdrew her auto insurance application and she left the agency angry.
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> Clearly, neither Mrs. A nor the agent had planned for this outcome. However, because the agent conducted the transaction legally, in compliance with his contract with the insurance company, and by doing the "right" thing, his behavior was ethical--despite Mrs. A's displeasure.

When people embrace the philosophy of ***The Ends Justifies the Means*****,** they believe their conduct or behavior is ethical if they achieve a desired result or outcome. Like the Golden Rule, the concept of the ends justifying the means has been embraced by many societies for thousands of years.

> When operating under the Ends Justifies the Means approach, a person would not have any reservations about lying on a job application Why? Because the desired result is being hired; therefore, any action undertaken to achieve that result is viewed as ethical because getting hired and working are worthwhile endeavors.

Another way to look at The Ends Justifies the Means is to avoid looking at intentions and, instead, only focus on the final result. If the outcome of a person's behavior is kind, good, fair, and/or right, then the person behaved ethically regardless of what conduct was undertaken to reach the goal.

> In the previous example with Mrs. A's auto insurance application, if the agent embraced the ethical philosophy of The Ends Justifies the Means, he would have behaved differently. Instead of refusing to collude with Mrs. A to lie on the application he would have done so.
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> Why? Because if the agent and Mrs. A agreed that the desired outcome was to have an auto policy issued without the boyfriend's bad driving record affecting the policy premium, then the goodness or badness of their conduct wouldn't have mattered. All that would have mattered was achieving the desired result.

A factor neither of the previous illustrations discussed was the existence of any stakeholders other than Mrs. A and the agent. ***Ethical behavior in the insurance industry is concerned with all parties to a transaction--not just the producer and client***.

The insurance company was clearly a stakeholder in Mrs. A's prospective purchase of insurance. In the first example, the one in which the agent was guided by the Golden Rule, the agent was concerned about his relationship with the insurer and complying with his contractual and fiduciary obligations to the insurer. In the second example, the one in which the agent was guided by the Ends Justifies the Means, he did not consider anyone other than himself and Mrs. A.

Often, when people act in a manner they know society, loved ones, or their business associates will view as wrong or bad, they tend to justify that behavior. The fewer people involved in a quandary, the fewer explanations have to be made and the fewer consequences have to be considered.

Because insurance regulation was created and exists for the protection of consumers and businesses, it should come as no surprise to learn ***the insurance industry's ethical guidelines and legal requirements endorse the Golden Rule rather than The Ends Justifies the Means.*** A number of laws exist that require insurance professionals to do no harm to consumers. Some of the concepts supporting those laws will be discussed later in the course.

Of course, other ethical theories exist and some weave themselves through the fabric of those just discussed--as do the personal beliefs and moral codes each individual adopts based on his or her life experiences. Everyone has an intrinsic belief about what is right and wrong, and those beliefs are not always shared by others. Depending upon the perspective of each individual, insider trading, rebating, and withholding information may be considered acceptable or unacceptable to a group of like-minded persons.

> Cheating, stealing, lying, not keeping promises, and exploiting seniors are universally considered wrong or bad. However, unethical producers have their reasons for cheating on an insurance exam, stealing a client's premium dollars, making a misrepresentation on an insurance application, failing to renew a client's policy, or swindling an 80-year-old client. The unethical producer has personal motivations, rationalizations, and explanations about why his or her behavior is neither wrong nor bad and should be viewed as acceptable.

The primary subject of ethics in the insurance industry is human behavior, the actions deliberately taken by producers and other insurance professionals when working with consumers and businesses. If an individual takes deliberate action, he or she is held responsible for that action.

Theory of Planned Behavior

"Practice makes perfect" is an adage that most people hear before they are old enough to go to school. And it's a truism for a good reason.

Before opening the opening night of a play, the actors, director, and behind-the-scenes crew conduct a dress rehearsal to be sure they've remembered their lines, know their cues, and are familiar with a multitude of other details that will help them perform at their best. Public speakers run through their speeches in front of a small audience, or simply in a room by themselves, to nail down their timing. In fact, most salespersons conduct a mental rehearsal as they prepare for important interviews.

Ethical codes of conduct and the NAIC's model laws and regulations help producers carry out their "practicing." These standards and guidelines provide a framework for making decisions in the event an ethical dilemma crops up.

The Theory of Planned Behavior illustrates the four major elements that have the ability to influence how people behave: attitude, subjective norms, perceived behavioral controls, and intentions.

Attitude has a significant effect on an individual's behavior. It has been proven that the more positive a person's attitude is, the more likely the person is to succeed. It's human nature to dwell on the negative--after all, it's the negative aspects of life that have the potential to cause harm. However, dwelling on the negative actually handicaps people and holds them back. On the other hand, focusing on the positive energizes people and propels them forward. Attitude is simply a reflection of how a person thinks.

A subjective norm is a collective opinion; in other words, what other people who are part of a group think. That group might consist of family members, the employees at a company, the residents of a neighborhood, or the citizens of a country. Every person's behavior is affected to some degree by the opinions of other people--especially when those other people are held in high regard. A subjective norm is what a group of people think collectively, in the aggregate rather than individually.

Perceived behavioral controls are the tools people believe they are equipped with. For instance, when people believe they're smart enough to pass an insurance licensing exam, they perceive themselves as having the tool of intelligence and are more likely to attempt to get licensed than individuals who believe they aren't equipped to pass the exam. Perceived behavioral controls help people decide whether they can accomplish specific tasks.

Intentions are the desires or wishes to behave in a particular fashion. They represent how strongly we do or don't want to take action.

In short, the easiest way to actually engage in desired behavior is to plan or run through it mentally. The Theory of Planned Behavior helps this process, as illustrated by the following example:

> A survey reported the attitudes consumers had toward buying insurance online. The friends and family members of most survey respondents indicated most of them had good experiences buying insurance via the Internet.
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> Younger respondents felt well-equipped to handle the challenges of online transactions, but older respondents tended to feel technologically challenged. In addition, younger respondents said they planned to buy insurance online (or had already done so), while older respondents wanted to do so but often didn't feel confident enough to actually attempt it.

The ethical attitudes and consensus adopted by an organization or industry can help shape the attitudes and opinions of those who work for it because they influence outcomes with support, guidance, and training.

There is a caveat about this theory: it doesn't always work. This lack of a guarantee revolves around the fact that although people often *intend* to behave in a particular way, circumstances, other people, and their own emotions interfere with and derail those intentions. In times of stress, an otherwise reputable, honest person might be driven to break the law or stretch the boundaries of propriety.

> A producer who never viewed the sales process in terms of the commission levels offered by insurers now finds himself a single parent who's struggling financially. The prospect of earning more money by selling one company's product over the products of several other companies might now become a factor in his sales presentations, when it never did before.

Ethical Perspectives

Forming Foundations

In addition to the ethical principles adopted by society, each individual adopts a unique and personal code of ethics. That personal code is formed based on the individual's own life experiences because no two people, even when living in the same society, go through precisely the same circumstances and events. People interpret occurrences and relationships from their own perspectives, filtering what they see, hear, and feel through their own singular viewpoints. ***Some of the foundations of an individual's personal code of ethics include:***

- ***Upbringing and childhood influences***
- ***Religion and culture***
- ***Friends and peers***
- ***Teachers and other adults who set examples***
- ***Degree of self-interest***
- ***Goals and desires***
- ***Socio-economic status***

Most children are raised by their parents. However, others are raised by grandparents, another relative, or in the foster care system. A child's upbringing has an enormous effect on the perspectives he or she will choose as an adult because ethics are often taught by example.

Ignorance of ethics has universally been understood to begin in early childhood. This is obvious in situations where a child's parents have been involved in illegal activities and the child learns to accept the parents' behavior as normal. When they are routinely exposed to illegal and/or unethical behavior conducted by parents, family members, and adults they respect and admire, children tend to adopt the attitude that the illegal/unethical behavior is right because everyone they know, love, and trust is engaging in it.

Clearly, children raised in such an environment are often unable to truly recognize the difference between right and wrong. When early training teaches an individual that it is acceptable to commit wrongful acts and earn money illegally, the person usually needs retraining and reeducation as an adult to not only understand the differences between good and bad behavior but also *why* a certain type of behavior is right or wrong.

Many scholars and other reputable sources consider virtue as a telling component of someone with a strong moral and ethical character. Essentially, ***virtue*** is conduct that exhibits high moral standards. People are not born virtuous; they develop the trait over time and by choice.

As a natural part of growing up, most children experience a phase where they tell lies. For many, when they realize their parents and teachers don't approve of lying, they come to learn and agree that the results of lying are "bad" and the virtues of honesty are preferable. As a result, they outgrow their fondness for being deceitful. However, for other children, lying simply becomes a habit--especially when no one explains to them why it is bad, or how it might cause harm, and what the results of lying might be.

In a similar fashion, children can develop other bad habits, or vices. Usually, they don't begin behaving badly all at once. Like virtue, vices and bad habits are developed over time. They can be taught by parents and adult role models or by friends, associates, teachers, and others with influence over the child's development.

In addition to a child's upbringing, the socio-economic status of the family may be a factor that dictates an individual's behavior and helps form ethical foundations. People who are raised in wealthy environments often have an entirely different world view than those who are raised in poverty. This does not mean people are inherently more or less ethical based on household income; however, few will disagree that the challenges faced by the children of a single mother on Medicaid are entirely different than those of children with a single mother whose monthly income consists of $50,000 in spousal and child support.

Another factor that helps shape an individual's personal ethics is religion. Regardless of the specific religion, if its teachings encompass and mirror many of the same ethical perspectives shared by society, children raised in that religion have more support when faced with ethical dilemmas. Why? Because they are exposed to the same ethical principles in multiple areas of their lives, and those principles are embraced by many other people.

Beginning in childhood and on through adulthood--but especially during the years a person attends school--***the influences of friends and peers can also affect an individual's ethical perspectives. Most people want to be liked, considered important, and to belong. Toward this end, they pattern their behavior on the friends and associates whom they most admire*** … those who are the most supportive of them and their ideas.

Research indicates that the middle school years is the period of development when a person is most susceptible to peer pressure, or peer influence. During this time, children are actually building themselves, and choosing personal identities as well as the types of behavior they will eventually embrace. On the other hand, this is also the time when children are most sensitive to the influence of their parents, which helps illustrate why some children are more susceptible to peer pressure than others are.

Peer pressure also exists in the workplace. It might only be a suggestion to look the other way when a fellow employee steals office supplies. On the other hand, it might be the theft of a client's cash premium payment spurred by a producer's personal financial troubles. Even when a coworker only suggests the producer "borrow" funds for a short while before replacing them, an otherwise honest and ethical individual might heed the suggestion simply because he or she feels encouraged to act.

The ethical culture within an organization, and how peer influence works, is largely determined by ownership and upper management. If an insurance agency's owner exhibits ethical behavior, rewards ethical behavior, and discourages unethical behavior, the environment at the agency--as experienced by both employees and clients--is far more likely to reflect "good" morals and values. On the other hand, if an agency owner's conduct is corrupt or unprincipled, that owner is more likely to overlook similar behavior in the workplace or actively encourage it … which, in turn, perpetuates it.

In some insurance companies and agencies, highly successful producers are rewarded for their sales success regardless of how sales are achieved. Experience has shown that persistency of insurance sold during a sales promotion is lower than that of insurance sold during the ordinary sales cycle. In fact, some of the unfair trade practices prohibited by insurance laws in most states--such as twisting and churning--became illegal precisely because of sales practices that were permitted to occur unchecked.

At some time in their lives, most people face situations where it is easy to succumb to the temptation of conducting themselves in a manner they know is wrong or bad. Regardless of whether they are children or adults, if people have the support of an ethical foundation at home, at school or work, and in society, it is much easier for them to resist any temptation that comes their way.

When describing personal and professional reputations, people are referred to as having a type of character--either good or bad. In reality, those who overcome temptation tend to develop a stronger moral character as a result of the challenges they faced in passing up the lure of being "bad." The goal of an individual seeking to conduct ethical behavior in all his or her dealings is to develop a strong character.

The importance of ethics training in insurance continuing education (CE) plays a major role in this process, which is why most states include it in their CE requirements for insurance licensees. The guidelines contained in an ethical code of conduct can help steer a producer to the right course of action while building a strong moral character.

Understanding Ignorance versus Willful Blindness

One other aspect of ethical conduct that needs to be addressed is the distinction between true ignorance and willful blindness. As mentioned earlier, an individual's intentions are usually considered when determining whether conduct or behavior was ethical.

> If a producer knew his client suffered a heart attack the previous week and submitted the client's life insurance application without revealing the heart attack to the insurer, the producer's behavior would be deemed unethical. But if the producer hadn't known about the heart attack and submitted the application with the client's misrepresentation, the producer's action would not be deemed unethical.

Ignorance--the true lack of knowledge or information--is not criminal or unethical. However, *pretending* ignorance can be criminal and/or unethical in certain circumstances.

Willful blindness is intentional behavior carried out for the express purpose of sidestepping or not learning the truth *because being aware of the facts would place the individual's behavior in a different light*--such as being criminal, negligent, or unethical. Another way to explain willful blindness is to refer to it as ignorance based on purposeful evasion of data that does not support one's own opinion.

> In the preceding example, the producer did not know about the client's heart attack, therefore, he couldn't report it to the insurance company. However, if the producer had overheard a conversation about the client being in the hospital for a condition similar to her brother's heart condition … and then did not inquire about the hospitalization, that behavior would be deemed willful blindness.

Ethical Quandaries

At some point, most insurance professionals find themselves in a situation where they don't know what to do, what to say, or how to act. These predicaments arise because producers either cannot determine the right and wrong of the situation or want to behave in a way they suspect (or know) is wrong.

An ***ethical quandary*** occurs when a producer is not sure how to act because good *and* bad reasons exist for behaving in a specific fashion. The dilemma often presents a laundry list of pros and cons … at least from the perspective of the person who is tempted to cross over the line between good and bad. In addition, the producer may be required to put aside personal opinions and interests to make the "right" decision and this behavior that may feel counterintuitive … *from a personal perspective.*

A producer's client, Mr. B, is an elderly widower who has been a resident of a nursing facility for the past year. This is the same facility that cared for his wife for several years before she passed away.

Mr. B decides to disinherit his adult children for a number of reasons, one being their objections to him bequeathing assets and cash to the nursing home. He asks his agent to submit a beneficiary change form naming the nursing facility as sole beneficiary on his life insurance policy and to locate an attorney who will help him handle the other necessary transactions to accomplish his goals.

What if YOU are Mr. B's long-term insurance agent and he seeks YOUR advice about this matter because of a trust and respect that has developed over the years? Before you provide any advice, assume you ask Mr. B for permission to review his insurance and financial information and he gives you access to all the records you need.

Do you comply with Mr. B's request to help him name the nursing facility as his life insurance beneficiary? Do you refer to a published code of ethics to figure out how to behave in situations such as this? Or do you decide you need to reach out to Mr. B's doctor, adult children, or some other individual who might be both familiar with the situation and concerned for Mr. B's welfare?

This dilemma is complex and before you can solve this ethical quandary, you must follow certain steps before determining how to proceed in an ethical fashion.

The first step toward resolving an ethical dilemma is collecting all relevant information. Identifying every one of the stakeholders is crucial. In the previous example, the agent and Mr. B are the primary stakeholders. But Mr. B's adult children should also be added to the list, along with his investment adviser, his accountant, the nursing facility, and anyone else who might have helped Mr. B handle his financial matters.

As information is collected, other individuals might also be discovered to have an interest in the matter. Hidden agendas might crop up and previously unknown reputational factors may come to light. On the other hand, one or more of the parties may present documentation and/or character references that paint them, or others, in a virtuous light.

Some believe that because an ethical dilemma involves two opposing positions, a third outcome must be presented to determine the appropriate outcome. The reasoning behind this perspective is that if one of the two options were the right choice and the other were the wrong choice a dilemma does not exist because it is a "black and white" situation, one without any shades of gray to consider. When the right choice is selected, the problem is solved.

But in connection with dilemmas painted entirely in shades of gray, a third option is essential. It may be a combination of the two opposing positions or an alternative that neither party previously considered. During the process of achieving resolution, all potential consequences should be considered--in both the short-term and the long-term. The final option chosen should:

a) Be viewed as fair by both parties.
b) Benefit and be in the best interest of the client.
c) Be consistent with accepted and ethical behavior in the insurance industry.

In addition to morality and the rightness or goodness of intentions, the principles of fairness, consistency, and best interests form the basis of rules of conduct. But when faced with an ethical quandary, very rarely can guidelines be applied without hesitation, anxiety, or second-guessing.

When attempting to arrive at an ethical outcome, some people appeal to fairness and rights over consequences, while others appeal to consequences over fairness and rights. This choice once again brings up the question of what ethical philosophy to embrace: the Golden Rule or the Ends Justifies the Means.

Ethical theories lay the foundations of principles which, in turn, establish the most important rationale behind pursuing or following a course of action. To determine whether an action is ethical, one might be concerned more with whether the behavior was undertaken fairly rather than with its outcome. Another person might view the action from the angle of whether it benefits more people than it harms.

> A classic example involves President Truman's decision about whether to use the atomic bomb to end World War II. Proponents of the decision believed it was the ethical choice because fewer lives were lost as a result of the bombings than would have been lost if the U.S. had invaded Japan. Opponents of the decision maintained that bombing Japan was not only immoral, but also a form of terrorism because of the number of civilian lives lost.

Application of Ethics to Insurance

Major Elements of Ethical Conduct in the Insurance Industry

When comporting themselves in accordance with accepted codes of ethics, producers must comply with certain requirements while understanding their obligation to safeguard consumers. When protecting the interests of the public, producers must keep in mind at all times that consumers have a number of rights: to be safe, choose freely, be heard, be informed, be educated, and receive the service and attention they deserve.

Education and Training

To the surprise of some insurance professionals, most of the states *require* ethics training in their continuing education requirements for license renewal. This requirement doesn't exist because insurance regulators believe producers are inherently bad or unethical, or that they won't know the difference between good and bad behavior unless they are regularly reminded of it.

The ethics requirement exists to help producers evaluate situations that might prove challenging from an ethical standpoint and view them from multiple perspectives. Ethics training helps producers recognize potential pitfalls and identify rationalization that only serves to support unethical choices. It

also offers advice, tips, and tools to help producers avoid being tripped up when they stumble across controversial scenarios that require thoughtful consideration to resolve.

In addition, a regular discussion of ethics and its application to the insurance industry helps producers remain current, especially in connection with the ever-evolving list of products and technology used on a daily basis. Most people find it easier to learn when presented with examples and circumstances in which they can exercise their critical thinking skills. Most ethics training is filled with examples--the dos and don'ts of good and bad behavior.

Keeping Promises

A promise is a commitment. When insurance professionals make promises and commitments, ethics requires them to do everything in their power to honor the pledges they make. Clearly, if a producer's outgoing voice mail message says she will return all calls by the end of the business day, she'll be breaking a promise if a client leaves a message at noon on Wednesday and the producer doesn't return the call before she goes home.

But what about the promises producers don't actually make … and consumers *believe* they make--the implied promises, the guarantees wishful thinkers believe they hear, and the pledges some people expect?

Even when producers take special efforts *not* to make promises--such as refusing to predict how an insurance policy will respond in the event of a hypothetical loss or referring a client to the claims department for a coverage determination--consumers often expect certain outcomes in connection with particular transactions.

For instance, when an insurance company issues an insurance policy, most consumers believe their insurer is guaranteeing to make a claim payment if a loss occurs. Theoretically they understand policy exclusions exist, however, they seldom expect those exclusions to apply to them and their personal situations in the future. Instead, most consumers make assumptions. Because they are not familiar with policy language or the concepts that underpin the insurance industry, they fully expect that the promises they attribute to their agents and insurance companies will be fulfilled.

> If a married couple purchases a homeowners policy, the pair expects the insurance company to make payment when their house burns down. They do not expect the insurer to deny the claim and refuse payment because their resident teenage son set the house on fire because he was angry with his parents.
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> It will not matter that the parents did not read the policy or it's Intentional Loss exclusion. What will matter is that the parents believed the policy would pay for all house fires and it didn't pay for this one.

Producers should be sure to identify their clients' expectations and, when striving to meet them, avoid making promises they cannot keep. The way to accomplish this goal is for producers to learn as much as they can about their clients by asking questions. Specifically asking clients about what they hope to accomplish and how they believe their insurance policies will help them is the major way to identify unreasonable expectations.

Rodney is an 18-year-old who just bought his first car. When he visits his parents' insurance agent, he tells her he only wants to buy minimum coverage. The agent guesses that since Rodney has never purchased an auto insurance policy before, he doesn't know how auto insurance works. To help him understand the new policy he'll be buying without lecturing, she says, "Okay, Rodney. You want your policy to protect you in case you cause an accident and hurt someone or damage their car, right?"

Rodney agrees, "Right. I want my car to be covered, too. But I don't want to pay a lot of money."

"I understand," the agent says. "Let me give you a scenario, and you tell me how you want your policy to respond. Okay?"

He looks confused, but says, "Sure."

"Imagine someone driving down the road in the winter. He slides on ice and hits a parked car. Then his car hits a pedestrian before crashing into a building and coming to a stop on the sidewalk." The agent lets all this sink in. "You could see that happening, right?"

"Yeah," Rodney says.

"Good. Now, imagine that driver is you. What do you want your auto insurance policy to do for you?"

Rodney shakes his head. "I don't know what you mean."

The agent explains patiently. "When you buy an insurance policy, the insurance company agrees to pay certain types of claims based on the coverages you buy. If you were the driver in the scenario I just explained, a number of claims would be submitted under your policy because you caused the accident. The pedestrian would be injured, so she'd expect your auto insurance policy to pay for her medical bills. Both your car and the parked car would be damaged, so those damages would need to be repaired. Finally, the building would be damaged, as well, and the building's owner would be submitting repair bills. Do you want your insurance policy to pay for all those claims?"

Instead of asking Rodney if he wanted to buy liability and collision coverages, and then explaining how they work, the agent provided Rodney with an example he could clearly understand. When Rodney says he wants all those claims to be paid, the agent now knows what coverages to include on the quote.

Then, she asks, “What if you were injured in that accident, Rodney? Would you want your auto policy to pay those medical bills?”

Rodney might say, “No, I’m covered under my parents’ health insurance.”

And the agent would probably answer, “Okay. And how about your passengers? If your friend were in the car with you, do you want your auto policy to pay for his injuries or do you want him to pay for his own injuries?” How Rodney answers will let her know if he wants to buy medical payments coverage.

Now, Rodney has to think. He has to run the scenario through his mind and decide what he wants his policy to do for him. Each customer is going to think and respond differently. In this situation, the agent allows Rodney the freedom to determine his own needs and wants on his own, without influence from her. He will probably leave her office with a far better understanding of insurance, and with more comprehensive coverage, than if she’d just written insurance for him at minimum limits as he requested and then sent him on his way.

Of course, it is possible Rodney--or any other client--might say, “I don’t care about the pedestrian’s injuries or the damages to my car, the other car, and the building. I only want to buy the least insurance I need to get the car on the road.” If that happens, the client will clearly state his or her position and intentions.

Which is exactly what the agent wants. It is the purpose of her providing scenarios and asking questions. She elicits information from her clients by asking them questions that allow them to identify their own needs and wishes and them communicate them clearly to her. The way she conducts business illustrates how she puts her clients’ needs and interests before anyone else’s needs and interests.

Important note: Price hasn’t even been mentioned yet. The agent hasn’t mentioned price and won’t do so because, in the absence of context, it has little meaning. Although Rodney has indicated he doesn’t want to spend a lot of money, he hasn’t stated what his budget limits are. They will be discussed later, once he finishes determining his needs.

Honoring Contractual Obligations

Later in the course a more detailed discussion of a producer’s legal and ethical obligations takes place, yet it cannot be overstated that producers must adhere to the requirements of the legal contracts to which they are a party. The insurance policy is a contract between the insurer and the policyholder; therefore, producers are *not* a party to the insurance contract.

However, producers are obligated by the contracts between themselves and the insurers they represent, the agencies and companies that employ them, and the verbal promises they make. Their contractual obligations are both legally and ethically binding.

Most carriers publish their underwriting guidelines online and producers not only have a duty to comply with them but also to understand the parameters of their authority when transacting insurance on behalf of their insurers. This applies to the territories within which they may solicit and write coverage, the binding authority they have for different types of risks, and the extent to which they may act on behalf of their insurance companies with respect to marketing and advertising.

Avoiding Conflicts of Interest

As insurance professionals, producers are legally required to act on behalf of the insurance companies they represent. When producers are also brokers, they have additional obligations to the consumers and businesses with whom they transact insurance. This legal duty requires producers, agents, and brokers to avoid all conflicts of interest and place the best interests of the parties they represent before all other parties, including themselves.

When a conflict of interest arises, a producer's loyalty is divided, meaning the producer cannot represent the party to whom a duty is owed because of conflicting loyalties.

> Kim is a producer whose client wants to buy a personal umbrella liability policy. The insurer that issued the client's homeowners policy offers two types of umbrella liability coverage. The annual premium for an umbrella liability endorsement that can be added to the homeowners policy (for eligible policyholders) is $15 and the annual premium for a basic standalone policy is $150. Both the endorsement and the policy provide the same coverage; the client is eligible for the endorsement.
>
> Clearly, it is in the best interests of the client to purchase the endorsement. But if Kim were to allow her personal interests to influence her decision, she might sell the policy because she will earn $30 commission instead of $3.

Conflicts of interest can also arise when a producer is required to represent the interests of multiple parties at the same time; however, most take place because the producer's attention to personal interests interfere with the performance of professional obligations. Conflicts of interest will be addressed more fully during the discussion of fiduciary duty.

Why do insurance producers behave unethically? Sometimes their actions are unintentional--they don't realize what they're doing is wrong. ***Usually, when a producer's behavior is not deliberately unethical, that action is the result of inexperience, a lack of training, or improper training.*** It might also be the result of poor decision-making skills, choosing a course of action without investing the appropriate amount of time or research, or trying to please the wrong people.

Sometimes, though, producers behave unethically while knowing exactly what it is they're doing--and why. In most of these cases, they justify their behavior. Their rationalization can be as simple as adopting the philosophy of the ends justifies the means or they invent another reason, one with a rightness that overpowers the wrongness of their behavior--at least to their way of thinking.

An insurance agency employs five producers and each month the producer who sells the most in terms of premium dollars is touted as “employee of the month.” This honor is rewarded with use of a special parking space right outside the front door (complete with a fancy sign) and dinner with the agency owner at a high-end local restaurant.

Although Betty consistently sells the highest number of insurance policies each month, the premium volume is lower so she has never achieved status as employee of the month. Betty resents Isabella, who has parked in that special space for five months in a row and has no plans of relinquishing it.

Isabella enjoys public recognition of her status, along with the admiration of their boss. She is on-target for being employee of the month for the sixth time in a row and has been boasting about her accomplishments, all while predicting the inability of her coworkers to compete.

As the end of June draws near, Betty realizes she is once again going to sell more policies than Isabella while falling short of achieving the highest premium volume. Frustrated, she devises a plan.

Betty conspires with two of her long-time clients. She convinces one of them to purchase a large life insurance policy by promising to pay the first quarterly premium out of her own pocket. She convinces the other client to pretend to purchase an equally large life insurance policy. For this client, not only does Betty promise to pay the first quarterly premium, she also coaches the client about how to return the policy for a full premium refund during the free look period.

Betty justifies her actions because she believes it isn’t fair that her boss considers the number of policies sold as less important than the premium volume sold. She also feels that her hard work and achievements are underrated and overlooked. Furthermore, Betty justifies her actions as follows:

Neither the first client nor the insurer is being harmed. The client is benefitting from the purchase of $2,000,000 of life insurance and the insurer is benefiting from issuing the policy. If Betty chooses to pay the first premium on behalf of her client, that’s her privilege--no one is being harmed.

The second client is also benefitting from the issuance of a life insurance policy … at least until he decides he doesn’t want it anymore. And who knows? Maybe he’ll decide to keep it. In fact, based on her knowledge of the client, that’s exactly what Betty is counting on. Since she chooses to believe her client’s final decision will be to keep the policy, the insurer will benefit from that sale, as well. Once again, no one will be harmed.

Betty knows her logic is faulty. Paying premiums for her clients is considered rebating--an unfair trade practice that is both unethical and illegal. It doesn’t matter that Betty views her boss as being “unfair” and her behavior as “doing no harm.”

> Betty's conduct disrupts the rate structure, which ultimately harms both insurers and policyholders. Her conduct also harms other producers, those who transact insurance within the framework of the law and ethical guidelines because it places her in a position of having an unfair advantage over them. Finally, Betty is harming herself. Even if her boss and insurance regulators don't discover what she's done, those two clients know she is unethical and sneaky. Doesn't Betty realize they will probably never trust her again?

Ethical conduct in the insurance industry calls for producers to perform their duties with the highest level of ***integrity***, which is defined as a firm adherence to a code of moral values. Producers must transact insurance for the right reasons and do so appropriately. In addition, they should ask themselves the following questions when evaluating their own personal morals and values in the context of working in the insurance industry:

- Do I have enough information to make a good decision?
- Do I have any personal interest in this situation?
- Have I communicated fully with all interested parties, and enough to make an informed and ethical decision?
- Can I follow a formal code of ethics to help me make the right decision?
- Whose interests am I required to protect and represent?
- Is the action I decide to make in the best interest of the party or parties I am obligated to represent?
- Will my conduct be legal?
- Will my conduct be ethical?

One of the easiest ways to answer the question *Why are insurance agents required to complete ethics training as a condition of renewing their licenses?* is to examine circumstances where the unethical behavior of individuals working in the insurance industry resulted in harm to consumers.

Senior consumers are exploited financially every day as part of a trend that abuses the older members of our society in a variety of ways. Experts report that family members and caregivers account for the majority of those who perpetrate elder abuse, but insurance professionals also commit this heinous crime. Producers, investment advisers, and financial planners more focused on their own personal gain than on their clients' welfare conduct shady transactions and commit crimes that harm consumers and the insurance industry, as well.

The primary reason older consumers are exploited is because of their vulnerability. Many seniors are isolated, suffer from medical conditions that weaken them in body and spirit, and tend to be exceedingly trusting. Unethical insurance professionals often find senior citizens to be easy prey.

In a series of incidents that took place in California, a life insurance agent promised his elderly clients that, through his two businesses, he would manage their money by investing it in annuities and other safe investments. In reality, the agent diverted his clients' funds into his own personal bank accounts and investments without their permission or knowledge.

After one client filed a complaint with the state Department of Insurance because her monthly interest and dividend payments had stopped and her agent did not respond to her inquiries, the Department launched an investigation. The investigation revealed that the agent had stolen nearly $2 million from five seniors, moved to Utah, and reported to his clients that their money was safe and earning interest. He provided some of his clients with periodic interest and/or dividend payments; however, two years after his move, the agent stopped making those payments and failed to respond to his clients' inquiries or to comply when they insisted he return their money.

Between the time he stole the money and moved to Utah, the agent's insurance license lapsed and was not renewed. After a felony complaint was filed against him in California, he was arrested in Utah and extradited back to California. The [now former] agent pleaded guilty to 12 felony theft counts, was sentenced to serve 15 years in state prison, and was ordered to pay $1,810,508 in restitution.

In the course of conducting business, agents and adjusters also transact insurance in ways they might view as necessary to meet their own needs but that, in fact, are illegal and/or unethical. This type of behavior isn't limited to insurance transactions involving forms of insurance with cash value and/or investment components, either. Two recent cases in Florida illustrate this point:

A licensed all-lines adjuster permitted an unlicensed and unappointed individual to adjust 21 claims for an insurer without the required license and appointment. The adjuster was fined $5,000.

###

An anonymous tipster filed a report with the state's Division of Investigative & Forensic Services alleging that an agent accepted 4 property and casualty insurance applications from a client and collected the respective premiums but never submitted the applications or bound coverage. The client learned about the agent's actions when she filed a claim and learned no coverage was in place.

Because he didn't want the client to submit a claim to his E & O carrier, the agent paid the cost of the woman's hurricane damages himself. The agent also reimbursed the client for the premiums she paid, and for which coverage was never issued--but only after the client demanded repayment.

The investigation resulted in the agent having his license revoked and being fined $5,000.

In the previous examples, the agents' behavior was both unethical and illegal. But what happens in situations where an agent acts within the law … but not in a professional manner or in a way that benefits the consumer?

For example, producers who claim to be "*financial planners*" are coming under greater scrutiny. Problems arise when agents who are only trained to sell life insurance products represent themselves as *financial planners.*

Certainly, they help their clients plan future financial matters; however, true financial planners do not only sell insurance. They also provide services that are far more complex and comprehensive in scope than simply selling life insurance and annuities. By claiming to be financial planners, some insurance producers mislead their clients and the prospects who seek their advice.

Another ethical issue arises when a financial planner who is also an insurance producer passes along client information to a stockbroker or mutual funds salesperson--either for a fee or for what the producer may call "goodwill." Many questions about this practice should be raised, the most important of which is: *What disclosures should the agent/financial planner make to the client* before *sharing the client's information?*

Ethical Codes of Conduct in Insurance

One of the greatest tools to use during ethical insurance transactions is exercising common sense. Unfortunately, as Voltaire said: "Common sense isn't so common." For some insurance professionals, understanding the differences between right and wrong is not as apparent as it is to others.

Different laws apply within the insurance industry. Insurance professionals and most consumers know the insurance industry is largely governed by insurance statutes in the state where the insured person lives, or where the insured property or business is located. But consumers may not know whether federal laws also apply and, if they do, what they are.

Similarly, insurance statutes vary by insurance industry segment. Although unfair trade practices apply to all segments of the insurance industry, unfair claims settlement practices only apply to property and casualty insurance claims. Different laws apply to surplus lines insurance than apply to insurance written by admitted insurers.

How are insurance producers supposed to understand all these laws … and precisely what type of behavior is expected of them?

Ethical codes of conduct help producers understand the distinctions between behavior that is ethical versus unethical, and legal versus illegal. They also help producers understand how to place the interests of others first, make better choices, resolve dilemmas, and avoid conflicts of interest.

One of the primary advantages of a code of ethics is that it provides a framework for making deliberate choices. When faced with an unexpected or challenging situation, individuals can follow

procedures and guidelines during a measured decision-making process rather than responding automatically or with little forethought.

Although no single, all-encompassing code of ethics has been published for use by all insurance professionals, a number of insurance organizations have published their own codes of ethics. These standards can be used by producers as benchmarks when putting together their own personal code of ethics.

Examples of published codes of ethics in the insurance industry include:

- International Association of Insurance Professionals (IAIP)
- National Association of Insurance and Financial Planners (NAIFA)
- Securities and Exchange Commission (SEC)
- Financial Industry Regulatory Authority (FINRA)
- Society of Chartered Property and Casualty Underwriters (CPCU)
- The American College
- Certified Financial Planner Board
- The National Alliance for Insurance Education and Research

NAIC Model Laws and Regulations

Another resource insurance professionals can use is the National Association of Insurance Commissioners (NAIC). The NAIC is a regulatory support organization formed by insurance regulators from all 50 states, the District of Columbia, and the five U.S. territories. It creates and maintains uniform standards for establishing best practices, conducting peer reviews, and coordinating regulatory oversight within the insurance industry.

On its website, the NAIC provides a free six-volume set of model laws, regulations and guidelines, along with other resources. In addition to listing every model, the NAIC provides information about each state's enacted model or legislation that is similar to it. ***Not only do these guidelines provide suggestions for insurance statutes and laws, they also provide a frame of reference for ethical behavior.*** We will cover these in greater detail later in this course.

Chapter 1 Review Questions

1. Failure to apply and use ethical standards in a business setting tends to result in which of the following outcomes? (page 3)
   a. Harm to those whose interests were ignored
   b. Harm to those who commit ethical violations
   c. Increased revenues
   d. Increased reputation

2. The Golden Rule focuses more on intentions and _____. (page 4)
   a. Outcomes
   b. Not doing harm
   c. Consequences
   d. Self-preservation

3. Which of the following is one of the primary advantages of an insurance code of ethics? (page 21)
   a. It applies to the entire industry
   b. Everyone understands it
   c. It is written in state law
   d. It provides guidelines

4. All the following help form the foundations of a person's personal code of ethics EXCEPT: (page 7)
   a. Upbringing and childhood
   b. Friends and peers
   c. Age and gender
   d. Degree of self-interest

5. When a conflict of interest arises, a producer's loyalty is _____. (page 17)
   a. Divided
   b. Eliminated
   c. Expanded
   d. Increased

Chapter 2: Legal and Ethical Principles for Insurance Agents

The insurance industry is highly regulated. Most legal requirements are imposed by state law; however, federal law also applies and, specifically, does so in cases where state law does not. As discussed previously, different segments of the industry publish codes of conduct to help producers and other insurance licensees carry out their legal and ethical duties responsibly.

What may not be as apparent as the laws and ethical "rules" that govern the insurance industry are the legal and ethical principles that form the basis of acceptable conduct and behavior. In this segment of the course, a discussion of some of those legal principles take place.

Law of Agency

The Law of Agency is a legal principle associated with business and contractual relationships. ***It was founded on the belief that those acting for another must do so as if they were acting for their own benefit.***

Under the law of agency, a relationship exists between two parties--the ***principal***, who legally grants its ***agent*** the authority to act on the principal's behalf. This authority conveyed permits the agent to help the principal enter into contractual relationships with ***third parties***. It can also permit the agent to act as the principal's representative in other circumstances.

Under the agency relationship in the insurance industry, the insurance company is the principal and the producer (or adjuster) is the agent. Consumers and businesses interested in buying insurance (and those who actually do buy it) are the third parties with whom the principal enters (or attempts to enter) into contracts.

Four legal implications exist in the agency relationship between producers and insurers:

> ***The producer represents the interests of the insurance company.*** This means the producer's legal responsibilities and obligations are to the insurer *and not to the policyholder.* (This will be discussed in more detail later.)
>
> ***The producer is given permission to act on behalf of the insurer as its representative. Because of this authority, producers can create legal liability for their insurance companies.***
>
> ***The acts of the producer are considered the acts of the insurance company.*** For example, if a producer collects an insurance premium or binds insurance coverage, those acts are deemed as if the insurer conducted them itself.
>
> ***Any knowledge the producer has is considered known by the insurance company.*** If a producer hears that a policyholder was arrested for committing arson, the producer is duty-bound to share that information with the insurance company.

When the agency relationship is established, certain boundaries must be respected and particular guidelines must be followed. The principal grants the agent authority to act on its behalf in one of three ways:

- By express appointment, which is explicitly stated (usually in writing, such as in the agent/company contract). So long as the agent complies with the parameters of the authority as defined, the principal is liable for the agent's actions. However, ***if the agent exceeds the authority granted, the agent is liable for his or her own actions.***
- By implied appointment, which is not spelled out in writing. Instead, the agent acts within the boundaries of assumed authority or authority communicated verbally, and the principal acknowledges the agent had the authority to act. For instance, if a producer collects a cash premium payment from a policyholder and submits it to the insurer, authority is implied when the insurer processes the payment and credits it to the policyholder's account.
- By apparent authority, which occurs when it *appears* to a third party that the agent has authority, despite the principal not stating or implying authority exists or when the principal has not notified a third party that previously granted authority was revoked. For instance, an insurer would be granting apparent authority in each of the following situations: (a) although the insurer did not issue an appointment for a producer to sell insurance, it accepts an insurance application and then issues a policy; (b) after a producer has sold numerous life insurance policies, he chooses not to renew that line of authority on his license and the insurer does not inform policyholders the producer now only has property and casualty lines of authority on his license.

Because the principal grants its agent the authority to act on its behalf, the agent must conduct business in accordance with specific duties fundamental to the agency relationship. Those obligations vary based upon the parties to the relationship.

Parties to Whom Obligations are Owed

In addition to producers owing obligations under the law of agency to their principals--the insurance companies with which they are appointed, producers also owe duties to other individuals and entities as well. One party to whom producers do *not* owe any obligations under the agency relationship is to themselves.

Although it is human nature to attend to one's own interests, the agency relationship does not allow the agent's personal interests to interfere with carrying out duties and responsibilities on the principal's behalf. ***One component of the agency relationship, fiduciary duty, actually calls for the agent to yield personal interests in favor of the principal's interests.***

Fiduciary duty is the highest obligation imposed by law or ethics. When an individual fails to honor fiduciary duty by breaching its requirements, that individual may be sued and, if found guilty or negligent, be ordered to pay damages. ***The legal requirements of fiduciary duty include:***

- Acting *solely* for the benefit of the principal
- Not allowing any conflicts of interest to arise
- Not benefitting from the relationship unless the principal grants explicit consent to the agent at the beginning of the relationship

Examples of individuals who owe a fiduciary duty to their principals include:

- Trustees are fiduciaries of the trusts they manage
- Executors and personal representatives are the fiduciaries of the estates they manage for deceased persons
- Attorneys are fiduciaries of their clients
- Directors of corporations are the fiduciaries of the corporations they run, as well as the corporation's stockholders
- Real estate agents are fiduciaries of the clients they represent
- Certain financial advisers--such as registered investment advisers (RIAs) and certified financial planners CFPs--are the fiduciaries of their clients
- Insurance producers and adjusters are fiduciaries of the insurance companies that appoint them

Fiduciaries have multiple duties, the two most important of which are the duties of care and loyalty:

The ***duty of care*** requires agents to be informed and knowledgeable about all matters concerning any transaction made on behalf of their principals.

The ***duty of loyalty*** calls for agents to only act for the benefit of the principal and actually prohibits them from acting for anyone else's benefit--including their own. Agents cannot disclose the principal's personal information or use it for their own personal gain.

The ***duty of good faith*** obligates agents to conduct themselves honestly and in accordance with law.

The ***duty of prudence*** compels agents to behave as a reasonably prudent person would, given the same set of circumstances and the same level of knowledge, experience, and training.

The ***duty of disclosure*** demands that agents act with complete candor, revealing all relevant information as required and not withholding or concealing information.

In addition to protecting the interests of their principals, producers also owe responsibilities to the public. They must strive for the highest level of professionalism in all their dealings with consumers and businesses to maintain a strong positive image of the industry. In addition, they must keep the public informed while exhibiting the highest level of integrity.

As mentioned earlier, the responsibility for regulating the insurance industry is shared by both the state and federal governments, with the states carrying the burden of regulating the conduct of the insurance industry. This includes the oversight of ethical conduct by insurance producers and adjusters.

The majority of regulations addressing the ethical conduct of producers and insurers is spelled out in statute under the state's unfair trade practices act. These guidelines focus primarily on sales and marketing practices. Many states also regulate the ethical conduct of adjusters and insurers under statute in their unfair claims settlement practices acts, as well. Regardless of the title of these sections of state law, all states require insurance licensees to comply with ethical standards of conduct by defining in law behavior that is expected and/or prohibited.

Violations of state and federal insurance laws can involve administrative action, or penalties that are civil and/or criminal. Producers and adjusters can be subject to monetary fines, suspension or revocation of their licenses, and jail or prison sentences. Depending upon the nature of a violation, producers and advisers may find that their ability to work in the insurance industry as a licensee may actually be revoked permanently.

Conflicts of Interest

In its most basic form, a conflict of interest occurs when an individual who owes a fiduciary duty opts to: (a) secure personal benefit rather than securing a benefit for his or her principal, or (b) misuses authority granted by the principal for personal gain or profit. In addition to being a breach of ethical conduct, a conflict of interest often has legal consequences.

Insurance agents undertake many normal business activities that have the potential to cause conflicts of interest if not managed properly. These include:

- Collecting and/or billing premiums on behalf of an insurer.
- Having knowledge of or access to trade secrets and other confidential information.
- Being granted certain types of authority, such as binding insurance coverage.

Self-dealing, insider trading, and rebating are all forms of conflicts of interest that are prohibited in the insurance and financial services industries. But keep in mind, not all conflicts of interest are illegal.

The following are examples of actual conflicts of interest:

- Having special or ownership interest in a business that provides services to insurers (e.g., auto body repair shops, paramedic services, and medical laboratories).
- Selling insurance based on the commission level paid rather than on the applicant's needs and best interests.
- Working in a managerial position within an insurance company or agency while supervising an employee who is also a family member (e.g., spouse, child, parent).

It is crucial for insurance producers and adjusters to avoid all appearances of a conflict of interest. Clearly, the appearance of a conflict of interest doesn't necessarily mean one exists; however, it is much harder to disprove unethical conduct when there is the appearance of impropriety.

Susan is the manager of an insurance agency. The agency's owner hired Susan's son, Elliott, to work at the agency as a customer service representative. It was verbally agreed by Susan, her boss, and her son that Elliott's actual job performance would be managed by the agency owner.

One day, a client complained about Elliott's issuance of her homeowners policy and insisted that the matter be investigated and resolved that day. As it would happen, the agency owner was on vacation for the week and Susan had no alternative but to handle the complaint herself.

The familial relationship between Susan and Elliott does not necessarily mean that a conflict of interest will arise or that Susan will mishandle her investigation and handling of the complaint. However, the unhappy client might assume a conflict of interest exists because Susan is Elliott's mother.

If the allegedly negligent employee were not Susan's son, the appearance of a conflict would not arise … unless some other relationship between the two existed or were revealed.

Good and Bad Faith

Insurance companies and the policies they issue are bound by the legal principle of ***Utmost Good Faith. This notion requires all parties to a contract to act honestly, not mislead any other party, and not withhold information that is essential to the other parties executing the contract.***

In other words, the concept of Utmost Good Faith requires complete disclosure of all relevant facts and information--even if it is not specifically requested. In the insurance industry, the doctrine requires insurers to describe coverage and its limits accurately, and provide full disclosure about premiums, rates, and all transactions. It also requires applicants to answer all questions truthfully and provide any information applicable to the coverage being requested.

Most insurance applications require the applicant and producer to make representations, which are statements made to the best knowledge and belief of the party making them. A ***misrepresentation*** is a false statement of fact. In its most basic form, the definition of misrepresentation does not address knowledge of the falsity, or intent. It simply encompasses a statement that is not true.

Consider this:

A producer received a call from a man asking to insure his restaurant. The producer took the application over the phone and collected the applicant's signature and premium check the following day when the restaurant owner visited the insurance agency. The producer did not inspect the property before binding coverage--as underwriting guidelines required him to do.

Six months after the policy was issued, the insurance company wound up denying a claim for fire damage to the restaurant after its investigation revealed that the application contained numerous misrepresentations. The application stated the business was a restaurant open from 11 a.m. to 10 p.m. seven days a week. In addition, the application stated the restaurant did not serve liquor and did not provide live entertainment. In reality, the business operated as a strip club that served both food and liquor. The club was open 24 hours a day and had dancers performing nightly.

Concealment is the withholding of information material to the insurance coverage at hand. It is viewed in the same vein as misrepresentation is because it is committed deliberately and in connection with ***material information--information that forms the basis of the decision whether to conduct the transaction***. In most cases, concealment committed by the applicant is viewed as grounds for an insurer to deny a claim or void an insurance policy. Concealment committed by the insurer, a producer, or an adjuster is viewed as a violation of unfair trade or claim practices.

Continuing from the previous example:

After the insurer denied the claim, the restaurant owner alleged that the producer had known the true nature of the business operations all along and had not reported them accurately on the application. Furthermore, the restaurant owner stated the producer had visited the club as a patron on many occasions.

The producer denied the restaurant owner's allegations and was later accused by the insurer of concealment. Although the insurer could not prove the producer had either colluded with the applicant or lied on his own, it was able to prove the producer did know the true nature of the strip club's operations. Insurance company records showed that the producer insured several other businesses in the same neighborhood--and he had personally inspected all of them before binding coverage. Because he was familiar with the neighborhood, and regularly drove by the strip club, the producer's claims of ignorance were not credible.

Misrepresentations and concealment have no role in activities that are conducted in utmost good faith. Material misrepresentations and concealment are examples of how individuals and insurers do NOT act with the utmost good faith required of them.

"Bad faith" is a term used by attorneys and claimants alike. In the context of the insurance industry, it usually refers to unethical claims practices committed, or allegedly committed, by insurers and

adjusters. However, conducting activities in the absence of good faith does not automatically mean they are conducted in bad faith.

Each state's laws define bad faith. What might be considered bad faith in one state may not be viewed in the same light in another state.

Generally speaking, ***bad faith*** is a deliberate action undertaken with the intention to deceive, not fulfill an obligation, or commit fraud. The person committing bad faith is hoping to gain a personal advantage or benefit to the other party's detriment. ***The commission of an honest error is not the same thing as committing an act in bad faith.***

Another thing to keep in mind is that insurance bad faith laws apply separately to the insurance industry. In most states, insurance bad faith is a tort (a non-criminal act that is either a civil wrong or negligent) committed against a policyholder or claimant by an insurance company, including its adjusters and claims personnel. However, producers should be aware of one distinction about bad faith in state insurance laws. While some states consider insurance bad faith a tort--and allow the aggrieved party to sue to recover damages--other states consider it an administrative offense, meaning the insurance department handles allegations and complaints rather than allowing the judicial system to handle lawsuits.

Examples of behavior conducted in bad faith include:

> General bad faith: A manager who promises to promote an employee with the full knowledge she will never promote that employee.
>
> Insurance bad faith: An insurance claim representative tells a policyholder the insurance policy in question does not provide coverage when, in fact, it does and the claim representative knows it does.

Doctrine of Reasonable Expectations

Insurance products, the different coverage options available, and the wording contained in policies are too technical for the vast majority of consumers to fully understand. For this reason (and good job security for you as an agent), consumers most often rely on the agent to offer them on the proper coverage they need. They also have an expectation that the policy they purchase will meet their needs. Unfortunately, not all producers communicate effectively and not all consumers interpret statements made by insurance professionals accurately.

Ambiguity is often the underlying issue at hand when a policyholder misunderstands, or a client's expectations aren't met by an insurer. Ethical violations are often alleged and the client may sue the agent and the insurer. In these situations, a client's unmet expectations are evaluated under the Doctrine of Reasonable Expectations.

When a statement, explanation, or policy language is ***ambiguous***, it can be interpreted in more than one way, have more than one meaning, or be too difficult to understand because it isn't expressed clearly

enough. Not only are producers ethically bound to understand the insurance products they sell and service, they are also obliged to explain them in such a way as to enhance a consumer's understanding and not to confuse it.

The Doctrine of Reasonable Expectations is a legal principle that applies to contracts, usually contracts of adhesion such as insurance policies and loan agreements. A contract of adhesion is written by one party, usually one that provides a product or service in high demand, and does not allow the other party the ability to negotiate its terms. Essentially, the contract is offered on a "take it or leave it" basis. Because the party with the weaker bargaining position had no role in writing the contract, disputes are usually settled in its favor when they arise from the ambiguity in the contract's language or terms.

The Doctrine of Reasonable Expectations favors a policyholder who can prove that policy language was ambiguous, and he or she believed coverage would apply--despite policy language or other indications to the contrary. In such a circumstance, the courts resolve the dispute in favor of the policyholder rather than the insurer.

Remember, because producers serve their insurers under the agency relationship and as fiduciaries, all statements they make have the potential to affect the carriers they represent when disagreements arise. For this reason, compliance with requirements of transparency and disclosure are crucial for all insurance licensees.

Transparency/Disclosure

Because insurance is a technical field and those who sell, solicit, and service insurance contracts are required to be licensed to transact business in the insurance industry, the public looks to insurance producers and adjusters to simplify the process of purchasing and understanding insurance. Insurance policies are legal contracts and, as such, contain many clauses and provisions that explain the relationship between the insurer and insured, and how the parties must carry out their individual responsibilities.

The purpose of insurance disclosure is to explain a policy's major features and benefits so consumers can make intelligent, informed purchases. In essence, disclosure protects consumers. In many cases, disclosure must be made in writing. Sometimes, the information required to be disclosed must be included in the language of the actual contract itself and provided in a manner approved by state regulators. At other times, required disclosures can be given to applicants and policyholders on separate documents.

Most of the time, disclosure documents must be signed by the policy's owner and/or the insured person, with a copy given to the policy owner and a copy retained by the insurer. Producers should also retain copies of all disclosures provided as evidence they complied with their obligations under insurance statutes and ethics.

In many cases, disclosure of certain information is required by federal and state law. For example, if an insurer plans to obtain certain types of consumer reports about insurance applicants, it must disclose

certain actions that might be undertaken under the Fair Credit Reporting Act (FCRA). If a life or health insurer wishes to obtain a urinalysis or blood test, the applicant must provide written consent for the insurer to do so and the insurer must disclose what actions it will take upon receipt of the test results.

Each line or type of insurance requires its own standard disclosures. Some of these include:

- Insurance Declination and Termination
- Coverage Exclusions
- Sales and Marketing Practices
- Advertising
- Privacy and Security of Personal Information
- Agent Compensation

The purpose of transparency is to disclose all relevant and required facts related to the insurance matter at hand--whether it is a sales transaction, processing a service request, the submission of a claim document, or a conversation or verbal explanation. Although most producers represent their carriers and not the consumers and businesses buying insurance from them, it is always in the insurer's best interest to treat prospects and policyholders fairly, honestly, and professionally by disclosing all relevant information.

Professionalism

Most insurance statutes require insurance producers to exhibit a required level of knowledge, skill, and competence--which is how the term professionalism is defined. When producers and adjusters act professionally, they:

- Are properly licensed and appointed.
- Meet all requirements of licensure, including the completion of approved continuing education and other training, as needed.
- Understand the insurance industry and how it operates, including the legal principles upon which it is based.
- Act honestly and ethically, in all their insurance dealings.
- Provide full disclosure, including information that may not be specifically requested but that is helpful and necessary.
- Admit their mistakes and take all appropriate measures to rectify them as quickly as possible.
- Avoid any and all behavior that is unprofessional and/or unethical.

Insurance Producers, Agents, and Brokers

Because the states regulate insurance in this country, all U.S. jurisdictions require individuals and entities that sell, solicit, or negotiate insurance to be licensed. Depending upon the state and its insurance statutes, an insurance salesperson may be licensed as a producer, agent, and/or broker.

Because each of the states had different licensing requirements for resident and non-resident licensees, the NAIC published its Producer Licensing Model Act to help regulators adopt uniform laws and requirements. Before the NAIC's Producer Licensing Model Act was written, insurance licensees were referred to as either agents or brokers. Even now, when most states refer to licensees as producers, state law may still refer to and define the terms "agent" and "broker."

Producers, agents, and brokers have certain characteristics in common. They all:

- ***Act as third-party intermediaries between insurance companies and the public (i.e., consumers and businesses)***
- ***Are required to be licensed to sell, solicit, and negotiate insurance***
- ***Are regulated by state insurance regulators as residents and/or nonresidents***

The major difference between the terms ***producer***, ***agent***, and ***broker involves whom the licensed individual represents***. In all cases, producers, agents, and brokers must abide by their contractual obligations with the insurance companies that appoint them.

Producers

The term producer refers to any individual who is required by state law to be licensed to sell, solicit, or negotiate insurance. ***Producers represent the insurance companies*** whose products they sell and service. This means that under the law of agency, ***producers are the fiduciaries of their insurers*** and they must place the interests of their insurers before all other interests.

In most states, producers are only required to obtain insurance per the requests of their clients and prospective clients. This means they are not legally obligated to offer advice, make recommendations, or shop their clients' renewal policies. Of course, if they choose to undertake these responsibilities, they are free to do so. When producers provide a higher level of care than that required by law they will be held to higher standards if accused of unethical behavior.

Different types of producers exist, depending upon state law and the type of insurance being sold.

Agents

Like a producer, an agent represents the insurance companies with which he or she is appointed. ***Agents are the fiduciaries of the insurers they represent*** and must place the insurers' interests before all other interests. Unless state law stipulates otherwise, an agent's duty is to help consumers and businesses obtain insurance as requested. Agents are not compelled by law to provide unsolicited advice, suggestions, or options.

Agents generally conduct business in one of two ways: as a captive agent or as an independent agent.

A ***captive agent*** typically represents a single insurance company or group of insurers. Two examples of captive agent arrangements are State Farm and Allstate. The agent is licensed by the state and is usually only appointed by the captive carrier and insurance companies within its group of insurers. The captive

agent can be an employee or independent contractor, and can be paid a salary, commission, or a combination of both.

The agency contract between the captive insurer and its agent spells out the authority the insurer grants to the agent. It states the insurer owns the book of business and expiration list and generally requires its agents to sign non-compete agreements. Additionally, the contract indicates whether the captive agents are permitted to sell insurance for other insurance companies.

In some cases, a captive insurer will permit its agents to sell insurance offered by other carriers. Usually, this permission is only granted for one of two reasons: (1) the line of insurance being sought by a prospect is not a product the insurer sells, (2) the applicant is not eligible for any product the captive insurer offers. Many captive insurers do not permit their agents to sell insurance for any other insurer under any circumstance.

The reason for this prohibition rests with conflicts of interest. Captive insurers do not want any potentials for a conflict of interest to arise and they phrase their agency contracts accordingly.

By comparison, an independent agent represents multiple insurance companies. The agent is licensed by the state and can be appointed by any number of insurance companies. Independent agents are independent contractors and not employees of the insurers they represent.

The agency contract between the independent agent (or agency) and each of its insurance companies spells out the authority it grants. Instead of the insurer owning the book of business and expiration lists, the independent agent/agency does. No non-compete agreement is required as all parties to the contract recognize and accept that the independent agent represents and is appointed by multiple insurers.

Another type of agent is a Managing General Agent (MGA). A Managing General Agent is a specialized agent that serves as the agent of multiple insurers and also performs functions of *both* insurer and agent. The duties required of MGAs, and the authority granted to them by insurers, is based in each insurer's individual needs. Generally, managing general agents can:

- Bind coverage.
- Handle pricing and underwriting duties.
- Appoint retail agents.
- Adjust and/or settle losses and claims.

Brokers

A broker represents the client. Because they are not the legal representative of their insurers under the law of agency, brokers often do not have the same authority to act on behalf of insurers that producers and agents do. Even when brokers do have agency contracts with insurers and are granted binding authority, they are still legally obligated to protect the best interests of their clients--the policyholders--rather than the insurance companies that appoint them. ***Brokers serve as the fiduciaries of their clients.***

Although brokers are obligated to fulfill their contractual obligations to the insurance companies they represent, their primary goal is to protect the interests of their clients and prospective clients by identifying risks and exposures, and locating the most appropriate type(s) of insurance to address them. Individuals and businesses actively seek the services of brokers because they value their insight and experience and hope to receive the advice and recommendations of professionals with knowledge that they, the consumers, lack.

Two types of brokers exist: retail and wholesale. A retail broker serves as the intermediary between an insurance company and the policyholder. Retail brokers work directly with individuals, families, and businesses and help them identify and purchase the insurance products that best fit their needs. A wholesale broker is also an intermediary, but one between an insurer and its retail brokers rather than between the insurance company and its applicants and policyholders.

Brokers can sell standard lines of insurance, such as at a typical retail insurance agency. They can also sell surplus lines, or non-admitted, insurance. Surplus lines brokers typically do not have binding authority and are subject to different insurance licensing requirements and regulations than other brokers (and agents). Surplus lines brokers and brokerages employ surplus lines producers, who are also subject to surplus lines legislation.

The following example illustrates the differences between how an agent and a broker are obligated to respond to the request of a consumer who visits with the intention of purchasing an insurance policy. The type of policy being requested doesn't matter but, for purposes of illustration, a life insurance policy is used.

> Ivan visits the insurance agency and tells Carmella, his "agent," that he wants to buy a $500,000 term life insurance policy.
>
> If Carmella were licensed as a producer or agent, she owes Ivan the duty to place coverage as he requests it. She is not obligated to suggest that he consider the purchase of permanent life insurance or that he consider purchasing $1,000,000 of coverage because the cost per $1,000 of insurance is less expensive at that amount. Once the sale is made, Carmella is not obligated to review Ivan's policy or to inquire in the future about any additional life insurance needs that might arise.

If Carmella were licensed as a broker, she owes Ivan the duty to inquire about his needs, about the risks and exposures he faces, and about any other matter than might affect his purchase of insurance. She is also obligated to disclose that other types of life insurance are available for purchase and to explain them--comparing and contrasting the different benefits and features. Additionally, Carmella is obligated to inform Ivan that higher amounts of insurance are available and why they might be more beneficial than the amount he has requested.

Generally speaking, producers and agents are order takers. If they worked at the drive-up window at a fast-food restaurant, they would not be required to ask patrons ordering a hamburger if they wanted fries with it. But if a broker worked at that same drive-up window, he or she would be required to ask patrons if they wanted fries with their burger, if they wanted to up-size their drinks from medium to large, and if they wanted a cookie for an extra dollar.

Remember: Each state has enacted its own laws and, judicially, has established precedents about how it handles the legal and ethical duties of producers, agents, and brokers. All insurance licensees should be familiar with the insurance statutes and jurisdictional climate in the states in which they are licensed.

Insurance and Financial Specialists

In addition to being licensed producers, some insurance professionals are licensed to sell securities, and/or provide services as financial planners, investment advisers, or insurance consultants. Each of these specialists is required to be licensed differently and, as a result, to fulfill different obligations and duties to the clients and organizations they represent.

Broker-Dealers and Registered Representatives

A broker-dealer, or brokerage firm, conducts business on behalf of its clients as the buyer and seller of securities, such as stocks, bonds, mutual funds, and other types of investment products. Sometimes broker-dealers also offer investment advisory services.

When buying or selling on behalf of its clients, the firm acts as a broker. When buying or selling on its own behalf, the firm acts as a dealer. The firm may also act as both a broker and a dealer. The individuals who work for broker-dealers as salespersons are registered representatives, and are often referred to as “stockbrokers.” Broker-dealers must register with and are regulated by the Financial Industry Regulatory Authority (FINRA).

A registered representative (registered rep) works for a broker-dealer or brokerage firm and must also register with FINRA. The registered rep is hired by clients who wish to trade investment products such as stocks, bonds, and mutual funds. Essentially, registered reps buy and sell securities for their clients and must be licensed to sell those securities. They are often referred to as “brokers.”

Registered reps are obligated to conduct business in accordance with suitability standards and are considered transaction-based service providers. As such, they are compensated based on the

transactions they conduct, usually on a commission basis. Some registered reps are paid an annual salary or a flat fee per transaction.

Broker-dealers and registered reps are required to comply with a legal standard based on suitability. This standard does not require them to act as a fiduciary of their clients; however, FINRA does impose strict rules and regulations governing their conduct.

Investment Advisers

A registered investment adviser (RIA) or investment adviser (IA) works for an investment advisory company or a broker-dealer and offers securities-related advice to clients in exchange for a fee. RIAs can only offer advice about products for which they are licensed. The term "investment adviser" is a legal term that defines an individual who is registered as an investment adviser with either the (SEC) or a state securities regulator.

Other terms used in lieu of "investment adviser" include *asset manager, investment counselor, investment manager, portfolio manager, wealth manager,* and *financial adviser.* Investment advisers can also be stockbrokers, insurance producers, money managers, estate planners, bankers, etc.

The SEC regulates investment advisers who manage $110 million or more in client assets. State securities regulators regulate investment advisers who manage client assets up to $100 million. Once a state-regulated investment adviser is managing $100 million in assets, the individual may also register with the SEC. In most cases, once the assets under management reach $110 million, the individual must register with the SEC.

Compensation paid to investment advisers is in the form of a flat fee or percentage of their assets under management. For this reason, they are prohibited from receiving compensation that is transaction-based.

Investment advisers are also subject to federal law (The Investment Advisers Act of 1940), which requires them to serve as the fiduciaries of their clients. The Act states that an individual is deemed an investment adviser based on whether he or she:

- Provides advice about the purchase and sale of securities.
- Is paid a fee for providing investment advice.
- Receives the majority of income from providing investment advice.

In addition, investment advisers are required to comply with the legal doctrine of Utmost Good Faith and to carry out strict standards of care and loyalty. Investment advisers cannot engage in any conflicts of interest and can never place their own interests above those of their clients. In most cases, investment advisers cannot engage in transactions on behalf of their clients without first obtaining authorization from their clients.

Financial Planners

The term financial planner refers to an individual who can perform one or more of a variety of services. However, all financial planners are not the same--and neither are the services they provide. Individuals who practice this profession evaluate and offer advice about one or more of the following topics during the process of creating a financial plan for the future:

- Investments
- Savings
- Insurance
- Retirement
- Estate planning
- Taxation

Some financial planners specialize in a particular area of expertise, such as estate planning, while others offer advice and services in all the areas mentioned. In addition, financial planners offer their services differently. Some of the noteworthy differences include:

Education and background. Some financial planners are also accountants, attorneys, insurance producers, or investment advisers. Some have college degrees and others have designations or credentials such as Certified Financial Planner (CFP)®, Chartered Financial Analyst, Chartered Financial Consultant (ChFC), or Certified Investment Management Analyst (CIMA).

Compensation. Based on a financial planner's licensing and credentialing, he or she may charge a flat fee or hourly rate for each particular planning service performed. If financial planners sell insurance or investment products, they may be paid a commission in connection with those sales. Some financial planners charge a combination of fees and commissions based on a number of factors.

Advice provided. Financial planners may only give investment advice if they are registered with the SEC or a state securities regulator. Similarly, they may only give insurance advice if they are licensed insurance producers or if they are exempt from insurance licensure because they are licensed or credentialed in another area (i.e., as an attorney, accountant, registered representative).

It is not ethical for insurance professionals to arbitrarily call themselves "financial planners." In fact, in some states it is illegal to do so. Licensed insurance and investment professionals may only refer to themselves by terms that accurately describe the type of licenses and certifications they hold.

Insurance and investment products are undeniably an integral part of a financial plan that is designed to meet the needs of an individual, family, or business. However, the inclusion of insurance and investment products in a financial plan does not automatically endow the individual *selling* those products with the authority, expertise, or knowledge to provide financial planning services.

Because a variety of terms are used interchangeably with "financial planner," consumers can easily misunderstand what they mean … and can be easily misled by individuals who falsely advertise themselves as financial planners.

"Financial adviser" and "financial planner" do not mean the same thing and these professionals do not serve in the same capacity. A financial adviser helps consumers manage money. This includes offering advice, facilitating the sales and purchase of investments, and *may* include financial planning. However, financial planners cannot give investment advice unless they are also licensed as investment advisers.

Adjusters

Adjusters are licensed and regulated based on the duties they perform and the parties they represent. Each state regulates adjusters differently; the following descriptions are provided in a general sense and for illustrative purposes.

Public Adjuster. A public adjuster is hired by and represents an individual (or business) to whom a property insurance policy was issued. That policyholder hires the public adjuster to assist with the negotiation and settlement of a property insurance claim submitted by the policyholder to the company. The policyholder hiring the public adjuster is responsible for paying the adjuster and payment to the adjuster is usually made in the form of a fee that represents a percentage of the claim settlement.

A company adjuster is employed by and represents the employer, an insurance company. Most company adjusters are paid a salary and work on a regular basis for their employers. They may adjust claims submitted in all lines of insurance or specialize in a single line of insurance or type of claim, such as workers' compensation or catastrophe losses.

An independent adjuster is either an individual or a company hired by an insurance company as an independent contractor. The independent adjuster represents the insurer for which it works and is paid based on the number and types of claims assigned. The rate of pay for adjusters who only work in an office is different from that of adjusters who work regularly in the field. This is especially true of outside adjusters who handle large, complicated claims or catastrophe claims. Payment to independent adjusters can be in the form of a fee per day, a flat fee for the claim, or a percentage of the claim settlement.

Public adjusters serve as the representatives and fiduciaries of the policyholders who hire them. Company and independent adjusters serve as the fiduciaries of the insurance companies that hire them.

In some states, a distinct section of insurance code applies to public adjusters and appears separately from statutes that apply to company and independent adjusters. Regardless, all adjusters are subject to state insurance laws and standards of ethical conduct.

The National Association of Independent Insurance Adjusters (NAIIA) and the National Association of Public Insurance Adjusters (NAPIA) display published codes of conduct on their websites. Each of these codes stipulate adjuster obligations and types of behavior that is prohibited.

For instance, it is generally accepted as unethical for any adjuster to refer a claimant to a repair shop or other business for service if the adjuster has an undisclosed financial interest in that business. In some states, such a referral would be prohibited even if the adjuster *did* disclose the financial interest.

The code of conduct that binds insurance adjusters differs somewhat from the standard imposed on insurance producers. The difference is attributed to the unique role adjusters play in insurance transactions, along with the distinct characteristics of the loss adjustment and claim settlement processes.

General business practices (i.e., trade practices) include activities such as sales, marketing, and advertising. They form the basis of the professional activities conducted by insurance producers. Unfair trade practices are spelled out in federal law, which forms the foundation of the unfair trade practices acts contained in state insurance statutes.

The processes of loss adjustment and claims settlement are viewed more as a function of market conduct (i.e., how well or poorly insurers comply with state insurance code) than they are a form of regular business practice. For this reason, most states have enacted two separate insurance laws for the prohibition of unfair trade and claim settlement practices.

The regulation of claim practices varies by state. Most states only apply their Unfair Claims Settlement Practices Act to first-party claims; however, some states apply them to first- *and* third-party claimants. Why? Because of the contractual relationship between insurers and their policyholders, as well as the contractual obligations contained in the insurance policies, insurance companies are bound to a higher standard when conducting transactions with their own policyholders.

A first-party claim is submitted by a policyholder/claimant to his or her own insurance company--the insurer from which the policy was purchased. A third-party claim is submitted by an individual or business to an insurance company that did NOT issue a policy to the claimant.

Doris owns a bookstore and one day, an electrical fire caused damaged to the bookstore. While Doris and her customer, Donald, fled the building, Donald fell and sprained his ankle.

When Doris submits a claim to her insurance company for the building's fire damage--the insurer that issued a businessowners policy to her--she submits a first-party claim. She is a first-party claimant.

When Donald submits a claim to Doris' insurer for the medical bills he incurred after falling--an insurer that did not issue a policy to him--Donald submits a third-party claim. He is a third-party claimant.

Under the law of agency, company and independent adjusters are the agents of their principals--the insurers that hire them. Therefore, they must serve as fiduciaries of the insurance companies and, by extension, honor the legal and ethical obligations imposed upon insurers when adjusting losses and settling claims.

Licenses and Registrations

Regardless of the type of insurance or financial services professional, and whether the licensee is an individual or an entity, it is unethical and/or illegal to provide services and give advice or recommendations without holding the appropriate license or registration. Insurance producers can be licensed in one or more of several lines of authority after passing an exam, including:

- Life
- Health
- Accident and sickness
- Variable products
- Medicare supplement
- Long-term care
- Property
- Casualty
- Personal lines
- Crop
- Surety
- Bail bonds
- Limited lines (e.g., credit, travel, pet, car rental)

In all cases, licensees cannot sell, solicit, or negotiate insurance in a particular line of authority without the appropriate license.

Each state describes what individuals and entities are eligible for licensure and what the requirements are. In other words, if a producer is only licensed in property and casualty lines of insurance, the producer cannot sell life insurance or make recommendations about the purchase of long-term care insurance.

Similarly, individuals can only conduct securities transactions and provide advice about securities if they are registered properly. Registration for broker-dealers and individuals is handled differently.

Broker-dealers cannot conduct securities transactions, nor can they conduct business with investors, until after they have been registered with FINRA and either the SEC or the state securities regulator. FINRA Rule 1000 Series and FINRA Rule 1014 outline all procedural requirements for broker-dealers. Individuals who work for broker-dealers must also be registered; they include salespersons, branch managers, department supervisors, partners, officers, and directors.

Before obtaining a securities registration, individuals must pass an exam. The exams include:

- Securities Industry Essentials (SIE) Exam
- FINRA Representative Exams
    - Series 6 - Investment Company and Variable Contracts Products
    - Series 7 - General Securities
    - Series 22 - Direct Participation Programs (Limited Representative Exam)
    - Series 57 - Securities Trader
    - Series 79 - Investment Banking
    - Series 82 - Private Securities Offerings
    - Series 86/87 - Research Analyst
    - Series 99 - Operations Professional
- North American Securities Administrators Association (NASAA) Exams
    - Series 63 - Uniform Securities Agent, State Law
    - Series 65 - Uniform Investment Adviser, Law
    - Series 66 - Uniform Combined State Law
- Other exams include:
    - FINRA principal-level exams
    - Municipal Securities Rulemaking Body (MSRB) exams
    - National Futures Association (NFA) exams

Investment advisers (IAs) and investment adviser representatives (IARs) are also required to register with their states' securities regulator unless they are exempt from registration. Most states establish additional requirements for advisers, such as requiring them to hold specific securities registrations (e.g., 7 and 66, or 65) or specific certifications (e.g., CFP, CHFC).

Chapter 2 Review Questions

1. Which of the following is NOT one of the parties to a relationship governed by the Law of Agency? (page 24)
   a. Regulator
   b. Principal
   c. Agent
   d. Third party

2. Which of the following is NOT one of the legal implications of the relationship between producers and insurers under the law of agency? (page 24)
   a. Producers represent the interests of the insurer
   b. Anything the producer knows, the insurer knows
   c. The producer's actions are considered the insurer's actions
   d. The insurer is given permission to act on behalf of the producer

3. Fiduciary duty requires an individual to do all the following EXCEPT: (page 25-26)
   a. Act solely for the benefit of the principal
   b. Not allow any conflicts of interest to arise
   c. Act for the principal and the third party
   d. Not benefit from the relationship without the principal's express consent

4. What occurs when an individual who owes a fiduciary duty chooses to secure a personal benefit rather than caring for the interests of his or her principal? (page 27)
   a. Violation of state law
   b. Conflict of interest
   c. Unfair trade practice
   d. Unfair claims practice

5. What legal principle requires all parties to a contract to act honestly, not mislead any other party, and not withhold essential information? (page 28)
   a. Utmost Good Faith
   b. Willful blindness
   c. Fiduciary duty
   d. Golden Rule

6. Producers, agents, and brokers share all the following characteristics EXCEPT: (page 33)
   a. They are third-party intermediaries between insurers and the public
   b. They are required to be licensed to sell, solicit, or negotiate insurance
   c. They are regulated by state insurance departments
   d. They represent their clients in a fiduciary capacity

7. Producers and agents represent _____. (page 33)
   a. Their insurance companies
   b. Their clients
   c. The state
   d. Themselves

8. Brokers represent _____. (page 34)
   a. Their insurance companies
   b. Their clients
   c. The state
   d. Themselves

Chapter 3: Relevancy of Ethics in Insurance

The Profession of Insurance

Most individuals working in the insurance industry consider insurance a profession and themselves as professionals. However, not everyone agrees with this assessment. A former president of the American Institute of Chartered Property and Casualty Underwriters listed several criteria that separate a profession from other vocations, namely:

- The existence of a highly unified body of specialized knowledge within the profession.
- A broad educational background that also includes general knowledge.
- A detailed, thoughtful, published code of ethical conduct.
- A requirement of all working in the profession to strive for the "ideal of altruistic attitude and behavior;" used in this context the meaning of "altruistic" is a concern for the welfare of others over one's own self.
- Detailed or "searching" examinations to determine if those working in the profession have sufficient mastery in the specialized skills required of the profession.
- A professional organization that controls entry into the profession and monitors its members' "continuing adherence to the tenets of that profession."
- The need for "careful mentoring" of those entering the profession by their more experienced colleagues.

Although the insurance industry itself does not meet all the previous criteria, an individual's career in the industry may be considered a professional vocation. In fact, based on the stated standards, the financial services segment of the industry that regulates investment advisers and registered representatives certainly does seem to meet the definition of "profession." Unfortunately, other segments of the industry do not.

Passing examinations and becoming licensed are not qualifications that, in and of themselves, qualify insurance producers and investment advisers as professionals. For instance, plumbers and bus drivers must pass examinations before obtaining their licenses, yet plumbing and driving are viewed as occupations and not professions.

Although those employed in the insurance industry--especially licensees--are required to complete training, the specifics of that training varies by state and the segment of the industry in which an individual is working. Is pre-licensing training adequate to categorize an individual as an insurance professional? Is ongoing training required? If so, must it be approved by the state insurance department or some other regulatory body … or is the approval of a self-regulatory authority sufficient?

Does the issuance of an insurance certification or designation qualify a person as a professional? Maybe. But maybe not.

True professional insurance training is time consuming and often costly. It can be provided by universities such as the College of Insurance and the Insurance Institute of America--as well as by state and private colleges and universities. The Society of Insurance Trainers and Educators (SITE) identifies dozens of different insurance professional designations, most of which require class attendance, study, and the passing of written examinations.

The National Alliance for Insurance Education and Research offers insurance designations such as Certified Insurance Counselor (CIC), Certified Insurance Service Representative (CISR), and Certified Risk Manager (CRM). The American College offers professional designations such as Certified Financial Planner (CFP), Chartered Financial Consultant (ChFC), and Chartered Life Underwriter (CLU).

Each of these colleges, universities, and insurance designation/certification organizations operates within the framework of a code of conduct. Each requires its members to comply with specific training standards and its ethical guidelines as a condition of membership. However, despite the availability of vast types and amounts of insurance training, education, certifications, and designations, the insurance industry does not require insurance licensees to earn any specific college degree or designation.

The most meaningful word here, when considering whether the insurance industry is a profession, is "require." ***The industry does not require those working within it to complete specific training, undergo advanced education, or acquire particular certifications or designations. These undertakings are entirely voluntary.***

Of course, to obtain an insurance license one must pass an examination and, in some states, complete pre-licensing education. To renew an insurance license, producers must complete approved continuing education in accordance with state law. But the producers, themselves, choose what types of licenses they want and the types of training and education they wish to complete.

On the other hand, to earn an insurance designation such as CLU or CIC, a licensee *must* meet specific requirements. But again, pursuit of a designation is optional.

Earlier in the course, a discussion of ethical codes of conduct took place and a list was provided to illustrate some of the insurance organizations that have published their standards. For example, if an insurance producer or investment adviser is a member of FINRA or has a CFP designation, that producer is usually deemed a professional because he or she is *required* to meet professional criteria.

It is important to understand that membership or certification alone, even when it requires observance of an ethical code of conduct, does not automatically signal an insurance licensee is professional. How the licensee comports himself or herself, and whether the individual behaves with integrity, is what determines professionalism.

Although businesses exist to make a profit for their owners, a profession exists to serve the needs of its clientele. This entails placing the clients' interests above those of the professionals providing services. It expects their acceptance of ethical standards that call for selfish commercial and personal viewpoints to

be rejected. In short, professionals avoid the pursuit of self-interest and focus, instead, on justice and fairness.

When embracing the Golden Rule, producers treat others as they wish to be treated: fairly, honestly, and transparently. If producers pursue their own interests at the expense of others, they are acting unethically.

Consumers and business owners choose to work with professionals precisely because of the perception they are not only highly qualified but also highly virtuous and principled. This trust is placed despite the possibility a professional's superior knowledge and position of authority may tempt the individual to abuse that faith and reliance.

Being tempted isn't unethical. Falling prey to temptation and harming another is.

At its root, professionalism requires the service provider to suppress his or her own personal goals and interests in favor of the client's goals and interests. Professionalism requires business to be conducted fairly, without harming *anyone*, while practicing the highest standards imposed by law and ethics.

Sales, Advertising, and Marketing

Salespersons and their occupation are often viewed negatively in our society. Why? Because many use their talents to manipulate and persuade rather than to educate and assist.

Basically, the consuming public would much rather receive help when making its buying decisions than be sold to. In addition, many salespersons and companies insist that the best purchase is the one that costs the least. To them, competition is all about price. They ignore the quality of the product or service being sold and the reputation of the party providing the product or service.

Unfortunately, this attitude not only permeates society, it also pervades the insurance industry. This concept is outrageous--at least to ethical insurance professionals. If the adage *you only get what you pay for* is true, then it stands to reason insurance purchases from ethical, reputable, knowledgeable insurance producers and carriers would cost more than those made from unethical, disreputable, ignorant producers and insurers.

When reviewing the codes of ethics published within the insurance industry, it becomes obvious that ***most of the requirements and prohibitions addressing unfair trade practices pertain to sales, advertising, and marketing***. It should surprise no one to learn that it is during these processes that the unsuspecting consumer is most at risk of being exploited. Remember: laws are created when a society decides current behaviors are no longer acceptable and protections need to be established to keep members of society safe.

So, what exactly are sales, advertising, and marketing and what is it about these processes that makes insurance consumers so vulnerable?

Sales is the process of giving up a product or service in exchange for something of value--usually money. For example, a car dealership gives away a car in exchange for $25,000 or a professional agrees to provide consulting services in exchange for a fee of $200 per hour. When a producer sells insurance, a trade is being effected. In exchange for the quoted premium, the insurance company agrees to perform as stated in the insurance contract.

Advertising is the process of calling the public's attention to something, usually by way of a paid announcement or other type of message. When advertising, an individual or business might pay for an ad in a magazine, newspaper, or on the radio. Advertising can also be conducted via email message, newsletter, direct mail letters and postcards, and on the Internet. The use of promotional items, such as logoed clothing and pens, may also be a form of advertising.

Marketing is a process that is not as tangible, or as easy to explain, as sales and advertising are. Basically, marketing is the act of selling or buying in a market. But it involves the technique of promoting, selling, and distributing products and services. Instead of being a single, easily identifiable function, marketing is the *aggregate* function of moving products and services from sellers to buyers. It can include selling, advertising, and networking--but does not always include each of the other functions.

Now that the three processes have been explained, it is important to delve into the characteristics of each to uncover how they have the potential to be manipulated to the advantage of the unethical insurance professional and the detriment of the client.

The goal of selling insurance is simple: trade an insurance policy for a specified amount of premium dollars. Producers are paid for effectuating the sales of insurance by receiving a percentage of the premium paid by the policyholder. That payment is made by the insurer in the form of commissions. The level or amount of commission is based on the type of policy sold, the insurer's commission schedule, and whether the commission is being paid for the initial purchase of a policy or its renewal.

The XYZ Insurance Agency receives commissions from its insurance companies as follows:

Line of Insurance	Company A's Rate of Commission	Company B's Rate of Commission
Personal Auto 1st year and renewals	10%	8%
Motorcycle 1st year and renewals	7%	5%
Homeowners 1st year and renewals	15%	12%
Commercial Lines (other than auto) 1st year and renewals	20%	15%
Term Life Insurance 1st year only	60%	40%
Term Life Renewals only	5%	4%
Permanent Life 1st year only	60 to 90%, depending upon product	40 to 70%, depending upon product
Permanent Life Renewals only	8%	5%

At first glance, the differences between the commission rates paid by the two insurance companies do not appear to be significant. If a producer were selling a personal lines auto policy with a $1,000 premium, the difference in commission paid by Companies A and B is $20.

But if the producer were selling a commercial lines auto policy with a $10,000 premium, the commission difference would be $500.

If a producer were to only sell Company A's products because of the higher commission levels paid and without regard to (a) any of his or her clients' needs, and (b) the differences in the companies' contract terms and provisions, that producer would have the potential to earn significantly higher annual compensation than if selling the policies of both insurance companies.

The topic of compensation sits squarely in the middle of the ethical conversation about producer conflicts of interest. When producers are employed by agencies that represent multiple insurance companies, the potential to yield to the temptation of selling based on commission level is more complex and multi-layered than it is for captive agents. Why? Because captive agents represent only one company or group of companies and have fewer product options to choose from. Independent agents have so many more options to choose from and, as a result, more opportunities to place their own self-interest before that of their clients.

Selling insurance based on commission levels isn't the only potential ethical pitfall associated with the sales of insurance--or when advertising and marketing insurance.

The Federal Trade Commission (FTC) Act prohibits "unfair or deceptive acts or practices in or affecting commerce." The NAIC, and by extension, each of the states' insurance departments has established guidelines, laws, and regulations based on federal law to regulate the business practices within the insurance industry. Unfair trade practices usually apply to the sales of products and services to consumers, tenants, and insurance policyholders/prospects. They are also often conducted in connection with debt collection and the settling of insurance claims.

For a trade act or practice to be deemed unfair, it must meet all three of the following criteria:

- Cause, or be apt to cause, serious harm to consumers.
- Cannot be reasonably avoided by consumers.
- Not be offset by compensating benefits to consumers or competitors.

For a trade act or practice to be deemed deceptive, it must meet all three of the following criteria:

- Tend to mislead consumers.
- Under the circumstances, be construed as reasonable by the consumer.
- The misleading aspect is material to the transaction.

Once again, the concept of intention is integral. When viewing the unfair or deceptive act or practice, the intention of the person committing the act or practice is called in to question. When producers explain the terms and features of insurance policies incorrectly but actually believe they are doing so accurately, they don't commit unfair or deceptive acts or practices in the insurance business. They simply make mistakes. It is the intentional and deliberate attempt to violate the law, lie, cheat, or mislead that makes certain practices unfair and/or deceptive.

In most cases, the states deem the conduct of business within the insurance industry to be unfair or deceptive--and therefore prohibited--when certain acts and practices are committed flagrantly and in conscious disregard of the law or with such frequency they indicate they are part of regular business operations.

Prohibited Practices in Sales, Advertising and Marketing

The following sales, advertising, and marketing practices are considered both unethical and illegal in most state insurance statutes:

Misrepresentations and False Advertising of Insurance Policies. This prohibition applies to producer statements, omissions, policy comparisons, and sales presentations as well as any written estimate, illustration, brochure, or other material. The practice of knowingly making false statements is prohibited when the producer misrepresents:

- Policy benefits, terms, or conditions.
- Policy dividends or surplus.
- An insurance company's financial condition.
- A policy's name, category, or description (i.e., term life insurance versus permanent life insurance).
- A policy as a share of stock.

A prohibited trade practice takes place when a producer misrepresents an insurance policy for the purpose of inducing a policy sale, effecting a policy loan or assignment, or terminating, forfeiting, or lapsing a policy. These prohibitions also include deliberately misquoting a policy rate or premium.

False Information and Advertising, Generally**.** This prohibition applies to producer conduct that places in the public sphere, in any fashion, an announcement or statement about the insurance industry or an insurer (including its employees) that is untrue, deceptive, or misleading.

Defamation. This prohibition applies to statements, either written or verbal, that are designed and intended to cause harm to an insurer. ***To find a person guilty of a defamatory act, four elements must be proven legally:***

- ***The statement must be false.***
- ***The statement must be witnessed (i.e., seen or heard) by an uninvolved third party.***

- ***The accused must be negligent when making the statement, acting with malice, or totally unconcerned with the truthfulness of the statement.***
- ***The claimant/plaintiff must suffer actual damages, which can include mental anguish.***

The language of this prohibition requires the statement to be "false, maliciously critical of or derogatory to the financial condition of any insurer" and that is "calculated to injure" the insurer. But legally, one of the most difficult aspects of proving that defamation took place revolves around the accused's *intentions*. How can one prove what another was thinking or planning?

Many individuals believe they can say whatever they choose about their competitors, especially if what they say is the truth. It is important for producers to keep in mind the difference between opinions and the truth.

If a statement is true, it is exact or precise. It is factual and describes what really is rather than what one perceives to be. An opinion is one's judgment or perception and does not have to be based on a fact or actual knowledge. Essentially, just because a person believes something to be true doesn't mean that belief is factual. Remember: scientists once believed the world was flat!

***Boycott, Coercion, and Intimidation*.** Restricting or restraining trade--activities that prevent a business from operating normally and without interference--are illegal under federal law and, specifically, with respect to interstate commerce (the transaction of business across state lines). Federal and state laws exist to preclude businesses from operating in such a way that harms consumers or the competition. State insurance laws specifically prohibit the practices of boycott, coercion, and intimidation in the business of insurance.

> Boycott. This activity is an organized effort to cease business transactions with a particular company to cause it financial injury or to change the way it operates. Boycotting can also be used to attract attention to a specific cause.
>
> Coercion. This activity involves the use of force, either physical or moral, to convince another to act or not act against his or her wishes. In effect, coercion prevents another from exercising free will.
>
> Intimidation. This activity makes a person act or not act through the use of tactics that instill fear.

Rebating. This prohibited practice involves the payment of a gift, cash, a return of premium not stated in the policy, or anything else of value as an inducement to purchase an insurance policy. If a producer who receives commission for the sale of an insurance policy pays any portion of the commission received to an individual who is not licensed to sell that line of insurance, the payment is viewed as an illegal rebate.

Examples of rebating include a producer:

- ***Giving a client tickets to a Major League Baseball game in exchange for purchasing an insurance policy.***
- Paying a $25 referral fee to a salesperson at a car dealership for every referral that results in the sale of auto insurance. (Note: the car salesperson is not a licensed insurance person.)
- Offering to pay the first premium on a life insurance policy as a way to thank the client for doing business.
- Who is only licensed to sell life insurance sharing commission with a producer who is only licensed to sell property and casualty insurance.

Misrepresentations in Insurance Applications. This prohibited practice applies to producers and two types of statements made in insurance applications: statements made directly by producers and statements made by applicants that producers know are false.

Insurance companies distribute insurance applications to producers because they expect producers to complete them. If they wanted and/or expected applicants to complete insurance applications on their own, insurers would supply the forms directly to applicants.

Every insurance application is designed for the purpose of the producer collecting information the insurer needs to underwrite the risk being considered. Insurance applications require the soliciting producer's signature. Some applications, such as life insurance applications, actually contain a section on the application--an Agent's Statement--that asks specific questions of the producer.

In all cases, the producer's signature is viewed by the insurer as the agent's confirmation that all questions on the application were asked of and answered by the applicant, that all information contained in the application is true to the producer's (and applicant's) best knowledge and belief, and that the producer actually met with the applicant and/or inspected the subject of insurance.

When producers submit applications that contain intentional misrepresentations, they breach the ethical and fiduciary duties they owe to the insurance companies they represent. Prohibited misrepresentations in insurance applications are false or fraudulent statements or representations made for the purpose of having a policy issued so the producer can receive a commission, fee, money, or any other benefit. The commission, fee, money, or benefit can be received from any insurance company, provider, or individual.

Claims

In the insurance industry, the adjusting of losses and settlement of claims are viewed more as functions of market conduct rather than as general business practices. Because of the uniqueness of the contractual relationship between insurance companies and their policyholders, as well as the highly complex nature of insurance products, claims practices are regulated separately from other insurance activities and transactions.

The NAIC created model laws and regulations for unfair claims settlement practices in a similar fashion to its adoption of models for unfair trade practices. Most states have incorporated into insurance statute their own versions of the NAIC Unfair Claims Settlement Practices Act. It is important for producers to identify any differences between the NAIC models and actual laws in the states where they are licensed.

Basic legal principles, along with those that only apply to insurance claims, apply to claim settlements. Before discussing some of those principles, a discussion about the differences between the terms "loss" and "claim" must take place.

A loss forms the basis of a claim. It can be an event, an occurrence, a wrongful act, an omission, or anything else that causes a claim to be submitted. In short, a loss means something happened. However, not every event or happening transforms into a loss or a claim.

A claim is a demand for recovery under an insurance policy. It is submitted because a loss occurred and a claimant believes a particular insurance policy will cover the loss that gave rise to the claim. Not all claims are covered by the policy under which they are submitted.

> Delaney is driving her car, slides on ice, and strikes a fence. This occurrence is a loss. If Delaney's car and the fence do not sustain damage, no claim will ensue because no demand for recovery will be submitted under any insurance policy.
>
> If Delaney's car is damaged, she will submit a claim to her insurance company. Similarly, if the fence is damaged, its owner will submit a claim to either Delaney's auto insurance policy or the owner's property insurance policy. In this case, the single loss will give rise to two separate and distinct claims.

When adopting unfair claims settlement practices statutes, each state does so differently. Under most state insurance statutes, insurers and their adjusters owe different duties to different types of claimants. In some states, insurers only owe duties to first-party claimants. In other states, insurers owe duties to both first- and third-party claimants.

A first-party claimant is an individual or entity that submits a claim for damages to its own insurance company. This means the claimant is the insured on a policy issued by that insurer. A third-party claimant is an individual or entity that submits a claim for damages to an insurance company with which it does not have a contractual relationship.

> In the previous example, when Delaney submitted her claim to her own insurance company, she was the first-party claimant. If the owner of the fence submitted a claim to his homeowners' insurance company, he was a first-party claimant. However, if the owner of the fence submitted a claim to Delaney's auto insurance company, he was a third-party claimant.

The reason the majority of the states require insurers to owe a higher duty to first-party claimants than third-party claimants is because they have contractual relationships with first-party claimants--they are policyholders. The insurance contracts stipulate certain terms and conditions that bind the insurer; therefore, insurers are obligated to observe a higher standard of care when handling claims submitted by their policyholders.

Insurers and their contracts are bound by the legal principle of Utmost Good Faith, which requires both parties to the contract to act honestly, not mislead the other party, and not withhold information essential to issuing coverage. Utmost Good Faith requires complete disclosure of all relevant facts and information in connection with the effectuation of insurance coverage. This applies both at the time of application--as mentioned previously--and at the time of a claim submission.

When an applicant commits concealment, the act of withholding information that is material to the insurance coverage at hand, it is viewed in the same vein as misrepresentation because it is committed deliberately and in connection with material information. The deliberate withholding or omission of material information in a claim document (i.e., concealment) is grounds for an insurance company to deny a claim or void the insurance policy.

Misrepresentations and concealment are examples of how individuals and insurers do NOT act with utmost good faith.

Many claimants and their legal counsel have alleged that when insurers do not act in good faith they are actually acting in bad faith. However, this is not always true. The simple utterance of a false statement, or the commission of a mistake, does not necessarily translate into “bad faith.”

As mentioned previously, although each state and its insurance code defines the term bad faith, it is generally construed to mean the *deliberate failure* of an insurance company (and/or its employees) to comply with the requirements of good faith. In some states, bad faith is defined as fraud; in other states it can be defined as deception or dishonesty. Furthermore, some states consider an act of bad faith a violation of their Unfair Claims Settlement Practices Acts as civil or criminal causes of action--meaning anyone harmed by a violation has the right to sue to collect damages. But in other states, bad faith actions must be handled by the insurance department as administrative actions, meaning they are not civil or criminal wrongs.

Remember: when evaluating an act or practice as unfair or deceptive, the following questions must be asked:

- Was the act or practice committed flagrantly or in conscious disregard of law?
- Was the act or practice committed so frequently that it constitutes a regular business practice?
- Who committed the act or practice--an insurance licensee or someone NOT licensed by the insurance department?

With respect to the unfair claims practices stated in insurance code, they are usually classified into one of four basic categories:

- ***Not using reasonable standards to investigate claims.***
- ***Not paying claims without first conducting an investigation.***
- ***Not confirming or responding to claims promptly.***
- ***Misrepresenting policy terms and conditions.***

One of the most contentious issues that arises with respect to the settlement of claims is the timeframe during which insurers have to offer settle and pay for the loss. Many consumers mistakenly believe insurers must issue a claim check "within 30 days."

But within 30 days of what? The date of loss? The date the loss notice or claim was submitted? The date the insurer received the loss notice or claim?

Each insurance policy contains conditions that spell out the insurer's obligations when settling losses. That condition also spells out the duties of the insured and any claimants. Specifically, the loss settlement provision of any insurance policy:

- States how and when losses and claims must be reported to the insurance company.
- States what the duties of claimants are (including policyholders) following a loss, an occurrence, a wrongful act, or any other event covered by the policy; examples include:
    - How and when notice must be provided (e.g., in writing--and sometimes under oath--and as soon as practical).
    - The claimant must cooperate with the insurance company and any ensuing investigation.
    - The claimant must forward to the insurance company any summons, notice, demand, or other process relating to the loss.
- Requires the claimant who suffered bodily injury to subject to examination by doctors of the insurer's choosing.
- Requires all claimants to submit a proof of loss within a specified number of days after the loss (usually 60 days), including any required documentation; for example:
    - If a life insurance death claim, submit a certified copy of the death certificate.
    - If an injury claim, submit medical bills, attending physician's statements, and other medical reports.
    - If a property damage claim, submit receipts and other documents showing the value of the damaged property.

A proof of loss is a sworn statement prepared and signed by the claimant under the penalties of perjury. It is usually required to be notarized. Most states require insurance companies to issue their claim payments within a specified number of days after receiving a signed, sworn, notarized proof of loss.

Essentially, a proof of loss is the claimant's official demand of payment from the insurance company. It includes the details of the loss, the damages suffered, and any other relevant information the insurance company needs to validate the claimant's damages and issue payment.

Insurance companies are not required to issue claim payments until the proof of loss is submitted. If the proof of loss is not completed fully or accurately, most states allow the insurer extra time to issue claim payments.

Producers are not adjusters; therefore, they are not permitted by state insurance laws to settle claims. They are permitted to assist with the process and are ethically bound to know how the process of claim settlement works and what state laws apply to it.

If producers suspect that an insurer or adjuster is violating state unfair claims settlement practices statutes, they should keep in mind that they are the fiduciaries of their insurance companies. As such, they owe their loyalty to the insurer … and not the policyholder (the first-party claimant) or to any third-party claimant.

This means their suspicions or knowledge of a violation should be reported to the insurance company. The direct supervisor of the claims representative or other employee should be notified first and, if the unethical or illegal act or practice is not corrected, the producer should move up the chain of command when providing notice.

After this process has been exhausted without resolution, the producer should then contact the state insurance department. Administrative action can be taken against insurers, adjusters, and others who violate unfair claims practices statutes, including the issuance of cease and desist orders, imposition of monetary penalties, and license suspension.

Although some producers believe that disclosing the unethical behavior of an insurance company employee or representative is the "right" thing to do, it actually opposes the concept of fiduciary duty. Because producers are the fiduciaries of the insurance companies they represent, they owe their loyalty to the insurers and NOT to policyholders or claimants.

The following table contains the prohibitions contained in the NAIC's Unfair Claim Practices model law:

Knowingly misrepresenting relevant facts or policy provisions regarding coverages at issue
Failing to acknowledge claim communications with reasonable promptness
Failing to establish and use reasonable standards to investigate and settle claims
Not attempting in good faith to settle claims promptly, fairly, and equitably

Compelling the filing of lawsuits by offering substantially less than would be recovered in a lawsuit
Refusing to pay claims without conducting a reasonable investigation
Failing to acknowledge or deny coverage within a reasonable time of investigating the loss
Attempting to settle claims for less than the amount a reasonable person would expect
Attempting to settle claims based on an application that was materially altered without the knowledge or consent of the insured
Making claims payments without indicating the coverage under which each payment is made
Unreasonably delaying investigation or payment of claims by requiring both a formal proof of loss and subsequent verification that results in duplication of information
Failing to provide a prompt, reasonable, and accurate explanation for a claim denial or offer of compromise
Failing to supply claim forms within fifteen (15) calendar days of a request for them
Failing to establish and use reasonable standards to ensure that repairs of preferred vendors are performed in a workmanlike manner

Underwriting

The concept of insurance is to spread the risk of loss among a pool of units that share similar risk characteristics. But differences of opinion often arise when it comes to define what "similar risk characteristics" means.

Everyone understands that the units in a pool of auto insurance risks are cars and trucks and the units in a pool of life insurance risks are human beings. The units in each pool are similar to each other but very different from those in the other pool. However, not everyone understands or agrees about the similarity of the following risk characteristics:

- In an auto insurance pool:
  - A 2000 Toyota Camry.
  - A 2020 Cadillac Escalade.
- In a life insurance pool:

- A 35-year-old man who is not a tobacco user, doesn't have any medical conditions, and doesn't take any medications.
- A 65-year-old woman who is a life-long smoker, has been diagnosed with both hypertension and diabetes, and takes prescription medications for both medical conditions.

Without having to understand actuarial science, it is apparent to most people that the costs of repairing and replacing vehicles that are 20 years apart in age and technology will be significant. Therefore, the cost of auto insurance for the two vehicles will be different. Similarly, common sense tells producers and consumers alike that a healthy young man will generate a lower life insurance premium than a woman who is 40 years his senior with multiple health issues.

The process of underwriting evaluates the differences within a similar group of units and determines whether the subject of insurance being requested by the applicant is an eligible risk. The elements of an insurable risk include:

- The pool of which the risk is a unit is large enough.
- Any loss that is likely to occur will be random, accidental, and predictable.
- Any loss that is likely to occur can be measured (i.e., by time, location, and/or amount).
- Any loss that is likely to occur will not be catastrophic.
- The proposed subject of insurance is not seeking coverage due to adverse selection (i.e., the tendency of those most at risk to buy insurance at a greater rate than those at less risk).

For insurance companies to remain financially sound, they must price insurance risks adequately so they can pay future claims. Any decision about whether to issue insurance--regardless of whether the subject of insurance is an automobile, a human being, or a business--must be based upon an underwriting review of all relevant facts. Not only does the underwriting review entail considerations relating to eligibility, it also involves the ethics of the transaction.

The insurance contract often creates a long-term relationship between the policyholder and insurance company. It involves large sums of money paid in premiums and, potentially, even larger sums of money paid in claims. Trust is one of the components of the relationship between insurers and their policyholders--and between insurers and their agents.

When underwriting an insurance policy, the character of the applicant is an important consideration of the insurer, along with any previous loss and claims history. Similarly, insurers are also concerned with the reputations of their producers, as well as with their levels of integrity. A producer's level of knowledge, adherence to underwriting guidelines, and overall professionalism can have considerable influence on an underwriter when faced with a challenging underwriting decision.

If a producer submits a cover letter with a long-term care application that details his observance that the applicant does not appear to be in as good health as he has stated, the underwriter will take notice and dive deeply into her review. Especially when the producer explains that the applicant exhibited a noticeable shaking of hands, an exceedingly pale complexion, and slurred, slow speech.

If the producer submits a questionable application in the future, the underwriter is more likely to believe the producer when he insists the client's condition is better than it might appear.

Obviously, underwriting practices and pricing change over time--based on the economy, the insurance cycle, advances in medicine, historical loss data, and a lot of other factors in addition to the trust between an insurer and its agents. But primarily, underwriting decisions are based upon the information provided to insurers by their agents, information that can be verified, and that is actuarially sound.

Ethical underwriting involves the transparency of all parties to the transaction--the applicant, the producer, and the insurance company.

State insurance codes specify in their unfair trade practices acts that insurance rates and premiums are not permitted to be excessive, inadequate, or unfairly discriminatory. Insurers must demonstrate to insurance regulators that the rate being charged does not violate these requirements by showing the rate being charged is actuarially sound. Whether a rate is actuarially sound is determined by processes outlined and approved by state insurance departments that include the collection of specific forms of data, the application of approved risk models, a review of historical loss data, the use of predictive analytics, and a host of other methodology.

When underwriting and pricing risks, one of the major ethical considerations is treating all applicants and insured parties fairly. The nature of insurance is discriminatory in the respect that insurers do not want to issue coverage to applicants it knows are certain to suffer losses. But because this treatment of applicants different is based in actuarial methodology and statistics, it is not considered true discrimination.

Remember the elements of an insurable loss? For example, property policies exclude the peril of earthquake because it causes catastrophic loss. Life insurance underwriting guidelines consider certain health conditions (e.g., heart disease, Type I diabetes, HIV/AIDs) to be uninsurable because they produce guaranteed losses--not random and accidental losses. Insurers are able to prove through actuarial data that earthquakes have the potential to cost more in premiums than could ever be charged with reasonable rates, so insuring against them is impossible. Likewise, they can easily show that individuals with heart disease, diabetes, and HIV/AIDs have a much shorter life expectancy, requiring much higher premiums to insure them. Because their reasoning is documented and actuarially sound, it is not viewed as discriminatory.

However, other actions taken by insurers and their producers *are* considered discriminatory. One of the unfair trade practices contained in most state insurance statues is titled Unfair Discrimination, and it prohibits specific types of discrimination, and/or allowing them to take place.

Generally, discrimination means treating categories of people differently unfairly or based on bias or prejudice. This includes treating a person differently because he or she is or is perceived to be a member of a category of people. However, in insurance, unfair discrimination takes place when it occurs *without* an actuarial basis.

The NAIC model law and regulation applies its definition of unfair discrimination differently to life and health insurance than it does to property and casualty insurance. In life and health insurance, the categories of people are those:

- With the same life expectancy (i.e., of the same age).
- Who are insured under policies issued with the same rate class (i.e., preferred or standard).

In property and casualty insurance, rates are applied differently based on the types of risk posed to insurers. For example, rates are calculated differently for auto insurance than they are for aviation or homeowners insurance. A car has an entirely different potential for suffering a loss than an aircraft or a house does.

Examples of prohibited conduct under the NAIC's definition of "unfair discrimination" include:

Violating state rescission laws. A rescission takes place when an insurance cancels a policy back to its inception date and issues a full premium refund. In reality, the policy is voided and the insurer acts as if coverage were never issued.

Prohibited rescissions are referred to as post-claim underwriting. In the past, some insurers chose not to incur underwriting expenses by requesting certain consumer reports or investigations. If claims were later submitted, the insurers would conduct underwriting at that time. If they discovered misrepresentations on the application after their post-claim underwriting, they would deny the claim, cancel the policy back to its effective date, and issue a full refund.

The practice was deemed unfair and discriminatory and each state regulates the practice of prohibited rescissions. Insurance companies are required to underwrite coverage at the time applications are submitted. They are not permitted to forego underwriting at the time of application and defer it until the time a claim is submitted.

Life and health insurance discrimination within a rate class or equal life expectancy. Life and health insurers cannot charge different rates or premiums to insureds in the same rate class or of the same age. Similarly, they can't treat people within these categories differently by paying different dividends or benefits or issue policies that have different terms and conditions.

Declining to issue, nonrenewing, canceling, or limiting coverage based solely on certain factors. No insurer may use any of the following reasons *on their own (i.e., based solely on the reasons shown)* to refuse, non-renew, terminate, or restrict coverage:

- Because another insurance company refused to issue coverage, nonrenewed coverage, canceled coverage, or imposed coverage restrictions.
- Because of age, marital status, race, religion, or national origin.
- In property and casualty insurance:
  - Because of the location of the risk to be insured.
  - Because of the age of the risk to be insured.
  - Because of the applicant's, insured's, or an employee's mental or physical impairment.

Unauthorized Insurance

One of the most disturbingly unethical acts committed in the insurance industry is the practice of selling ***unauthorized insurance, which is "insurance" written by companies that do not have approval by the state to issue that type of insurance.*** Over time, insurance regulators have considered it so harmful and deplorable nearly all the states' insurance statutes now ban the practice of selling unauthorized insurance.

Before an insurance company can issue insurance, it must be appropriately licensed. In the U.S., insurers first obtain a license to do business in the states in which they are domiciled, known as their home state. The insurer is referred to as a domestic insurer when it does business in its state of residence.

Policyholders of insurers that are admitted to do business in a state are protected by the state's guaranty fund. Admitted carriers pay into the guarantee fund of each state to cover the claims of policyholders of other admitted insurers that have been declared insolvent (bankrupt). If it wishes to do business in a state other than its home state or in multiple states, an admitted insurance company can then apply for licensure in those other states as a foreign insurer.

Insurers can be either admitted or non-admitted. An admitted insurer chooses to do business in the state on a regular basis and files its policy forms and rates with the state. It can only sell the lines of insurance included in its filing with the insurance department and does business as an admitted insurer whether it is domestic or foreign.

A non-admitted insurer does not regularly conduct business in a particular state and, therefore, does not obtain a license or file policy forms and rates in the state. If it chooses to write insurance for a particular risk located in a state where it does not have a license, it may do so--but only subject to the surplus lines legislation in the state. Non-admitted insurers *do not participate in a state's guaranty fund.*

In most cases, insurance companies, the products they sell, and the transactions in which they engage are regulated at the state level. This applies to admitted and non-admitted carriers, to which separate and distinct sections of insurance statute apply.

Certain insurers and products are not subject to state law if they are regulated by federal law under the Employee Retirement Income Security Act (ERISA). ***Essentially, ERISA regulations impose standards upon some private employers and their retirement and pension plans, health plans, and employee welfare benefit plans. This includes life, disability, and apprenticeship plans, as well.***

ERISA only applies to private employers (not government employers) that offer certain types of voluntarily established employer-sponsored plans for the benefit of their employees. Its laws spell out *minimum* standards for the protection of both employees and employers.

This discussion of state and federal regulation provides a backdrop for explaining the unethical and illegal sale of unauthorized insurance, which can be conducted by both legitimate insurance companies doing business in unethical or illegal ways and entities that are not licensed or admitted to sell insurance at all. In other words, a "real" insurance company can sell insurance it's not permitted to sell, or a fraudulent entity acting as though it's a licensed insurance company.

One of the more popular methods of committing this unfair, unethical, and usually illegal practice of selling unauthorized insurance is to market health insurance to small businesses by offering excellent benefits at highly competitive prices. Often, this type of insurance is marketed by unethical insurance producers to businesses that self-insure, or it is not subject to state insurance laws because it is regulated by ERISA.

A typical scam would involve an allegedly out-of-state trust marketing and selling employee benefit plans, attributing certain practices and procedures the employer is not familiar with to requirements of federal and state law. By the time the employer realizes something isn't right--usually because employee claims are not paid, the unauthorized producer and/or insurer is no longer doing business in the state and have disappeared.

Specialty and Surplus Lines Insurance

Because insurance producers are required to be skilled and efficient--both from legal and ethical standpoints--it is incumbent upon them to understand the extent of their expertise. They should only transact business in lines of insurance for which they are licensed, and about which they have sufficient training and experience.

One of the conundrums about experience is that the only way to acquire it is through trial and error. The insurance industry provides producers with a variety of resources: organizations that conduct training and provide education, insurance companies that provide support and assistance, peers and other professionals with whom referrals can be exchanged.

Most producers work with ordinary consumers and businesses--those with standard exposures and risks for loss. As a result, they are appointed with standard insurers. But what is a producer to do when a prospect requests coverage and the producer doesn't have an insurer willing to write coverage?

In the specialty and surplus lines markets, admitted and non-admitted insurers write insurance for applicants posing a higher than ordinary degree of risk. The average producer always has the option to become appointed with specialty carriers and/or to work with surplus lines brokers and brokerages.

Specialty and surplus lines insurers concentrate in issuing insurance for unusual or high-risk clients because they have singular experience in underwriting and rating specialty and nonstandard risks. Because they focus in certain areas, their underwriting pools contain different types of units than those of standard insurers.

For example, a standard auto insurer only issues policies to applicants who drive ordinary cars and with driving records that don't contain more than a limited number of at-fault accidents and moving violations. By comparison, a specialty auto insurer only issues policies to applicants who drive antique or classic cars. A nonstandard auto insurer only issues policies to applicants with poor driving records and those who have had one or more DUI convictions, multiple at-fault accidents, and/or numerous moving violations.

The units in the risk pools of specialty insurers exhibit similar characteristics, which allows them to amass a large pool and rate each policy similarly. When reviewing the elements of risk in connection with its pool of nonstandard risk, the specialty insurer is able to answer each question in a like manner.

One of the most well-known types of specialty insurance is for classic and antique autos. Most standard insurers refused to issue coverage for these types of vehicles because their exposure to loss falls outside the "normal" range. A Model T Ford is far more likely to be stolen than a Toyota Corolla is, and a 1965 Ford Mustang is probably worth a whole lot more than a brand new Mustang is.

Valuation is nearly always a problem for these types of vehicles, as well. Why? Because the owner of a classic or antique auto usually perceives the value of the car at a higher amount than just about anyone else does--including insurance companies. Typically, the value of classic or antique auto fluctuates based on the amount a willing buyer is willing to pay. Therefore, the market value of the vehicle is hard to pin down.

Even so, this still creates a problem because the personal auto policy does not settle losses on a market value basis--it settles them on an actual cash value basis. The actual cash value of a vehicle is defined as its replacement cost minus depreciation. Depreciation on a typical 50-year-old car is enormous. In order to collect a reasonable settlement under the actual cash value loss settlement provision of an auto insurance policy, the insured will have to submit a great deal of documentation--from experts that are viewed as both qualified and reputable by the insurance company.

These same considerations apply to high-value and exotic vehicles because they, too, present the significant risks of loss by theft and vandalism. Repair costs are also very expensive and often include additional expenses for purchasing parts that are manufactured outside the U.S. and having them shipped here. This process often involves a longer than usual wait time for the replacement parts to arrive which, in turn, generates higher rental reimbursement costs.

Agents should be familiar with the differences between the standard and specialty insurance markets. Although most producers understand it is not ethical to discuss or sell insurance in a line for which they are not licensed, they should also keep in mind that dabbling in the sales of insurance in particular niches of certain markets should also be avoided.

Of course, specialty insurers and their brokers often assist retail agents and producers, and help educate and train them. Even so, the ethical producer will be sure to verify that all information they relay to their clients is accurate and explained properly.

Surplus lines insurance is different from standard and specialty lines of insurance because it protects risks that are not eligible for coverage anywhere else, usually because of one or more of three distinct reasons:

- ***The risk exhibits undesirable characteristics, such as poor claims history or property that does not meet a standard insurer's underwriting criteria (i.e., with respect to age, physical condition, or location).*** Examples include a business with a great number of employees who have submitted workers' compensation injury claims or a residence with subpar electrical wiring, such as a fuse box rather than circuit breakers.
- ***The risk requires being insured for limits that are higher than those a standard insurer can write.*** This type of a situation occurs when a standard insurer lacks adequate reinsurance cover or underwriting capacity. Examples include a pollution contractor required to purchase $5 million in liability insurance or a hotel on the seashore that must purchase $40 million in flood insurance.
- ***The risk is so unusual no standard insurer can write coverage because it doesn't have the appropriate rate and form filings, or it hasn't written enough similar risks to be able to arrive at an appropriate premium.*** Examples include the owner of an airplane asking his homeowners insurer to issue coverage or an otherwise standard life insurance applicant asking for an exception to underwriting guidelines because her unique form of cancer has been in remission for six years.

Surplus lines insurance exists to complement standard insurance and is intended as coverage of last resort. For this reason, most state surplus lines statutes require surplus lines brokers and retail agents to verify that they were unable to find standard insurers willing to issue coverage before issuing a surplus lines policy.

Non-admitted insurers are licensed to transact insurance in the states where they write coverage; however, they have not submitted their policy forms, endorsements, rates, and applications to the states' departments of insurance for approval. Because they haven't submitted their forms and rates for filing, they have the flexibility to design coverage for the particular risks they write--and to price it accordingly.

Even more so than with specialty lines of insurance, it is crucial for producers to be sure they understand the special laws, rules, and requirements that apply to surplus lines insurance. The ethical requirements

and duty of care owed when transacting insurance in an unfamiliar segment of the industry are enhanced.

Privacy and Confidentiality

The insurance industry and those working in it are subject to both federal and state laws that regulate the protection and safeguarding of consumer information collected and held during the process of conducting business. ***The primary federal regulations that affect consumer privacy with respect to information collected on insurance applications are the Gramm-Leach-Bliley Act (GLBA), the Health Insurance Portability and Affordability Act (HIPAA), and the Fair Credit Reporting Act (FCRA).***

The Gramm-Leach-Bliley Act (GLBA) was enacted in 1999 and one of its major provisions was to allow banks and insurance companies to merge and offer a broader array of services. The GLBA contains a Privacy Rule, which allows consumers limited protection against the sale of their personal financial information. Its Safeguards Rule requires "financial institutions" to develop and implement written security plans.

The particulars of the GLBA can be found online at https://www.ftc.gov/tips-advice/business-center/privacy-and-security/gramm-leach-bliley-act.

Under the GLBA, a financial institution is any business that is "significantly engaged" in "financial activities." These activities are described in the Bank Holding Company Act and include lending money and securities, issuing insurance, providing financial investment services, and dealing in securities. Based on this definition, insurance companies and producers are subject to the GLBA and are required to protect and safeguard consumers' personal information.

Personally identifiable information (PII) is protected by the GLBA and includes any information a consumer provides on an insurance application, any information collected during an insurance transaction, and any information obtained on a consumer report issued in connection with an insurance transaction. Examples of PII include a consumer's name, address, Social Security number, policy number, bank account number, and credit card number.

In addition to protecting and safeguarding PII, producers must also hold nonpublic personal information (NPI) as confidential. NPI is a form of PII; specifically, it is information that may or may not be made available to the public and that is associated with a particular individual who can be identified by that information. For instance, if a producer discloses that Jane Doe is a client in a public setting, the producer violated federal law by disclosing NPI without the consumer's authorization because the fact that a consumer is a customer is protected.

Although the GLBA requires insurers (and all financial institutions) to provide policyholders with opt-out and other notices relating to their PII and NPI, state laws may impose even stricter privacy laws. So long as a state's laws meet the minimum requirements of the GLBA, they will be deemed compliant with federal law.

Federal regulations under the Health Insurance Portability and Accountability Act (HIPAA) define protected health information (PHI) as individually identifiable information that is "held or maintained by a covered entity or its business associates acting for the covered entity, that is transmitted or maintained in any form or medium." To be considered PHI, the information must be related to an individual's physical or mental health or condition (including current, past, and future conditions) or to the provision of health care to an individual (including payment for that health care). Information is only protected if it is created or received by a health plan, a health care provider, or a health care clearinghouse.

Examples of PHI include a person's medical records, genetic information, health plan account numbers, date of birth, Social Security number, dates of hospital admissions or discharges, dates of death, and facial photographs.

HIPAA only protects PHI when it is held or maintained by a "covered entity" or a covered entity's "business associate."

A covered entity is a health plan (e.g., Medicare, an HMO, a PPO), a health care provider (e.g. doctor, nurse, hospital, medical supply company), or a health care clearinghouse (e.g., a billing company or service). A business associate is a person or entity that performs specific activities on behalf of a covered entity but only if those activities involve the use or disclosure of PHI. Insurance companies that issue medical or health care benefits are covered entities and producers are business associates.

Electronic protected health information (ePHI) is also protected by HIPAA and is PHI that is submitted or received via electronic means, such as via fax or by email.

It is important for all producers to understand that HIPAA does not only apply to life and health insurance applications and documents. It also applies to ANY type of insurance or insurance document that contains information related to the consumer's health or medical benefits. A claim submitted under the personal auto policy's medical payments coverage is subject to HIPAA, as is a workers' compensation claim.

Breach notification laws apply at the federal and state levels when PII and PHI are accessed without authorization or when a data breach occurs. With respect to PHI, *only unsecured PHI is subject to HIPAA's breach notification laws*. This means that if encrypted PHI is the subject of a data breach, notification rules do not apply.

The particulars of HIPAA can be found online at https://www.hhs.gov/hipaa/for-professionals/index.html.

The Fair Credit Reporting Act (FCRA) protects information collected by consumer reporting agencies, which include credit bureaus, the Medical Information Bureau, and tenant screening services. Before obtaining a consumer credit report, a requesting person or entity must have a legal purpose (i.e.,

"permissible purpose") to ask for and view the information. When underwriting insurance, the insurer is not permitted to request a consumer report without the consumer's written authorization.

Consumer reports in insurance typically contain information about an individual's credit history, medical and health conditions, driving record, criminal background, and participation in dangerous sports. If an insurer decides not to write insurance or takes an adverse action based on information contained in a consumer report, the FCRA spells out what steps the insurer must take.

An adverse action taken by an insurance company would be to decline to issue insurance, to charge a higher premium rate, or cancel an existing policy based on information contained in a consumer report. For example, if a life insurer requested a report from the Medical Information Bureau and learned the applicant suffered from a heart condition that was not revealed on the application, it might choose not to issue the policy.

If an adverse action is taken, the insurer must provide notice in accordance with law. The FTC reports that some consumer reports contain errors--which is the primary reason providing notice of adverse actions is so important. These notices give consumers the opportunity to have the inaccurate information corrected.

When insurers and producers no longer need the consumer reports they have requested, they must dispose of them in accordance with data disposal laws. This means paper reports must be burned, pulverized, or shredded and electronic reports must be altered so they can't be read or reconstructed. The FTC's Data Disposal Rule provides the requirements for disposing of client data.

The particulars of the FCRA for insurers can be found online at https://www.ftc.gov/tips-advice/business-center/guidance/consumer-reports-what-insurers-need-know#:~:text=You%20must%20have%20a%20permissible%20purpose%20before%20obtaining,adverse%20action%20based%20on%20information%20in%20the%20report.

In addition to a multitude of federal and state laws that regulate cybersecurity, the NAIC has adopted its Insurance Data Security Model Law (Model 668) to establish standards for insurance licensees with respect to data cybersecurity events. According to the model law, a cybersecurity event is an event that results in unauthorized access to, disruption or misuse of, an information system or data stored on an information system. Exceptions to the definition exist and include acquisition of encrypted NPI or NPI that was accessed by an unauthorized party but that was not used or released and that was either returned or destroyed.

The model law requires producers, insurance companies and agencies, and all other insurance licensees to implement information security programs and to incorporate risk assessment and risk management into those programs. In addition, licenses must develop written incident response plans to respond and recover from cybersecurity events that compromise the confidentiality of the information they possess.

The ethics involved in protecting consumer information cannot be overlooked. As discussed throughout this course, a producer's ethical responsibilities call for business to be conducted with good intentions and while always protecting the interests of insurers and clients. Yet many producers inadvertently fail to fulfill their responsibilities when it comes to protecting their clients' information.

How often do producers:

- Fail to protect their computers, laptops, smartphones, and other electronic devices with a password?
- Leave their computers, laptops, smartphones, and other electronic devices running without shutting them down or locking them?
- Discuss client matters when in a restaurant or public space without realizing others can overhear?
- Share the names of customers without first obtaining their customers' permission to disclose that information?
- Use their work computers and devices on unsecured public WiFi hotspots or Bluetooth networks?
- Send texts and emails with customer information--without first checking that their transmissions AND devices are encrypted?
- Jot down a client's credit card information on a piece of paper, planning to destroy it after entering a payment, and then don't destroy it?
- Toss documents containing personal information into the recycle bin rather than shredding them?

The insurance industry conducts most of its transactions electronically these days. Because sending an email is so easy and quick, and because the majority of people are available by mobile phone at a moment's notice, it is understandable that data security procedures might be overlooked. It is equally understandable that producers might not understand all the implications of failing to protect and safeguard consumer information.

Insurers and producers are entrusted with the financial security of their clients. With little hesitation or reserve, policyholders and applicants provide their names, addresses, dates of birth, and Social Security numbers. They provide the same information for their spouses and children. They pay their bills online using credit and debit cards, or via electronic funds transactions (EFTs), allowing access to their banks and credit unions. They share details of their medical histories--personal, private information they seldom share with other people.

Not only do insurance professionals need to understand how the insurance industry operates, the details of the products they sell, and the insurance and other laws that directly affect the insurance industry, they also need to understand a variety of other laws, rules, and regulations that have been enacted for the protection of their clients.

Why? Because in addition to following the Golden Rule and acting with the most altruistic of intentions, insurance professionals must also consider outcomes. They usually consider and explain to consumers the consequences of buying and not buying insurance. But the ethical consequences of their actions and failures to act are equally important.

Chapter 3 Review Questions

1. From an ethical standpoint, sales, marketing, and advertising are the major subjects of _____. (page 47)
   a. Insurance training
   b. Insurance unfair trade practices statutes
   c. Continuing education requirements
   d. Producers, agents, and brokers

2. When an insured woman dies, her husband submits a death claim to the insurance company. The woman's death is referred to as a _____. (page 54)
   a. Loss
   b. Claim
   c. Practice
   d. Act

3. The sale of _____ insurance involves the sale of insurance by insurance companies that are not licensed to sell insurance. (page 62)
   a. Life
   b. Auto
   c. Authorized
   d. Unauthorized

4. The specialty and surplus lines insurance markets would typically issue coverage to all the following applicants EXCEPT: (page 64)
   a. The owner of an amusement park
   b. The owner of a Ferrari
   c. The owner of a single family residence
   d. The owner of an 80-story skyscraper

5. Which of the following is NOT a federal law that regulates consumer privacy? (page 66)
   a. Gramm-Leach-Bliley Act (GLBA)
   b. Health Insurance Portability and Accountability Act (HIPAA)
   c. Fair Credit Reporting Act (FCRA)
   d. Employee Retirement Income Security Act (ERISA)

Chapter Review Question Answer Key

Chapter One

1. A When ethics are abandoned, the overlooked parties are usually those who suffer the most and are the least equipped to cope with the consequences.
2. B The Golden Rule embraces the concept of doing the right thing, being fair, and not doing harm to anyone.
3. D One of the primary advantages of a code of ethics is that it provides a framework for making deliberate choices.
4. C The foundations of an individual's personal code of ethics include upbringing, childhood influences, religion, culture, friends, peers, degree of self-interest, and goals.
5. A When a conflict of interest arises, a producer's loyalty is divided, meaning the producer cannot represent the party to whom a duty is owed because of conflicting loyalties.

Chapter Two

1. A Under the law of agency, a principal grants an agent legal authority to enter into contractual relationships with third parties.
2. D Producers are given permission to act on behalf of insurers as their representatives.
3. C The legal requirements of fiduciary duty include acting solely for the benefit of the principal, not allowing any conflicts of interest to arise, and not benefitting from the relationship unless the principal grants explicit consent at the beginning of the relationship.
4. B In its most basic form, a conflict of interest occurs when an individual who owes a fiduciary duty opts to (a) secure personal benefit rather than securing a benefit for his or her principal, or (b) misuses authority granted by the principal for personal gain or profit.
5. A Utmost Good Faith requires all parties to a contract to act honestly, not mislead any other party, and not withhold information that is essential to the other parties executing the contract.
6. D Producers, agents, and brokers all act as third-party intermediaries, are required to be licensed, and are regulated by state insurance departments.
7. A Producers and agents represent the insurance companies that appoint them. They serve their insurers as fiduciaries.
8. B Brokers represent their clients and are the fiduciaries of those clients.

Chapter Three

1. B When reviewing the codes of ethics published within the insurance industry, it becomes obvious that most of the requirements and prohibitions addressing unfair trade practices pertain to sales, advertising, and marketing.
2. A A loss forms the basis of a claim. It can be any type of happening that causes a claim to be submitted. A claim is a demand for recovery under an insurance policy.
3. D Unauthorized insurance is sold by both legitimate insurance companies doing business in unethical or illegal ways and entities that are not licensed or admitted to sell insurance at all.
4. C In the specialty and surplus lines markets, admitted and non-admitted insurers write insurance for applicants posing a higher than ordinary degree of risk.

5. D The primary federal regulations that affect consumer privacy with respect to information collected on insurance applications are the Gramm-Leach-Bliley Act (GLBA), the Health Insurance Portability and Affordability Act (HIPAA), and the Fair Credit Reporting Act (FCRA).