

Insurance and the U.S. Economy[®]

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Chapter 1 The Development of the Insurance Industry

Insurance works. It works for individuals, for families, and for the economy as a whole. Most people know from personal experience how important it can be. Most people do not have a very clear idea of how and why insurance works. Most people are unaware of the insurance products available or how they can be employed in individual cases. Most people are unaware that the insurance industry plays an important role in the economic security of the country.

Insurance works because it is based on scientific principles. It is an applied division of economics. It has been defined as the science of wealth. The basic purpose of insurance is to protect wealth. This is easy to understand when the insurance protects tangible property. Tangibles include buildings, ships or the goods being stored in the buildings or moved by ships. All these things are exposed to risk.

Their dollar value is covered by property and casualty insurance. Life insurance, however, assigns a dollar value to an intangible. A dollar value is assigned to life. Life is an intangible with emotional overtones.

The concept of protecting "human life values" in terms of dollars is a recent development. An understanding of how it evolved and its function is helpful to anyone involved with insurance.

During this time it was up to each family to provide its own financial security. The idea of buying insurance was practically unheard of. An ordinary individual's life work consisted of producing tangible things to fill the needs of family members. Food came from crops, herds, and game in the nearby woods. Fuel came from the wood lot. The home-built house provided shelter for the family, including those too young, old, or sick to work. But major changes were coming.

Maritime Risk-Takers

The precise time and place of the origin of marine insurance in the modern form is not known. Marine insurance industry is thought to have begun about 1400 A. D. It is reported to have begun among the Lombard and Venetian traders in the Mediterranean. The insurance proposal was presented at a common meeting place of traders. The traders would accept part of the risk of shipping. They would do this by attaching their signature at the bottom of the proposal 'under' the stated terms. From this custom comes the term "underwriter."

Later, in England, the coffeehouse of Edward Lloyd became a congregating place for men interested in seafaring ventures and a center of marine news.

It became a headquarters for traders. Over time the traders became marine risk underwriters. Traders began to specialize in underwriting as the demand for the service increased. In 1769, the coffeehouse group became known as Lloyd's, London.

In New England some people made a living in trade rather than in farming. A farmer took his chances with the crops and annual harvests. A merchant shipped cargo and risked a loss that could mean total ruin.

In the New England coffeehouses, a contract system of risk-sharing evolved that had its roots in antiquity. At first these contracts were concerned only with accidental loss of property. Then the underwriter began to offer policies covering the risk of capture by pirates. The next step was to add policies covering death during voyages. But life insurance coverage for the general population was not yet an idea whose time had come.

In the rural, self-sufficient social structure of colonial America, families and friends were responsible for the security of each individual. There was no demand for life insurance. The first life policy known was issued in England in 1583, but the idea did not spread until after the industrial revolution. By the late 1700's the industrial revolution changed western society by splitting production and consumption.

Rise Of Cities

As industries grew, people moved from farms to cities in order to find work. Factories meant a cash economy. The family became less self sufficient. Savings became a means for individual security. A complex society grew in which goods and services were produced for sale. Life insurance is an outgrowth of modern industrial democracy.

People who came from the farms to the growing cities no longer had their own food growing outside the door. They were far away from relatives who once took care of them. They could not barter their services. They were paid in cash. Insurance began to make sense to a few responsible workers who wanted to provide a future for their families.

First Company Founded

The first life insurance company in this country was the Presbyterian Ministers' Fund. It was founded in 1759. The Insurance Company of North America was established in 1794. The growth of the insurance industry was slow in the 1700's. By 1800 very few Americans had life insurance or felt the need of it.

The War of 1812 increased the speed at which America moved towards industrialization. European imports were no longer to be had. Factories began to spring up in New England and the Mid-Atlantic states. Cities grew around the factories. Young people came to the city from the farms to work. Between 1810 and 1860, the number of people in cities and towns grew more than 1,000 per cent. The population grew from 525,000 to 6,200,000.

Growth Of Insurance

Growth of cities meant an increasing need for insurance. It was necessary for the families in the city to use part of their income to buy life insurance. Insurance provided the security the family farm had once provided for the surviving dependents.

In response to this need, many life insurance companies were formed in the early 1800's. As might be expected in a new, fast-growing industry, there were failures. Companies that were poorly financed soon disappeared. The financially sound insurance companies prospered.

The difference between the 1800's insurance companies and the early coffeehouse underwriters was claims payments. The coffeehouse underwriters often disputed claims or were unable to pay the claims they acknowledged. The well managed insurance companies met the obligations they had undertaken.

Insurance stock companies began to be organized in the early 1800s. The companies operated on a systematic, dependable basis. But the idea of life insurance was still comparatively new and unfamiliar. By 1840, the total life insurance in force in the United States was only \$4,690,000.

Then came the start of an explosive era. The 1840s boomed. Gold was discovered in California. Canals and turnpikes linked the Atlantic coast with the rest of the country. The first huge wave of Irish, German, and other European immigrants arrived. Texas joined the Union. The war with Mexico added the great Southwest to the United States. Population jumped 32 percent from 1840 to 1850. There was large growth in industrial America.

With the rise of urbanization and industrialization, the popularity of life insurance grew. Two important changes in the life insurance business itself contributed to the growth. Mutual companies were started. The agency system developed as more aggressive sales techniques developed.

Development Of Mutual Insurance

In England, mutual life insurance companies were well established. The idea of mutual companies carried over to the fire insurance field in the United States. The first American mutual life company began operations in 1843. It was the Mutual Life Insurance Company of New York, founded by Morris Robinson, a former Canadian and banker.

Others companies were soon established. The New England Mutual Life Insurance Company began issuing policies in late 1843. State Mutual issued its first policy in 1844. Mutual Benefit and New York Life issued their first policies in 1845. Connecticut Mutual followed in 1846, and Penn Mutual in 1847. Many more came later.

Sales Promotion

Early insurance companies had waited for customers to come to them. The new mutual and the stock companies began an aggressive insurance marketing strategy for insurance. Newspaper, magazine and other types of advertisement stated the advantages of life insurance. An army of agents grew throughout the country.

The agents were not trained well. They did not have formal contracts with the insurance companies that hired them. The new agent had a form sheet. The form sheet included the insurance rates, commission schedules and a list of the agent's duties. Commissions were 5 or 10 per cent of the first-year premiums and 5 per cent on renewal premiums for a limited period.

Even in the booming early 1800s, selling life insurance was not easy. Most people were still unfamiliar with the idea. Also, the cost of insurance

compared with today's rates was very high in proportion to income. A factory worker at the time was earning \$1.50 a day. The cost of a participating policy at age 30 was \$25 to \$30 per \$1,000. Companies set policy face value limits between \$5,000 and \$10,000. The agent did not have a chance to write a large policy even for a prospect who could afford one.

Insurance Totals Grow

In spite of limited coverage and high cost, sales of life insurance policies continued to accelerate. By 1850 the insurance in force in this country reached \$97,100,000. In the next ten years it grew to \$173,300,000. The increase over two decades was more than 3,000 per cent.

The Civil War did not interrupt the insurance boom. Insurance increased at a faster rate than ever. In the postwar period the growth rate reached 50 per cent a year. Twenty-four new companies were formed in 1866 and 1867. The number of companies reporting to the New York State Insurance Department rose from 17 in 1862 to 71 in 1870. By the end of the 1860s, insurance in force reached two billion dollars, an enormous figure for those days.

The first great period of growth in the insurance industry occurred in the mid 1800s. Several factors accounted for the strength of the life insurance industry. Sheppard Homans of Mutual Life discovered that American mortality rates differed from those in England. He found the mortality rate to be higher at younger and older ages than in England. He found that the mortality rate for middle aged Americans was much lower than in England. From his findings, Homans produced the first American Experience Mortality Table. The AEM table was used by the insurance industry for the next 75 years.

Other sweeping changes took place in the insurance industry. New York Life first recognized nonforfeiture provisions as the right of a policy holder in 1860. The application of this principle became widespread. The fraternal and the fraternal system were imported from England. Fraternal insurance became important. The general agency system evolved in the early 1860s. By the middle of the decade the general agency system was an accepted method for selling insurance. Level premium whole life policies became popular.

Postwar Crisis

The Civil War brought unprecedented demand for manufactured goods. After the war American enterprise continued at a fast pace. New industries sprang up. Railroads crossed the continent. Cables crossed the oceans. Coal, copper, and iron mines fed the factories. America was on its way to becoming the industrial colossus of the world.

In the excitement, attitudes changed. Business and political life were no longer governed by the ethical standards once taken for granted. Tax and other scandals rocked the Grant administration. Business was drawn into wildcat schemes, stock-watering, and embezzlement.

The life insurance industry began to play a major role in the social and economic life of the country. It too, was influenced by the spirit of the times. Many agents and companies forgot that life insurance had been called "a great cooperative scheme . . . with unlimited liberating possibilities which would alleviate, even eliminate, human distress." They concentrated on

achieving personal power and prestige through success in business.

As a result sound business practices were often ignored. Commissions were recklessly raised. Exaggerated advertising claims were made. Some companies built themselves ornate offices costing more than their total assets. Risks were underwritten carelessly. Unearned dividends were declared. Premium and reserve calculations were applied improperly. Some companies tried to frighten policy holders into forfeiting their policies in an attempt to lower their liabilities to asset ratio.

Publicity about these abuses came simultaneously with the depression of the 1870s. The most trying period in the history of American life insurance followed. The shakier companies went down first and others followed. By 1882, more than half of the life insurers in business in 1870 had failed. Only 55 companies operating in the United States.

Introduction Of Regulation

A long campaign waged by Elizur Wright resulted in the passage of state insurance laws regulating reserves and asset management. In the 1840s, the hit-or-miss methods used by most insurance companies to calculate their reserves became the concern of Wright. During this era, the few rules governing life insurance were written into the individual companies' charters. State regulation of the insurance industry in America was almost unknown.

Wright thought that state laws should require insurance companies to maintain adequate reserves. Wright produced "net valuation tables." The tables were used to calculate the reserves that should be held annually during the life of various policies. Wright used nearly 200,000 calculations to compile the tables.

In 1858 the Massachusetts legislature passed a version of Wright's legal reserve principle into law. A state insurance department was created to enforce the new laws. Three years later, Wright was appointed to head the state's insurance department.

The Massachusetts events were the beginning of state regulation of the United State's insurance industry. Other states passed similar legislation. During the next ten years, 35 states created special departments or appointed supervisors to oversee the insurance industry. Elizur Wright became known as the father of life insurance in America.

Revival Of Confidence

Public confidence was restored in the insurance industry by close official supervision. Also the disappearance of weaker companies, during the depression of the 1870s, restored public confidence.

Economic recovery was under way. Industrial development was expanding again. Money in circulation increased. The population of the country soared from 17 million to 50 million between 1840 and 1880. A majority of the population increase came in the cities. The need for life insurance was becoming recognized in the cities.

The western part of the country was rapidly being settled. The insurance industry expanded its horizons. Older companies expanded into the West. New companies offered protection to cattlemen, farmers, and miners who followed the frontiersmen.

After 1880, life insurance provisions were liberalized. As people began to travel more, insurers removed travel restrictions from their policies. Home Life of New York started the trend in 1888. Then cash and surrender values, 30 days grace periods, and statements of incontestability were added. Substandard risks were pioneered by Connecticut General. In 1896 waivers of premiums were issued in the life insurance policy. Prudential introduced insurance for low-income groups. It became widely accepted. Improvements and expansion pushed the total of insurance in force in this country from \$1,522,000,000 in 1880 to \$3,522,000,000 in 1890. By the end of the 1800s the figure had risen to \$7,500,000,000. The American life insurance industry became the largest in the world.

New Investigation

Growth again brought difficulties. At the turn of the century financial developments were proceeding at a frenzied pace. "Muckrakers" exposed questionable business practices. The American public took notice. Life insurance companies were the custodians of much of the nation's wealth. There were many reputable firms. There were also those which were not. The public urgently demanded an investigation of the insurance industry.

In 1905 the Armstrong Investigating Committee investigated the life insurance practices in New York. Its chief counsel was Charles Evans Hughes. Hughes made it clear that the committee's aim was not to attack the entire life insurance industry. The committee would strengthen and protect the insurance industry through reforms.

Recommendations by the committee led to the New York Insurance Code, adopted in 1906. Responsible insurance companies backed the regulations. It included state supervision in insurance company election of officers. The deferred dividend system was outlawed. Insurance companies were prohibited from investing in common stocks. This prohibition was later modified. Limits were set on the amount a company could spend to secure new business.

For a period after the Armstrong investigation new insurance fell sharply. As public confidence was restored the industry moved ahead again. During World War I government life insurance was introduced in volume. Group insurance was introduced. Disability clauses and double indemnity benefits were included in policies. Optional settlements of policy proceeds were developed.

The demand for life insurance in the private sector of business grew steadily. The cost of insurance decreased with favorable mortality experience ratings. In the insurance industry, new business, company assets, and insurance in force steadily increased. A record \$20 billion in new insurance was written in 1929. In the same year, insurance in force passed \$100 billion.

Crash And Depression

From the highest peak came the deepest slide. The stock market crash of 1929 led to the depression of the 1930s. By 1932 the national income had been cut in half. Stocks were worth about ten percent of what they had been in 1929. About 13 million people were unemployed. Suicides rose to 30 per cent above normal.

The effect on the insurance business was severe. The amount of new

insurance written dropped sharply in 1931 and 1932. For the first time in a generation the total insurance in force decreased. Mortality losses rose with the suicide rate. Disability claims went up. Policies lapsed and were surrendered. The earnings of insurance companies declined sharply. The decline was due to defaults in mortgage payments and lower interest rates.

Compared with most U.S. industries, life insurance was in good shape. Only 20 companies went into receivership out of a total of about 350. A little more than one per cent of the total insurance in force was involved in failures. The failures were reinsured by solvent companies. There was little actual loss to policy holders.

Search For Security

The depression experience resulted in an enormous desire for financial security. As a result of this trend the Social Security Act was passed in 1935. It was amended in 1939 to provide survivors' benefits. The depression actually benefited the life insurance industry.

The immense government administered insurance program did not reduce the demand for private coverage. The public understanding of financial security improved. This increased the sale of privately issued policies. The increase of life insurance in force went from steady to spectacular.

New policies such as the family plan were introduced. Low-cost group insurance tripled in ten years. Annuities, insured pension plans, and credit life insurance added to the total. Life insurance became useful in many segments of society. Americans began using life insurance as a major tool in building a secure society.

Life insurance companies placed increasing emphasis on agent training and education. Individual companies offer six months to two years training programs. The Life Underwriter Training Council provides courses. An advanced training program is available in colleges, insurance company classrooms, and study groups. The program is under the direction of the American College of Life Underwriters. This organization designates its graduates as Chartered Life Underwriters (C.L.U.). The designation identifies the graduates as fully trained professionals.

Savings And The Economy

In addition to this massive individual protection, life insurance plays another basic role in society itself. Life insurance premiums represent the savings of millions of Americans. The premiums are poured back into the economy in investments. Insurance thus provides financial stability for individuals and the nation.

In early America the life insurance business helped buy bonds to pay for canals and turnpikes that tied the country together. During the Civil War the industry's purchase of government bonds bolstered the Union's credit. The purchases stimulated industry growth. Nineteenth century inventions provided new conveniences and insurance funds supported the expansion of public utilities. Public services such as gas, electricity, water, telegraph and telephones were made available nationwide through the investment of insurance funds.

Life insurance funds provided mortgage loans and eased the housing crises after the Civil War and both World Wars. Loans to farmers put machinery to work producing crops that have helped feed the world. Life insurance dollars fueled American industry. The development of an industrial society brought

about the life insurance industry. In turn that industry became a great source of capital for industrial expansion.

Insurance companies buy industrial bonds. They free corporate capital through sale and lease-back arrangements. Through stock purchases insurance companies invest in other industries.

Insurance functions include protection of individuals and placement of the individuals' savings into our economy. The ingenious combination of these functions has blueprinted the complex society we have today. Life insurance serves as an indispensable security system for individuals and for their institutions.

Structure Of The Insurance Industry

Insurance coverage has grown enormously in the United States since World War II. Around 1940, about 19 per cent of the population had health insurance protection. Now, more than 70 per cent of medical costs in this country are paid by third parties.

Company structures of the life insurance and health insurance business differ. Most life insurance is issued by legal reserve companies. There are two types of legal reserve companies. Mutual companies are owned by their policy holders. Stock companies are owned by stockholders.

Several different types of carriers issue health insurance. They include life, casualty, and health only insurance companies. There are hospital and medical service organizations such as Blue Cross and Blue Shield, and prepaid group medical plans.

There are five times as many companies in business today as in the 1940s. The insurance field is highly competitive. We have firms that provide coverage in a single state or in a limited number of states. Accordingly, company home offices are spreading across the nation. There is at least one in every state. This dispersal of companies facilitates the distribution of insurance to families across the country.

Mutual And Stock Companies

The typical mutual insurance company is older and larger than the typical stock company. A mutual company's funds are held for the exclusive benefit of policy holders. The policy holders own the company. Mutual companies issue participating policies that pay annual dividends to policy holders. The dividends reduce the cost of the policy.

The great majority of insurance companies are stock companies. A stock company is financed through its stockholders. They assume the responsibility for management and receive a return on their investment. Nonparticipating policies are issued by stock companies. The premiums for nonparticipating policies are lower than comparable participating policies. Some stock companies issue participating and nonparticipating policies.

Fraternal groups issue policies to their members under special laws. Assessment companies issue policies with set premiums. The premiums can vary according to the insured's experience rate. The federal government operates the veterans' insurance program.

Casualty companies were the only insurers when coverage originated more than a century ago. Today, life insurance companies write much of the health insurance. Monoline insurers cover the rest. All three types can be operated as a mutual or as a stock company.

Medical group plans are set up on a prepayment basis. The physicians, surgeons, and dentists provide health care as needed. They are paid a monthly or annual fee. Unions, employers, or fraternal societies often make arrangements for care on a medical group basis.

Insurance Business Organizations

Organizations in the insurance industry and related fields are an important source of strength to practitioners. They serve as a way to exchange ideas and information in order to solve common problems. They have stimulated competition in the industry. The competition serves the general public's interest. Some of these organizations serve life and health insurance fields. The American Life Convention, Life Underwriters Association, Underwriter Training Council, Million Dollar Round Table, National Association of Underwriters, and Society of Actuaries are a few of the major organizations.

A few groups make contributions to the effectiveness of the insurance industry. These organizations have staff specialists in medical, legal, investment, public relations, accounting, and statistical fields.

The American Risk and Insurance Association is devoted to advancing the science of risk and insurance. The association accomplishes its goals through education, research, literature, and communications. State insurance supervisory officials exchange ideas and trends through the National Association of Insurance Companies. It aims for standardization of regulatory practices throughout the states.

Insurance related organizations make an important contribution to the advancement of insurance in the interest of the policy holders. They have intensified competition among individual companies while also providing the framework for extensive cooperation in research and methods.

Contributions To The Economy

The size of the insurance companies' financial operations and the unique way that insurance funds are channeled toward specific social goals gives the insurance industry special importance in the nation's economy. Insurance companies, as investors and employers make vital contributions to the stability of the economy.

As insurers, they provide money when the family most needs it. Insurance companies make a direct contribution to the stability of the basic unit of society. The total annual benefit payments, nationally, are enormous. The benefit payments are more than impressive on an individual family basis. They are a lifeline. Life insurance is one of the most important long-term savings arrangements. It provides billions of dollars of financial resources for individual families.

The insurance industry contributes to a healthy national economy through carefully selected investments. In this way it also contributes to individual financial security. The security of individuals is basic to the national economy in turn.

Insurance company investment in residential mortgage loans. These loans made it possible for millions of American families to improve their standards of living. Insurers invest in businesses and industry. This provides economic growth that increases the national product and employment. Insurance company investments are designed to meet long-term future obligations to policy holders. For this reason the investments play a most important part in the national economy.

**Research Programs For
The Future**

Long-term basic research programs are supported by the industry. The industry wants to learn more about the changing socioeconomic climate in which personal insurance operates. Many people in the industry feel that an increase in the knowledge of human behavior will benefit the insurance business. It will also benefit the society.

Independent studies by social scientists are done at the Institute of Life Insurance. The program centers on the family. Studies investigate the impact of social changes and the impact of family members' attitude as a contribution to the behavior of the family unit. These programs are designed to aid the insurance business in responding adequately to changing needs.

In some industries, prices are based on competition. In insurance, rates are based on scientific principles. To compute policy rates low enough to encourage the spread of the benefits of insurance and yet high enough to give margins of safety for the companies providing it is a science resting on hundreds of years of study. Records have been kept, monitored, and updated over those years to establish workable rates.

Although the public knows more about insurance principles than in the past the principles can easily be misunderstood. A well informed industry professional can teach the principles with confidence.

A new frontier for the U.S. insurance industry is developing internationally. Perceptive insurance executives are measuring two global economic processes. The economic integration of Western Europe and the rise of Asian countries can have a major impact on our economy. Advances in communications and transportation make it feasible to open overseas offices on a large scale. The prospect offers American insurers the combined opportunity of providing greater financial security to millions of clients around the globe. At the same time, this opportunity could contribute to a more favorable balance of international trade.

**Importance Of
Background**

Knowledge about the general organization of the insurance industry and the history of its development gives the prospective underwriter an understanding of the importance of the insurance industry. Knowledge about income and the risks associated with it makes the professional aware of "income requirement" patterns that must be underwritten if people are to lead financially secure lives. The scientific principles underlying the operations of an insurance company explain soundness and continued solvency of insurance as a financial institution.

Chapter 2 The Development of Fraternal Insurance

An important part of the U.S. insurance picture in the 1800s and early 1900's was developed by fraternal organizations. Like early marine insurance, this type of policy had historical roots. Religious and fraternal societies under the Roman Empire paid benefits when members died. The guilds in the Middle Ages took care of their own.

The first recorded fraternal policy in the United States was issued in 1868 by the Ancient Order of United Workmen, founded by John Jordan Upchurch at Meadville, Pennsylvania. Earlier fraternal societies are believed to have existed in the country, but there are no records dating back to the beginning.

Social changes in the last half of the 1800s brought about the rise of fraternal insurance. After the Civil War, the United States was still largely rural. People who moved from the farms to the growing cities usually became members of the working class. The middle income, salaried workers and businessmen were proportionally smaller than today. Labor and farming accounted for a major percentage of the people living in the United States. Members of these groups were not usually protected by life insurance. They were in lower income brackets. They could not afford ordinary life policies. Government protection was not offered at this time. Most people found life insurance beyond their reach.

Class Antagonisms

The farm and labor segments of the population did not trust corporations. Level premiums, reserve accumulations, and nonforfeiture values were difficult to understand. For this reason many people distrusted the insurance industry. In this environment, the need for protection for lower income groups brought on the introduction of other forms of life insurance protection. One was industrial life insurance. Fraternal life insurance combined protective functions with social functions.

Social activities for lower income groups in the late 1800s were few. There were no movies, no radio or television, not even phonographs. Social visits were limited due to transportation limitations. It was Upchurch's idea to offer life insurance through a group with social bonds between the members. Members of his organization were mechanics and artisans and they had a trade in common.

Objectives of the Ancient Order of United Workmen were as follows:
To unite into one common brotherhood all persons employed in the mechanical arts.
To create a means of prompt and effective cooperation in matters of common interest.
To oppose unfavorable legislation and to foster favorable legislation.
To establish libraries, provide lectures and provide other education.
To establish and maintain harmony and equity between employers and employees.
To better the conditions of unfortunate, afflicted, and oppressed members.
To establish an insurance fund. To pay no less than \$500 to the legal heirs of a deceased member.

The group or lodge had a membership organized on a restricted basis. Modern Woodmen of America, the Order of Railway Conductors of America, the Free Sons of Israel, and the Daughters of America are a few examples of the societies of the time.

Group dinners, picnics, Christmas parties, athletic contests, and dances were held in addition to regular weekly or monthly meetings. In that sense the groups were similar to social and special interest organizations of today.

The fraternal organizations incorporated welfare, benevolent, and charitable works into their programs. They accepted responsibility for members and their families. Less fortunate members were provided with hospitals, sanitariums, visiting committees, and financial help. The extra funds were contributed periodically by members in addition to insurance assessments.

Organization of Fraternal

The local group is the foundation stone of the fraternal society. Some have state organizations and most have national officers to carry out the objectives of the group. Delegates elected from the local groups choose the state and national officers. This representative form of government from the beginning of the fraternal movement was a distinguishing factor between it and private life insurance companies. Fraternal are required by state statutes to maintain a representative type of government, and voting by proxy usually is not permitted.

Assessment Plans

Death benefits for members of fraternal societies were provided at first by the uniform post-mortem assessment plan. In the Ancient Order of United Workmen, when a member first joined he contributed an initiation fee of \$1.00. Beneficiaries of the deceased member received a payment of \$1.00 per active member. Each surviving member contributed \$1.00 when an active member died. The upper limit for the death benefit was \$2,000. If the membership was more than 2,000, each member contributed a pro rata share of \$2,000.

The people who did not trust reserves maintained by private insurers found this idea of assessment insurance appealing. They did not want to pay into the reserve of a commercial insurance company. Uniform assessments, with each member contributing the same amount, also reinforced the idea of fraternalism.

There were defects, however, inherent in the assessment idea. Most

important was a lack of reserve to offset high mortality costs in a society with an increasing average age. To continue to function successfully, an assessment type of operation needed to have young members joining at a rate which would maintain a constant age distribution. This was the theory, but in actual fact it turned out that new members were not attracted by a uniform rate of assessment.

This loss in attracting young members eventually forced societies to disband, merge, or adopt a scientific method of computing their premiums. The idea of graded assessment contributions was developed to attract and hold members dissatisfied with the uniform assessment plan.

On the graded assessment scale, members' assessments were based on the age of each member when he entered the society. The premium determined by age of entry was presumed to remain level for the duration of the member's life. Graded assessment plans ran into the same problems that affected uniform assessments.

Recognizing their problems, twelve fraternal benefit societies joined in the National Fraternal Congress. In 1895 statistics of 25 commercial companies and 27 fraternal benefit societies were compared in tabulated form. The statistics were used to produce the National Fraternal Congress Table of Mortality. Meetings between the Fraternal Congress and the National Association of Insurance Commissioners resulted in legislation that put the fraternal on a sound actuarial basis.

The Uniform Fraternal Code was adopted by a number of states in its entirety and by others in part. It defined a fraternal benefit society as follows: "Any incorporated society, order or supreme lodge, without capital stock, conducted solely for the benefit of its members and their beneficiaries and not for profit, operated on a lodge system with ritualistic form of work, having a representative form of government, and which makes provision for the payment of benefits in accordance with this Article, is hereby declared to be a fraternal benefit society." The 'lodge system' differentiates a fraternal benefit society from a commercial enterprise.

Members of fraternal societies are required by statute to be members of a local lodge of the society. Modern developments in communication and travel have changed social priorities. Many societies regard their charitable and educational activities as more important than the ritualistic ceremonies formerly given great significance.

The fraternal societies are required to be non-profit organizations. Under the code definition, a fraternal society is "without capital stock, formed, organized and carried on solely for the benefit of its members, and of their beneficiaries and not for profit." This requirement also applies to a mutual life insurance company. The membership of the fraternal organization is entitled to any surplus generated from its operation. Such a surplus usually is distributed to members as a surplus refund in much the same way as dividends from mutual life insurance company.

Open-Contract Provisions

The most significant difference between fraternal insurance and private company insurance is the "open-contract" provision of fraternal contracts as opposed to the "closed- contract" provision of company contracts. Laws governing fraternal societies require that the contract consist of the certificate of insurance, the application for membership, and the declaration of

insurability. In addition fraternal societies require the charter or articles of incorporation, the constitution and bylaws of the society, and amendments as elements of the contract.

Tax Exemption

The fraternal are exempt from federal income taxes, and from state, local, and municipal taxes. They are not exempt from taxes and special assessments on real estate and office equipment. The exemption is similar in philosophy to the nontaxation of churches, charitable institutions, and mutual savings banks. Fraternal groups justify the exemption by stating that their charitable expenditures total more than taxes they would be required to pay.

Marketing Plans

Large fraternal organizations now have field organizations similar to those of private company insurers. New members in the beginning were obtained through the lodge. Members were encouraged to solicit new members.

Today the marketing plan of fraternal resembles that of their company counterparts. Many fraternal have an officer in charge of sales. He oversees a field force of full-time agents and extensive training programs. Fraternal agents are given membership privileges in many local associations of the National Association of Life Underwriters.

Separate Reserve Funds

Separate reserve funds maintained by fraternal differ from private company practice. Originally, level assessment societies maintained separate funds for expenses, for mortality, and for benevolent projects. Less than half the states, however, now require maintenance of separate funds by fraternal societies. The Uniform Code, Section 31, allows the maintenance of either a single fund or a multiple arrangement if desired.

Certificate Provisions

Definition of the rights, benefits, conditions, and privileges accruing to parties to a fraternal contract is by the certificate itself. The bylaws and constitution of the society apply where fraternal state statutes or common law does not apply. The diversity explains any lack of uniformity within fraternal contract provisions.

The facility of payment clause is a feature found in some fraternal certificates. This clause is common to industrial insurance contracts but not in ordinary life contracts. It defines instances in which the fraternal society or insurance company may disburse benefits to others than the named beneficiaries or where there is no named beneficiary.

Fraternal insurance contracts offer settlement options to beneficiaries, but generally not to a great extent. Most fraternal settlements are made in lump-sum payments. Nonforfeiture values offered by fraternal are the same as those offered by private insurers. There is a difference between lapsed premium options. In the event of a lapse, private insurers usually utilize an extended term or an automatic premium loan. There seems to be no generally used option among fraternal societies.

The fraternal insurance certificate is similar to the private contract. Also, each has provisions for a grace period and an incontestable clause. The grace period, similar to that provided in commercial contracts, is usually 30 days. The incontestable clause is included in all fraternal certificates.

Disability Coverage

An important contribution to the life insurance industry was made by fraternal societies. They pioneered total and permanent disability coverage attached

to life insurance contracts. The disability experience rates of certain fraternal societies were used to create the first disability tables used in this country.

Continued Significance

Changes in the social and cultural environment have caused the lodge system and its original sphere of activity to decline. Fraternal leaders, however, maintain that the local lodge continues to be an integral part of the system. Differences between the insurance operations of good fraternal benefit societies and good private companies have become less significant. The financial strength of the organizations is of great concern.

The contrast between the organizations is now chiefly in the non-insurance activities of the fraternal benefit societies. These include the lodge system, representative government, and charitable or other service programs. As such the fraternal benefit societies remain a separate and significant part of the total system of insurance protection in America.

Chapter 3 Life, Health and Disability Insurance

Health insurance originally was a "casualty" line. Life and health insurance however, are complementary in nature. Accordingly, a large amount of the health insurance is underwritten by life insurers.

Life insurance and health insurance are income protection products. They protect against the absence of earned income, permanently or temporarily. They are in the category of human life value insurance. This is distinct from property value insurance.

The life insurance waiver-of-premiums assures continuance of the insurance in a case of prolonged disability. Health insurance protects the insured's life. By providing medical payments when needed it guards against involuntary liquidation of assets.

The Human Life Value Concept

The benevolent aspects of life insurance were stressed in the early years of the industry's development. The profit motive of life insurance to the premium payor was not stressed in the early days of insurance. The head of the family had no prospect of benefiting personally from insurance.

Life insurance was generally regarded as pure "death" insurance until the late 1920s. There was no explanation or value placed on life and death. It was a matter of selecting a contract without any thoughtful valuation of the insured's life. The personal estate included property, and was given much consideration. The person in that personal estate was overlooked.

Little stress was placed on the "living values" of cash value life insurance. Living values include freedom of mind to venture into sound and profitable investment and improved credit. The insured neglecting his own life insurance advantages, did not appraise the monetary value of his life to his dependents.

Life insurance contracts would meet their promises because of their actuarial foundation. There could be no cheating of the policy holder no matter what type of contract he purchased. In theory the buyer always received his money's worth. The agent's goal was to sell the largest volume of contracts possible. There was little opportunity for a dedicated insurance professional. In 1924 the human life value concept was proposed as a philosophical framework for the analysis of basic economic risks facing individuals. Under

this concept, there was a material change in the view of life and death. The concept rejects the idea that life insurance is a physical death proposition that cannot offer a profit motive to the insured. The concept rejects the concept of sheer volume selling.

The concept involves six important considerations for life insurance service:

1. The human life value, expressed with a dollar valuation, should be carefully appraised and capitalized for insurance purposes. This may be defined as the capitalized value of that part of the current earning power of the individual which is devoted to the support of family dependents, and sometimes the protection of business associates.

An illustration of one simple method of appraising the economic value of a human life might be as follows: The gross annual income of a man age 35 from his personal efforts is \$36,000. After income tax he has a net income of \$29,000. He uses \$9,000 for his direct self-maintenance, leaving \$20,000 of his earnings for the support of his wife and children.

He plans to retire at age 65, so he can expect 30 more earning years. Assuming that his earnings, taxes, and distribution of income will remain approximately the same over those years, the economic value of his life can be calculated by discounting at a reasonable rate of interest, say six per cent, the income flow of \$20,000 a year for 30 years.

FDA six per cent interest, \$1 per year for 30 years is worth \$13.765, and this amount times \$20,000 rounds off at \$275,296, his life's economic worth to his family.

The human life value concept is being expressed as the present value of an income stream. Look at the example another way. Even without taking inflation into account, a dollar today is worth more than the assurance of receiving a dollar a year from now. It is preferable to receive \$1,000 now rather than the promise of \$1,000 at some distant future date. This preference rests on the time value of money.

Generally, the term interest is used to describe the price charged for using money over time. When we make payments for the time value of money (an automobile payment), we incur interest expense. When we receive payments for the time value of money (a savings account), we earn interest revenue. The accumulated amount of a single sum invested at compound interest can be computed period by period using a series of multiplications. We may also, through a series of computations, arrive at a discounted present value of a principal sum to be paid or received at a fixed future date. Used here is the concept of annuity payments, involving periodic payments or *rents* with interest over a fixed period of time.

With our 35-year old male above, the future value of his income can be computed. "Payment" in the computation represents the component of the 35-year old male's income used to support his wife and children.

Payment = \$20,000
Interest = 6%
Number of periods = 30

$$fv = P \frac{(1+i)^n - 1}{i}$$

-Or-

$$\begin{aligned} fv &= 20,000 \frac{(1+.06)^{30} - 1}{.06} \\ &= 20,000 (79.058187) \\ &= \$1,581,163, \text{ the future value of his current income.} \end{aligned}$$

Now find a present value of this future cumulative worth, using the same assumptions;

$$pv = fv \left(\frac{1}{(1+i)^n} \right) \text{ or } pv = \frac{fv}{(1+i)^n}$$

-So that-

$$= 1,581,163 \div 5.7434912$$

$$= \$275,296 \text{ again, his life's current economic worth to his family.}$$

Many variables can enter into the appraisal of human life value. The illustration only shows the logical basis for appraising and capitalizing the values inherent in a human life.

The total human life values in the United States under this system would give a monetary total of about five times the monetary total of property values in the country. As the current population structure ages, the total of capitalized life values will continue to increase. Economic worth needs to be maintained for dependents in case of premature death of the breadwinner. It also lessens the children's financial support of aging parents.

For example, the money invested by parents in a child's education could increase human life values. Also human life values could increase through interest income. Business profits from corporations, partnerships, and sole proprietors could also increase human life values. Human life values could easily amount to ten times the property values in the nation.

2. The human life value should be recognized as the creator of substantially all property values. The human life is the cause and property values are the effect. Human life value motivates otherwise inanimate property into a productive force.

3. The family can be regarded as a business partnership from an economic point of view. There are other points of view, including religious, social, and legal. However, a logical and realistic attitude includes viewing the family as an economic unit.

Throughout human history the family has been regarded as man's first and most important business enterprise. It needs to be organized and managed. Its economic value is liquidated in the manner that other business enterprises are liquidated. The vocation of the family head(s) is regarded as a secondary business. It is pursued to give the advantages to the first enterprise, the family business. The head(s) of the family must recognize life insurance as a means for personal income advancement. This will allow the

head(s) of the family to support the first and most important business, the family business.

4. The human life value can be regarded as the principal link between present and future generations. The link is fortified by the benefits derived from life and health insurance.

5. The same fundamental principles of property values should be applied to human life values. Such principles can include property appraisal, indemnity, accounting and accumulation of surplus. Applying these principles to the larger and more significant human life values is possible through life and health insurance. These products make it possible to apply our current earning capacity.

6. Human life value is subject to loss of earning power through four serious hazards: Premature death, or "casket death," eliminates earning power. Temporary disability, including medical and surgical expenses can cause loss of earning power. Total and permanent disability, known as the "living death," causes loss of earning power. Compulsory retirement, known as "retirement death," can cause loss of earning power. The head(s) of the family must consider the rights of dependents. The head(s) considers the dependents claims in the family unit with respect to these four hazards.

Life Value and Earning Capacity

A young bridegroom may say "With all my worldly goods I thee endow." In the beginning of his working life his current income may be small. In this case "worldly goods" means potential future earning capacity. Through life and health insurance, this capacity can be recognized and capitalized. The maximum human life value is obtainable.

The family's standard of living improves as income increases over time. It is important for the head of the family to increase life and health protection to assure the current standard of living. Most family heads survive to retirement age. Accordingly it is important for insurance to provide substantial retirement income. The husband and wife can assure their financial independence in this manner.

Vocational Group Variation

Vocational groups that make up the economic life of the country determine are factors of the business worth of the human life. When wage and salary earners die or become disabled there can be a total loss of income to family dependents. The family should protect itself against the loss of the family breadwinner's earning capacity.

In professional vocations, where the chief asset is the goodwill of clients, the situation is similar to that of wage and salary earners. The life value from a current income is much greater than accumulated property values. Regular income from the profession is largely associated with the continued patronage of clients. This in turn is dependent on the continued working life of the practitioner. Some vocations involve the fulfillment of long- running contracts. The life value of the contractor is usually greater than the monetary value of the business assets.

In agricultural endeavors large amounts of property are usually involved. Current income is still primarily attributed to personal ability and hard work. The difference in ability can make a difference in the monetary life value.

The final group includes persons involved in manufacturing, mercantile, and

other industrial activities. There is a high demand for property involved in these ventures. A detailed appraisal of life values and property values and applicable debts involved must be made. Usually, after deducting the amount of borrowed funds, the equity in the property is less than the monetary worth of the person directing the operation.

Community Role of Life Insurance

It was Benjamin Franklin who observed it was a strange thing that men "should be careful to insure their houses, their ships, their merchandise, and yet neglect to insure their lives, surely the most important of all to their families, and more subject to loss."

Life insurance protects against all forms of economic death. The first of these considered is physical death. The total of the life insurance in force in this country represents only a few years of protection for individual families. Life insurance annual premiums amount to a very small percentage of disposable income. The average amount of life insurance per family may represent about 10 per cent of the full obligation of a family. For sound economic welfare, the family budget must include payments for life insurance protection.

The most dreaded of all forms of economic death is total and permanent disability. The victim cannot earn income and the family spends its nest egg on current living expenses and on medical expenses. The amount of disability insurance in force is less than the amount of life insurance in force. The need for increased coverage in this area is vital to the health of the economy.

From an economic standpoint, compulsory "retirement death" has become more important than premature physical death. With the increasing life spans, it is likely that a breadwinner will live to retirement age.

As previously discussed, income should be available to the retired couple for the rest of their lives. This will insure financial independence. The joint and last survivor annuity arrangement is often desirable for couples alive at 65 or 70.

Principles of Value Treatment in Life Insurance

The fundamental principles of organization, management, and liquidation that apply to property values can be applied to the organization, management, and liquidation of human life through the medium of life insurance.

Appraisal

A family budget can determine the proportion of income devoted to the support of dependents. The capitalized amount required for the benefit of survivors must be determined.

At this point it is important to plan what type of insurance contract to use. The total family needs should be considered by the underwriter at the time of solicitation. For example, a term policy may be chosen if the insured's case represents essentially a potential estate situation. Approximately 10 per cent of human life values are covered with life insurance. Approximately 80 per cent of property values are covered by fire insurance. Approximately 100 per cent of applicable property values are covered by marine insurance.

Capitalization

Through cash value life insurance capitalization of life values can occur. Such life insurance constitutes a "callable sinking fund bond." The sinking fund's monetary value is small at inception. It increases until the

value accumulates to face value.

The callable side is applicable in case the insured dies prematurely. It starts at near the face value and decreases. The callable feature is in the form of decreasing term insurance. The callable value will reach zero at the same time the sinking fund value reaches face value. The two sides move in opposite directions at exactly the same rate. At all times during the policy period the two values equal the face of the contract.

Accounting Principles

The sinking fund feature of the life insurance contract as stated above represents the principle of accumulation of surplus. It is an installment plan investment. The callable feature represents the accounting principle of "obsolescence."

The sinking fund is created scientifically to meet future unknown contingencies. The callable feature recognizes the exhaustive nature of the human life at an average of perhaps 65 or 70. A fund is methodically accumulated to equal the depreciation of life value. In this manner, the fund will be available for liquidation on a life annuity basis.

Male/Female Rates

Women on the average live longer than men. This is the reason such things as mortality tables, premium rates, and life income settlement options traditionally have been based on the less favorable male mortality or life expectancy.

Measuring Risk

Life insurance has as its fundamental principle sharing the risk of death by members of a group. The financial loss caused by death can be distributed among the members of a group at a small cost to each. Group sharing cannot eliminate death, but it can offset death's disastrous financial consequences.

Mortality Tables

Rates of death compiled statistically for all ages are known as mortality tables. The data is based on mortality figures of very large groups of people over long periods of time. Life insurance companies can rely on the data with confidence. The mortality table shows the average mortality experience for all people of a measurable group over many years. It is revised at intervals as time goes on and more statistics become available.

Mortality as a Rate Element

An important assumption in life insurance rate-making is that people will die at the same rate in the future as they have in the past. The mortality tables show the past death rate. It is assumed that the same rate will hold good in the future. If this assumption proves not to be correct, new mortality tables have to be produced.

Insurance premiums collected by insurance companies are invested in the society. The interest earned on the investments becomes an important factor in computing the rate to be paid for insurance coverage.

Actually, the nation's life insurance companies hold billions of dollars worth of assets. Interest earnings on these investments decrease the cost of life insurance to the policy owners. It serves as a huge fund for long-term investment in the economy of the country.

Level Premium Construction

It took creative mathematical minds to find a solution to the problem of drastic increases in premiums for older individuals. Complex mathematics is involved, but an understanding of the basic principles will provide confidence in the structure of premium rates.

In simple terms, the increase in the yearly term rate is leveled over the anticipated lifetime by charging more than is currently necessary in the earlier years and thus creating a fund for the heavier mortality charges of the later years. The level premium is higher than necessary in the early policy years and lower in the later policy years. The excess premiums collected in the early years are placed in a special fund known as the reserve or the legal reserve. The reserve is invested in order to earn interest. An interest rate was assumed when the level of the premium was set.

Estate Analysis

Development of the level premium made it possible for the life insurance industry to offer a new service. The industry can help people provide for their overall financial needs.

An individual has only one basic financial problem. That is to create an estate that will provide cash or income exactly when needed. Dividing the estate into two parts simplifies the problem. One part is the growing estate during life and the other is accumulated estate at death.

Both divisions of estates are important and they need to be kept in balance. The estate during a lifetime accumulates cash for emergencies. It accumulates funds for old age benefits. If either estate is missing at the time it is needed, hardship and suffering result.

If a person tries to concentrate on some type of savings-investment plan and eliminates the protection of life insurance, his financial plan is out of balance. Such a plan might work if the person using it can get by three big "ifs":

- ⇒ If he can stay alive long enough to meet family responsibilities.
- ⇒ If he can save enough consistently, and keep what he has saved. Most savings plans are intentions rather than realities.
- ⇒ If he can arrange to die or retire at just the right time, when his investments are at peak value. A forced sale during a period of depressed prices could mean disaster.

Life insurance companies operating under the level premium arrangement are custodians of large sums of money put in reserve to provide for death claims to be paid many years in the future. The companies must invest these funds in a prudent way and make a strict accounting of them. They are guaranteeing future delivery of a definite amount of money. Insurance companies operate as depositories of large funds.

Insurance companies have become investment experts. They are trustees of long-term policy reserves. Insurance companies today, provide many valuable services.

A critical financial need of most people is the need for cash. Life insurance, while primarily designed to provide death protection, has developed into a balanced service providing a financial contract that can solve the basic financial problem whether the insured person lives or dies. This kind of policy, called permanent life insurance, provides an easy and systematic way for the individual to build an adequate, balanced estate.

The life underwriter's chief function is to guide purchasers in making a choice of the most appropriate kind of life insurance. That is why the underwriter needs to understand rate structure and cash values of insurance.

The cash value is the amount the company will pay the insured in cash if he or she decides to give up the policy, in effect selling it back to the company. The policy holder always has a guaranteed buyer for the policy and also a guaranteed selling price. The cash value is also the amount the policy owner can borrow on the policy for emergencies. In later years of the policy, the cash value and reserve are the same, but in earlier years the cash value is slightly smaller than reserve.

A company must spend money to operate, and a new policy is an expense to the company for several years. The company also must allow for "adverse selection" because policy holders who know their health is impaired are less likely to surrender their policies than those who feel they are in good health. To calculate its rates a company depends on a normal group of lives carrying through on their contracts. Some adjustment must be made to offset the possibility that lapsing and surrendering of policies might leave the company with only bad risks.

The life insurance company invests its reserves in long-term securities. If a large number of policies were suddenly surrendered, the company might have to dispose of such securities at a loss, or it would have to carry a large amount of cash on hand at no interest.

All legal reserve companies use the same mortality tables. They employ the same formulas to compute basic rates and reserves. All must qualify under the same minimum standards of solvency to do business under state laws.

Benefits of Creative Functions

Life insurance originally was purchased as a death proposition, with no profit motivation to the insured. More recently life insurance has become highly creative for the payor of the premium in at least five important ways;

1. Elimination of fear and worry: These human traits make many people unwilling to undertake economic pursuit of real merit. They are afraid to use existing capital profitably as long as the risk of death or disability is a consideration. The elimination of this fear stimulates personal initiative.
2. Greater creation of estates: The significant factors in business pursuits are thrift and investment. There must be one before there can be the other. In most cases capital must be accumulated through personal thrift on an installment plan. Once accumulated it can be invested for a financial return. Investment is the result of human thrift.
3. Life insurance as property insurance: When the insured pays life insurance premiums, the insured is also protecting real property. He is protecting against a forced asset liquidation required to pay burial expenses and estate taxes.
4. Life conservation: Life conservation efforts represent the most sensible investment the insured can make for himself and his dependents. Time is of the essence in discovering serious ailments which can now be cured or controlled. Keeping a healthy person healthy assures the continuance of the creative functions of life insurance for the holder.
5. Insurance as a Will: The life insurance policy is a will. The life insurance policy represents a will bequeathing to survivors the monetary value of the economic forces within an individual.

THE ROLE OF HEALTH INSURANCE

Development of health insurance in this country began more than a hundred years ago. It only reached major proportions during the depression decade of the 1930s. Accident insurance, employers' liability, and workmen's compensation coverage were mainly provided by multiple-line casualty insurance companies. In the 1930s, life insurance companies entered the field of health insurance and by 1950 were writing more than half of all individual health coverage.

A teammate of Life Insurance

The Massachusetts Health Insurance Company of Boston was the first company that offered insurance against the cost of medical care. The first accident policy was issued by the Franklin Health Assurance Company of Massachusetts. It was organized to offer that type of policy.

Health insurance owed its early growth mainly to coverage against travel accidents, since travel was a dangerous activity in the last half of the 1800s. Travelers Insurance Company of Hartford, formed in 1863, was the first company organized to insure against railroad accidents.

The first disability policy was offered in 1890. Surgical and hospital expense benefits were introduced into some individual disability policies in the first decade of the twentieth century. The first guaranteed renewable, noncancellable disability income policy was issued in 1907.

Group Policy Development

In 1932 the first Blue Cross employee benefit packages was introduced. The idea soon spread nationwide. During the 1940s Travelers, Aetna, and other established companies entered the field. Liberty Mutual Insurance Company in 1949 issued the first major medical expense type policy. It protected families against catastrophic illness.

Massive federal and state programs of Medicare and Medicaid began in the 1960s. These programs are modified as social changes dictate. Formerly incurable or crippling diseases have become treatable, but the treatment is expensive. Lengthening lives means lengthening care. Average life expectancy in 1910 was 46.3 years for men and 48.3 years for women.

Today, average life expectancy continues to increase. Supplementary medical coverage is a major part of the insurance business. Public awareness of health insurance protection has never been higher.

Basis of Earning Capacity

The very basis of health insurance is the current earning power of the individual that will benefit others. Current earning power is dependent on six fundamental characteristics. They include good character; and good health; and a willingness to work; willingness to make a suitable investment; creative ability and judgment; and the patience and ambition required to convert dreams into tangible realities.

Good character is a basis for a successful economic career. Good health is vital, and executives now recognize the value of life conservation work. The willingness to work can economically divide individuals. Patience and ambition represent creative abilities. They have made possible man's major achievements.

Uses of Health Insurance, Income Replacement

For most people, the inability to work means that income stops or is drastically reduced. The primary function of health insurance is income replacement. During the disability, personal and family expenses continue. Without means to meet them, the individual and family become a burden on society. Health insurance to replace income is regarded as primary because it keeps the family together with a roof over their heads and bread on the table.

- Reimbursement of medical expense: Costs of medical care in case of serious illness or injury have risen enormously. Meeting these costs has obscured the basic income-replacement function of health insurance. Many people are impelled to have medical expense coverage before purchasing disability insurance.

Doctors and hospitals have an obvious interest in the spread of health coverage. Not only does health insurance ease the problems of the insured and his family, but it also eases the financial problems of doctors and hospitals. Insurance proceeds are a principal source of income for them.

- Stimulus to adequate health care: Lack of personal means has caused many people to defer seeking needed medical care. When the financial obstacle to early treatment is removed through insurance funds speedy recovery is more certain. The existence of a sound insurance program provides peace of mind. It can alleviate tension and the fear of insecurity that in themselves can cause illness or make it worse.

- Maintenance of credit: The income producer is changed by disability into a large-scale consumer. His credit crumbles without the income provided by health insurance. Creditors like to see adequate plans of health insurance. To prevent delinquencies on installment purchases, creditors offer plans of health insurance with benefits payable in the amount of the loan obligation if the insured is disabled.

- Safeguard for the insurance estate: Other insurance is insured by health insurance. Life insurance and property insurance payments may be kept up by the benefits of health insurance in times of emergency.

- Business insurance: Many important uses of health insurance are now of financial value to business enterprises.

Health insurance is a vital factor in providing the means of implementing buy-and-sell agreements that become effective in the event of prolonged disability of one of the parties. Health insurance now has come to serve business as one of the most important means of improving employer-employee relations, increasing productivity, and attracting and keeping good people.

- Health conservation: Many lines of insurance make important contributions by preventing the hazard underwritten. Health insurance is a major factor in easing the disability problem. Steam boiler and machinery insurers promote safety by providing inspection services. Health insurers encourage their policy holders and the general public to be safety conscious. They support timely steps to prevent or cure illness. The insurer supports the educational work of the Public Health Service, doctors, and hospitals. However, the nature of the individual health hazard limits what the insurer can do to

prevent illness and injury.

Voluntary System Advances

Under the American system, insurance companies function to finance the costs of health care. They do not actually provide the care. They do not interface with the medical relationship between the patient and the physician or hospital. The insurance company supplies the financial means for securing care. Insurance companies help preserve the freedom of choice for the individual who needs medical treatment.

Competition in the health insurance business has produced a wide variety of contracts and benefits. No field of insurance offers a greater variety of insurers. The principal division of the business between insurers providing cash benefits and plans offering service benefits has encouraged competition and stimulated improvement of all plans. Voluntary health insurance has provided major support to the American system of private enterprise.

THE ROLE OF DISABILITY

Good health and long life are the universal aims of the health insurance industry. However, no one is exempt from illness and injury. In spite of the efforts by society to prevent or cure ills, disability remains inevitable.

Disability is affected by many factors. These include age, occupation, financial status, physique, and temperament of the affected person. Disability has a broad base. It can result in limited disabilities occurring in hay fever sufferers. It can result in the complete disability of a paralyzed victim of a cerebral hemorrhage. A hand injury that is disabling to a concert violinist would not be as serious to a banker.

Disability is not a purely personal, individual affliction. The prosperity of the organized society in which modern man lives depends on the productivity of its members. The person who works supports himself, his family, and contributes to the community. Our society must be protected against disability. Otherwise, a productive person may become a burden on all society. Thus disability and protection from disability are of great general concern.

Measurement of Cost of Disability

Two principal elements make up the cost of disability. One is the loss of earned income. The other is the medical and maintenance expenses required to care for the disabled person. Both elements can be measured with reasonable accuracy. The concept of earning ability as a capital asset is as basic to health insurance as it is to life insurance.

For most individuals and families the earning ability of the breadwinner is the most important asset of the family. The capital value of the human life can be destroyed by premature death or by disability. Life insurance guarantees an individual that his dependents will be able to provide for themselves if he should die prematurely. In the same way health insurance guarantees the preservation of earning power and the payment of medical expenses.

Cost of Disability

Surveys determining extent of disability vary in results according to their methodology. The definition of disability and the time when the survey is made are also factors. Surveys have shown that up to 5% of the population can be disabled at any one time. Each person suffers an average of one substantial and recognized illness a year. About half of these illnesses are

disabling. The disability interrupts work, school, or other activities.

In the past the American family spent an estimated average of 4% of its budget on medical care. At this percentage families could pay their own costs of medical care. The astronomical increases in medical costs in the last 20 years have made health insurance a necessity to meet the medical needs of the family.

Ways of dealing with risk include elimination, assumption, or transference. Elimination would be preferable. However, so far there is no solution that eliminates the risk of disability. Most people can't assume the risk because of its high cost. They need to transfer the disability risk through insurance.

Substitution of certainty for uncertainty is the purpose of insurance. The individual transfers his risk of loss to an insurer. The insurer, by pooling many individual risks, can foresee a relatively certain and predictable loss for the entire insured group. There is no way to predict which members of the group will be afflicted.

The disability hazard conforms to the insurability specifications. An insurable hazard should be represented by a sample group of exposure units that permit accurate prediction of average loss. This is done by applying the law of large numbers. It must produce a loss definite in time and place. It must produce a loss that is accidental, unexpected, and unpredictable by the insured in time and place. It must produce a loss that does not affect a major section of the insured group at the same time.

Insurability of Disability Risks

Within a practical framework of risk classification, the hazard of disability permits accurate enough prediction of loss to be insurable. Although less predictable and precise than death claims, health claims and disability are still subject to approximate measurement. Illness and injury are unpredictable and not induced by the insured, in most cases. Epidemics and catastrophic accidents vary the impact of disability from time to time. If, however, large numbers of widely separated individuals are insured, the disability insurer is reasonably secure. The disability hazard has proved to be insurable. It required underwriting ingenuity to make the coverage conform to sound, fundamental insurance principles. Most people want to be well, but there are malingerers, and caution is necessary.

Contract Safeguards and Deductibles for Health and Disability

The underwriter establishes contract conditions as a necessary protection. A typical exclusion clause denies benefits if disability is incurred because of illness existing at the time the insurance becomes effective. To discourage those who anticipate early disability, the contract sometimes incorporates a probationary or waiting period.

The deductible provision is important in the sound underwriting of health insurance. It does not allow benefits category losses that are minor, routine, and recurrent. Nearly all persons have some health care expense or suffer a few days of disability almost every year. To provide benefits to cover loss the insurer collects the dollars that will be returned to the insured through medical and maintenance payments. In addition, the substantial sum necessary for the administration of small claims must be collected. By eliminating small claim coverage through deductibles, the insured's premium dollar provides protection against the insurable risk that can be large, costly, and disabling.

**Coinsurance
Participation**

An important device used by insurers to align the interest of insured and insurer is coinsurance or percentage participation. In health insurance the coinsurance clause requires the insured to bear part of loss. In a contract to reimburse medical expense, the insured may be required to pay 20 per cent while the insurer pays 80.

To avoid tempting the insured to malingering by providing a loss-of-time benefit equal to earned income, insurers apply the percentage participation principle to loss-of-time benefits by insuring them for no more than 80 per cent of the insured's average income after taxes. The hazard of disability is insured successfully by underwriting ingenuity and conformance of contract provisions to fundamental insurance principles.

**Forces Stimulating
Disability Insurance
Growth**

People who lived simple rural lives relied for the necessities on their own brain and brawn. As they began to live together in communities, absolute independence was replaced by interdependence. Each individual contributed the product of his special talent or skill. This trend was vastly speeded up by the industrial revolution.

At the same time, people living together in crowded environments were faced with new and considerable health and injury hazards. The former simple arrangements of the individual and family caring for the disabled were no longer adequate in complicated modern society. Socioeconomic mechanisms developed to satisfy people's innate craving for security. In the United States, voluntary health insurance developed to fill this need. As the science of medicine progressed, a need for collective security increased. Insurance met the need of society.

Life expectancy in America has almost doubled in the twentieth century. This development resulted in more and more victims of the degenerative diseases of old age, as the infectious diseases that had affected young people were brought under control. Costly equipment and highly trained and expensive personnel are required by the scientific progress of medicine. People appreciate the need for early and adequate attention to health problems.

All these forces have combined to make disability losses greater because of the rising cost of treatment. Inflation, higher taxes, and installment buying have made it difficult for most people to save or pay for disability expense out of their current income.

Disability is a social as well as an individual problem. Thus organized groups in the community have become concerned with its increasing costs. Organized labor has made the provision of health insurance a major bargaining objective.

Government, ultimately responsible for the indigent, has moved through social security disability benefits, Medicare, workmen's compensation and other programs to enlarge the general public's safety net.

General education to develop a wider appreciation of the importance of adequate health insurance has been encouraged by hospitals, physicians, and insurers, all of whom have a natural interest in the subject.

Chapter 4 The Annuity

An annuity is not classified as life insurance. It does not provide insurance protection. It is however, issued by life insurance companies. The annuity buyer might be compared to a person who buys a house with no intention of living in it. The house in this case is an investment to produce income in the form of rent.

The basic purpose of an annuity is to distribute a regular, guaranteed lifetime income through a scientific liquidation of invested capital. Life insurance also provides for liquidating capital in death proceeds or cash value over a lifetime, but the fundamental purpose of life insurance is to distribute cash at death.

A life insurance company can accept a certain amount of capital and guarantee that it will pay a specific lifetime income to the annuitant. Life insurance companies have accurate, scientific methods of predicting the annuitant's length of life.

Annuity tables have been developed based on the law of averages and the record of life spans compiled over generations. Some annuitants will die sooner than expected and some will live longer, but the company's annuity transactions will work out on the average over a period of years.

Annuities

The original meaning of "annuity" was an annual payment. Now annuities come in many different forms and can be paid at a wide choice of intervals.

An annuity is an appropriate investment for people who have no dependents and expect to have none. It is an appropriate investment for people who have already made provision for survivors' coverage and need only to consider their own old age income.

Annuities also provide a good solution to the problems of uninsurable individuals who have responsibilities for dependents. The annuity allows them to set aside substantial amounts regularly. If they die, their families will receive at least the sum total of the annuity premiums and probably much more from interest earnings.

A portion of retirement income can be generated through permanent insurance, but a portion of the premium must go to pay for current insurance protection. Only the remainder can go into the reserve, from which cash

values are paid. If death protection is not needed, the money can go into the purchase an annuity. These are some of the individuals for whom annuities may be the best solution:

- ☐ A middle-aged to elderly person who has inherited a substantial sum of money, has no dependents, and is concerned about reduction of the principal.
- ☐ A career person who makes good money and wants to quit working at an early age, or realizes that age and business pressures may force retirement.
- ☐ A person who has unusually large earnings in a relatively short period, such as a sports professional, an actor, or an entertainer.

How Annuities Work

It may be difficult for a prospective annuity buyer to understand how an insurance company can promise to pay out more than is being put into an annuity in its early stages if that buyer thinks in terms of a savings account or certificate of deposit. In these cases the account owner gets back just what was deposited plus whatever interest has accumulated. In these cases also, the federal government insures the deposits.

Annuities draw on a pool created by many investors. This makes it possible to provide more flexible returns, but they are not backed by federal insurance. For that reason it is important to be sure of the stability of the issuing institution.

Annuities may be purchased from insurance agents or from banks, brokers, financial planners, or mutual fund companies. No annuity is any safer than the firm that issues it.

Nevertheless annuities have become popular. The changes in the federal tax laws during the 1980s have made the annuity a good investment and provide tax advantages simultaneously.

The big advantage in an annuity is that income taxes on earnings are deferred until the earnings are paid out. In the case of a long-term annuity the investor may well expect to be in a lower tax bracket when tax is due on the earnings.

Also, it is possible to put as much as the investor can spare into an annuity, while Individual Retirement Accounts are limited to \$2,000 a year or less depending on the taxpayer's pension status.

Development of Annuities

The use of annuities to pay out estates in annual installments is not a new idea. It is believed to have been used in the Babylonian empire of Nebuchadnezzar II, which had well developed banking and commercial facilities.

The first recorded annuity system is the Falcidian Law of 40 B.C., during the Roman empire. Regulations were established to pay specific legacies. A rough system of mortality estimates was used. They calculated that an annuitant up to age 30 could expect 30 more years of life. An annuitant older than 30 could expect to live the number of years that added to his age would equal 60.

Not many people in those days lived to be older than 60. A refinement of this system was produced by a Roman judge about 200 A.D. The foundation of scientific annuities and modern life insurance tables, however, did not come until 1771 in England. The first publication was the "Northampton Table of Mortality" by Richard Price.

Refinements and adaptations were added over the next two centuries with the development of actuarial science. The annuity was more popular in Europe than in America until the depression years of the 1930s. The depression brought to attention the need for a secure investment.

Types of Annuities

People who had any assets left during the 1930s were primarily concerned with finding an investment that would yield an unfailing fixed dollar income. That need was filled by the conventional or fixed annuity. This provides for payment of money in fixed installments over a time period, with each payment representing part interest and part principal. The combination makes possible a greater return over the annuitant's lifetime or other chosen periods than from other investments.

Postwar inflation brought changing needs for investors. You could put a stack of \$100 bills away in a safe deposit box and depending on how long you left them there they might be like a stack of \$20 bills in buying power when you or your heirs took them out.

Beginning in the 1950s, a new type of annuity designed to cope with inflation was developed. It is called the variable annuity. It yields income on the basis of investment results. The first variable annuity on the market was designed by the Teachers Annuity and Insurance Association. It appeared in 1952 as the College Retirement and Equities Fund (CREF).

Annuity Conditions and Terms

Under the two major divisions of fixed and variable annuities there are a number of sub-classifications. There are pure annuities, refund annuities, immediate or deferred payment annuities, single premium or periodic premium annuities. There are annuity contracts covering one or more lives.

The general definition of an annuity is a contract between the company issuing it and the person buying it in which the purchaser agrees to pay the issuing company a certain amount of money in exchange for a regular income over a specified period. The time period may be the individual's lifetime or an exact number of years.

According to the plan of distribution, the contract may be a straight life or a refund annuity. Straight life or pure annuities pay the largest return for a given premium. They guarantee the annuitant maximum income for life in proportion to the amount of money invested. They are not as frequently issued now as they were formerly because no matter how many or how few payments have been made, the death of the annuitant ends the obligation of the issuing company.

More buyers prefer the refund annuity. If an annuitant dies before the income has begun, a refund annuity provides for the return of premiums paid. In some cases interest is also paid. If the annuitant dies after the income payments have begun, a refund annuity paid on an installment basis provides a minimum number of payments. If a person at age 65 buys a life annuity with a guarantee of 120 monthly payments, and dies after 60

payments have been made, the named beneficiary will continue to receive monthly payments for five more years (60 months).

If the annuitant dies before receiving the cost of the annuity, an installment refund life annuity provides for payments to continue until the payments equal the cost of the annuity. A man purchases a \$20,000 annuity that would pay \$100 a month for the rest of his life. He dies after 120 months. His beneficiary would continue to receive the \$100 monthly payments for another 80 months. At this time the full purchase price is returned. A 50 per cent installment refund annuity is offered by some companies at a larger payout than the 100 per cent refund annuity.

Cash refund life annuities pay a lump-sum amount when an annuitant dies. The sum is equal to the remainder of what was paid for the annuity and the total of annuity payments received before death. If \$15,000 had been paid out on a \$20,000 annuity, the balance of \$5,000 would be paid to the beneficiary in a lump sum.

Annuities with refund provisions cost more than pure annuities. For younger buyers the difference is less than for older buyers.

Annuity Terminology

Annuities are structured through the use of life insurance mortality tables. Insurance terms generally describe annuities. Payments made by the annuitant are called premiums. Like money deposited in a savings account, these premiums earn interest. They are invested by the issuing company in order for them to increase in value. The annuity contract states what return interest rate will be paid for what period to the annuitant. A rate may be guaranteed for one to five years. The contract may call for the return rate to be reviewed at specified intervals after that time.

The rate paid on Treasury bills is often used as an index for setting annuity interest rates. Cost-of-living calculations also may be used. The issuing company guarantees a minimum interest rate, typically of three to five per cent.

Usually there are charges for sales commissions. There are surrender charges on early withdrawals exceeding ten per cent of the accumulated investment. Also the tax-deferred advantage for accumulated interest is lost. A ten per cent tax penalty is imposed on the early withdrawal. For this reason an annuity is not suitable for a short-term investment. A minimum of five to fifteen years is necessary before withdrawals are not subject to penalties.

As in insurance, the buyer of the annuity is called the owner. The person who is to receive the payments is the annuitant. The annuitant may or may not be the contract owner.

Payment Options

Annuities are divided into immediate and deferred categories. An immediate annuity makes payments to the annuitant soon after the purchase date. Payment periods can be monthly, quarterly, semiannual, or annual basis.

Ted sells a house, for instance. He wants to provide for a regular income in exchange for a cash investment. Ted can buy an immediate annuity. He will have income payments that start within a month and continue for many

years or a lifetime.

A deferred annuity begins payment to the annuitant at a future date as specified in the annuity contract. The time between the purchase of the annuity and the maturity date is known as the accumulation period. The period after the maturity date, during which the annuitant receives payments, is called the liquidation or distribution period. The contract payment schedule determines the annuity payment start date and the deferred annuity payment period.

A typical purchaser of a deferred annuity might be a middle-aged man who wants to provide economic security for his retirement. He wants an additional income besides Social Security and his company's pension plan. A deferred annuity will begin to provide him with additional income at age 65. It can be purchased with a lump sum payment or with a regular schedule of payments up to the time he reaches 65.

After the purchaser decides whether he wants a deferred annuity or an immediate, there are other options to be considered. There are premium options. There are settlement options. The prospect chooses the method and frequency of payments he will want. He must determine the number of lives to be covered by the contract. The purchaser must choose the surrender terms he wants in case of contract termination before maturity. Immediate or deferred annuities may be purchased with a lump sum. The purchaser buys the annuity in a single payment. Some annuities can start at a cost of \$10,000 and go up from there according to the customer's wishes.

Options on Premiums

A deferred annuity can be purchased on an installment plan. The buyer may select monthly, quarterly, semiannual or annual premium payments. The premium payments will continue on a regular basis until the maturity date. This option fits in with a familiar habit for investors who have been accustomed to making regular savings account deposits. A deferred annuity can be purchased on a flexible payment basis. This arrangement allows the purchaser flexibility in making payments at a time in life when income may be low while obligations are high. Changes can be made in the timing and amount of premium payments. Prospective annuity buyers who have irregular incomes may need a program in which they can vary the amounts they save every year.

Families with growing children also may need flexibility to take care of changing or unexpected needs. An annuity contract can be purchased with a minimum deposit of \$2,500. The funds continue to accrue interest even if no further payments are made. Some companies now will sell an annuity contract with an opening payment of \$250 and a flexible premiums schedule for future years.

Options for Settlement

The way in which annuity funds are distributed is known as a settlement option. The issuing company and the annuity owner agree on what this option will be. There are four major settlement options.

The lump sum settlement is paid in its entirety at the maturity date of the annuity. The payment includes the cost of the annuity and the annuity interest payment.

An interest-only settlement will pay the annuitant the total of interest earned. The principal is not paid at this time, leaving another settlement option for a

later date.

The owner may choose to have the settlement paid in a set number of payments or a set dollar amount over a number of years. For example the annuitant may receive equal quarterly payment paid over a ten-year period.

Probably the most familiar settlement arrangement for annuities is the life income option. Life income options guarantee fixed amount payments to the annuitant until death. As discussed previously, payments after the annuitant's death may or may not continue as determined by the contract.

A straight life contract guarantees payments that will end when the annuitant dies. No remaining balance is paid to a beneficiary or the estate of the annuitant. If a man with a straight life annuity begins receiving his payments at 65 and lives to be 100, the issuing company pays him throughout that time span. On the other hand, if he died at age 66, the payments would stop at that time.

The straight life annuity does not guarantee that the annuitant will receive payments equal to the premium payments made on the contract. If however, the annuitant dies during the accumulation period, the premiums paid to date will revert to the beneficiary or to the annuitant's estate. The straight life annuity has a high degree of risk. Accordingly, the straight life annuity pays the highest return of all the annuities issued.

Period Certain Options

The buyer does not have to use the date of death as a settlement date. The buyer may not want to gamble on whether the owner or the issuing company will make a profit. The buyer can choose to purchase a period certain or refund option annuity. These guarantee that a minimum amount will be returned on the annuity. The guaranteed payment after death amounts to death benefits. They provide for a payment to the beneficiaries when the annuitant dies. They offer a lower investment return than straight life annuities. They also have less risk involved.

A period certain annuity guarantees payments to an annuitant throughout his or her life time. A period certain annuity guarantees payments to the beneficiary for a specific time after the death of the annuitant.

The use of a beneficiary guarantees that a specific sum will be paid out by the issuing company. An annuity with a five-year period certain option and a payment schedule of \$6,000 per quarter would guarantee payment of \$120,000 regardless of whether the owner died before the five-year period was up. It is customary for insurance companies to pay the beneficiary in a lump sum after the annuitant's death rather than continuing to make installment payments. If the annuitant lives past the five-year period, the payout will continue in the normal manner until the annuitant's death.

Another life income option guarantees a payment after the death of the annuitant equal to the remainder of premiums paid in. This is called the refund option. Since this is an option on a life income annuity, the annuitant will receive payments throughout his life in accordance with the annuity contract regardless of whether he lives past the point of the guaranteed refund.

Types of Refund Options

There are two basic refund options. Under a cash refund agreement, the company guarantees that in the event of the annuitant's death, a refund in cash will be made to the beneficiary. The amount will equal the difference

between the income that the annuitant received and the amount paid in premiums plus interest earned on that amount.

When the refund option is an installment agreement, the insurance company will make payments to the beneficiary until the total of what was paid to the annuitant and the beneficiary equals what the owner paid for the annuity contract plus interest. The amount of the payments to the beneficiary is dependent on the payment period. The longer the period the smaller the individual payments.

Refund option annuities pay lower amounts than annuity contracts without refund options. The refund options represent an added cost for the issuing company. At the same time, they are attractive for consumers who do not like the idea of investing substantial sums in a product with the amount of return depending entirely on the length of the annuitant's life.

Singular or Plural Annuitants

The annuity contract may be written to provide for one annuitant only. The insurance company agrees to provide that person an income beginning on a specific date and continuing for a certain period.

An annuity contract may cover multiple annuitants. A joint and survivor annuity is a common type of annuity. Its annuitants include two people such as husband and wife. Payments are made to the annuitants beginning on the date set in the contract. The payments are guaranteed to continue as long as either annuitant survives. Payments to the survivor may continue in the amount received when both annuitants were alive, or the payments may be reduced.

Under a joint and two-thirds survivor option, the survivor receives two-thirds of the original income. Under a joint and one-half income, half the original amount is paid to the survivor.

Surrender Charges

The termination of an annuity by the owner is called a surrender. The terms for such an action are included in the annuity contract. An individual who surrenders a contract turns the annuity contract documents in to the issuing company. The issuing company gives the owner a predetermined payment as set out in the contract. The payment is known as the surrender value of the contract.

The surrender value of a policy is in proportion to the number of premiums paid. The surrender value does not normally equal the amount the annuitant paid on the contract. Surrender charges are imposed by the issuing company. Most annuities have a seven year penalty period. If the annuity is surrendered within the first 7 years of the contract period a penalty is charged. As seen, the annuity is not a short term liquid investment. The annuity is designed to be a long-term investment.

Loan privileges are available on some annuities, but the loans carry interest charges and may be subject to income taxes.

Benefits of Fixed Annuities

The annuity is not a truly liquid investment since it carries early withdrawal penalties. The annuity, however, does provide security to the annuitant through the guaranteed life income. The cost of this benefit is included in the premium paid for the annuity. A person accustomed to thinking in terms of an individual investment in a savings account may not realize that the issuing company pools the funds it receives from annuitants and prices the annuity according to statistical projections based on mortality tables.

The tables allow an insurance company to project what its future obligations to annuitants will be. The tables allow the insurance company to project the company's positive monetary return provided by annuitants who die.

The company projects its expected earnings on the premiums and other funds it holds as well as its operating costs using statistical data available. The resulting information is used to set the premium payment to be made by the purchasers of the annuities. In this way an insurance company can promise to pay an individual a guaranteed income for life even if that income exceeds the total amount of premiums paid plus interest.

Numbers in mortality tables are used by actuaries to calculate risks. Mortality tables are used to set premiums and reserves necessary for successful operation of companies issuing annuities. Average life expectancies are used in these calculations.

A current mortality table, structured to show that all annuitants will have died by age 115, indicates that out of 100,000 people born in the same year, only 87,149 will be alive at age 65. During the following year 1,348 will probably die, leaving 85,801 survivors.

Using such projections based on averages for every year of life, actuaries can calculate statistically sound, feasible premium rates and charges.

Unlike savings accounts or Cds, annuities are pooled funds based on the participation of many investors. When an investor receives income from an annuity, the money is coming from a pool that provides an insurance benefit to annuitants living long enough to collect. The death total benefit to surviving annuitants grows larger each year during the liquidation period. If the annuitant lives long enough to use his entire principal and interest accumulation his continued payments will be made from the fund which is replenished by new annuitants' payments and annuitants that die before they receive their full return.

Tax Advantages

The major advantage in purchasing an annuity is that under current tax laws the tax on earnings is deferred during the accumulation period. When the annuitant begins to receive annuity payments, only a portion of each payment is taxable. The remaining portion of the payment is considered a return of premiums paid and is not subject to tax.

A calculation specified by the U.S. Department of the Treasury determines what part of the annuitant's income will be considered taxable. The amount is based on a projection of how much the annuitant will receive from the annuity by living to life expectancy. This total income is called the expected return. The percentage of that amount which was invested in the annuity is calculated.

If the expected return is \$300,000 and the annuitant paid \$180,000 on the contract, the expense of purchasing the annuity equals 60% of the total amount that will be returned to the annuitant. 40% of each payment is earned interest income. The percentage figures are used each year to determine what amount of the annuity payment is return of capital and what amount of the payment is earned interest income. The earned interest income is subject to income taxes.

A 10% penalty is applied by the IRS to lump sum withdrawals from annuities before age 59 1/2. The penalty does not apply if the withdrawal is one of a series of withdrawals of approximately equal size over the remaining lifetime. A penalty exemption may apply in cases of death or disability. The 10% withdrawal penalty applies whether the amount is a loan or an actual withdrawal.

Annuities owned by businesses may not receive a tax deferral benefit. If a corporation, partnership, or trust owns an annuity on the life of an employee, the annual interest earned on that annuity is taxable in the year in which it was earned. It is not tax deferred. If annuities are an element of a company's qualified retirement plan they will retain the tax deferred benefits. Another exemption is for immediate annuities. The tax deferral benefits also apply to IRAs and 403(b) tax-sheltered annuities sponsored for employees by certain non-profit corporations.

For an individual, the tax-shelter advantage of an annuity is a major consideration. It has brought about the sharp increase in popularity of the annuity.

Annuities are well suited for college funds. An annuity purchased for a pre-teen and held at least ten years would carry at present rates a tax on withdrawals of around 25 per cent. This rate probably compares favorably with the parent's tax bracket. Of course there is always a possibility that tax rates might be raised by the maturity date. There is a chance that Congress may revoke the tax-deferral advantage for annuities. This is unlikely in the present financial environment. However, no investment on the market offering a similar return is without risk.

Interest Earnings

Many investors are attracted to annuities because they provide competitive interest rates. The interest rates fluctuate but often rank above Cds, high-yield tax-free bond funds, and similar investments. Interest guarantees vary with issuing companies. Some companies will pay an initial rate for one or two years then adjust annual rates on a periodic basis. Others will offer interest rates pegged to Treasury bill or consumer price indexes.

A bailout provision in an annuity contract will allow the owner to cash in the policy without paying a surrender charge if the interest rate falls below a certain percentage. The provision may be available even after the expiration of the initial guarantee interest rate period. For example, a contract offers a guaranteed one year interest rate of 8%. The contract has a seven year surrender charge clause to cover premature withdrawals. It also has a bailout provision of one and one-half per cent. The interest rate the following year is 6%. The interest rate has dropped 2%.

The annuitant can invoke the bailout provision. The annuitant will not have to pay a surrender charges when the annuity is cashed in. The bailout provision has precedence over the surrender provision. An annuity is not as liquid as a savings account in a bank. Funds in a savings account can be withdrawn at anytime without penalty. Annuities can be withdrawn during the accumulation period, but in most cases carry a penalty for such action. Penalties and surrender fees will be specified in the annuity contract. The alert investor will compare the offerings and their terms of various companies.

Risks Involved

Annuities are not protected by the Federal Deposit Insurance Corporation and the buyer needs to be very careful in selecting an annuity provider. Fixed annuity contracts, however, are protected by state and federal regulations governing insurance company operations. Many states require other insurance companies to help meet the obligations of one that fails, but delays and paper work are involved in such cases.

Inflation is a risk facing the fixed annuity investor. An annuity that provides an income of \$3,000 a month might seem adequate today. In twenty years with inflation that amount could be insignificant. The guaranteed return does not fluctuate with inflation but stays the same. They are worth more in times of deflation. They are worth less during times of continuous inflation, as in the current national and world situation. This problem led to the development of the second major type of annuity investment, the variable annuity.

Introduction of Variable Annuities

The public greeted the variable annuity with much interest and controversy. The variable annuity was introduced by the College Retirement Equities Fund in 1952. The Teachers Annuity and Insurance Association designed the CREF when it became apparent that inflation was a permanent problem of the society. Some companies in the insurance business accepted the variable annuity while others opposed it. Legal questions were raised. The Supreme Court ruled in 1959 that variable annuities are not insurance and are subject to federal regulation as securities.

The variable annuity offers payments that fluctuate according to the funds' investment results. Premium dollars for variable annuities are invested chiefly in fluctuating dollar investments like common stocks and other equity investments. Premium dollars for the conventional annuity are invested in bonds and mortgages. The aim of fixed and variable annuities is liquidation of principal over a period of time, often the lifetime of the annuitant. The difference is that one pays fixed dollar amounts and the other pays variable dollar amounts.

Over the long inflationary period in the second half of the twentieth century, the general trend has been for stock prices and the cost of living to move in the same direction. For this reason the purchaser of a variable annuity looks forward to receiving a higher dollar income in times of higher prices so that stability in terms of purchasing power will be maintained by the investment. A fixed dollar annuity cannot provide this type of stability.

Unit Values

Most insurance companies have adopted a unit method to express variable annuity values. Two types of units are used corresponding to the two time classifications for annuities, the accumulation period and the distribution period.

The premiums paid by the annuity owner are used to buy units. The value of the units fluctuates in the case of an installment annuity being paid for on a monthly, quarterly, semiannual or annual basis. For an annuity with quarterly payments, the premium for the first quarter of the year might buy six units, for the second quarter five units, for the third quarter eight units, for the fourth quarter seven.

The purchasing ability of the dollar does not run in a straight upward line. Changes in the cost of living and changes in common stock prices do not always move exactly together. Thus a well managed flexible annuity fund

**Company-Managed
Annuities**

requires maintaining a balance in the type of investments that will offer the greatest advantage.

The first variable annuities introduced in the 1950s were managed by the companies issuing them. In this type of annuity, premiums paid in by owners are pooled and placed in a separate account from the company's other investments.

Like a mutual fund, the account is under the direction of investment managers who buy and sell a mix of stocks, bonds, government securities, and other investments on a continuing basis to generate a competitive return for the annuitants. Various economic indicators are used by the investment managers to make timely decisions with the aim of maximizing profits.

Companies selling variable annuities must meet state and federal regulations under the supervision of the Securities and Exchange Commission, Internal Revenue Service, and state regulatory agencies. An advantage to annuity investors is that their premium annuity fund is separate and beyond the reach of the creditors of the company issuing the annuities.

An annuity fund investment portfolio might consist of a blend of stocks, bonds, and money market instruments. For example, at the beginning of the year, 37 per cent of the fund may be invested in stocks, 18 per cent in bonds, and 45 per cent in the money market instruments. If a stock market slide begins, the investment managers sell the stocks and go to a mixture of 63 per cent in bonds and 37 per cent in money market instruments.

Such institutional block trading on the part of institutional investment managers has been blamed for making the stock market slide down further when otherwise it would stabilize. When stocks begin to rise, institutional investment managers are quick to take advantage of the market up-swing and assume a different portfolio mix. By the end of the year the fund may be more evenly divided, 39 per cent in stocks, 36 per cent in bonds, and 25 per cent in the money market.

**Self-Directed
Annuities**

An annuity owner can control the way his premiums are invested by choosing a self-directed variable annuity. The self-directed annuity payments are not invested by the issuing company's investment managers. A knowledgeable owner can vary investments instruments as economic conditions or the investor's own objectives change.

The application form for a self-directed variable annuity will show what choices are available in the selection of investments. There may be a fixed account with interest guaranteed for a certain period. That period may be a calendar quarter, a year, two years, or possibly longer. Under this option the safety of the principal is guaranteed. Along with the fixed account choice the form may offer mutual funds with various objectives. An emerging mutual growth fund's main investment would be composed of common stocks of growth oriented companies. These companies have a good potential for long-term capital growth. A growth stock fund's main objective is long-term. It invests for future income through growth of capital. An income stock fund demands current income. Its investments would be in common stock of companies with good growth histories and regular dividend payments.

A cash management fund might choose investments predominantly in U.S. government securities. The primary objectives of cash management funds are simultaneously preservation of capital, current income, and liquidity. A financial bond fund would be composed of high-grade bonds and have as objectives high-yield current income and preservation of capital.

Contract stipulations would set out conditions established by the issuing company for frequency of fund transfers. The contract stipulates, minimum transfer amounts, withdrawals, guarantees to beneficiaries, annuity payout terms, and initial and subsequent minimum payments.

The customer indicates on the annuity application, in percentage units, how each premium paid in is to be allocated between funds. The entire premium can be invested in a single fund, or the units can be divided among the different funds in whatever mix the applicant chooses.

Investment Changes

An individual's choice of investments, unless entirely on a random basis, will depend on three factors. They are economic conditions, the individual's financial status, and the objectives and philosophy behind the investment. These change as time goes by. The appeal of a self-directed annuity is that it gives the annuitant the opportunity to change the investment mix to suit changing conditions.

Most individuals grow more conservative as they grow older. They may prefer to switch from a stock-dominated portfolio to one that emphasizes security, perhaps even to a fixed fund. On the other hand, a large investor with sufficient accumulated wealth may be inclined to be aggressive. Such an investor may choose a high return high risk investment. A self-directing annuitant that experiences losses may switch his annuity into a fixed fund.

The investor who is directing his own annuity must watch economic indicators. The investor may switch from stocks to bonds when the stock market starts down and back to stocks when the Dow begins to show signs of recovery. Keeping up with changing economic conditions is a time consuming and risky business. Those who want to spend their energy and time in other ways will choose the fixed annuity or the variable annuity with a fixed fund. A 20 to 30 year old individual with some investment capital might select speculative growth funds in the belief that there will be plenty of time available to switch to more conservative funds if necessary. A man in his middle years may begin to shift funds to a fixed option, leaving only 10 per cent or so in growth funds. Someone who has reached age 65 and is receiving annuity payments may divide his investment units half and half between a fixed fund and the bond market.

Types Of Units

Statements on the value of variable annuity accounts are provided regularly to investors. The computation of the exact worth of the investment at any given time is complex because of fluctuating market values. Most companies express annuity values in units rather than dollars. During the accumulation period while premiums are being paid in, the term accumulation units refers to the current status of the account. When the annuity matures and payout start to the annuitant, accumulation units are converted into what is called annuity units.

The value of accumulation units changes as market values change. If the annuity is company-managed, the changing values correspond to the

performance of the investment pool. Like a mutual fund share, each accumulation unit of a variable annuity has a designated value on any given day. In the case of a self-directed annuity, the value of each accumulation unit is determined when the values of the fund or funds the annuitant has chosen are totaled and divided by the number of units.

As time goes by, the number of accumulation units increases as additional purchases are made. The value of each unit will vary through the life of the contract according to market activity. This is similar to the way mutual share values are calculated.

If an annuity investor paid a \$100 monthly premiums and the accumulation unit value was \$5.00 on the day of his first payment, he would purchase 20 units. By the time his next premium payment is due, the unit value might have risen to \$5.05. He would only purchase 19.80 units with his \$100. The next month if the unit value dropped to \$4.87 the total of investment units purchased by the \$100 payment would be 20.53. Thus the investor would be adding a certain number of units to his portfolio each month. If the premium payment remains constant, the exact number of units purchased would depend on the current market price for each unit.

The value of the units will continue to fluctuate throughout the accumulation period. When the annuity matures, the accumulation units will be converted into annuity units. The number of annuity credits received by the annuitant will depends on current market value, and four other factors.

Choice of Payments

The first determining factor is the annuitant's age. The issuing company calculates from mortality tables what is needed to provide a designated amount of lifetime income at a specified age.

The second factor is the number of guaranteed payments. An annuitant can choose a period certain life income option. The annuitant will incur an additional charge for the guaranteed period. The charge will enter into the annuity unit calculation.

As the third factor, the issuing company projects what interest rates can be expected while the annuity is in force. If a high interest rate is predicted, the value of the annuity unit will be greater than if a lower rate is expected. Usually rates are projected annually to determine projected investment returns.

As a final factor, the company's administrative expenses are projected into the calculation to determine the annuity unit value.

Payment Options

The number of annuity units credited to each payout will remain constant over the payment period. The annuitant May choose a fixed or a variable payment or a combination of both.

With a variable payment the value of the annuity may fluctuate as it did during the accumulation period. The performance of the investment portfolio and general administrative costs of the company will cause the variations. Thus the amount of annuity payments will fluctuate. For example, an annuitant had 10,000 accumulation units when the payments were to begin. The company converted the accumulation units into 100 annuity units. Each annuity unit is worth \$10. The first monthly payment would be \$1,000 to the annuitant. If the annuity unit value went up to

\$10.17, the next payment to the annuitant would be \$1,017. If the unit value declined to \$9.73, the annuitant would receive \$973 for the next monthly payment. If the unit value then rose to \$10.57 the next check to the annuitant would be for \$1,057.

Variable annuities continue to fluctuate after the retirement income period begins. They fluctuate because the value of the portfolio changes constantly to reflect current market conditions. They fluctuate because the investment mix, in the annuity contract, change just as they did during the accumulation period. The insurance company's investment managers are still buying and selling stocks and bonds and other instruments in the fund portfolio. The annuitant may change the contents of the portfolio in a self-directed plan.

Theories of Performance

When the variable annuity was first put on the market in 1952, the idea behind it was the designing of a financial instrument to combine the guarantees of annuities with the growth potential of equities for a hedge against inflation.

A widely held theory at that time was that common stock prices and the cost of living tended to move in the same direction. Through the 1950s and 1960s this theory seemed to be valid. In the next two decades there were wide fluctuations in the relationship between the consumer price index and Standard & Poor's index of 500 stocks.

Inflation still continued even through periods of recession. As explained by financial experts this phenomenon occurs due to the fact that rapidly rising prices correspond to sharp rises in interest rates. Sharp rise in interest rates brings a downward stock market reaction.

It was pointed out by variable annuity proponents that the product was not intended as a temporary hedge against sudden inflation. The variable annuity was based on the expectation of a long-term correlation between inflation and investment returns. In this view a variable annuity would give investors an increase in income as the economy increased in productivity.

Nevertheless, holders of CREF annuity instruments were considerably disturbed when their unit value dropped almost 40 per cent in three years beginning in 1973. Individuals who had started drawing their annuity payments saw the amount of money they were receiving go down while consumer prices zoomed upward. Those who were still in the accumulation period, paying premiums on their annuities, saw an even worse drop in unit prices of more than 50 per cent.

Risk Factors

Variable annuities are not suitable for every investor. The combination of flexibility and guarantees offered by the annuity is an advantage. There are, however, special concerns connected with its use. There are concerns especially for a person accustomed to fixed investments.

Neither a fixed nor a variable annuity is covered by federal insurance. Guarantees backing the contract are those made by the issuing company. For that reason it is essential for the prospective investor to check into the record and reputation of the carrier before signing a contract. In the past, when insurance companies failed, other carriers took over the financial obligations of the failed companies. This process can cause delays and does not always pay the interest originally promised. Investors must

understand that the money they invest in annuities can increase or decrease in value. The investor's financial position and tolerance for risk must be evaluated when constructing a portfolio.

During the annuity accumulation period there is time to correct errors and adjust to market conditions. When the retirement period comes, an investor may need to make adjustments and will tend to be conservative in choices. There is less time available then to recover from wrong decisions.

The choice between a company-managed and a self-directed annuity will depend on the investment experience of the customer and how much he may wish to be involved in portfolio decisions. A person with limited knowledge of the stock market would be better off with a company managed annuity. The customer who chooses a self-directed annuity will need to keep up with changing economic conditions. The customer will need to periodically review his investments to see if they are appropriate both to the economic situation and to personal needs.

Fees and Charges

Fund managers for the issuing company have fee schedules and other charges for each annuity contract. The customer needs to be aware of these before concluding the purchase.

Both fixed and variable annuities carry a surrender charge limiting the amount of money that may be withdrawn during the early years of the contract. In some cases there is a declining charge. For example the surrender charge may start at 6% of the total value of the policy during the first year. It will then decrease by 1% each year after that. In such a contract there would be no surrender charge for withdrawals after the sixth year.

Management charges usually are imposed for investments in company-managed accounts. The contract charge might be \$25 a year for administration in addition to an investment management fee of one per cent or more of the total value of the account. A guaranteed death benefit and coverage of administrative expenses involved in providing a life income usually are provided with these charges.

Tax Benefits

The major factor in the current popularity of annuities is the tax advantage they offer. The same tax deferral is available in an Individual Retirement Account, but the maximum investment in an IRA is \$2,000 a year. The investment in an annuity is limited only by the investor's financial status.

A mutual fund investor has to pay income tax on yearly dividends and capital gains. An investor in mutual funds through an annuity is not subject to income tax on the earnings until the money is paid out. With a successful investment policy that takes advantage of market conditions the annuity purchaser can build a retirement fund with tax deferred accumulations. When money is withdrawn, taxes are due.

An investor who has a lifetime income from an annuity during retirement probably will be in a lower tax bracket than during the accumulation period. Accordingly, the taxes due will be less than if they had been due during the accumulation period. The annuitant keeps more of his accumulations and pays Uncle Sam less. Who can beat a deal like this?

Chapter 5 Marine, Fire, Casualty, Surety, Fidelity Insurance

The oldest form of insurance known is marine insurance. Coverage for goods being shipped to faraway places began when Babylon was the financial capital of the world, around 2000 B.C. Merchants and traders had to borrow funds to finance their trade or to get goods on consignment. As security for these loans they had to pledge not only their ships or caravans but their lives. In case of loss, they and their families could be sold into slavery.

To meet the risk of losing liberty as well as property, a contract system was devised by the Babylonians. The lender agreed to cancel the loan if the merchant was robbed of his goods. Such contracts carried a surcharge for protection over the usual rate of interest. They developed into a system of respondentia loans. The loans were made on the security of a venture and were repayable with interest if the voyage was successfully completed. The loan was canceled if the voyage failed. If a lender negotiated enough loans, he had a more or less regular ratio of loss. The interest charged in the respondentia loan actually amounted to an insurance premium to cover losses. These arrangements were practical. Word of them carried through the Phoenicians to the Greeks and Romans. They became part of early systems of contract law over a wide area.

The practice of providing insurance simply on a premium basis is believed to have its origin in the Italian maritime city-states of the Middle Ages. The first known insurance contract was dated 1347 in Genoa.

English Developments:

The idea of insurance was brought by Mediterranean traders to London. The Italian origin of the written insurance contract is indicated by the word "policy," which comes from the Italian "polizza," meaning a written and folded document.

In the early days of the insurance business, transactions were not handled by corporations. They were handled by individual insurers. The proposal for coverage of a risk was presented at a meeting place of traders. Those willing to accept part of the coverage signed at the bottom of the document, with indications of the amount and other limitations agreed upon. This practice is the origin of the term "underwriter". An underwriter is an individual who has special knowledge of risk-taking.

In London, a meeting place for those interested in sea voyages was a coffeehouse owned by a man named Edward Lloyd. This became headquarters for many traders in maritime risks. In 1769 an organization of

the underwriters was formed at Lloyd's. Lloyd's continues to do worldwide business today in much the same manner as in the 18th century. The old Lloyd's contract provides the basis of all marine insurance policies. The main features of the American system are the same as those of the old contract, although it is not rigidly followed in form.

Insurance Principles

As marine insurance developed, questions regarding disagreements were settled in the merchants' courts. The courts were established by the merchants to determine disputes in accordance with established mercantile custom.

The general principles of insurance law were recognized through dealing with marine risks in a time when long distance communication was slow at best. This posed a problem for early insurers. The insurer could inspect vessels before they sailed, but then had to rely on information from the insured concerning vessels in foreign ports, embarking on return voyages.

Accordingly, under the law, the insurance contract became an instrument of the utmost good faith. Under this requirement the doctrines of concealment, representation, and warranty were developed.

Inland Marine insurers recognized the need for protection of goods and property being moved in other ways than by sea. Early in the 19th century this new class of transportation insurance was named "inland marine" to distinguish it from "ocean marine." Besides covering moving or movable property and the facilities for its transportation, such as warehouses and docks, inland marine came to deal in "all risk" coverage. Industrialization and the growth of cities increased the need for protection against industrial and transportation accidents, theft, and third-party liability. This became known as casualty insurance.

Insurance In America

Two English corporations were granted a monopoly in 1720 in the American colonies. This prevented the organization of corporate insurers in the colonies. Individuals could issue insurance, but they could hardly compete with such organizations as Lloyd's of London. Mutual fire insurance groups were formed in the colonies. Some were a combination volunteer fire companies and insurers. Benjamin Franklin was an organizer of one of the first of these, which is still in existence.

After the American Revolution the first capital stock insurance corporation was chartered in 1794 by the Pennsylvania Assembly. Early insurers in this country were chartered and regulated by the colonies and after the Revolution by the states.

The Supreme Court in 1896 held in the *Paul v. Virginia* decision that insurance was not commerce and thus not subject to federal law. This decision was reversed in 1944 in the case of the *United States v. South-Eastern Underwriters Association*. The court held that insurance was commerce and when conducted across state lines, was subject to federal jurisdiction.

Congress in 1945 passed the McCarran-Ferguson Act that allowed the states to retain control and regulation of insurance as long as they did not violate federal laws. The Act made state regulation the primary force in controlling the insurance industry. Regulation is overseen at the federal level by the Federal Trade Commission and the Securities and Exchange Commission, as well as Congress.

Monoline Insurance

Small insurers in the early days of American developed. They usually specialized in only one class of insurance. This tradition was followed by state regulations and became known as the "American System" of monoline insurance developed. Monoline contrasted with the English system that allowed insurers to write all lines of coverage.

The Insurance Company of North America, in 1944, began an industry movement. As a result all of the states adopted regulations that allowed non-life insurers to write all kinds of insurance except life insurance and annuities. The regulations allowed life insurers to write health insurance and annuities as well as life insurance. This change made it possible to develop such packages as homeowners and family automobile policies.

Fire Insurance

As cities grew throughout the world, large buildings were constructed close to each other. As the trend continued the demand for fire insurance developed. Fire insurance has been referred to as "the most important contract in the world." The great London fire of 1666 resulted in such interest in fire insurance that the first fire insurance office was established in London the next year, in 1667.

Early fire insurance companies prepared their own forms. The forms included many fine print clauses that made restrictions hard to read. To prevent excessive losses to insurers in a single fire, several policies were issued on the same property. With separate policies differing in restrictions, it was hard for the insured to recover the full loss. Sometimes the insurers themselves were victimized.

In the United States during the 19th century efforts were made to standardize policies. Prominent New Yorkers who had been victimized by the fine print and conflicting policies lobbied for the standardization of forms. Finally the New York Board of Fire Underwriters prepared a standard policy and standard modifying endorsements. The policy form and endorsements became effective in 1887 in what was known as the New York form.

After the San Francisco earthquake of 1906 a more liberal form was adopted in California. Various states used versions of the two forms until a final combined standard form was adopted in most states in the 1940s.

Present fire insurance policies cover financial loss equal to the value of the property destroyed. The property value maybe adjusted through an allowance for depreciation in some cases. In insurance contracts where there are several limits or boundaries, the smallest or narrowest is effective. Specific condition endorsements override such limiting boundaries.

When a company closes due to a catastrophic event several areas of the business loss must be considered. For example if a manufacturing business closes the closing will involve the loss of net profits and payment. Continuation of expenses will be incurred to keep the staff together, meet indebtedness obligations, and assure the possibility of resumption of business. Insurance protection to cover such catastrophic events is known as "business interruption loss coverage," formerly known as a "use and occupancy loss coverage," and is still sometimes termed "U and O." The form for this type of coverage specifies the insurer's liability for total or partial suspension of the insured's business and defines a number of necessary terms.

A private individual may be protected against additional living expenses caused by a home fire. Coverage of expenses for rent while the homeowner's property is being repaired or rebuilt is known as rental-value insurance. A landlord whose premises are lost to fire and whose income from rents is cut off may obtain rental insurance under a form similar to a use and occupancy business policy.

A commercial firm may get coverage for the loss of profits on finished merchandise in a profits insurance policy. As for commissions on the sale of goods destroyed by fire, there is some question as to whether such a contract is justified as an indemnity, because the values insured are not in existence and may never come into existence. Profits have always been insurable under marine insurance. Some insurance companies will issue established retailers policies covering the loss of goods at the retail selling price.

All-risk policies under the expanded development of inland marine insurance now provide competition for traditional fire insurance policies and their endorsements. For that reason many fire insurance companies now offer supplementary coverage for buildings and contents that insure against such risks as windstorm, hail, explosion, and other forms of damage.

Casualty Insurance

Fire insurance carriers when expanding into casualty coverage issued policies that covered, by substitution of terms, such hazards as riot and civil commotion, windstorm and tornado, earthquake, hail, water damage and rain. Other casualty companies specialized in burglary and robbery insurance, plate glass insurance, boiler and machinery insurance, and credit insurance. Sometimes one casualty company would carry all of these, but many carriers would write only one or two lines. Livestock insurance and title insurance are usually handled as exclusive lines.

A basic property coverage form lists the parties to the contract, consideration, risk transferred including property covered, term, hazards, loss procedure provisions, and limitations and qualifying clauses. With the consolidation of coverage made possible by the lifting of monoline restrictions, many hazards in addition to fire are now covered in a standard homeowner policy.

Flood insurance is a separate hazard from damage caused by rain or broken pipes. Many people do not realize that in a standard homeowner policy, flood coverage is excluded. Damage caused by flooding, flood-related erosion, flood-caused mudslides, or other flood-related losses will only be covered under flood insurance. This coverage is required for homes with federally funded mortgages if they are located in Special Flood Hazard Areas (SFHA) designated by the Federal Emergency Management Agency. These areas have a one per cent chance of flooding in any given year. It is estimated that more than 85 per cent of home owners with property in SFHA have not carried the required flood insurance. The property owners are now subject to their lender purchasing the coverage after notification and noncompliance by the owner.

The millions of households in regulated flood-prone areas are estimated to stand a 26 per cent chance of being flooded during the life of a typical mortgage as against only a one per cent chance of burning during that time.

Auto Insurance

The form of casualty insurance which affects the largest number of people in the United States is automobile insurance. Because by its nature the auto moves about, special policy forms had to be devised for it as distinct from

those on fixed property such as fire insurance. The first liability insurance was written in England on an electric cab in 1895, and the first collision insurance in 1899. The original basic coverage for property loss on automobiles protected against destruction by fire, theft, injury through collision, and other damage to the car by breakage of glass or while being transported. The risk of being called on to respond for damages done to others through the use, ownership, or maintenance of the car came under liability coverage.

Laws requiring auto liability insurance are in effect in most jurisdictions. Starting in the 1990's, several states made auto liability insurance mandatory and enforcement became stricter. Now there is a requirement that drivers must show auto financial responsibility before receiving license plates or a driver's license. Creditors require collision and comprehensive coverage for damage or theft to a vehicle for which they hold liens.

Aviation Risks

Many new risks arose with the development of aviation in the 20th century. Forms and practices had to be established to deal with them, but the basic form of inland marine insurance was retained. Many details are involved in this specialized type of insurance. A clear definition of the risks involved is always necessary.

Among the risks to property are those of destruction or damage to the plane or its contents. There is risk of damage to property on the ground caused by falling planes or their contents. Aviation coverage may be carried by the owner of the plane. It is also available to the owner whose property on the ground is in potential danger.

Fire insurance for planes is written in two forms. One covers fires in the air. The other covers fires under all circumstances. Crash insurance is written with large deductibles. In some parts of the country a special form is written covering tornado damage to airplanes. New forms of coverage are developed as size and construction costs of airplanes increase.

Boiler and Machinery Insurance

Manufacturers carry a type of policy known as boiler and machinery insurance. This originally covered only the explosion of steam boilers but eventually was combined with other policies to apply to any type of machinery breakdown. This insurance covers loss from accidents to designated objects described in the policy schedule. It protects the owner against destruction of his own property. It provides the owner with liability coverage for the property of others. It also can cover death or injury of persons involved in such accidents. The policies set limits per accident but usually do not set a total limit of liability, since multiple accidents within the policy period are a remote contingency.

Burglary, Robbery, Theft Insurance

Loss of property through piracy and theft by crew members has always been covered under marine insurance. Only in fairly recent times has it been possible to secure protection against loss of property by theft from its normal location. A royal charter was sought in England in 1787 for a company to offer such insurance, but that and other sporadic attempts during the next hundred years did not amount to much. Even as late as 1900 this branch of insurance was regarded by companies and their representatives as a sideline. During the 20th century it became a multi-million dollar business, even excluding car theft coverage which is classified as a marine insurance risk.

Theft is a generic, not a legal term. Stealing under the law is known as larceny, and specific terms are used in policies to indicate the coverage

involved. Burglary is defined in standard original policy forms as loss of contents "occasioned by any person or persons who shall have made felonious entry into the premises by actual force and violence . . . of which . . . there shall be visible marks made upon the premises at the place of such entry." Robbery means "a felonious and forcible taking of property by violence inflicted upon a custodian or by putting him in fear of violence."

The terms "theft" and "larceny" are synonymous and are used in connection with residence and office policies designed to cover every form of stealing, such as that by employees. "World-wide" policies cover felonious loss of specifically names articles of jewelry or furs anywhere in the world.

Other Property Insurance

Various hazards to property owners now come under combined coverage such as that in homeowner's policies. They may, however, be obtained in separate policies or endorsements. Damage from water leakage became an important commercial consideration with the development of automatic sprinkler systems guarding against fire loss. Exceptions to water damage liability include leakage caused by fire, lightning, earthquake, explosion, invasion of foreign enemies, civil commotions, riots, any military or usurped power, order of a civil authority, or any fraudulent acts of the insured. Damage to the system itself is also excluded. A similar policy will cover accidental leakage from plumbing on the premises besides the sprinkler system. As explained earlier, standard water damage insurance does not include flood loss coverage.

Loss or damage due to strikes, riots, and similar violence is covered under riot and civil commotion insurance. It also covers explosions due to such causes as well as other explosions not covered under boiler and machinery policies. Riot and civil commotion policies are written on certain property for a fixed time and up to a fixed maximum limit.

Separate policies may be obtained covering windstorm damage, although this usually is included in fire insurance. Loss to specified property by "windstorms, cyclones, and tornadoes" is covered under windstorm insurance. A precise definition if given in the policy can exclude hail, snow, or other weather disturbances which often accompany high winds.

The form for earthquake insurance is adapted from fire policies by substituting the word "earthquake" for "fire" wherever it occurs, and eliminating provisions that obviously apply only to fires. Earthquake damage is usually partial, and provisions are made for coinsurance as well as for deductibles to eliminate trivial claims. No attempt is made to define "earthquake" in the policy. There is a provision that if more than one earthquake shock occurs within 72 hours during the term of the policy it is to be considered a single quake. Earthquake insurance is written almost entirely on the Pacific coast.

Rain Insurance

Rain in itself seldom causes direct property loss. Policies known as rain insurance are usually written as protection against cancellation of outdoor events and the resulting expense of having to issue "rain checks" and re-schedule arrangements. Even a department store sale that has been extensively advertising may come under rain insurance. Rain insurance is more frequently purchased for such things as sports events, fairs, and public exhibitions.

The loss under the policy becomes payable if a stated amount of rain falls between specified hours on a given day. Expenses incurred, loss of expected income, or both may be covered under the policy. Premiums are payable in

cash and an application must be made at least a week before the event.

Hail insurance is written mainly on agricultural crops. The policy begins 24 hours after receipt of the application by the company. If the company declines the risk, it must immediately notify the applicant and the insurance ceases on delivery of the notice. The policy does not have a fixed term but has an expiration limit, usually at the end of the expected hail or crop season. Settlement of partial losses is provided on a 100 per cent coinsurance basis.

Frost insurance for growers of citrus and other deciduous fruits is not widely written. There has been a considerable demand for it and some efforts have been made to cover hail, frost, and other crop losses under government-backed insurance. One difficulty is determining the amount of actual loss. Crop values fluctuate and in times of falling prices such policies may become price rather than crop damage insurance. Determining what proportion of the crop has been damaged is difficult. Government subsidized crop insurance has been tried in some areas.

Livestock Insurance

Many small associations and some commercial carriers offer livestock insurance. It has been carried on from ancient times by mutual benefit organizations. Conditions are hard to control, values are variable, and the major impediment is the moral hazard involving care given the covered livestock.

One policy states that "the company shall not be liable beyond the actual cash value of any animal at the time any loss occurs in the condition in which said animal then may be." Although important to producers of valuable breeding stock, such insurance is not generally considered commercially significant except for full floater, full mortality policies covering animals anywhere in the United States or Canada and including the risk of transportation. Such coverage is used for race horses, show animals, and similar stock.

Surety and Fidelity Bonds

There is a Biblical warning in Proverbs against becoming a surety for a stranger. Suretyship is obviously an ancient practice. In modern civilization, when one person enters an agreement and a second person guarantees the actions of the first person, the second person is called a surety for the first. Suretyship with financial guarantees was on a personal basis until the 1800s. Surety was provided because of friendship or other personal considerations. Heavy losses could result. The first company offering corporate suretyship in the United States began to do so in 1878.

Under professional suretyship, banks and others companies that employ a number of people have bonds written that cover whoever may hold a particular position, rather than a named individual. Such a bond is effectively an insurance contract, although it is a service fee for investigation of individuals or for the lending of credit.

A fiduciary bond guarantees the performance of an individual charged with a special trust, such as the guardianship of a minor. Most public officials are required to be bonded. Contractors, licensees, and many other individuals involved in contractual relationships are guaranteed by surety bonds. The fidelity bond provides indemnity only for dishonest actions on the part of the covered person.

Surety bonds also assume the risk of incapacity, whether technical or

financial. Fidelity bonds are usually given as security for an implied obligation, while surety bonds cover an expressed obligation put in writing. The modern tendency is towards the issuance of a "blanket bond" to financial institutions. This essentially combines fidelity with burglary, robbery, and theft insurance.

A specialized form of coverage is found in a commercial blanket bond. One form provides protection from losses due to "larceny, theft, embezzlement, forgery, misappropriation, wrongful abstraction, willful misapplication, or any other fraudulent or dishonest act or acts" of any employee of the insured. Such a policy is not as broad as a banker's blanket bond. It does not cover loss due to robbery or other acts of strangers, or simple mistakes or misplacement of documents. Such coverage is available under combination contracts. Blanket position bonds are also available covering the occupants of named positions instead of the entire staff.

Credit Insurance

An important cause of loss to business proprietors, especially manufacturers and wholesale merchants, is failure of debtors. Credit insurance provides protection against such losses in excess of normal. Since the definition of "normal" controls the amount that can be called "excess," such policies require clear definition of the insured's credit practices and collection methods. The insurance carrier in order to be able to minimize loss must be given the opportunity to collect accounts which are likely to result in claims. Thus the writing of credit insurance is a complicated specialty.

Title Insurance

Title insurance developed from the fact that an abstract or report of title prepared by a lawyer or other professional title searcher contains no guarantee that the title is without defect. Negligence on the part of the searcher might result in a damage suit, but recovery would depend on the financial responsibility of the searcher. The title insurance policy covers the insured up to the limit named in the policy. It protects against loss due to defects in the title to real estate, subject to whatever exceptions are named in the policy. The coverage is not for future events that might occur. The coverage protects against loss that might be sustained in the future due to defects existing but undiscovered at the time the policy is issued.

Liability

Legal actions to preserve and protect individual and property rights have grown more and more frequent. The risk of being accused of negligence has grown in modern society. It now affects almost every action, as well as non-action, in individual and corporate life. Liability insurance provides coverage designed to protect from financial hardship due to negligence. Negligence is a tort, a civil wrong not based on contract. Most liability cases are based on common law, although some are covered by statutes.

Potential loss from liability is often considered a more important risk for coverage than property insurance. A homeowner might feel secure in having full coverage for the value of a \$75,000 home, but the liability risk he could face for a serious injury on his property might result in a loss greater than the home value.

Liability insurance is third-party coverage. It arises out of loss or damage to persons other than the insured. Such policies generally provide two maximum limits. One covers the claim of one person and another covers the total claims in a single accident. There are many types of policies covering different classes of operations. Most familiar to the general public are automobile and employer's insurance.

There are also general and miscellaneous liability policies. A professional person needs protection against lawsuits charging error or malpractice. Medical cases are most frequent in this area. Insurance professionals, attorneys, accountants, engineers, and consultants now require liability coverage.

For businesses a comprehensive general liability policy is popular. It covers on-premises and off-premises events. Products liability is growing in significance as million-dollar awards become common for injuries caused by defects in automobiles, appliances, foods, drugs, or other products. An excess liability contract is gaining in popularity for both individuals and businesses. It is an umbrella policy that can provide coverage for claims that are above existing liability coverage.

Workmen's Compensation

Special problems with the responsibility for work-connected injuries and disease developed with the rise of the industrial society. Common law covering the master-servant relationship made it difficult for an employee to collect damages from an employer. The employee had to prove negligence on the part of the employer.

A system of workmen's compensation laws began in the early 20th century. The laws provided relief for employees. They established the principle that the employer is liable, regardless of fault, for injuries to employees in the work place. The basic idea that the laws are based on is that of economic loss. Economic loss to employees due to accidents occurring at work is part of the cost of producing goods. The worker's economic loss is applicable to the work that was being done. As such it should be borne by consumers of those goods. To accomplish this, the cost is first assessed on the employer who produces and controls the marketing of the goods.

Workmen's compensation is now a recognized type of social insurance. It covers about two thirds of private employees and almost all public employees in the United States. Legal exceptions to the coverage include agricultural, domestic, and casual labor. Also, employees of firms having less than a specified number of workers may not be covered.

Employers are required by law to provide coverage through insurance. State agencies administer the law. The applicable provisions of the state statute are included in workmen's compensation policies. The law takes precedence over any other policy provision. Scheduled benefits may vary considerably from state to state. In general coverage includes medical expenses, loss of income, rehabilitation expenses, disability, and death. Insurance rates are based on the actual loss experience of the individual employer.

Chapter 6 Social Insurance

Social Insurance

Mutual benefit societies and work-related organizations helped provide economic security for certain segments of the population for centuries in Europe. These groups were established in colonial America. During the industrial revolution, through the growth of cities poverty became more widespread. The government had to step in to provide adequate economic security for its citizens. People left the farms and became dependent on wages in exchange for their labor. Unemployment as well as sickness or injury could mean total financial disaster for the new city dwellers. Families could starve. Social unrest due to economic conditions began to be a serious threat to established governments.

Social insurance has been defined as the attempt of government to apply the principle of insurance to the prevention of poverty. It modifies the traditional attitude that every man is master of his own fate. It incorporates acceptance of the belief that society as a whole has an obligation for at least the minimum welfare of its members. The first social insurance went into effect in Germany in the 1880s. In addition to citizen assistance, it provided a more efficient and stable labor supply, as predicted by Chancellor Bismarck. It contributed to the stability of government and industry. Britain began its social security program in 1897. France and other European nations followed suit.

In the United States the first social insurance was workmen's compensation. It was enacted for federal employees in 1908 and made effective in various states beginning in 1911. This country, however, was still largely rural in the early 20th century. The idea that there was an unlimited supply of land and opportunity in the West was slow to lose its popularity.

Jurisdiction controversies between the states and the federal government also made the development of social insurance slow in this country. It took the Great Depression to persuade Washington that something had to be done. The Social Security Act of 1935 was a revolutionary piece of legislation. This Act with its amendments and its revisions affects almost everyone in the country today.

Private pension plans for employees in industry were the exception rather than the rule in the 1930s. The Social Security Act brought millions of persons under a retirement plan for the first time. Social Security created a mammoth annuity system.

The original act levied a tax of 1% of wages on the employee and employer to cover the employee. Payments were made to retired employees 65 or over

who were covered by the system. Self-employed individuals, federal employees, and many other groups were exempt. In 1939 survivorship benefits were added. These benefits covered dependents of workers who died. In 1965 the Social Security Act was amended to include hospital and medical insurance for the elderly covered under Medicare. Today coverage, benefits, and taxes have increased many-fold. Almost all jobs, businesses, and professions come under the Act. Three trust funds receive the taxes collected that finance Social Security. The funds include one for old age and survivors' insurance, one for disability insurance, and one for the federal hospital insurance fund. The trust funds must be invested in obligations of the United States. The Social Security Administration is an executive agency under the Department of Health, Education, and Welfare. It administers the social insurance programs.

In addition to the federal programs directly administered by HEW, subsidies are provided for state-administered welfare. Unemployment taxes collected by the federal government are returned to the individual states for administration by the state unemployment services.

In 1975 the Social Security Act was amended to provide automatic raises in benefits. This was designed to increase benefits to keep up with inflation. Benefits are increased whenever the Consumer Price Index increases three per cent or more.

Veterans Insurance

The Veterans Administration operates one of the world's largest life insurance programs. It also supervises mortgage life insurance coverage for qualified disabled veterans. World Wars I and II introduced millions to life insurance coverage who had never had it before. Life and casualty insurance companies were unable to cover war risks in 1917. Accordingly, the Bureau of War Risk Insurance was set up within the Treasury Department. It provided coverage for Army and Navy personnel using a one-year renewable term insurance plan. The original plan called for continuing the policies for five years after the signing of the peace proclamation. After five years the policies had to be converted to a permanent policy. In actuality this deadline was extended several times.

Administration of the program was transferred to the Veterans' Bureau when it was established by Congress in 1921. Permanent policies were then known as U.S. Government Life Insurance. They were made available to veterans of World War I and members of the armed forces up to a limit of \$10,000. A trust fund was set up to administer the program on a legal-reserve participating basis.

The program was terminated in 1940. The National Service Life Insurance Act replaced the program. A new system was established. It offered voluntary life insurance for persons on active duty with the military and naval forces. A National Service Life Insurance fund was established under the Treasury Department. Policies were issued on a five-year level premium plan. They were convertible into ordinary life or 20 payment or 30 payment policies. The limit of insurance to any one person was \$10,000. Benefits were payable in equal monthly installments.

Some commercial insurance companies tried to discourage the veterans of World War I from converting their wartime policies. That was not the case after World War II. Insurance companies at this time found that many veterans wanted to purchase additional private coverage. Providers of

supplementary insurance to both active and retired military personnel now find a wide market for various types of policies

Chapter 7

Professional Ethics in the U.S.

For a society to function, rules are necessary. Without rules and enforcement, there can only be anarchy. Ideally, the values basic to a civilized society are handed down to individuals through customs. These are rules of behavior that over generations have been found to help make it possible for people to live together peacefully. Observing these rules is largely a result of family training and peer pressure.

There are always individuals who through ignorance, lack of training, or sheer perversity will not follow the rules. Penalties for rule-breakers make up the basic legal system of a society, backing up customs with force.

Ethics and the Law

Ethics goes further than law in determining everyday behavior. Law cannot cover every aspect of human relationships. Personal ethics, or individual morality, has been called "what one does when nobody is looking." Law, on the other hand, sets standards for behavior in situations involving other people, and backs those standards with the power invested in law enforcement.

The subject of ethics has been prevalent in the insurance industry since the early days of insurance. In Europe, regulation was found to be a means of enforced ethics within the industry.

In America, the original pattern of expansion filled legitimate needs. The insurance industry, as well as of other forms of business, grew eventually into a relentless drive for more and more success.

Rise Of Regulations

The results of this uncontrolled expansion and unethical practices brought on a demand for regulation. In the insurance business, state laws and licensing practices gradually developed to set required standards for companies and agents.

At the beginning of the 19th century there were only five million people in the United States, 90 percent of them farmers. There were only six cities in the country with a population of more than 8,000.

The growing cities produced an increasingly complex society in 19th century America. Individuals working for wages in a cash economy could no longer live the self-sufficient lives of their rural ancestors. In this setting, insurance rapidly became a recognized necessity for the protection of families and property.

Early insurance companies had waited for customers to come to them. As time went on and more insurers competed for business. It became the practice to advertise and send out agents in an aggressive effort at expansion. Many of these agents had little training or understanding of the principles involved in the policies they were selling.

Ethics Into Law

Insurance stock companies were organized to take advantage of the growing market, and unregulated expansion continued. **From 1830 to 1850, insurance in force increased by more than 3,000 per cent.** After the Civil War, the growth rate of the industry was even faster. The amount of insurance in force increased at 50 per cent a year, reaching a total of two billion dollars by the end of the 1860s.

Insurance executives and agents concentrated on achieving personal power and prestige through business success. There were exaggerated advertising claims, carelessly written risks, and recklessly raised commissions.

The Massachusetts legislature in 1858 was the first to pass a law making a version of Wright's legal reserve principle a requirement for insurers. A state insurance department was created to enforce the new law and Elizur Wright became its head.

As the western part of the country was settled, the insurance industry again expanded its horizons. New companies grew up to offer insurance in the growing western cities as transportation and manufacturing facilities followed the trails blazed by the pioneers.

People moved about more, and travel restrictions were removed from insurance policies. Prudential pioneered insurance for low-income groups and it became widely accepted. By the end of the 19th century, the total of insurance in force in the United States had risen to seven and a half billion dollars.

Rapid growth again led to difficulties. Since insurance companies were the custodians of much of the nation's wealth, attention focused on them as a new "muckraking" phase of attacks on questionable business practices began shortly after the turn of the century. There was a renewed public demand for investigation of the insurance industry.

The Armstrong Investigating Committee in 1905, with Charles Evans Hughes as its chief counsel, turned its attention to insurance practices in New York. Its recommendations, backed by responsible insurance companies, resulted in the adoption of the New York Insurance Code in 1906. State supervision of insurance practices was tightened by this code, and eventually public confidence in the insurance industry was restored. Throughout the 20th century insurance regulation has grown.

The National Association of Insurance Commissioners (NAIC), a group made up of insurance officials from all states, has drafted model legislation which has been widely adopted by state legislatures.

The unfair trade practices act recommended by the NAIC defines unfair claims settlements, false advertising, defamation, and unfair discrimination and prohibits all these practices. This NAIC model has been adopted by nearly every state.

The resulting laws give state insurance commissioners the power to investigate when such practices are suspected and to levy fines and suspend or revoke licenses when violations are found. Marketing and disclosure standards for life insurance agents also are recommended by the NAIC. These make deceptive practices designed to mislead clients not only unethical but also illegal.

Any statement misrepresenting the benefits or coverage offered by a policy is a deceptive practice which can lead to the loss of an agent's license. Implying that future dividends provided by a participating policy will be enough to take care of premium payments would be such a misrepresentation. So would an implication that future policy dividends are guaranteed.

To tell a prospect that certain benefits in a policy being offered cannot be found in any other policy, or that an offer must be taken at once or the opportunity will be lost, would be considered unacceptable tactics. Any misleading use of figures as to cost comparisons or other significant policy features would come under the guidelines. So would statements defamatory to competing agents or insurers.

Legitimate agents recognize such actions as unethical. They also have been made illegal in states that have adopted the NAIC recommendations. There are other prohibitions, such as offering a rebate to make a sale, or persuading a client to drop a policy just for the sake of selling a replacement that will be discussed later in detail.

While an ethical agent would not knowingly violate these guidelines, it is necessary for any insurance professional to be aware of the particular legal provisions in effect in the state with jurisdiction. The laws are to be followed first, supplemented by one's own ethical standards.

Licensing

Insurers must be licensed by a state to issue policies there. A state's guarantee fund usually covers only insurers authorized to do business in that state. An agent representing an unauthorized company may be held personally liable for losses on a contract placed with an unauthorized insurer. The agent needs to be sure the company being represented is authorized to do business in that state.

It is also important for both the agent and the company office to be aware that laws can change. Actions of the state legislature and regulations issued by the state insurance commission both can vary with time and the pressure of public opinion.

Court Decisions

The court appeared to place no responsibility on the owner for reading the policy, the declarations page, or the bill for the premium on the \$10,000 coverage. The decision was that the insured was justified in believing that the agent had obtained the limit of liability they had discussed. The resulting point of case law is that an insurance provider cannot count on having any responsibility placed on the insured to analyze the coverage provided.

The issue of professional responsibility on the part of insurance agents and agencies is playing an increasingly important part in court cases. In a Georgia decision involving business interruption policies, an insurance agency had been provided with a client's books to use in determining what coverage limit was needed. The agency used the gross profits figure rather than gross earnings to determine the coverage needs, leaving the client underinsured.

The plaintiff's argument in the court case was that the insurance agency had held itself out as an expert in the field with the needed qualifications to examine the books and determine coverage limits. The agency agreement with the client was to maintain adequate business interruption insurance

based on yearly audits, and this agreement, the court held, was violated.

Such court decisions set the precedent of requiring a high standard of competence on the part of insurance professionals. Both agents and agencies need to be aware of this situation.

In addition to staying well informed and exercising due care, the responsible insurance practitioner can have professional representation available for claims protection by carrying Errors and Omissions (E & O) insurance. The E & O carrier will investigate claims situations and provide legal representation if necessary.

In the case of claims, the insurance professional needs to be prepared to deal with the claimant in a calm and competent way without overstepping limits on giving legal advice or otherwise prejudicing the case. Quick adjustment and settlement procedures are desirable in case of claims to uphold the reputation of the insurance provider, but it is important to have all the facts at hand before action is taken.

In dealing with a claimant, the insurance provider needs to remember not to give advice or promise to get the claim paid.

It is also important, however, not to deny a claim without positive knowledge that it is invalid. Also, a claim should never be paid without certain authority. Any of these actions can create legal liability.

It is helpful in avoiding legal difficulties for the agent to maintain friendly relations with clients and establish a reputation for being trustworthy over the long term. A personal relationship of trust and confidence between agent and client may help avoid lawsuits and make settlements easier.

Ethic Commissions

In addition to court cases, changes in the law can be brought about by an increasingly important agent, the ethics commission. Under pressure from activists, consumer protection groups and others, Ethics Commissions have been set up in state and national legislative bodies as well as in local government agencies.

Ethics Commissions tend to focus on lobbying, gifts to officials, conflicts of interest, and election procedures. They also, however, can consider other areas of public concern and produce legislation in response to consumer complaints.

An ethics commission can hold public hearings. It can determine what legislation needs to be passed in order to prevent abuses. It can investigate whether behavior of a public official has violated existing laws.

Congressional committees in both the Senate and the House have been conducting investigations into insurance cases with a view to possible federal legislation supplementing state level regulation of the industry. A Senate committee probe has centered on offshore insurers and reinsurers which are not subject to state regulation.

One reinsurer listed as its primary assets \$22 million in "treasury bills" claimed to have been issued by a Texas Indian tribe. Senate investigators believe this group to be fictitious. One of the tribe officials known as "Wise

Otter" is thought to be a British subject.

The House investigation that followed the failures of large domestic insurance companies has focused on the possibility of setting up a federal support mechanism similar to the banking industry's Federal Deposit Insurance Corporation in order to protect policy holders beyond state agencies' limits. It is important for insurance professionals to keep abreast of such legal developments affecting the industry and its traditional standards.

SEC Requirements

Financial planning, a relatively new field for insurance providers, requires some specialized knowledge relating to securities and investment regulations. The Securities and Exchange Commission through the Investment Advisers Act sets high ethical standards for professional providers of investment advice.

Any transaction or business practice intended to deceive a client or prospective client is strictly forbidden under the act. The agent acting as a securities representative is legally required to act with due diligence, meaning that documented financial information must be furnished on companies whose stocks or bonds are being sold.

In contrast to due diligence for securities salesmen, the standard established in court cases for agents only involved in selling insurance is due care. The client is given financial information on request, but the state insurance department is the agency responsible for requiring reports from companies authorized to do business in that state. The agent's legal obligation is to sell policies of insurance companies licensed in that state and not to sell policies of companies the agent knows to be insolvent.

An agency can establish a back-up line of defense against claims arising from insurance company insolvency. This can be done by showing proof that the agency has maintained a system for tracking financial conditions in the industry through figures from the various reporting agencies and by other means available.

It is important for the insurance agent to know the specific do's and do not's that constitute ethical behavior. Specifics that will be discussed are advertising, commissions (rebates), agent conduct, clients' files, illustrations and underwriting.

AGENT COMPLIANCE

Advertising

When the agent advertises, he/she is making the product known to the public at large. There are many different ways to advertise. The following are the major methods, of advertising.

- Printed and/or published materials.
- Newspaper, radio, television, computers, billboards.
- Ads, circulars, leaflets, descriptive literature.
- Business cards, business brochures, prepared sales talks.
- Telephone solicitations.
- Any material used to sell, modify, update or retain a policy of insurance.

Agents wishing to advertise must obtain approval from their respective insurance company. All advertisements for life, accident, and health insurance

must include and identify the insurance company the agent represents.

Advertisement that would not require prior insurance company approval would be one in which the only information given is the agent's name, address, telephone number, and description of the services being offered. Agency history and a simple statement of products offered, such as life, health, and/or annuities would also apply. There must be no reference made to specific policies, benefits or cost.

The agent must do the following in all advertising:

- Make clear that insurance is the subject of the solicitation, clearly identify the type of insurance being sold, and the full name of the insurer.
- Include all limitations and exclusions affecting the payment of benefits or cost of a policy, as well as disclose any charges or penalties, such as administrative fees, and surrender charges contained in a life or annuity policy, or withdrawals made during the duration of the contract years.
- If a policy offers optional benefits or riders, disclose that each optional benefit or rider is available for an additional cost.
- For a life insurance policy with accelerated death benefits, clearly disclose the conditions, care or confinement which will initiate any acceleration of payment of the death benefit and/or other values under the life policy.
- If a policy includes a payment endorsement, disclose that fact.

The agent MUST NOT do the following in all advertising:

- ✱ Be deceptive or misleading by overall impression or explicit information.
 - ✱ Refer to considerations paid on an individual policy or annuity, including policy fees.
 - ✱ Use terms such as "Financial Planner", "Investment Advisor", "Financial Consultant", or "Financial Services" in such a way as to imply the engagement in an advisory business in which compensation is unrelated to insurance sales, unless this is actually the case.
 - ✱ Use a service mark, trade name or group designation without disclosing the name of the actual insurer, if specific coverage benefits or costs are described.
 - ✱ Make unfair or incomplete comparisons of policies.
 - ✱ Disparage competitors, their products, their policies, their services, business or marketing methods.
 - ✱ Make untrue or misleading statements with respect to another company's insured assets, financial standing or relative position in the insurance business.
 - ✱ Imply group coverage, certificate or enrollment when the policy offered is actually an individual policy.
 - ✱ State that the policy is a limited offer and the applicants will receive advantages by accepting the offer, and that such advantages will not be available at a later date, if this is not the fact.
 - ✱ Advertise a free gift, bonus, or anything of value outside of the policy contract, which is an inducement to buy and considered rebating.
 - ✱ Advertise for life, health, accident or annuities, use the existence of the GUARANTEE ASSOCIATION as an inducement to buy.
 - ✱ Use misleading words or symbols or imply the material is being sent by a government entity.
 - ✱ Use the phrase "low cost" without providing disclosures and the caveats associated with the particular plan.
- Advertising can be one of the best career enhancing tools, when utilized

effectively, legally and ethically.

Commissions

Commissions are the direct result of work performed by the agent with a new or existing policy owner. The agent's compensation is paid direct from the respective insurance company for the type of product and services recommended and are willing to provide. In addition to the initial commission, most insurance companies provide "renewal commissions", as an inducement to continue servicing the existing policy owners. This concept, initiated many decades ago, was intended to accomplish two primary objectives:

Rebating

1. Compensate the agent for future servicing needs the policy owner will require - such as beneficiary changes, bank draft changes, endorsements, etc.
2. Provide the agent with an opportunity to perform periodic reevaluations of the policy owners' needs, thereby resulting in additional sales opportunities.

The agent, as a licensed insurance person, shall not directly or indirectly rebate or attempt to rebate all or any part of a commission for insurance. Rebating is illegal in Texas, and is strictly prohibited. It can be punishable by fine, cancellation of contract with insurance company, and loss of license, or a combination of all three. Rebating can be described as offering any type of inducement other than what is contained in the policy itself, in exchange for purchase of insurance. Examples include, but are not limited to the following:

- ✧ Any verbal or written agreement for the agent to pay any part of a policy owner's premium.
- ✧ Any payment, allowance, or gifts of any kind offered or given as an inducement to purchase insurance.
- ✧ Any paid employment or contract for services.
- ✧ Returning any part of the premium to the policy owner.
- ✧ Offering any special advantage regarding the dividend, interest, or other policy benefits to the policy owner which are not specified in the policy.
- ✧ Offering to buy, sell, or give any type of security (stocks, bonds, etc.) or property, or any dividends or income from securities or property, to the policy owners' benefit.
- ✧ Giving anything of value to the policy owner in return for buying an insurance product.

Rebating, or the attempt to rebate, is an offense not only under the Code of Ethics, but also under the Texas Insurance Laws. There may be borderline situations in which it is difficult to determine whether rebating has taken place.

It is fairly common practice, as an example, for an insurance agent to entertain policy owners or prospective purchasers with a meal and perhaps give a nominal or token gift such as a policy wallet. Such things are considered to be normal business practice, and not in the nature of a rebate. However, should the agent contemplate anything more than such token gestures of appreciation, then the greatest caution and good judgment must be exercised. Excessive benefits or gifts conferred upon policy owners or prospective purchasers, will at the very least be considered in bad taste, and at the worst, depending on all the circumstances, may expose the licensee to a charge of rebating. In no circumstances should a gift of anything of value be given as an inducement to purchase insurance.

The rules for rebating do not apply to splitting of business with another licensed insurance agent. Joint case work is very common throughout the industry, and splitting of commissions is normal business practice. This

practice does not apply to equity and variable life products, since they are sold under the rules and guidelines of the Securities Exchange Commission.

Agents' Conduct

As an insurance professional, the agent becomes part of the insurance industry's public relations arm. The agent meets the public every day, and the manner and conduct exhibited leaves a lasting impression with everyone with whom that agent had contact.

A big part of professionalism is the attitude toward competition; therefore, agents should avoid criticizing other agents. Such activity is detrimental to everyone in the business. Any criticism of another company's policies should be avoided. An incomplete comparison is not only misleading and harmful to the public, it can also result in license revocation for the guilty party. Respect for competitors helps to keep policy owners satisfied.

The agent is under an obligation to make accurate and complete disclosure of all information which policy owners or prospective purchasers should have, in order for them to make a decision in their best interest.

The agent is called upon daily to make many statements and representations, oral and written, upon which policy owners and prospects are entitled to rely. Such statements and representations must not only be accurate, but must also be sufficiently complete to prevent any wrong or misleading conclusions from being made by policy owners or prospects. It is just as wrong for a life underwriter to omit giving essential information, such as, failing to correct a mistaken impression which is known to exist, as it is to give inaccurate or misleading information. Representing insurance products as exclusively "retirement plans", "college education plans" or "savings plans", without noting that the life insurance is primary and the cash value features are secondary, can result in serious charges of misrepresentation of insurance products. Use of the word "deposit" versus "premium" can have a like effect.

Deceptive practices as they pertain to our industry have countless examples, a few of which are:

- ☒ Passing off the agent's own goods or services as someone else's.
- ☒ Misrepresenting the benefits, uses, or characteristics of the product.
- ☒ Making disparaging remarks pertaining to someone else's products, services, company, by making false or misleading representations.
- ☒ Advertising the product or rates while intending not to sell them as advertised.
- ☒ Misrepresenting the agent's authority as a sales person, representative, or agent to negotiate the final terms of the contract with the policy owner.
- ☒ Offering, in connection with an insurance purchase, participation in a "multi-level distributorship" under which payments are conditioned on the recruitment of additional sales people rather than the proceeds from the product sales.
- ☒ Using the terms "corporation" or "incorporated" or their abbreviations in the name of a non-incorporated business.
- ☒ Failing to disclose information during a transaction with the intent of inducing a prospect or policy owner to do something he or she would not do otherwise.

The law allows courts to award an insured triple damages, court costs, and attorney fees, for deceptive insurance trade practices.

Insurance is not only a complex product; it is an extremely complex industry. The insurance agent must be very careful not to mislead the

consumer regarding any aspect of an insurance transaction.

Misrepresentations can be in the form of an oral or written statement, advertisement in any media, use of a business logo or advertising slogan, or anything else that communicates a false or misleading idea. A few examples of misrepresentation include:

- False or misleading statements about a particular policy.
- False or misleading statements about the financial condition of a respective insurance company.
- Telling a prospect or policy owner that dividends or current assumption mortality charges are guaranteed.
- Identifying a term life policy by a name that implies cash value accumulation, or vice-versa.
- Indicating that premiums on a policy are payable for a shorter time period, when the premiums may be payable for life.
- Indicating that the agent represents several insurance companies, when in fact the agent represents only one.

A high degree of ethical representation is good solid business. The agent's insurance career can provide financial gain and personal growth. Practicing as an ethical professional will bring both. The agent's actions will gain the respect of the policy owners as well as that of the insurance carriers. The agent's reputation will be significantly enhanced, and people in the community will want to do business with that agent.

Documenting Clients' Files

Documenting the client files involves keeping track of the actions taken in dealing with the policy owner. A properly documented file should contain complete and accurate answers to all pertinent questions. This allows the agent to properly assess the need for insurance and substantiates the reason for the sale.

After the fact-finding meeting, the agent should send a discovery agreement to the prospective policy owner summarizing the initial meeting and outlining the agent's understanding of the policy owner's short-term and long-term financial goals. This document should also contain information about the policy owner's salary and expenses, and the amount of money in savings accounts and investments. It should also reiterate the amount of insurance in force and the amount of money the policy owner would be able to allocate for insurance premiums. In addition to this, the discovery agreement should thank the policy owner for the chance to work with them, and confirm the date of the agent's next meeting.

The agent should always keep on file a proper ledger illustration. This should be an approved insurance company ledger, a sales proposal/idea that contains the following elements:

1. Insurance company name.
2. A full dividend/interest rate crediting disclaimer.
3. A clear description of the product.
4. The agent's name and illustration date.
5. Guaranteed values.
6. A page containing full explanation of any assumptions or special instructions.

Effective case notes should also be kept in the policy owner's file. These should list the date and time of contact with the policy owner and concise summaries of all interactions. It is also recommended that the agent

document the level of service provided to the policy owner.

An effective log of all telephone calls should be kept, listing the date, time, reason, and follow-up action of all telephone conversations with the policy owner. The agent should also note all unsuccessful calls to the policy owner in order to verify the attempts to provide proper service, thus, once again, documenting the level of service provided.

A delivery letter should be sent to each policy owner with a copy kept in their file. This letter would reinforce the information already discussed, such as the reason for purchasing the insurance, and the type of plan as well as the face amount of coverage. The agent should reiterate the amount and duration of premium payments, as well as the premium payment method. The agent should also restate the impact on policy values as it relates to borrowing, partial surrenders, advanced premiums, interest requirements, dividend usage, and if appropriate, interest or dividend crediting performance.

Many companies provide a delivery receipt with the policy that must be signed by the policy owner upon delivery. If the company does not, it is recommended that the agent prepare such a document to be signed upon delivery to the policy owners. It should list the date the policy was received by the agent, the policy number, and the insurance company's name. It should also contain the owner's signature and the date they signed for delivery of the policy. All of this should be kept in the policy owner's file.

Illustrations

Illustrations have been used extensively in the insurance industry for several decades to help secure sales. In the past, they were obtained from the respective insurance company, and were fairly bland and standardized for many years. They were straight forward and represented a close approximation of actual future performance. Beginning in the early 1980's, a radical change began, primarily due to three events occurring simultaneously:

1. A significant reduction in mortality charges, due to advancement in medical technology.
2. Significant advancement in electronic technology -- also known as low cost personal computers.
3. A significant economic change resulting in double-digit market interest rates.

These three events, coupled with consumer demand, helped produce a product called Universal Life -- an unbundled, interest sensitive, whole life policy with a high degree of flexibility.

Insurance was viewed more as an investment product consisting of "mortality" and "side funds". Illustrations began to change and use historically high double-digit interest rates as the basis for projected values. As interest rates began to fall in the late 80's, projected values did not hold up to reality. Many policy owners received notices that premiums would have to be increased or death benefits reduced to keep policies in force. Policy owners became angry, and many accused agents and companies of unethical behavior.

It cannot be overemphasized that illustrations are mere projections based on current interest rates, current mortality charges and other expenses. These conditions are not contractual obligations. Agents who have competed on the basis of high interest returns will produce projections that are unrealistic. This

blatant misuse of illustrations has led to policy owner confusion and dissatisfaction. Agents, companies, and the insurance industry have suffered tarnished reputations.

The results have been fierce disciplinary actions backed by a series of heavy fines on some insurance companies by state regulators. Some examples of illustration abuse are as follows:

- . Falling prey to the allure of high interest returns.
- . Use of "assumed" interest rates in competitive situations.
- . The sales technique of "Vanishing Premiums".
- Heavy emphasis on accumulated values verses death benefits.
- Poor emphasis of contractual guaranteed values and the potential problems that could exist in the future.

Remember, the policy owner does not necessarily see the illustrations as hypothetical. Policy owner dissatisfaction has resulted in increased demands by state regulators for heavy regulations regarding illustrations. Some insurance departments are considering the elimination of current assumptions, and only allowing illustrations based on guaranteed values. The parameters of an illustration under these proposals would be strictly monitored. They have also suggested that disclosure of past performance will be all that is permissible.

Many companies provide guidelines regarding interest rates to be used in product illustrations. The agent is advised to stay within the company guidelines to avoid policy owner dissatisfaction. Policy owners should be aware that current illustrations are a snap shot of how a policy might work if the current rates remained unchanged. To help with this awareness, illustrations should have three distinct columns:

1. Guaranteed Values.
2. Current Return Values.
3. Current Return Minus 1%.

This type of diligence will reward the agent with greater policy owner understanding of how interest rates and dividend scales can affect cash values and premiums.

Illustrations are rarely valid for policy comparisons. They are designed to show how a particular product of a particular company works. There are too many inconsistent variables from one company to another to allow for valid comparison. Policy selection should be made on knowledge of the product and analysis of assumptions underlying each policy. Policy provisions, company financial condition, and quality of service are valid considerations. Illustrations only, can be a dangerous criterion for policy selection without additional considerations.

The vanishing premium concept has been particularly damaging to the public perception of insurance industry ethics. This concept is based on the premise that premiums may be discontinued after a certain number of years through the use of cash value or dividends. It was used as a marketing tool extensively in the 1980's. Projections of vanishing premiums (typically in six to eight years) were based on high interest rates in effect at that time. Many policy owners did not understand that a continuation of high interest rate was necessary to fulfill illustrated projections. When interest rates fell, policy owners charged that no one explained the fact that the illustrated "vanish"

was not guaranteed. This disappointment can be avoided with proper disclosure of illustrated concepts and the effect of changing interest rates. Good ethics and business practice dictates that illustrations show both guaranteed and non-guaranteed values with the difference clearly explained to the policy owner. Any illustrations showing non-guaranteed values may be incorrect after the first year. The agent should be thoroughly informed about "assumptions" and "hypothetical" and the effect of fluctuating interest rates and mortality charges. This additional risk should be communicated to the policy owner in written as well as verbal form.

There are many types of new generation policies which require due care and full disclosure. These include Blended Policies (permanent and term), Adjustable Policies, First-to-Die Policies, and Second-to-Die Policies. When two or more lives are insured under the same contract, particular care should be taken to explain to the policy owners that the death benefit is paid on the death of only one of the insureds.

Falling interest can create a climate where actual performance falls short of illustrated projections. Very often, policy owners do not understand the difference between hypothetical projections and contractual guarantees. This can lead to policy owner dissatisfaction, complaints and potential litigation. Increased policy owner complaints lead to adverse insurance department rulings, state regulations, fines and lawsuits against companies and agents. This affects the public perception of ethical conduct of the entire insurance industry. The solution lies in ethical business practices, particularly concerning policy owner understanding of illustrations. Self-policing through education, discretion and common sense will lead to field practices of a high ethical standard. It is important to remember that the policy owner will retain that information they see as most beneficial. As a professional community, our watch words are, tell the policy owner the truth.

Replacement of a contract of life insurance means any transaction which includes a:

- ✕ Rescinded, lapsed or surrendered policy.
 - ✕ Charge to paid-up insurance, continued as extended term insurance or placed under automatic premium loan.
 - ✕ Change in any manner to effect a reduction of benefits.
 - ✕ Change so that cash values in excess of 50% are released.
 - ✕ Policy subjected to substantial borrowing of cash value, but does not include the purchase of an additional life insurance contract.
- The agent should not, when it could be detrimental to the interest of the policy owner, replace an existing contract of life, health, disability and annuity contracts with a new insurance contract. Every reasonable effort should be made to maintain the existing contract in force.

Where it appears that, due to a change in circumstances, an existing contract of insurance should be amended or changed; the agent should ensure that the policy owner is fully informed of any values, credits, or privileges in the existing contract which can be transferred to an amended or changed contract of insurance.

Service

One study indicated that the average insured purchases insurance seven times during their lifetime -- from six different agents. Is part of the reason because of poor or lackluster service?

The insurance industry employs and contracts nearly two million people. It is quite evident that insurance is an intricate and essential service in our society. It is a field upon which our society depends more and more for financial protection. Life and health insurance purchases continue to increase each year. Property and casualty insurance is a part of every mortgage contract, auto ownership, and business coverage. On a daily basis a large group of people will die, enter retirement, experience a cash emergency, or have a physical asset damaged or destroyed. This is the real world -- it affects everyone! These are critical times. The agent's insurance company, the agent, and the policy sold, stand between the client and financial disaster.

The insurance agent must be the "value added" benefit for the insured as well as the insurance company. In the decade of high tech mega information highway, The agent has to be the interpreting guide and the analyst for the general public to solve financial problems with an insurance purchase. The agent must also become the motivator, leading a prospect to action.

People like to do business with people they trust. Trust is built on ethical behavior. When potential prospects and existing policy owners find an agent with high ethical standards, they tend to do more business with the agent -- therefore becoming a client. In perhaps no other industry is the element of trust more important.

Charging fees for service is common practice in most occupational groups; however, Texas has an exception for insurance agents. Group I licensed agents are not allowed to charge fees for service unless they are properly licensed as a Certified Insurance Counselor (CIC). Property and casualty licensed agents are also allowed to charge fees for certain services.

The service to a policy owner/client is not only qualitative, but also quantitative. Periodic contact is essential, but can take various forms:

- ◆ Daily phone contact with the same policy owner would not only be extremely expensive and cumbersome, but also non productive and obnoxious. Most policy owners tend to accept three to six months intervals as a good basis for agent contact. This could be in the form of telephone calls, letters, informative announcements, as well as birthday and Christmas cards. Many agents use Thanksgiving cards as an alternative to the more commonplace Christmas card mailing.

- ◆ It is definitely recommended that the agent staff her/his office with people able to handle day to day service needs, such as change of beneficiary designations, bank draft changes, policy amendments or endorsements, etc. If the agent elects to refer all of these tasks to the respective insurance company home office, it would significantly reduce the "value added" benefit that serve the policy owner. It would also enhance the likelihood of future replacement from another insurance agent -- who specializes in service.

Generally speaking, policy owners want convenience and immediate response. An agent, who refers policy owner service duties directly to the insurance company, is missing tremendous future sales opportunities, alienating themselves from building the trusted relationship necessary to maintain a strong business practice, and presenting themselves in less than an exemplary fashion.

Underwriting

Perhaps no other area pertaining to compliance and ethics deserves as much attention as agent underwriting. When any type of claim occurs, the insurance application becomes the basis for a claim dispute, denial or acceptance. An agent, who compromises part of the underwriting process with false or misleading information, as it pertains to the prospective insured, is creating potential wealth for litigating attorneys.

The agent must always remember that an underwritten application becomes part of any insurance contract. It is critical that all questions be answered completely and honestly. Too often it is tempting for an agent to "trim" ten or twenty pounds off a rather overweight insured or help them grow one or two inches, in order to assure a standard issue from the respective insurance company. Asking a potential policy owner to discard a lit cigarette during the application process may create non-smoker discounts, but in all likelihood would initiate a claim denial. Insurance companies have challenged fraudulent non-smoker rated policies through the court system, and won. It is also naive for the agent to believe that a two-year incontestability clause will exempt him/her or the insured from blatant, fraudulent underwriting. Insurance companies may pay a claim, but they can and do pursue legal action against the insured's estate.

The agent should make every effort to provide the insurance company with all accurate information pertaining to the prospective insured. Cover letters should be submitted with the application to provide details of unusual or extensive medical history or information; unusual business uses of insurance; foreign travel and residence; unusual financial situations; unusual beneficiary and ownership arrangements to clarify the insurable interest; unusual occupational duties; and any case discussions with an underwriter prior to the application submission.

Many insurance agents order medical examinations, attending physician statements, and financial information through third party sources, and upon receipt forward these items to the insurance company. This is not an illegal practice, but it may be against the company's practice. Since underwriting information is highly confidential, both the originals and photocopies of financial statements, attending physician statements, hospital abstracts and other confidential records that have been obtained by agency personnel require safeguarding.

⊕ Access to files containing confidential material must be restricted to employees who have legitimate "need to know" in order to perform their assigned duties.

⊕ Confidential information stored in personal files, should be retained only as long as there is legitimate need.

⊕ Some companies absolutely forbid the acquisition and retention of medical examinations, attending physician statements, hospital abstracts or other medical histories.

⊕ It is up to the agent to know what the insurance company's practices are.

Since the application is such an integral part of the insurance contract, care should be utilized in presenting all information to the insurance company in a professional manner. One of the most consistent complaints with insurance company underwriters is illegible applications. Not only does this impair the underwriting process, but it could be grounds for significant dispute during the processing of a claim.

Generally, changes or alterations to the application must be initialed by the insured/applicant. This is specifically important in changes in plan, face amount, owner, beneficiary, medical or financial representations and dates. Some companies are more lenient and allow amendment signatures at the contract delivery.

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To comply with state and federal privacy laws, and to control and protect confidential information provided to the company by applicants, guidelines need to be followed to insure the strictest handling of these documents. Examples to follow are:

- ✦ Access to files containing confidential material must be restricted to employees who have legitimate "need to know" in order to perform their assigned duties.
- ✦ Confidential information stored in personal files, should be retained only as long as there is legitimate need.
- ✦ Some companies absolutely forbid the acquisition and retention of medical examinations, attending physician statements, hospital abstracts or other medical histories.
- ✦ It is up to the agent to know what the insurance company's practices are.

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The National Association of Insurance Commissioners (NAIC) has a Model Privacy Act that requires any applicant/insured to be notified of any adverse action taken in regard to their application. This Act allows an insured the right to know the details of the personal information about themselves in the company files, and has the right to request an insurance company to amend, delete, and correct such information.

Chapter 7 Professional Ethics in the U.S.

For a society to function, rules are necessary. Without rules and enforcement, there can only be anarchy. Ideally, the values basic to a civilized society are handed down to individuals through customs. These are rules of behavior that over generations have been found to help make it possible for people to live together peacefully. Observing these rules is largely a result of family training and peer pressure.

There are always individuals who through ignorance, lack of training, or sheer perversity will not follow the rules. Penalties for rule-breakers make up the basic legal system of a society, backing up customs with force.

Ethics and the Law

Ethics goes further than law in determining everyday behavior. Law cannot cover every aspect of human relationships. Personal ethics, or individual morality, has been called "what one does when nobody is looking." Law, on the other hand, sets standards for behavior in situations involving other people, and backs those standards with the power invested in law enforcement.

The subject of ethics has been prevalent in the insurance industry since the early days of insurance. In Europe, regulation was found to be a means of enforced ethics within the industry.

In America, the original pattern of expansion filled legitimate needs. The insurance industry, as well as of other forms of business, grew eventually into a relentless drive for more and more success.

Rise Of Regulation

The results of this uncontrolled expansion and unethical practices brought on a demand for regulation. In the insurance business, state laws and licensing practices gradually developed to set required standards for companies and agents.

At the beginning of the 19th century there were only five million people in the United States, 90 percent of them farmers. There were only six cities in the country with a population of more than 8,000.

The growing cities produced an increasingly complex society in 19th century America. Individuals working for wages in a cash economy could no longer live the self-sufficient lives of their rural ancestors. In this setting, insurance

rapidly became a recognized necessity for the protection of families and property.

Early insurance companies had waited for customers to come to them. As time went on and more insurers competed for business. It became the practice to advertise and send out agents in an aggressive effort at expansion. Many of these agents had little training or understanding of the principles involved in the policies they were selling.

Insurance stock companies were organized to take advantage of the growing market, and unregulated expansion continued. **From 1830 to 1850, insurance in force increased by more than 3,000 per cent.** After the Civil War, the growth rate of the industry was even faster. The amount of insurance in force increased at 50 per cent a year, reaching a total of two billion dollars by the end of the 1860s.

Ethics Into Law

Insurance executives and agents concentrated on achieving personal power and prestige through business success. There were exaggerated advertising claims, carelessly written risks, and recklessly raised commissions.

The Massachusetts legislature in 1858 was the first to pass a law making a version of Wright's legal reserve principle a requirement for insurers. A state insurance department was created to enforce the new law and Elizur Wright became its head.

As the western part of the country was settled, the insurance industry again expanded its horizons. New companies grew up to offer insurance in the growing western cities as transportation and manufacturing facilities followed the trails blazed by the pioneers.

People moved about more, and travel restrictions were removed from insurance policies. Prudential pioneered insurance for low-income groups and it became widely accepted. By the end of the 19th century, the total of insurance in force in the United States had risen to seven and a half billion dollars.

Rapid growth again led to difficulties. Since insurance companies were the custodians of much of the nation's wealth, attention focused on them as a new "muckraking" phase of attacks on questionable business practices began shortly after the turn of the century. There was a renewed public demand for investigation of the insurance industry.

The Armstrong Investigating Committee in 1905, with Charles Evans Hughes as its chief counsel, turned its attention to insurance practices in New York. Its recommendations, backed by responsible insurance companies, resulted in the adoption of the New York Insurance Code in 1906. State supervision of insurance practices was tightened by this code, and eventually public confidence in the insurance industry was restored. Throughout the 20th century insurance regulation has grown.

The National Association of Insurance Commissioners (NAIC), a group made up of insurance officials from all states, has drafted model legislation which has been widely adopted by state legislatures.

The unfair trade practices act recommended by the NAIC defines unfair claims settlements, false advertising, defamation, and unfair discrimination

and prohibits all these practices. This NAIC model has been adopted by nearly every state.

The resulting laws give state insurance commissioners the power to investigate when such practices are suspected and to levy fines and suspend or revoke licenses when violations are found. Marketing and disclosure standards for life insurance agents also are recommended by the NAIC. These make deceptive practices designed to mislead clients not only unethical but also illegal.

Any statement misrepresenting the benefits or coverage offered by a policy is a deceptive practice which can lead to the loss of an agent's license. Implying that future dividends provided by a participating policy will be enough to take care of premium payments would be such a misrepresentation. So would an implication that future policy dividends are guaranteed.

To tell a prospect that certain benefits in a policy being offered cannot be found in any other policy, or that an offer must be taken at once or the opportunity will be lost, would be considered unacceptable tactics. Any misleading use of figures as to cost comparisons or other significant policy features would come under the guidelines. So would statements defamatory to competing agents or insurers.

Legitimate agents recognize such actions as unethical. They also have been made illegal in states that have adopted the NAIC recommendations. There are other prohibitions, such as offering a rebate to make a sale, or persuading a client to drop a policy just for the sake of selling a replacement that will be discussed later in detail.

While an ethical agent would not knowingly violate these guidelines, it is necessary for any insurance professional to be aware of the particular legal provisions in effect in the state with jurisdiction. The laws are to be followed first, supplemented by one's own ethical standards.

Licensing

Insurers must be licensed by a state to issue policies there. A state's guarantee fund usually covers only insurers authorized to do business in that state. An agent representing an unauthorized company may be held personally liable for losses on a contract placed with an unauthorized insurer. The agent needs to be sure the company being represented is authorized to do business in that state.

It is also important for both the agent and the company office to be aware that laws can change. Actions of the state legislature and regulations issued by the state insurance commission both can vary with time and the pressure of public opinion.

Court Decisions

The court appeared to place no responsibility on the owner for reading the policy, the declarations page, or the bill for the premium on the \$10,000 coverage. The decision was that the insured was justified in believing that the agent had obtained the limit of liability they had discussed. The resulting point of case law is that an insurance provider cannot count on having any responsibility placed on the insured to analyze the coverage provided.

The issue of professional responsibility on the part of insurance agents and agencies is playing an increasingly important part in court cases. In a

Georgia decision involving business interruption policies, an insurance agency had been provided with a client's books to use in determining what coverage limit was needed. The agency used the gross profits figure rather than gross earnings to determine the coverage needs, leaving the client underinsured.

The plaintiff's argument in the court case was that the insurance agency had held itself out as an expert in the field with the needed qualifications to examine the books and determine coverage limits. The agency agreement with the client was to maintain adequate business interruption insurance based on yearly audits, and this agreement, the court held, was violated.

Such court decisions set the precedent of requiring a high standard of competence on the part of insurance professionals. Both agents and agencies need to be aware of this situation.

In addition to staying well informed and exercising due care, the responsible insurance practitioner can have professional representation available for claims protection by carrying Errors and Omissions (E & O) insurance. The E & O carrier will investigate claims situations and provide legal representation if necessary.

In the case of claims, the insurance professional needs to be prepared to deal with the claimant in a calm and competent way without overstepping limits on giving legal advice or otherwise prejudicing the case. Quick adjustment and settlement procedures are desirable in case of claims to uphold the reputation of the insurance provider, but it is important to have all the facts at hand before action is taken.

In dealing with a claimant, the insurance provider needs to remember not to give advice or promise to get the claim paid.

It is also important, however, not to deny a claim without positive knowledge that it is invalid. Also, a claim should never be paid without certain authority. Any of these actions can create legal liability.

It is helpful in avoiding legal difficulties for the agent to maintain friendly relations with clients and establish a reputation for being trustworthy over the long term. A personal relationship of trust and confidence between agent and client may help avoid lawsuits and make settlements easier.

Ethic Commissions

In addition to court cases, changes in the law can be brought about by an increasingly important agent, the ethics commission. Under pressure from activists, consumer protection groups and others, Ethics Commissions have been set up in state and national legislative bodies as well as in local government agencies.

Ethics Commissions tend to focus on lobbying, gifts to officials, conflicts of interest, and election procedures. They also, however, can consider other areas of public concern and produce legislation in response to consumer complaints.

An ethics commission can hold public hearings. It can determine what legislation needs to be passed in order to prevent abuses. It can investigate whether behavior of a public official has violated existing laws.

Congressional committees in both the Senate and the House have been conducting investigations into insurance cases with a view to possible federal legislation supplementing state level regulation of the industry. A Senate committee probe has centered on offshore insurers and reinsurers which are not subject to state regulation.

One reinsurer listed as its primary assets \$22 million in "treasury bills" claimed to have been issued by a Texas Indian tribe. Senate investigators believe this group to be fictitious. One of the tribe officials known as "Wise Otter" is thought to be a British subject.

The House investigation that followed the failures of large domestic insurance companies has focused on the possibility of setting up a federal support mechanism similar to the banking industry's Federal Deposit Insurance Corporation in order to protect policy holders beyond state agencies' limits. It is important for insurance professionals to keep abreast of such legal developments affecting the industry and its traditional standards.

SEC Requirements

Financial planning, a relatively new field for insurance providers, requires some specialized knowledge relating to securities and investment regulations. The Securities and Exchange Commission through the Investment Advisers Act sets high ethical standards for professional providers of investment advice.

Any transaction or business practice intended to deceive a client or prospective client is strictly forbidden under the act. The agent acting as a securities representative is legally required to act with due diligence, meaning that documented financial information must be furnished on companies whose stocks or bonds are being sold.

In contrast to due diligence for securities salesmen, the standard established in court cases for agents only involved in selling insurance is due care. The client is given financial information on request, but the state insurance department is the agency responsible for requiring reports from companies authorized to do business in that state. The agent's legal obligation is to sell policies of insurance companies licensed in that state and not to sell policies of companies the agent knows to be insolvent.

An agency can establish a back-up line of defense against claims arising from insurance company insolvency. This can be done by showing proof that the agency has maintained a system for tracking financial conditions in the industry through figures from the various reporting agencies and by other means available.

It is important for the insurance agent to know the specific do's and do not's that constitute ethical behavior. Specifics that will be discussed are advertising, commissions (rebates), agent conduct, clients' files, illustrations and underwriting.

AGENT COMPLIANCE

Advertising

When the agent advertises, he/she is making the product known to the public at large. There are many different ways to advertise. The following are the

major methods, of advertising.

- Printed and/or published materials.
- Newspaper, radio, television, computers, billboards.
- Ads, circulars, leaflets, descriptive literature.
- Business cards, business brochures, prepared sales talks.
- Telephone solicitations.
- Any material used to sell, modify, update or retain a policy of insurance.

Agents wishing to advertise must-obtain approval from their respective insurance company. All advertisements for life, accident, and health insurance must include and identify the insurance company the agent represents.

Advertisement that would not require prior insurance company approval would be one in which the only information given is the agent's name, address, telephone number, and description of the services being offered. Agency history and a simple statement of products offered, such as life, health, and/or annuities would also apply. There must be no reference made to specific policies, benefits or cost.

The agent must do the following in all advertising:

- Make clear that insurance is the subject of the solicitation, clearly identify the type of insurance being sold, and the full name of the insurer.
- Include all limitations and exclusions affecting the payment of benefits or cost of a policy, as well as disclose any charges or penalties, such as administrative fees, and surrender charges contained in a life or annuity policy, or withdrawals made during the duration of the contract years.
- If a policy offers optional benefits or riders, disclose that each optional benefit or rider is available for an additional cost.
- For a life insurance policy with accelerated death benefits, clearly disclose the conditions, care or confinement which will initiate any acceleration of payment of the death benefit and/or other values under the life policy.
- If a policy includes a payment endorsement, disclose that fact.

The agent MUST NOT do the following in any advertising:

- ✱ Be deceptive or misleading by overall impression or explicit information.
- ✱ Refer to considerations paid on an individual policy or annuity, including policy fees.
- ✱ Use terms such as "Financial Planner", "Investment Advisor", "Financial Consultant", or "Financial Services" in such a way as to imply the engagement in an advisory business in which compensation is unrelated to insurance sales, unless this is actually the case.
- ✱ Use a service mark, trade name or group designation without disclosing the name of the actual insurer, if specific coverage benefits or costs are described.
- ✱ Make unfair or incomplete comparisons of policies.
- ✱ Disparage competitors, their products, their policies, their services, business or marketing methods.
- ✱ Make untrue or misleading statements with respect to another company's insured assets, financial standing or relative position in the insurance business.

- ✱ Imply group coverage, certificate or enrollment when the policy offered is actually an individual policy.
 - ✱ State that the policy is a limited offer and the applicants will receive advantages by accepting the offer, and that such advantages will not be available at a later date, if this is not the fact.
 - ✱ Advertise a free gift, bonus, or anything of value outside of the policy contract, which is an inducement to buy and considered rebating.
 - ✱ Advertise for life, health, accident or annuities, use the existence of the GUARANTY ASSOCIATION as an inducement to buy.
 - ✱ Use misleading words or symbols or imply the material is being sent by a government entity.
 - ✱ Use the phrase "low cost" without providing disclosures and the caveats associated with the particular plan.
- Advertising can be one of the best career enhancing tools, when utilized effectively, legally and ethically.

Commissions

Commissions are the direct result of work performed by the agent with a new or existing policy owner. The agent's compensation is paid direct from the respective insurance company for the type of product and services recommended and are willing to provide. In addition to the initial commission, most insurance companies provide "renewal commissions", as an inducement to continue servicing the existing policy owners. This concept, initiated many decades ago, was intended to accomplish two primary objectives:

1. Compensate the agent for future servicing needs the policy owner will require - such as beneficiary changes, bank draft changes, endorsements, etc.
2. Provide the agent with an opportunity to perform periodic reevaluations of the policy owners' needs, thereby resulting in additional sales opportunities.

Rebating

The agent, as a licensed insurance person, shall not directly or indirectly rebate or attempt to rebate all or any part of a commission for insurance. Rebating is illegal in Texas, and is strictly prohibited. It can be punishable by fine, cancellation of contract with insurance company, and loss of license, or a combination of all three. Rebating can be described as offering any type of inducement other than what is contained in the policy itself, in exchange for purchase of insurance. Examples include, but are not limited to the following:

- ✧ Any verbal or written agreement for the agent to pay any part of a policy owner's premium.
- ✧ Any payment, allowance, or gifts of any kind offered or given as an inducement to purchase insurance.
- ✧ Any paid employment or contract for services.
- ✧ Returning any part of the premium to the policy owner.
- ✧ Offering any special advantage regarding the dividend, interest, or other policy benefits to the policy owner which are not specified in the policy.
- ✧ Offering to buy, sell, or give any type of security (stocks, bonds, etc.) or property, or any dividends or income from securities or property, to the policy owners' benefit.
- ✧ Giving anything of value to the policy owner in return for buying an insurance product.

Rebating, or the attempt to rebate, is an offense not only under the Code of Ethics, but also under the Texas Insurance Laws. There may be borderline

situations in which it is difficult to determine whether rebating has taken place.

It is fairly common practice, as an example, for an insurance agent to entertain policy owners or prospective purchasers with a meal and perhaps give a nominal or token gift such as a policy wallet. Such things are considered to be normal business practice, and not in the nature of a rebate. However, should the agent contemplate anything more than such token gestures of appreciation, then the greatest caution and good judgment must be exercised. Excessive benefits or gifts conferred upon policy owners or prospective purchasers, will at the very least be considered in bad taste, and at the worst, depending on all the circumstances, may expose the licensee to a charge of rebating. In no circumstances should a gift of anything of value be given as an inducement to purchase insurance.

The rules for rebating do not apply to splitting of business with another licensed insurance agent. Joint case work is very common throughout the industry, and splitting of commissions is normal business practice. This practice does not apply to equity and variable life products, since they are sold under the rules and guidelines of the Securities Exchange Commission.

Agents' Conduct

As an insurance professional, the agent becomes part of the insurance industry's public relations arm. The agent meets the public every day, and the manner and conduct exhibited leaves a lasting impression with everyone with whom that agent had contact.

A big part of professionalism is the attitude toward competition; therefore, agents should avoid criticizing other agents. Such activity is detrimental to everyone in the business. Any criticism of another company's policies should be avoided. An incomplete comparison is not only misleading and harmful to the public, it can also result in license revocation for the guilty party. Respect for competitors helps to keep policy owners satisfied.

The agent is under an obligation to make accurate and complete disclosure of all information which policy owners or prospective purchasers should have, in order for them to make a decision in their best interest.

The agent is called upon daily to make many statements and representations, oral and written, upon which policy owners and prospects are entitled to rely. Such statements and representations must not only be accurate, but must also be sufficiently complete to prevent any wrong or misleading conclusions from being made by policy owners or prospects. It is just as wrong for a life underwriter to omit giving essential information, such as, failing to correct a mistaken impression which is known to exist, as it is to give inaccurate or misleading information. Representing insurance products as exclusively "retirement plans", "college education plans" or "savings plans", without noting that the life insurance is primary and the cash value features are secondary, can result in serious charges of misrepresentation of insurance products. Use of the word "deposit" versus "premium" can have a like effect.

Deceptive practices as they pertain to our industry have countless examples, a few of which are:

- ☛ Passing off the agent's own goods or services as someone else's.
- ☛ Misrepresenting the benefits, uses, or characteristics of the product.
- ☛ Making disparaging remarks pertaining to someone else's products, services, company, by making false or misleading representations.

- ⌘ Advertising the product or rates while intending not to sell them as advertised.
- ⌘ Misrepresenting the agent's authority as a sales person, representative, or agent to negotiate the final terms of the contract with the policy owner.
- ⌘ Offering, in connection with an insurance purchase, participation in a "multi-level distributorship" under which payments are conditioned on the recruitment of additional sales people rather than the proceeds from the product sales.
- ⌘ Using the terms "corporation" or "incorporated" or their abbreviations in the name of a non-incorporated business.
- ⌘ Failing to disclose information during a transaction with the intent of inducing a prospect or policy owner to do something he or she would not do otherwise.

The law allows courts to award an insured triple damages, court costs, and attorney fees, for deceptive insurance trade practices.

Insurance is not only a complex product; it is an extremely complex industry. The insurance agent must be very careful not to mislead the consumer regarding any aspect of an insurance transaction.

Misrepresentations can be in the form of an oral or written statement, advertisement in any media, use of a business logo or advertising slogan, or anything else that communicates a false or misleading idea. A few examples of misrepresentation include:

- False or misleading statements about a particular policy.
- False or misleading statements about the financial condition of a respective insurance company.
- Telling a prospect or policy owner that dividends or current assumption mortality charges are guaranteed.
- Identifying a term life policy by a name that implies cash value accumulation, or vice-versa.
- Indicating that premiums on a policy are payable for a shorter time period, when the premiums may be payable for life.
- Indicating that the agent represents several insurance companies, when in fact the agent represents only one.

A high degree of ethical representation is good solid business. The agent's insurance career can provide financial gain and personal growth. Practicing as an ethical professional will bring both. The agent's actions will gain the respect of the policy owners as well as that of the insurance carriers. The agent's reputation will be significantly enhanced, and people in the community will want to do business with that agent.

Documenting Clients' Files

Documenting the client files involves keeping track of the actions taken in dealing with the policy owner. A properly documented file should contain complete and accurate answers to all pertinent questions. This allows the agent to properly assess the need for insurance and substantiates the reason for the sale.

After the fact-finding meeting, the agent should send a discovery agreement to the prospective policy owner summarizing the initial meeting and outlining the agent's understanding of the policy owner's short-term and long-term financial goals. This document should also contain information about the policy owner's salary and expenses, and the amount of money in savings accounts and investments. It should also reiterate the amount of insurance in force and the amount of money the policy owner would be able to allocate for

insurance premiums. In addition to this, the discovery agreement should thank the policy owner for the chance to work with them, and confirm the date of the agent's next meeting.

The agent should always keep on file a proper ledger illustration. This should be an approved insurance company ledger, a sales proposal/idea that contains the following elements:

1. Insurance company name.
2. A full dividend/interest rate crediting disclaimer.
3. A clear description of the product.
4. The agent's name and illustration date.
5. Guaranteed values.
6. A page containing full explanation of any assumptions or special instructions.

Effective case notes should also be kept in the policy owner's file. These should list the date and time of contact with the policy owner and concise summaries of all interactions. It is also recommended that the agent document the level of service provided to the policy owner.

An effective log of all telephone calls should be kept, listing the date, time, reason, and follow-up action of all telephone conversations with the policy owner. The agent should also note all unsuccessful calls to the policy owner in order to verify the attempts to provide proper service, thus, once again, documenting the level of service provided.

A delivery letter should be sent to each policy owner with a copy kept in their file. This letter would reinforce the information already discussed, such as the reason for purchasing the insurance, and the type of plan as well as the face amount of coverage. The agent should reiterate the amount and duration of premium payments, as well as the premium payment method. The agent should also restate the impact on policy values as it relates to borrowing, partial surrenders, advanced premiums, interest requirements, dividend usage, and if appropriate, interest or dividend crediting performance.

Many companies provide a delivery receipt with the policy that must be signed by the policy owner upon delivery. If the company does not, it is recommended that the agent prepare such a document to be signed upon delivery to the policy owners. It should list the date the policy was received by the agent, the policy number, and the insurance company's name. It should also contain the owner's signature and the date they signed for delivery of the policy. All of this should be kept in the policy owner's file.

Illustrations

Illustrations have been used extensively in the insurance industry for several decades to help secure sales. In the past, they were obtained from the respective insurance company, and were fairly bland and standardized for many years. They were straight forward and represented a close approximation of actual future performance. Beginning in the early 1980's, a radical change began, primarily due to three events occurring simultaneously:

1. A significant reduction in mortality charges, due to advancement in medical technology.
2. Significant advancement in electronic technology -- also known as low cost personal computers.
3. A significant economic change resulting in double-digit market interest

rates.

These three events, coupled with consumer demand, helped produce a product called Universal Life -- an unbundled, interest sensitive, whole life policy with a high degree of flexibility.

Insurance was viewed more as an investment product consisting of "mortality" and "side funds". Illustrations began to change and use historically high double-digit interest rates as the basis for projected values. As interest rates began to fall in the late 80's, projected values did not hold up to reality. Many policy owners received notices that premiums would have to be increased or death benefits reduced to keep policies in force. Policy owners became angry, and many accused agents and companies of unethical behavior.

It cannot be overemphasized that illustrations are mere projections based on current interest rates, current mortality charges and other expenses. These conditions are not contractual obligations. Agents who have competed on the basis of high interest returns will produce projections that are unrealistic. This blatant misuse of illustrations has led to policy owner confusion and dissatisfaction. Agents, companies, and the insurance industry have suffered tarnished reputations.

The results have been fierce disciplinary actions backed by a series of heavy fines on some insurance companies by state regulators. Some examples of illustration abuse are as follows:

- . Falling prey to the allure of high interest returns.
- . Use of "assumed" interest rates in competitive situations.
- . The sales technique of "Vanishing Premiums".
- Heavy emphasis on accumulated values verses death benefits.
- Poor emphasis of contractual guaranteed values and the potential problems that could exist in the future.

Remember, the policy owner does not necessarily see the illustrations as hypothetical. Policy owner dissatisfaction has resulted in increased demands by state regulators for heavy regulations regarding illustrations. Some insurance departments are considering the elimination of current assumptions, and only allowing illustrations based on guaranteed values. The parameters of an illustration under these proposals would be strictly monitored. They have also suggested that disclosure of past performance will be all that is permissible.

Many companies provide guidelines regarding interest rates to be used in product illustrations. The agent is advised to stay within the company guidelines to avoid policy owner dissatisfaction. Policy owners should be aware that current illustrations are a snap shot of how a policy might work if the current rates remained unchanged. To help with this awareness, illustrations should have three distinct columns:

1. Guaranteed Values.
2. Current Return Values.
3. Current Return Minus 1%.

This type of diligence will reward the agent with greater policy owner understanding of how interest rates and dividend scales can affect cash

values and premiums.

Illustrations are rarely valid for policy comparisons. They are designed to show how a particular product of a particular company works. There are too many inconsistent variables from one company to another to allow for valid comparison. Policy selection should be made on knowledge of the product and analysis of assumptions underlying each policy. Policy provisions, company financial condition, and quality of service are valid considerations. Illustrations only, can be a dangerous criterion for policy selection without additional considerations.

The vanishing premium concept has been particularly damaging to the public perception of insurance industry ethics. This concept is based on the premise that premiums may be discontinued after a certain number of years through the use of cash value or dividends. It was used as a marketing tool extensively in the 1980's. Projections of vanishing premiums (typically in six to eight years) were based on high interest rates in effect at that time. Many policy owners did not understand that a continuation of high interest rate was necessary to fulfill illustrated projections. When interest rates fell, policy owners charged that no one explained the fact that the illustrated "vanish" was not guaranteed. This disappointment can be avoided with proper disclosure of illustrated concepts and the effect of changing interest rates. Good ethics and business practice dictates that illustrations show both guaranteed and non-guaranteed values with the difference clearly explained to the policy owner. Any illustrations showing non-guaranteed values may be incorrect after the first year. The agent should be thoroughly informed about "assumptions" and "hypothetical" and the effect of fluctuating interest rates and mortality charges. This additional risk should be communicated to the policy owner in written as well as verbal form.

There are many types of new generation policies which require due care and full disclosure. These include Blended Policies (permanent and term), Adjustable Policies, First-to-Die Policies, and Second-to-Die Policies. When two or more lives are insured under the same contract, particular care should be taken to explain to the policy owners that the death benefit is paid on the death of only one of the insureds.

Falling interest can create a climate where actual performance falls short of illustrated projections. Very often, policy owners do not understand the difference between hypothetical projections and contractual guarantees. This can lead to policy owner dissatisfaction, complaints and potential litigation. Increased policy owner complaints lead to adverse insurance department rulings, state regulations, fines and lawsuits against companies and agents. This affects the public perception of ethical conduct of the entire insurance industry. The solution lies in ethical business practices, particularly concerning policy owner understanding of illustrations. Self-policing through education, discretion and common sense will lead to field practices of a high ethical standard. It is important to remember that the policy owner will retain that information they see as most beneficial. As a professional community, our watch words are, tell the policy owner the truth.

Replacement of a contract of life insurance means any transaction which includes a:

- ☒ Rescinded, lapsed or surrendered policy.
- ☒ Charge to paid-up insurance, continued as extended term insurance or placed under automatic premium loan.

- ✕ Change in any manner to effect a reduction of benefits.
- ✕ Change so that cash values in excess of 50% are released.
- ✕ Policy subjected to substantial borrowing of cash value, but does not include the purchase of an additional life insurance contract.

The agent should not, when it could be detrimental to the interest of the policy owner, replace an existing contract of life, health, disability and annuity contracts with a new insurance contract. Every reasonable effort should be made to maintain the existing contract in force.

Where it appears that, due to a change in circumstances, an existing contract of insurance should be amended or changed; the agent should ensure that the policy owner is fully informed of any values, credits, or privileges in the existing contract which can be transferred to an amended or changed contract of insurance.

Service

One study indicated that the average insured purchases insurance seven times during their lifetime -- from six different agents. Is part of the reason because of poor or lackluster service?

The insurance industry employs and contracts nearly two million people. It is quite evident that insurance is an intricate and essential service in our society. It is a field upon which our society depends more and more for financial protection. Life and health insurance purchases continue to increase each year. Property and casualty insurance is a part of every mortgage contract, auto ownership, and business coverage. On a daily basis a large group of people will die, enter retirement, experience a cash emergency, or have a physical asset damaged or destroyed. This is the real world -- it affects everyone! These are critical times. The agent's insurance company, the agent, and the policy sold, stand between the client and financial disaster.

The insurance agent must be the "value added" benefit for the insured as well as the insurance company. In the decade of high tech mega information highway, The agent has to be the interpreting guide and the analyst for the general public to solve financial problems with an insurance purchase. The agent must also become the motivator, leading a prospect to action.

People like to do business with people they trust. Trust is built on ethical behavior. When potential prospects and existing policy owners find an agent with high ethical standards, they tend to do more business with the agent -- therefore becoming a client. In perhaps no other industry is the element of trust more important.

Charging fees for service is common practice in most occupational groups; however, Texas has an exception for insurance agents. Group I licensed agents are not allowed to charge fees for service unless they are properly licensed as a Certified Insurance Counselor (CIC). Property and casualty licensed agents are also allowed to charge fees for certain services.

The service to a policy owner/client is not only qualitative, but also quantitative. Periodic contact is essential, but can take various forms:

- ♦ Daily phone contact with the same policy owner would not only be extremely expensive and cumbersome, but also non productive and obnoxious. Most policy owners tend to accept three to six months intervals as

a good basis for agent contact. This could be in the form of telephone calls, letters, informative announcements, as well as birthday and Christmas cards. Many agents use Thanksgiving cards as an alternative to the more commonplace Christmas card mailing.

♦-It is definitely recommended that the agent staff her/his office with people able to handle day to day service needs, such as change of beneficiary designations, bank draft changes, policy amendments or endorsements, etc. If the agent elects to refer all of these tasks to the respective insurance company home office, it would significantly reduce the "value added" benefit that serve the policy owner. It would also enhance the likelihood of future replacement from another insurance agent -- who specializes in service.

Generally speaking, policy owners want convenience and immediate response. An agent, who refers policy owner service duties directly to the insurance company, is missing tremendous future sales opportunities, alienating themselves from building the trusted relationship necessary to maintain a strong business practice, and presenting themselves in less than an exemplary fashion.

Underwriting

Perhaps no other area pertaining to compliance and ethics deserves as much attention as agent underwriting. When any type of claim occurs, the insurance application becomes the basis for a claim dispute, denial or acceptance. An agent, who compromises part of the underwriting process with false or misleading information, as it pertains to the prospective insured, is creating potential wealth for litigating attorneys.

The agent must always remember that an underwritten application becomes part of any insurance contract. It is critical that all questions be answered completely and honestly. Too often it is tempting for an agent to "trim" ten or twenty pounds off a rather overweight insured or help them grow one or two inches, in order to assure a standard issue from the respective insurance company. Asking a potential policy owner to discard a lit cigarette during the application process may create non-smoker discounts, but in all likelihood would initiate a claim denial. Insurance companies have challenged fraudulent non-smoker rated policies through the court system, and won. It is also naive for the agent to believe that a two-year incontestability clause will exempt him/her or the insured from blatant, fraudulent underwriting. Insurance companies may pay a claim, but they can and do pursue legal action against the insured's estate.

The agent should make every effort to provide the insurance company with all accurate information pertaining to the prospective insured. Cover letters should be submitted with the application to provide details of unusual or extensive medical history or information; unusual business uses of insurance; foreign travel and residence; unusual financial situations; unusual beneficiary and ownership arrangements to clarify the insurable interest; unusual occupational duties; and any case discussions with an underwriter prior to the application submission.

Many insurance agents order medical examinations, attending physician statements, and financial information through third party sources, and upon receipt forward these items to the insurance company. This is not an illegal practice, but it may be against the company's practice. Since underwriting information is highly confidential, both the originals and photocopies of

financial statements, attending physician statements, hospital abstracts and other confidential records that have been obtained by agency personnel require safeguarding.

⌘ Access to files containing confidential material must be restricted to employees who have legitimate "need to know" in order to perform their assigned duties.

⌘ Confidential information stored in personal files, should be retained only as long as there is legitimate need.

⌘ Some companies absolutely forbid the acquisition and retention of medical examinations, attending physician statements, hospital abstracts or other medical histories.

⌘ It is up to the agent to know what the insurance company's practices are.

Since the application is such an integral part of the insurance contract, care should be utilized in presenting all information to the insurance company in a professional manner. One of the most consistent complaints with insurance company underwriters is illegible applications. Not only does this impair the underwriting process, but it could be grounds for significant dispute during the processing of a claim.

Generally, changes or alterations to the application must be initialed by the insured/applicant. This is specifically important in changes in plan, face amount, owner, beneficiary, medical or financial representations and dates. Some companies are more lenient and allow amendment signatures at the contract delivery.

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To comply with state and federal privacy laws, and to control and protect confidential information provided to the company by applicants, guidelines need to be followed to insure the strictest handling of these documents.

Examples to follow are:

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⌘ Confidential information stored in personal files, should be retained only as long as there is legitimate need.

⌘ Some companies absolutely forbid the acquisition and retention of medical examinations, attending physician statements, hospital abstracts or other medical histories.

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The National Association of Insurance Commissioners (NAIC) has a Model Privacy Act that requires any applicant/insured to be notified of any adverse action taken in regard to their application. This Act allows an insured the right to know the details of the personal information about themselves in the company files, and has the right to request an insurance company to amend, delete, and correct such information.

Chapter 8 Economic Effects of Insurance Legal Aspects

The insurance industry operates as a part of the overall economic system. As with any system, there are laws, rules, and regulations that apply to the conduct of business. The insurance industry is no exception. In the following sections, we will look at how laws affect the insurance industry and its operation in the economic environment. First, we will look at the nature of the insurance contract. This is the heart of the relationship between the insured and the insurer. The body of law that has built up around the interpretation of the insurance contract naturally affects the way insurers plan and execute their business. We will then look at the way the insurance industry is regulated by the states and the federal government. Several legal decisions are also included that give insight into the court's decision making process in the development of case law for the insurance industry.

Nature of Insurance Contracts

The basic principles of contract law are applicable to insurance contracts, but whereas most contracts involve a fairly even exchange between the parties, this is not necessarily true of insurance contracts. The insurer's promise to pay involves a far larger sum than it is receiving in premiums from the insured, and its promise to pay is enforceable only under certain conditions. Those conditions probably will not occur (or in the case of life insurance, probably will not occur prematurely) or else the insurance would not be written. Since insurance companies do a large volume of business over wide areas, their policies are standardized and in some cases standardization is required by State law. This method of business operation usually means that the insured must accept a given policy or do without insurance, and for this reason insurance contracts are sometimes said to be contracts of adhesion.

Insurable Interest- The concept of insurable interest has been developed over many years, primarily to eliminate gambling and to reduce what is called the moral hazard. If one were free to take out an enforceable insurance policy on the life of another, or a fire insurance policy on property which he did not own or in which he had no interest, he would be in a position to profit by the loss of such person's life or the destruction of the property. In general, an insurable interest is some relationship between the insured and a specified contingency, such that the happening of the contingency will cause a substantial loss or injury to the insured. Because of this interest and relationship, an insurance policy is not regarded by the law as a gambling agreement but as an aleatory contract.

In property insurance, ownership of the fee creates an insurable interest in the property, whether the ownership is sole, or by joint tenants or tenants in common. In some instances, shareholders in corporations have been held to have an insurable interest in the corporation's property. Lessees of property have interests which are insurable as do holders of security interests, such as mortgagees or conditional sellers. The interest must exist at the time the loss occurs and not when insurance is procured, al. though the latter is sometimes said to be necessary.

In life insurance, those who may take out insurance on another's life are practically limited to close relatives, creditors, and business associates or employers, depending generally on the particular facts involved. The insurable interest must exist at the time the policy is taken out and need not exist at the time of death (except possibly in Texas). Except for that written by fraternal benefit societies, an insured may take out a policy on his own life and name any one he chooses as beneficiary, although that particular beneficiary may have no insurable interest in the insured's life. An insured may assign the life policy proceeds to a third per son who has no insurable interest.

In fire insurance policies, the recovery usually the replacement value of the property, minus depreciation. In some States the insurer and the insured are permitted to agree in advance upon the value of the property insured (a "valued policy") and in cases the agreed value is the recovery on a total loss. An owner or lessee of property may take out rent loss or business interruption insurance to protect himself against loss during the time that the property is unusable. Fire insurance policies are not assignable before loss occurs.

Offer and Acceptance- Insureds often know the names of the life insurance companies in which they have policies, but know the names of the fire or casualty companies which insure them. One reason which has been advanced for this situation is that life policies are generally solicited by company agents, whereas those who desire fire or casualty insurance usually call an insurance agent or broker, and leave the selection of the company to him.

No matter how assiduously a life insurance agent has solicited a person to take out a policy, it is generally true that it is the applicant who makes the offer, and the contract is created when that offer is accepted by the company. The company's acceptance may be conditioned, for instance, upon payment of the premium or delivery of the policy while the insured is in good health. If the company writes a policy which differs from the application, then it is the company which makes a counter-offer which the applicant may or may not choose to accept.

This situation arises most frequently where the company is unwilling to write the policy which the agent proposed, because of the results of a physical examination of the applicant, but is willing to write a different policy based on the particular risk involved. Some companies will not intentionally insure persons who have had certain physical ailments or a history of disease, while other L companies will write such life insurance for a premium which they consider appropriate to the risk.

Binding Receipts and Binders. Life insurance agents cannot bind the company to a contract with the insured, although on occasion a "binding receipt" may be issued by an authorized agent, acknowledging payment of the premium and providing for the issuance of a standard policy effective from the

date of the medical examination, so long as the company has no bona fide reason to reject the application. In fire and casualty insurance, agents often have authority to make the insurance effective immediately, when needed, by means of a "binder." In the event of a loss before the company has actually issued a policy, the binder will be effective on the same terms and conditions the policy would have had if it had been issued

Representations- A representation is a statement made by or on behalf of an applicant for insurance to induce an insurer to enter into a contract. The representation is not a part of the insurance contract, and if the application containing the representation is incorporated by reference into the contract, as in liability or burglary insurance, the representation becomes a warranty. For a representation to have legal consequences, it must have been relied upon by the insurer as an inducement to enter into the contract, and it must have been substantially false when made or it must have become so, to the insured's knowledge, before the contract was created. The principal remedy of the insurer, on discovery of misrepresentation, is rescission of the contract. To rescind the contract, the insurer must tender to the insured all premiums which have been paid, since a rescission restores the parties to the same position they were in before the contract was made. Rescission may or may not be available to the life insurer; however, because of the "incontestability clause" which makes the policy incontestable by the insurer after a specified period of time, such as one or two years after the policy has been in effect during the lifetime of the insured. To be effective, rescission must be made as soon as possible after discovery of the misrepresentation.

An innocent misrepresentation of a material fact (not opinion) is a sufficient ground for avoidance of a policy by the insurer. Whether the fact is material or not depends, generally, upon whether the policy would have been issued had the truth been known. An immaterial misrepresentation, even though fraudulently made, is not a ground for avoidance of the policy.

Warranties- Representations are inducements made by the applicant to the insurer to enter into the contract but are not part of the contract itself. If they are incorporated into the contract, they become "warranties." By statute in many States, representations cannot be converted into warranties in life insurance policies by incorporating the application into the policy by reference.

Warranties are of great importance in insurance contracts because they state conditions which must exist before the contract is effective or before the insurer's promise to pay is enforceable. Failure of the condition to exist or to occur relieves the insurer from any obligation to perform its promise. Broadly speaking, a condition is simply an event the happening of which or its failure to happen precedes the existence of a legal relationship, or terminates one previously existing. Conditions are either precedent or subsequent; for example, payment of the premium is a condition precedent to the enforcement of the insurer's promise, as is the happening of the insured event. A condition subsequent is an operative event the happening of which terminates an existing matured legal obligation. A provision in a policy to the effect that the insured shall not be liable unless suit is brought within twelve months from the date of the occurrence of the loss operates as a condition subsequent.

Usually, those statements in policies which the insurer looks upon as express warranties can be identified by the use of the words "warrant" or "on condition that" or "provided that" or words of similar import. Other statements which are

important to the risk assumed, such as the building address in the case where personal property at a particular location is insured against fire, are sometimes held to be informal warranties. Generally, the trend is away from allowing an insurer to avoid liability on the policy for *any* breach of a warranty by an insured; the breach must usually be "material" to have such an effect.

The effect of warranties is frequently regulated by statute. The New York statute provides that all statements made by an applicant for life insurance shall be deemed representations and not warranties, regardless of what the policy or application may state.

Affirmative warranties state conditions which must exist at the time the insurance contract is made, while promissory warranties are undertakings to do or cause something to be done during the period of the policy. A statement in a fire insurance policy that the premises are used as a grocery store probably will be considered an affirmation warranty which need be true only at the time the policy is issued. Unless the character of use is changed to such an extent that there is a substantial increase in the policy will remain enforceable. A statement in a burglary policy that a watchman will be on duty at all times is a promissory warranty.

Concealment- While rarely relied upon in life insurance; the doctrine of concealment has vitality in other fields of insurance. Concealment is simply the failure of an applicant for insurance to disclose material facts which the insurer does not know. For example, if an applicant telephoned an insurance company agent for a policy protecting against damage by windstorm, effective immediately, and at the same time was watching a tornado approach, he could hardly complain if the insurer objected to settlement for a total loss. The non-disclosure must normally be fraudulent as well as material to invalidate the policy; that is, (1) did applicant have reason to believe the fact was material, and (2) would its disclosure have affected the acceptance of the risk by the insurer?

Waiver and Estoppel- There are instances when an insurer would normally be entitled to deny liability under a policy because of a misrepresentation or breach of condition or concealment, but because of other facts, the insurer is said to be "estopped" to take advantage of the defense or else to have "waived" the right to rely on it.

The distinctions between "waiver" and estoppel are usually only verbal. The terms are used interchangeably, although by definition they are not synonymous. As generally defined, waiver is the intentional relinquishment of a known right, and estoppel means that a person is precluded by his own conduct from asserting a position which is inconsistent with his acts which have been relied upon by another with justification. Since a corporation, such as an insurance company, can act only by agents, situations involving waiver invariably find root in an agent's conduct. The higher the agent's position in the company organization, the more likely his conduct to bind the company, since an agent acting within the scope of his authority binds the principal. Insureds have the right to rely on representations made by the insurer's employees and where such representations induce or cause a change of position by the insured, or prevent the insured from causing a condition to occur, the insured may not assert the failure of the condition to occur, whether the term applied to this situation by waiver or estoppel.

Companies have tried in many ways to limit the authority of local selling agents

to bind the company through waiver or estoppel, but it is most difficult to do effectively. A general rule, when a local agent delivers a policy with knowledge of the non-occurrence of a condition precedent to the company's liability which would make the policy void or violable at the company's option, the condition is waived. While there is always a question whether the agent had authority to waive the condition, most courts will find an effective waiver even though the condition is a delivery-in-good-health clause or the medical-treatment clause in a life insurance policy. Such clauses provide that a life insurance policy shall not take effect unless delivered to the applicant while his insurability or good health continues, and that the policy shall not take effect if the applicant has been treated by a physician or has been hospitalized between the date of the application and the date of delivery of the policy

Performance and Termination- Most contracts of insurance are performed according to their terms, and due performance terminates the insurer's obligation. In life insurance contracts, the insurer pays the principal sum due on death, and the contract is thereby performed and discharged. In other insurance contracts, there may be a dispute over the amount due upon the happening of the insured event, but when the conflict is resolved and the agreed sum is paid, the insurer has performed its obligation.

Cancellation of an insurance contract by mutual consent is one way of terminating it. Cancellation by the insurer alone means that the insurer is liable according to the terms of the policy until such time as the cancellation is effective. This is not always a right which is available to insurers, but where available, it is sometimes mistakenly used where rescission is preferable, from the insurer's point of view. If an insurer under an accident policy elects to cancel after the occurrence of an insured event, where a right of rescission existed because of material misrepresentation, this will be taken as an admission of liability for events occurring before cancellation. To cancel a policy, the insurer must tender the unearned portion of the premium to the insured. To affect a rescission, all premiums received by the insurer must be returned to the insured.

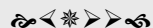
Occasionally, a life insurance company will decline to pay a death benefit because of a material misrepresentation by the insured. In a suit by the beneficiary against the insurer, the company may be faced with facts pointing to waiver or estoppel due to the actions of a local agent, and his problem will ordinarily be resolved by a jury. In the event the insurer learns of a material misrepresentation during the lifetime of the insured, the proper remedy is rescission of the contract. Because of the incontestability clause in life insurance policies, the insurer's rights to rescind are restricted, but an insured may cancel the policy and recover the cash surrender value at any time. The minimum cash surrender value payable on cancellation by the insured is determined by calculations specified in the non-forfeiture statute, but, in general, this value will approximate the reserve on the policy, at least after the policy has been in effect long enough to amortize certain expenses incurred in writing the policy.

The New York standard fire insurance policy gives the insured the right to cancel at any time and the insurer must refund the "excess of the paid premium above the customary short rates for the expired time." The company has a right to cancel at any time (with or without cause) by giving five days' written notice to the insured "with or without tender of the excess of paid premium above the pro rata premium for the expired time, which excess, if not

tendered, shall be refunded on demand," and the notice must so state, if a tender is not made. If the loss is payable to a designated mortgagee, the mortgagee is entitled to ten days' notice. When a fire policy is canceled, the company is entitled to retain a portion of the premium in payment for the protection which the insured has received when the policy was in force. Upon cancellation by the company the premium retention is only that proportion of the premium paid which the time the policy was in effect bears to the time the total premium covered; whereas, upon cancellation by the insured the "short rates" apply whereby the company is entitled to retain a larger proportion of the premium paid to cover reasonable expenses incurred in writing the policy.

After the occurrence of the insured the insured is required to give notice to the insurer and, in the case of property insurance, proof of loss within a specified time, such as 60 days for fire insurance. In liability policies the requirement of immediate notice is construed by the courts as notice within a "reasonable" time. The period within which an insured may commence suit against the insurer upon a fire policy is limited by the policy, usually to one year.; Automobile liability policies require that the insured immediately notify the insurer of any accident or occurrence which may involve liability as well as notify the insurer of the institution of suit and forward any summons or process served upon him. These notice requirements are conditions precedent to the insurer's contractual liability, but all of them may be waived by the insurer if an insured under an automobile liability policy fails to forward a summons to the insurer and a judgment by default is entered, insurer may lose the opportunity to defend the suit. The insured's breach of condition will give the insurer a defense in any action brought to enforce the policy. Delay of only a few days, even though "immediate" notice is required, may not prejudice the insurer.

The proper procedure is for the insured to give notice as promptly as possible after the happening of an insured event and to furnish a proof of loss, if required, within the time allowed. If the terms of the policy are complied with, it is beneficial to both insured and insurer. An insurance company will rarely rely upon a strict construction of notice provisions unless the company has been prejudiced by the insured's delay, but these provisions are in policies for sufficient reasons and failure to perform a condition in a contract normally excuses performance by the other party.



HAWKEYE-SECURITY INS. CO. v.

GOVERNMENT EMP. INS. CO.

(1967) 207 Va. 944, 154 S.E.2d 173.

SNEAD, J. On August 18, 1962, Einer Carl Mattson, Jr. was operating an automobile owned by and with consent of his father, Einer Carl Mattson, Sr. It became involved in a collision with another vehicle operated by William Henry Droughn who received personal injuries. Mattson, Sr. reported the accident to Government Employees Insurance Company, appellee, which had issued to him a liability insurance policy on his car involved in the mishap. Under the terms of the policy, Mattson, Jr. was an additional insured. On November 20, 1962, after some investigation, Government Employees wrote Mattson, Sr. advising "[W]e hereby declare the captioned policy null and void and of no effect as of its inception date" because of a material misrepresentation made

in his application for the insurance coverage, and it enclosed a check for a refund of premiums paid.

On September 22, 1964, Droughn recovered a judgment in the sum of \$2,000 against Mattson, Jr., and on the same day Droughn assigned to it Hawkeye-Security Insurance Company, appellant, for a value consideration. Execution on the judgment was returned "unsatisfied."

Pursuant to the provisions of Code, § 38.-1-380 Hawkeye, assignee, instituted an action against Government Employees seeking a judgment for \$2,000 against it. In its answer and grounds of defense, Government Employees denied that the Mattson vehicle was insured by it, and denied that it was liable to Hawkeye in any amount. A trial by jury was waived, and after hearing all the evidence, the court found that Mattson, Sr. had made a material misrepresentation in his application to Government Employees for the insurance policy and on November 3, 1965, rendered judgment in its behalf. We granted Hawkeye a writ of error.

In its assignments of error, Hawkeye asserts that the judgment appealed from was contrary to the law and the evidence and was without evidence to support it. The crucial issue presented in this appeal is whether the insurance policy issued to Mattson, Sr. by Government Employees was in full force and effect on August 18, 1962, the date Droughn was injured, or whether it was void *ab initio* because of an alleged material misrepresentation made by Mattson, Sr. in the procurement of the policy.

The record shows that Mattson, Sr. was insured under an automobile liability policy issued by State Farm Mutual Insurance Company from January 29, 1959, until it was canceled by the Company on August 5, 1959. Douglas R. Mays, an underwriter for State Farm, testified that the policy was canceled for "general underwriting reasons" and that Mattson, Sr. was notified of the Company's action by registered mail.

Thereafter, Mattson, Sr. obtained another policy from Home Indemnity Insurance Company which he retained until October 20, 1960 when he was issued the policy here involved by Government Employees. This policy was twice renewed with coverage extending through October 20, 1963. All premiums were duly paid.

Mattson, Sr. testified that he contacted Government Employees by mail for the insurance and was mailed an application for him to complete and return. Above the space for his signature and the questions to be answered the application read:

"I understand and agree that if the answers to questions 7, 8, 9 or 10, or any of them, are other than 'No,' the insurance requested will not be effective until approved by the Company. The Company agrees that ***if the true answers to questions 7, 8, 9 and 10 are 'No,' the insurance applied for will be effective as of: postmarked time and date * * *

"IMPORTANT- ISSUANCE OF A VALID POLICY IS DEPENDENT UPON YOUR TRUE ANSWERS."

We are here concerned only with question No. 7, which follows:

"7. Has any insurance company (including this Company) ever refused, cancelled, refused to renew, or given notice of intention to cancel or refuse, any automobile insurance for you or any member of your household? * * *. If 'yes,' see above (the quoted statement) (Give full information on separate sheet) "

The application which Mattson, Sr. admitted that he himself completed and signed, contained a "No" answer in response to question No. 7. * * *

Gerald T. Jackson, underwriting manager for Government Employees, testified that he had the responsibility of deciding whether a policy should or should not be issued by his Company to an applicant. He said that if question No. 7 had been answered "yes" without elaboration, the application of Mattson, Sr. would have been rejected; * * *

Jackson, on the other hand, testified that when an application contained a "No" answer to question No. 7, and the rest of the application showed no accidents or violations, the answer would be accepted as true and no investigation would be made.

Hawkeye concedes that the answer "No" to question No. 7 was untrue, but contends Government Employees did not clearly prove that such answer was material to the risk when assumed.

Code, 38.1-336 is applicable and provides:

"All statements, declarations and descriptions in any application for a policy of insurance * * * shall be deemed representations and not warranties, and no statement in such application * * * shall bar a recovery upon a policy of insurance * * * unless it be clearly proved that such answer or statement was material to the risk when | assumed and was untrue."

Whether a representation was made and the terms upon which it was made are factual questions for the jury, but when proved its materiality becomes a question for the court to decide. Materiality of a misrepresentation is an affirmative defense, and the burden is upon the insurer to prove it. [Citation.]

"A fact is material to the risk assumed by an insurance company if the fact would reasonably influence the company's decision whether or not to issue a policy." [Citations.] *Mutual of Omaha Ins. Co. v. Echols, et al.* Adm'rs, 207 Va. 949, 154 S.E. 2d 169, 172.

In *Inter-Ocean Ins. Co. v. Harkrader*, 193 Va. 96, 100, 101, 67 S.E.2d 894, 897, we said:

"Representations in an application for a policy of insurance should not only be true but full. The insurer has the right to know the whole truth. If a true disclosure is made, it is put on guard to make its own inquiries, and determine whether or not a risk should be assumed. A misstatement of material facts by the applicant takes away its opportunity to estimate the risk under its contract. A knowledge or ignorance of sub facts would naturally and reasonably influence the judgment of the insurer in making the contract or in establishing the degree or character of the risk or in fixing the rate of premium." (Citing cases.) [Citation.]

We have repeatedly held that under Code, § 38.1-336, supra, a

misrepresentation of a fact material to the risk when assumed renders an insurance contract void. [Citations.]

Here, Government Employees carried its burden of clearly proving that the untrue answer to question No. 7 in the application for insurance made by Mattson, Sr. was material to the risk when assumed. The uncontradicted testimony of Jackson, underwriting manager for Government Employees, owed that, if Mattson, Sr. had answered the question "yes" without elaboration, his application would have been rejected; and that, if such answer had been accompanied by an explanation, Mattson, Sr. would have been questioned further and an independent investigation might have been made before deciding to issue the policy. Jackson further testified that when an applicant states that no insurance company has ever refused, canceled etc. any automobile insurance for him or any member of his family, and the rest of the application shows no accidents or violations, the "No" answer to question No. 7 would be accepted as true without an investigation, as was the situation in the case Mattson, Sr.

Government Employees was entitled to know the whole truth. The false answer ("No") to question No. 7 caused the company to forego an opportunity to investigate why the State Farm policy was cancelled and to determine whether or not the risk be assumed as well as the premium rate applicable to the risk in the event the policy was issued. [Citation.]

Hawkeye argues that because Government employees showed only that State Farm cancelled the policy issued to Mattson, Sr. "general underwriting reasons" and did not show the precise reason therefore, it failed to clearly prove that the misrepresentation was material to the risk assumed by Government Employees. We find this contention to be without substance.

Under the evidence adduced, the trial court properly held that the misrepresentation was material to the risk when assumed and that the policy was null and void *ab initio* for that reason.

Accordingly, the judgment appealed from is Affirmed.

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SOMMER v. METROPOLITAN LIFE INSURANCE COMPANY

(1967 Mo.) 449 S.W.2d 644.

FINCH, J. Plaintiff, the beneficiary in two life insurance policies which provided additional benefits in the event of death by accidental means, brought suit thereon, claiming her husband died as a result of an accident. Trial before the court without a jury resulted in a judgment for \$3,325.00 (\$1,000.00 principal, \$312.50 interest, \$100.00 penalty, and \$250.00 attorney's fees on each policy). Defendant appealed to the St. Louis Court of Appeals, which reversed. * * * We reverse and remand with directions to enter judgment for the accidental death benefit, plus interest, on each policy.

The facts are simple and were stipulated. Insured died December 6, 1961, as the result of a self-inflicted gunshot wound in the head. At the time of death, he had lost contact with reality (a mental infirmity), which was stipulated to be

insanity. The parties also stipulated that if insured had not lost contact with reality, he would not have taken his life.

It has been held that the taking of one's own life while insane is an accident. [Citation.] Hence, the insured died as the result of an accident and his death is covered by the policies unless excluded by some permissible policy provision.

The accidental death provision in the first policy sued upon is as follows:

"Accidental Means Death Benefit—The Company promises to pay to the Beneficiary under this Policy, in addition to the amount otherwise payable according to the terms of this Policy, an additional sum equal to the Amount of Insurance shown on page 1, upon receipt at the Home Office of due proof of the death of the Insured, while this provision is in effect, as the result, directly and independently of all other causes, of bodily injuries caused solely by external, violent, and accidental means, and that such death shall not have occurred (a) more than 90 days after the date of such injuries, or (b) as the result of or by the contribution of disease or bodily or mental infirmity or medical or surgical treatment therefore or infection of any nature unless such infection is incurred through an external visible wound sustained through violent and accidental means, or (c) as the result of self-destruction, whether sane or insane, or (d) as the result of travel or flight on any species of aircraft except as a fare-paying passenger on a regularly scheduled passenger flight of a commercial aircraft, or (e) as a result of participating in or attempting to commit an assault, or (f) while the Insured is in the military, naval, or air forces of any country at war."

The comparable provision in the other policy sued upon varied slightly in terminology, but exclusion (b), with which we are concerned in this case, was identical with (b) in the provision quoted above.

It is clear that the producing cause of insured's death was a gunshot wound in the head, a nonexcluded cause of death under the terms of the policies. Nevertheless, it is defendant's position that insured's mental infirmity (insanity) contributed to cause his death, so as to make exclusion (b) applicable. Obviously, this mental infirmity entered into what occurred only in that it affected the functioning of insured's mind, moving him to decide to take his own life. We must determine, therefore, whether death by self inflicted gunshot wounds, the decision to inflict which was induced by insured's insanity, is eliminated from coverage by exclusion (b) of the policies.

This question has been considered previously, with differing results, by the Kansas City and the St. Louis Courts of Appeal. In *Spillman v. Kansas City Life Ins. Co.*, 238 Mo.App. 419, 180 S.W.2d 605, decided by the Kansas City Court of Appeals, recovery under the accidental death provisions of an insurance policy was sought on account of the death of the insured from a self-inflicted gunshot wound. The policy sued upon contained an exclusionary provision which provided "that there shall be no liability here under for death resulting from self-destruction, while sane or insane, * * * or directly or indirectly, wholly or in part, from * * * any kind of illness, disease or infirmity, * * * ". Testimony was presented that insanity is a mental illness or disease, and the insurance company argued that since insured would not have taken his life except for the disease of insanity from which he suffered, his death was due, indirectly at least, to illness. In affirming a judgment for plaintiff, the opinion held that the law would not go back in the line of causation further than to find

the active, efficient, procuring cause of death, which was determined to have been the gunshot wound. The court also concluded that to construe the exclusion otherwise would be to disregard the provisions of Missouri's so-called suicide statute, then § 5851, RSMo 1939, but now designated as § 376.620, (all references are to RSMo 1959, V.A.M.S., unless otherwise indicated).

The question next arose in the St. Louis Court of Appeals in *Kaskowitz v. Aetna Life Ins. Co.*, Mo.App., 316 S.W.2d 132. In that case the insured committed suicide by jumping from the sixth story window of an office building. The policy contained the following exclusions from coverage: "(a) Resulting from suicide or any attempt thereat while sane or insane; (b) Resulting directly or indirectly, wholly or partly, from bodily or mental infirmity * * * even though the proximate or precipitating cause of death is accidental bodily injury; * * * ." The defense pleaded was that insured's death resulted from suicide while he was afflicted with a mental infirmity or disease and hence the death was excluded from coverage. The court, while recognizing that § 376.620 makes void any clause excepting liability for suicide while insane, nevertheless denied recovery, saying, 1. c. 137: "In the case at bar the policy excludes all accidental deaths resulting from mental infirmity. Thus, where an insane person, by reason of his insanity, places himself in a dangerous situation and as a result of that act suffers an accidental death, no recovery can be had." On this basis, the court concluded that the case was not governed by § 376.620.

In *Jeppert v. John Hancock Mutual Life Ins. Co.*, Mo.App., 347 S.W.2d 436, the insured, while insane, hanged himself. The policy provided for nonliability if death resulted directly or indirectly from bodily or mental disease or infirmity. The trial court ruled for defendant on motion for summary judgment, holding that insured met his death indirectly or in part from mental diseases or infirmities. The St. Louis Court of Appeals, citing *Kaskowitz*, affirmed, saying, 1. c. 446: "It is clear from the evidence that insured's mental infirmity was the condition which brought about the final result, namely, the death of the insured, and was the proximate cause thereof as that term is understood in the law."

Defendant, for its defense in this case, also relies on the mental defect of insanity of insured which caused him to shoot himself. However, in asserting that defense, it does not rely upon exclusion (c) in the policies which specifically excluded from coverage any accidental death resulting from self-destruction while insane. Defendant's brief pointedly states that it does not rely on (c). This is understandable because the general assembly, by the enactment of § 376.620, has declared it to be the public policy of this state that an insurance company may not provide for nonliability on the basis that an insured committed suicide while insane.

The question, then, is whether exclusion (b), on which defendant does rely, permits it to escape liability on the ground that insured committed suicide while insane, even though it may not do so under exclusion (c). We hold that it may not. The words referring to death "as the result of or by the contribution of disease or bodily or mental infirmity" which appear in (b) have reference to instances in which "disease or bodily or mental infirmity" is a producing cause of death. To construe the exclusion as applying also to insanity of an insured which merely induces him to commit suicide would mean that the exclusion "goes not to the *means* of death, but to the very *condition* on which all recovery for suicide under an accident policy is based, i. e., mental disease

and infirmity." 2 So construed, any insurance company, merely by inserting exclusion (b) or a clause substantially similar, could and would completely nullify § 376.620 and thereby defeat the declared public policy of this state. This they may not do.

In so far as they are inconsistent with this opinion, *Kaskowitz v. Aetna Life Ins. Co.*, Mo.App., 316 S.W.2d 132, and *leppert v. John Hancock Mutual Life Ins. Co.*, Mo.App., 347 S.W.2d 436, no longer should be followed.

[Reversed and remanded with directions.]

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Government Regulation and Control of the Insurance Business

As discussed in the beginning of the text, since the New York Armstrong Committee investigations of 1905-1906, the insurance business is now a heavily regulated industry with the dual purpose of promoting fair business practices and maintaining insurer solvency. Insurance law is thus a hybrid mixture of private contractual law and state statutory law which seeks to control the substantive terms of the insurance policy so that the insured may enter into a fair and equitable contract.

Accordingly, various "standard" statutory policy forms have been enacted at the insistence of the National Association of Insurance Commissioners (NAIC) in an attempt to bring certainty and uniformity into state statutory and regulatory practices, and efforts towards standardization have been successful to the extent that "standard" fire insurance policies and "standard" accident and sickness insurance policies in most states are now wholly mandated by statute. Life insurance and automobile liability insurance provisions are also largely controlled by state statutory law. If any conflict exists between the contractual provisions in an insurance policy and state statutory requirements, the statute prevails. In fact, state regulation of the insurance business is so well established that in *California State Auto. Ass'n v. Maloney*, 341 U.S. 105, 71 S. Ct. 601, 95 L. Ed. 788 (1951), the United States Supreme Court held that the individual states could arguably take over the entire insurance business, leaving no part to private insurance companies. Moreover, after the passage in 1947 of Section 2(b) of the federal McCarran-Ferguson Act [15 U.S.C. § 1011 *et seq.*], which mandates that federal regulation "shall be applicable to the business of insurance to the extent that such business is not regulated by State law," the insurance industry appears more willing to be subject to existing state regulation rather than to face the possibility of greater federal control.

Within this state statutory framework, domestic, foreign, and alien insurance companies are also administratively regulated by state insurance departments through their insurance commissioners or superintendents by virtue of authority delegated by the state legislature. Such departments are responsible for licensing or delicensing insurance companies and their agents; approving or disapproving insurance policy forms and rates; and periodically examining the insurers to ensure solvency and compliance with applicable state law. But an insurance commissioner is a ministerial officer, and possesses only such powers as state statute confers upon him.

There follows selected examples of governmental control over the insurance industry, and demonstrates how the private contractual relationship between the insured and the insurer is often largely controlled and regulated by public

statutory and administrative law.

The Individual State's Power to Regulate

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The ability of a political subdivision of the United States to set rules for the insurance industry

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SILVER v. GARCIA

SILVER v. GARCIA

United States Court of Appeals, First Circuit
760 F.2d 33 (1985)
Bownes, Circuit Judge.

This action presents a constitutional challenge to a Puerto Rican statute which requires applicants for an insurance consultant's license to have resided in Puerto Rico for one year prior to application. The plaintiffs below, Leonard J. Silver and Alvin E. Mangold, were denied insurance consultants' licenses on the basis of this residency requirement, and brought suit against the Commissioner of Insurance and Secretary of Justice of the Commonwealth of Puerto Rico claiming that the residency requirement abridged the privileges and immunities of citizenship guaranteed in Article IV of the United States Constitution. The district court agreed and enjoined the enforcement of the residency requirement. We affirm.

Silver and Mangold are residents of Pennsylvania, where they have owned and operated an insurance consulting business, First Risk Management Company, since 1956. Silver and Mangold act strictly as advisors, evaluating the liability, property and marine risks of clients and recommending management and operations changes designed to minimize such risks. These recommendations may include modification of insurance coverage. From time to time, they engage in negotiations, accompanied by their clients, with insurance brokers and companies concerning the terms and costs of policies. As independent risk consultants, Silver and Mangold do not maintain any business relationship with insurance companies, brokers, or agents and do not sell insurance either directly or indirectly. They receive no commissions from insurance companies, brokers, or agents for their services, but are compensated by their clients at an hourly rate for consulting services received.

Both Silver and Mangold possess extensive experience in the insurance consulting field. They have represented clients worldwide and in more than two dozen states. Both have passed the examination and fulfilled the experience, character, and ethics requirements to obtain the highest professional designation in their field, that of Charter Property Casualty Underwriter from the American Institute of Property and Liability Underwriters, Inc. In addition, both have earned the Associate in Risk Management degree awarded by the Insurance Institute of America. Silver has written extensively in the field of risk management and is a founding member and past president of the Insurance Consultants' Society. Mangold has served terms as vice-president and treasurer of the Insurance Consultants' Society. The Insurance Consultants' Society is one of two professional organizations in the risk consultant field and its members consist solely of independent consultants who, as a matter of professional ethics, maintain no relationship or affiliation with insurance companies, agents, or brokers.

In 1963, Mangold and Silver established First Insurance Management (P.R.)

Inc. in Puerto Rico. The name has since been changed to First Risk Management (P.R.) Inc. In 1963 there was no licensing requirement for insurance consultants. However, in 1974, the Insurance Code of Puerto Rico was amended to require licensure of "insurance consultants." Six requirements for such a license were set out.

Every applicant for an insurance consultant license shall meet the following requirements:

- (1) Must have resided de facto in Puerto Rico and must have been a bona fide resident of Puerto Rico for at least one year immediately preceding the date on which license is applied for.
- (2) Must be worthy of trust and competent and must comply in other respects with section 907 of this title.
- (3) Must have satisfactorily passed any examination required under section 911 of this title.
- (4) Must have at least five years of experience as an insurance adjuster or insurance broker with regard to the kinds of annuity or insurance to be covered by the license. Must have also the special training and additional experience necessary to fulfill the responsibilities of a consultant.
- (5) Must post the bond required from a consultant by section 924d of this title.
- (6) Must not be stockholder, member, partner, agent or employee of any insurer or agent who is authorized to engage in or is engaged in the insurance business in Puerto Rico, or who has economic or financial interest or a contractual relationship in the insurance field with any authorized insurer or agent, except as a policyholder. Provided, that if an insurance consultant is also a broker, he may not act as a broker in regard to any insurance policy, contract or coverage involved in or produced by the advice, counsel, recommendation or information given to his client in his role as insurance consultant, nor may he receive commissions on account of said policy or contract.

The application for a license shall be made on the form furnished by the Commissioner. The license fees shall be two hundred (200) dollars a year.

Upon request of any government instrumentality, the Commissioner may issue provisional licenses, exempting them from requirements one, three, four, five and from the payment of fees.

P.R. Laws Ann. tit. 26, § 924a (1976 and Supp.1983). The bond required under this provision was set at \$10,000. *Id.* at § 924d.

Between 1974 and 1978, Silver and Mangold made several attempts to obtain insurance consultants' licenses, submitting application forms and detailed descriptions of their qualifications and experience. They also indicated a willingness to post the required bond. In August of 1978, the Commissioner formally denied Silver's request for a license on the basis that he did not meet the residency requirement. In August of 1982, the Commissioner of Insurance issued an order stating that First Risk (P.R.) and its officials were to immediately cease and desist "from acting as insurance consultants in Puerto Rico until the persons acting on its behalf obtain an insurance consultants' license...." and a copy of the order was sent to First Risk's Puerto Rican

clients. In December of 1982, Silver and Mangold reapplied for licenses, but were once again turned down because they had not fulfilled the residency requirements.

Suit was filed in the United States District Court for the District of Puerto Rico. The case was decided on cross-motions for summary judgment. Under the Puerto Rican Federal Relations Act, "the rights, privileges, and immunities of citizens of the United States shall be respected in Puerto Rico to the same extent as though Puerto Rico were a State of the Union and subject to the provisions of paragraph 1 of section 2 of article IV of the Constitution of the United States." 48 U.S.C. § 737 (1982). The district court found that since one of the fundamental rights protected under the privileges and immunities clause is "the right of a citizen of one state to pass through, or to reside in any other state, for purposes of . . . professional pursuits, . . ." Puerto Rico's refusal to issue a license to either Silver or Mangold implicated a fundamental right. Applying the analysis set out in *Hicklin v. Orbeck*, 437 U.S. 518, 98 S. Ct. 2482, 57 L. Ed. 2d 397 (1978), the district court found that Puerto Rico could not show that the discrimination imposed by the residency requirement fell within the limits permitted by the Constitution, holding that nonresidents do not constitute a peculiar source of the evil at which the statute was aimed and the discriminatory means does not bear a substantial relationship to the evil it was meant to prevent.

We find the analysis provided by the district court to be entirely accurate. "[T]he Privileges and Immunities Clause was intended to create a national economic union." The privileges and immunities clause encourages a national economy by allowing persons to cross state lines freely in pursuit of economic gain.... There can be no doubt that insurance and occupations in the insurance industry are important to the national economy. Consequently, the ability of a citizen of one state to act as an insurance consultant in another state must be considered a fundamental right or privilege protected by the privileges and immunities clause.

The Commissioner of Insurance argues, however, that occupations in the insurance industry should not be considered to be protected by the privileges and immunities clause. He points to the fact that the field of insurance has long been recognized as a proper subject for extensive state regulation because of its critical role in the protection of local personal and property interests.... Furthermore, with the enactment of the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015 (1982),

"Congress removed all commerce clause limitations on the authority of the States to regulate and tax the business of insurance." . . . This act, which permitted the states to enact discriminatory insurance taxes and regulations which would otherwise have violated the dormant aspect of the commerce clause, was found to be a valid exercise of Congress's power under the commerce clause. The Commissioner then points to the common origin of both the commerce clause and the privileges and immunities clause in the Articles of Confederation, and their shared purpose of fusing the several states into one nation. He argues that if the privileges and immunities clause is construed to prohibit discriminatory treatment of nonresidents in the insurance occupations, this would bring it into direct conflict with Congress' power to permit such discrimination under the commerce clause. Such a conflict, the Commissioner argues, is particularly sharp where the two clauses are viewed as sharing a common goal.

The McCarran-Ferguson Act, which expressly authorized state regulation of "the business of insurance, and every person engaged therein," is a prime example of congressional legislation which authorizes state action which might otherwise have been considered to interfere with interstate commerce. This does not mean, however, that Congress meant to authorize state action which might violate the Constitution in other ways.

Nor is it necessary to conclude that Congress, by enacting the McCarran Act, sought to validate every existing state regulation or tax. For in all that mass of legislation must have lain some provisions which may have been subject to serious question on the score of other constitutional limitations in addition to commerce clause objections arising in the dormancy of Congress' power. And we agree with Prudential that there can be no inference that Congress intended to circumvent constitutional limitations upon its own power.

In any event, even if it intends to do so, Congress cannot legislate away protections provided by the Constitution. Therefore, while the McCarran-Ferguson Act may protect discriminatory state legislation from attack under the commerce clause, it cannot shield such legislation from attack under the privileges and immunities clause. Our conclusion that the opportunity to act as an insurance consultant is a "fundamental right" protected by the privileges and immunities clause is, therefore, unaffected by the insurance industry's status under the commerce clause.

However, the fact that an activity is a "fundamental right" does not, in itself, prevent states from regulating the activity in a manner which discriminates against nonresidents; "like many other constitutional provisions, the privileges and immunities clause is not an absolute." Discrimination against nonresidents is permitted where there is a substantial reason for the difference in treatment; and (ii) the discrimination practiced against nonresidents bears a substantial relationship to the State's objective.... In deciding whether the discrimination bears a close or substantial relationship to the State's objective, the Court has considered the availability of less restrictive means.

We now consider the reasons offered by the Commissioner to justify a one-year residency requirement for the practice of insurance consulting.

The legislative history of the Puerto Rican insurance code suggests only that the purpose of the code was to protect the "insurance consumer public." Committees on Consumer Affairs and Civil Law, Joint Report to the House of Representatives of Puerto Rico of 1974, 7th Assembly, 2d Sess. 5 (1974). In his brief, the Commissioner of Insurance has suggested that the legislature was primarily concerned with ensuring that insurance consultants be trustworthy and competent. He suggests that the residency requirement was chosen in light of Puerto Rico's geographic isolation from the continental United States and its limited economic resources. By requiring that insurance professionals reside in Puerto Rico for one year prior to licensing, investigations into the trustworthiness and competence of the candidates could presumably be confined to Puerto Rico, thereby making them easier to complete and less expensive. The Commissioner also suggests that the residency requirement makes it possible to make periodic checks on the practice of licensed insurance consultants, thereby maintaining the standards of trustworthiness and competence.

Even had we found that nonresidents were a unique source of problems which Puerto Rico might legitimately address, the discriminatory means chosen by the Commonwealth to address these problems must "bear a substantial relationship" to the Commonwealth's objective. The one-year residency requirement cannot satisfy this standard. As we have already seen, in order to do a good job of investigating the trustworthiness and competence of candidates for insurance consultants' licenses, the Commissioner must investigate the candidates' prior work background. Since one of the other requirements for an insurance consultant's license is at least five years of experience as an insurance adjuster or broker, even nonresidents who become residents by living in Puerto Rico for a year will have extensive out-of-state insurance experience. Furthermore, by barring these new residents from practicing as insurance consultants during the one-year period, there can be no record of practice to investigate in Puerto Rico at all. As a result, the one-year residency requirement does not succeed in reducing the burden of investigation at all.

We conclude that the requirement that applicants for an insurance consultant's license reside in Puerto Rico for at least one year prior to the date of application violates Art. IV, § 2 of the United States Constitution. The opportunity to work as an insurance consultant is a "fundamental privilege" protected by the privileges and immunities clause and Puerto Rico has not offered substantial reasons for its discriminatory treatment of nonresident insurance consultants, nor has it shown a substantial relationship between these reasons and its discriminatory treatment of nonresidents. The opinion of the district court is affirmed.

The states can regulate insurance and all aspects associated with the industry. But the scope of regulation extends to other facets of the business. Exactly what is insurance under the law can be open to debate. "If it walks like a duck, quacks like a duck, looks like a duck, then it's a duck," as the old saying goes. Business transactions brought under the wing of state regulation are varied. Often a legal decision is required to determine the reach of statutory provisions.

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**What Constitutes
"Insurance" for
Regulatory Purposes****UNITED HEALTHCARE
BENEFITS TRUST v.
INSURANCE
COMMISSIONER OF
PENNSYLVANIA**

An Issue Addressing that which Constitutes "Insurance" for Regulatory Purposes

**UNITED HEALTHCARE BENEFITS TRUST v. INSURANCE
COMMISSIONER OF PENNSYLVANIA**

*Pennsylvania Commonwealth Court
620 A.2d 81 (1993)
Pelligrini, Judge*

United Healthcare Benefits Trust, United Association of Small Business, Inc., United Health Insurance Administrators, Hameed Ullah, Small Business Insurance Services, and Nonnie Maria Bryan appeal the grant of summary judgment to the Insurance Department by a final order of the Deputy Insurance Commissioner.

United Healthcare Benefits Trust (trust) is a foreign trust which is not a licensed insurer in Pennsylvania. United Association of Small Business, Inc. (UASB) is a corporation organized under the laws of the State of California whose members include small businesses employing fewer than 500 employees and who are eligible for health benefits coverage for their employees under the trust. United Health Insurance Administrators (UHIA) administers the trust health benefits. Hameed Ullah and Nonnie Maria Bryan are individuals, who are employed, respectively, by the Small Business Insurance Services and UHIA. None of the Petitioners (collectively referred to as "United") are licensed to transact the business of insurance in Pennsylvania.

The Insurance Commission (Commission) instituted a proceeding against United by issuing an Order to Show Cause on April 17, 1991. The Commission alleged that the trust was doing the business of insurance within the Commonwealth of Pennsylvania without a license (*i.e.*, a certificate of authority), and that the other defendants were acting as agents of the trust in the insurance business and were, therefore, in violation of Section 208 of the Insurance Department Act of 1921 (Insurance Act)¹ § 46.

The Commission alleged two instances of unlicensed insurance activity: (1) the sale of a health insurance package to G.D.S. Systems, including the collection of premiums to the trust and the payment of claims by UHIA, and, (2) the sale of a health insurance package to Martin's Auto Body. United filed a timely answer to the Order to Show Cause denying that they do insurance business within the Commonwealth and are covered by the Insurance Act.²

The Commission filed a Motion for Summary Judgment contending that the facts were undisputed that United was doing the business of insurance in the Commonwealth without a license. The Deputy Insurance Commissioner

reviewed the motion after briefs were filed by the parties. The Deputy Commissioner granted the Motion for Summary Judgment, finding that no facts were in dispute. The Deputy Commissioner held that the trust was subject to the Department's regulation³ and that it was acting as an unlicensed insurer in violation of Section 208. The Deputy Insurance Commissioner also found that UASB, UHIA, Small Business Insurance Services, Hameed Ullah and Nonnie Maria Bryan acted as agents for an unlicensed insurer in violation of Section 208 of the Insurance Act, and ordered that pursuant to Section 209 of the Insurance Act, 40 P.S. § 47, each of the Petitioners pay a civil penalty of \$10,000 per instance of unlicensed activity, totaling \$120,000. United then filed this appeal.

United presents three issues on appeal: (1) the Deputy Commissioner acted in violation of the Administrative Agency Law in granting summary judgment because an evidentiary hearing was not held, (2) the Deputy Commissioner lacked subject matter jurisdiction because the Insurance Act does not extend to foreign trusts, and, (3) the imposition of \$120,000 in civil penalties was not supported by substantial evidence and was an abuse of discretion.

I.

While 2 Pa. C.S. § 504 mandates that a party receive an opportunity to be heard, that opportunity does not require the equivalent of an evidentiary hearing. This court has held that where no factual issues are in dispute, no evidentiary hearing is required under 2 Pa. C.S. § 504....

II.

United next contends that the Insurance Department lacks subject matter jurisdiction because it is a foreign trust that is not subject to Section 208 of the Insurance Act. United argues that Section 208 applies exclusively to an "insurance company, association, or exchange" which are defined terms in Section 101 of the Insurance Act, 40 P.S. § 21, and because those defined terms do not include foreign trusts, the statute does not apply to it.

In Section 208, the legislature established that an organization transacting insurance within the Commonwealth must be licensed by the Insurance Department. The statute expressly applies to those foreign organizations "doing the business of insurance" within the Commonwealth and their agents. Subsection b of Section 208 defines doing the business of insurance as:

- (1) the issuance or delivery of contracts of insurance to persons resident in this Commonwealth, or
- (2) the solicitation of applications for such contracts, or other negotiations preliminary to execution of such contracts, or
- (3) the collection of premiums, membership fees, assessments or other consideration for such contracts, or
- (4) the transaction of matters subsequent to execution of such contracts and arising out of them.

United admittedly is not licensed to transact insurance in the Commonwealth. Without regard for licensing requirements, United solicited members of UASB with written information concerning health benefits; issued G.D.S. Systems

and Martin's Auto Body health benefits insurance policies, collected membership fees and premiums, and paid claims under the policy. These activities fall squarely within the activities defined as "doing the business of insurance." Consequently, the Deputy Commissioner did not err in concluding that United was doing the business of insurance in the Commonwealth in violation of Section 208.

United argues that even if it is doing the business of insurance within the Commonwealth, it is not subject to the jurisdiction of the Insurance Department because it was structured as a trust and is not an insurance company as defined in Section 101. United's argument ignores the interaction between the trust, UHIA, and UASB, which work in concert to solicit its members, contract for health insurance benefits, and administer those insurance benefits. As a group, the enterprise's actions are those of an insurance company which would fit within the definition in Section 101, regardless of the incorporation of the trust as a separate entity....

Accordingly, we affirm the order of the Deputy Commissioner except that we vacate that portion of the order concerning civil penalties on the individual Petitioners and we remand for specific findings on which to base those civil penalties.

¹Section 208 of The Insurance Act of 1921, provides: No insurance company, association or exchange of another state or foreign government shall do an insurance business within this Commonwealth without first having obtained a certificate of authority from the Insurance Commissioner authorizing such company, association or exchange to do such business.

² United also filed a Motion to Dismiss contending that the trust was organized under the Employee Retirement Income Security Act of 1974 (ERISA) and, therefore, United was preempted from state regulation. After the parties briefed the issue, the Hearing Officer denied the motion.

³ The Deputy Commissioner held that state regulation was proper because, even if United was an ERISA organization, it was excluded from ERISA preemption under 29 U.S.C. § 1144(b)(6)(A)(ii) as a not fully insured "multi-employer welfare arrangement." United did not appeal the issue of ERISA preemption.

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From the case above, it can be seen that there is no quick and easy definition as to what constitutes an insurance contract. In the financial sense, insurance is a financial arrangement that redistributes the costs of unexpected losses. It transfers many different exposures to loss to one insurance pool, which combines the numerous exposures. Others may give an economic definition of insurance. Insurers pay compensation in certain eventualities like fire, death, or accident. It spreads risk, so that loss by an individual is compensated for at the expense of all those who insure against it.

Either way, the legal concept of "insurance" will be determined by statutory and case law and for that reason it is important to understand how these decisions are reasoned by the courts. In the same vein, the constant tug-of-war between state and federal regulation is an ongoing process subject to political pressures and the opinions of whoever is on the bench at the time a decision is reached by the court.

Federal versus State Regulation

UNITED STATES DEPARTMENT OF TREASURY v. FABE

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UNITED STATES DEPARTMENT OF TREASURY v. FABE

United States Supreme Court

—U.S.—, 113 5. Ct. 2202 (1993)

JUSTICE BLACKMUN delivered the opinion of the Court.

The federal priority statute, 31 U.S.C. § 3713, accords first priority to the United States with respect to a bankrupt debtor's obligations. An Ohio statute confers only fifth priority upon claims of the United States in proceedings to liquidate an insolvent insurance company. Ohio Rev. Code Ann. § 3903.42 (1989). The federal priority statute pre-empts the inconsistent Ohio law unless the latter is exempt from preemption under the McCarran-Ferguson Act, 59 Stat. 33, as amended, 15 U.S.C. § 1011 et seq. In order to resolve this case, we must decide whether a state statute establishing the priority of creditors' claims in a proceeding to liquidate an insolvent insurance company is a law enacted "for the purpose of regulating the business of insurance," within the meaning of § 2(b) of the McCarran-Ferguson Act, 15 U.S.C. § 1012(b).

We hold that the Ohio priority statute escapes pre-emption to the extent that it protects policyholders. Accordingly, Ohio may effectively afford priority, over claims of the United States, to the insurance claims of policyholders and to the costs and expenses of administering the liquidation. But when Ohio attempts to rank other categories of claims above those pressed by the United States, it is not free from federal pre-emption under the McCarran-Ferguson Act.

The Ohio priority statute was enacted as part of a complex and specialized administrative structure for the regulation of insurance companies from inception to dissolution. The statute proclaims, as its purpose, "the protection of the interests of insureds, claimants, creditors, and the public generally." § 3903.02(D). Chapter 3903 broadly empowers the State's Superintendent of Insurance to place a financially impaired insurance company under his supervision, or into rehabilitation, or into liquidation. The last is authorized when the Superintendent finds that the insurer is insolvent, that placement in supervision or rehabilitation would be futile, and that "further transaction of business would be hazardous, financially or otherwise, to [the insurer's] policyholders, its creditors, or the public." § 3903.17(C). As liquidator, the Superintendent is entitled to take title to all assets, § 3903.18(A); to collect and invest moneys due the insurer, § 3903.21(A)(6); to continue to prosecute and commence in the name of the insurer any and all suits and other legal proceedings, § 3903.21(A)(12); to collect reinsurance and unearned premiums due the insurer, §§ 3903.32 and 3903.33; to evaluate all claims against the estate, § 3903.43; and to make payments to claimants to the extent possible, § 3903.44. It seems fair to say that the effect of all this is to empower the liquidator to continue to operate the insurance company in all ways but one—the issuance of new policies.

Pursuant to this statutory framework, the Court of Common Pleas for Franklin County, Ohio, on April 30, 1986, declared American Druggists' Insurance Company insolvent. The court directed that the company be liquidated, and it appointed respondent, Ohio's Superintendent of Insurance, to serve as liquidator. The United States, as obligee on various immigration, appearance, performance, and payment bonds issued by the company as surety, filed claims in excess of \$10.7 million in the state liquidation proceedings. The United States asserted that its claims were entitled to first priority under the federal statute, 31 U.S.C. § 3713(a)(1)(A)(iii), which provides: "A claim of the United States Government shall be paid first when . . . a person indebted to the Government is insolvent and . . . an act of bankruptcy is committed."

Respondent Superintendent brought a declaratory judgment action in the United States District Court for the Southern District of Ohio seeking to establish that the federal priority statute does not pre-empt the Ohio law designating the priority of creditors' claims in insurance-liquidation proceedings. Under the Ohio statute, as noted above, claims of federal, state, and local governments are entitled only to fifth priority, ranking behind (1) administrative expenses, (2) specified wage claims, (3) policyholders' claims, and (4) claims of general creditors. § 3903.42. Respondent argued that the Ohio priority scheme, rather than the federal priority statute, governs the priority of claims of the United States because it falls within the anti-preemption provisions of the McCarran-Ferguson Act, 15 U.S.C. § 1012.'

The District Court granted summary judgment for the United States. Relying upon the tripartite standard for divining what constitutes the "business of insurance," as articulated in *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 102 S. Ct. 3002, 73 L. Ed.2d 647 (1982), the court considered three factors: first, whether the practice has the effect of transferring or spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry. Reasoning that the liquidation of an insolvent insurer possesses none of these attributes, the court concluded that the Ohio priority statute does not involve the "business of insurance."

A divided Court of Appeals reversed. 939 F.2d 341 (CA6 1991). The court held that the Ohio priority scheme regulates the "business of insurance" because it protects the interests of the insured. Applying *Pireno*, the court determined that the Ohio statute (1) transfers and spreads the risk of insurer insolvency; (2) involves an integral part of the policy relationship because it is designed to maintain the reliability of the insurance contract; and (3) focuses upon the protection of policyholders by diverting the scarce resources of the liquidating entity away from other creditors.

Relying upon the same test to reach a different result, one judge dissented. He reasoned that the liquidation of insolvent insurers is not a part of the "business of insurance" because it (1) has nothing to do with the transfer of risk between insurer and insured that is effected by means of the insurance contract and that is complete at the time the contract is entered; (2) does not address the relationship between insurer and the insured, but the relationship among those left at the demise of the insurer; and (3) is not confined to policyholders, but governs the rights of all creditors.

We granted *certiorari*,—U.S.—, 112 S. Ct. 1934, 118 L. Ed. 2d 541 (1992), to

resolve the conflict among the Courts of Appeals on the question whether a state statute governing the priority of claims against an insolvent insurer is a "law enacted . . . for the purpose of regulating the business of insurance," within the meaning of § 2(b) of the McCarran-Ferguson Act.

II.

The McCarran-Ferguson Act was enacted in response to this Court's decision in *United States v. South-Eastern Underwriters Ass'n*, 322 U.S. 533, 64 S. Ct. 1162, 88 L. Ed. 1440 (1944). Prior to that decision, it had been assumed that "issuing a policy of insurance is not a transaction of commerce." *Paul v. Virginia*, 75 U.S. (8 Wall.) 168, 183, 19 L. Ed. 357 (1869), subject to federal regulation. Accordingly, "the States enjoyed a virtually exclusive domain over the insurance industry." . . .

The emergence of an interconnected and interdependent national economy, however, prompted a more expansive jurisprudential image of interstate commerce. . . . Thus, in *South-Eastern Underwriters*, it held that an insurance company that conducted a substantial part of its business across state lines was engaged in interstate commerce and thereby was subject to the antitrust laws. This result, naturally, was widely perceived as a threat to state power to tax and regulate the insurance industry. To allay those fears, Congress moved quickly to restore the supremacy of the States in the realm of insurance regulation. It enacted the McCarran-Ferguson Act within a year of the decision in *South-Eastern Underwriters*.

The first section of the McCarran-Ferguson Act makes its mission very clear: "Congress hereby declares that the continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States." Shortly after passage of the Act, the Court observed: "Obviously Congress' purpose was broadly to give support to the existing and future state systems for regulating and taxing the business of insurance." *Prudential Ins. Co. v. Benjamin*, 328 U.S. 408, 429, 66 S. Ct. 1142, 1154, 90 L. Ed. 1342 (1946). Congress achieved this purpose in two ways. The first "was by removing obstructions which might be thought to flow from [Congress'] own power, whether dormant or exercised, except as otherwise expressly provided in the Act itself or in future legislation." The second "was by declaring expressly and affirmatively that continued state regulation and taxation of this business is in the public interest and that the business and all who engage in it 'shall be subject to' the laws of the several states in these respects."

III.

"[T]he starting point in a case involving construction of the McCarran-Ferguson Act, like the starting point in any case involving the meaning of a statute, is the language of the statute itself." *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 210, 99 S. Ct. 1067, 1072, 59 L. Ed. 2d 261 (1979). Section 2(b) of the McCarran-Ferguson Act provides: "No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance... unless such Act specifically relates to the business of insurance." The parties agree that application of the federal priority statute would "invalidate, impair, or supersede" the Ohio priority scheme and that the federal priority statute does not "specifically relate to the business of insurance." All that is left for us to determine, therefore, is whether the Ohio priority statute is a law enacted "for

the purpose of regulating the business of insurance."

This Court has had occasion to construe this phrase only once. On that occasion, it observed: "Statutes aimed at protecting or regulating this relationship [between insurer and insured], directly or indirectly, are laws regulating the 'business of insurance,' " within the meaning of the phrase. *SEC v. National Securities, Inc.*, 393 U.S. 453, 460, 89 S. Ct. 564, 568, 21 L. Ed. 2d 668 (1969). The opinion emphasized that the focus of McCarran-Ferguson is upon the relationship between the insurance company and its policyholders:

The relationship between insurer and insured, the type of policy which could be issued, its reliability, interpretation, and enforcement—these were the core of the "business of insurance." Undoubtedly, other activities of insurance companies relate so closely to their status as reliable insurers that they too must be placed in the same class. But whatever the exact scope of the statutory term, it is clear where the focus was—it was on the relationship between the insurance company and the policyholder. *Id.*

In that case, two Arizona insurance companies merged and received approval from the Arizona Director of Insurance, as required by state law. The Securities and Exchange Commission sued to rescind the merger, alleging that the merger solicitation papers contained material misstatements, in violation of federal law. This Court held that, insofar as the Arizona law was an attempt to protect the interests of an insurance company's shareholders, it did not fall within the scope of the McCarran-Ferguson Act. *Id.* The Arizona statute, however, also required the Director, before granting approval; to make sure that the proposed merger "would not 'substantially reduce the security of and service to be rendered to policyholders.'" The Court observed that this section of the statute "clearly relates to the 'business of insurance.'" *Id.* But because the "paramount federal interest in protecting shareholders [was] perfectly compatible with the paramount state interest in protecting policyholders," the Arizona statute did not preclude application of the federal securities laws.

In the present case, on the other hand, there is a direct conflict between the federal priority statute and Ohio law. Under the terms of the McCarran-Ferguson Act, 15 U.S.C. § 1012(b), therefore, federal law must yield to the extent the Ohio statute furthers the interests of policyholders.

Minimizing the analysis of *National Securities*, petitioner invokes *Royal Drug* and *Pireno* in support of its argument that the liquidation of an insolvent insurance company is not part of the "business of insurance" exempt from pre-emption under the McCarran-Ferguson Act. Those cases identified the three criteria, noted above, that are relevant in determining what activities constitute the "business of insurance." See *Pireno*, 458 U.S., at 129, 102 S. Ct., at 3008. Petitioner argues that the Ohio priority statute satisfies none of these criteria. According to petitioner, the Ohio statute merely determines the order in which creditors' claims will be paid, and has nothing to do with the transfer of risk from insured to insurer. Petitioner also contends that the Ohio statute is not an integral part of the policy relationship between insurer and insured and is not limited to entities within the insurance industry because it addresses only the relationship between policyholders and other creditors of the defunct corporation.

To be sure, the Ohio statute does not directly regulate the "business of insurance" by prescribing the terms of the insurance contract or by setting the

rate charged by the insurance company. But we do not read *Pireno* to suggest that the business of insurance is confined entirely to the writing of insurance contracts, as opposed to their performance. *Pireno* and *Royal Drug* held only that "ancillary activities" that do not affect performance of the insurance contract or enforcement of contractual obligations do not enjoy the antitrust exemption for laws regulating the "business of insurance"

There can be no doubt that the actual performance of an insurance contract falls within the "business of insurance," as we understood that phrase in *Pireno* and *Royal Drug*. To hold otherwise would be mere formalism. The Court's statement in *Pireno* that the "transfer of risk from insured to insurer is effected by means of the contract between the parties . . . and . . . is complete at the time that the contract is entered," presumes that the insurance contract in fact will be enforced. Without performance of the terms of the insurance policy, there is no risk transfer at all. Moreover, performance of an insurance contract also satisfies the remaining prongs of the *Pireno* test: it is central to the policy relationship between insurer and insured and is confined entirely to entities within the insurance industry. The Ohio priority statute is designed to carry out the enforcement of insurance contracts by ensuring the payment of policyholders' claims despite the insurance company's intervening bankruptcy. Because it is integrally related to the performance of insurance contracts after bankruptcy, Ohio's law is one "enacted by the State for the purpose of regulating the business of insurance." 15 U.S.C. § 1012(b).

The broad category of laws enacted "for the purpose of regulating the business of insurance" consists of laws that possess the "end, intention, or aim" of adjusting, managing, or controlling the business of insurance. *Black's Law Dictionary* 1236, 1286 (6th ed. 1990). This category necessarily encompasses more than just the "business of insurance." For the reasons expressed above, we believe that the actual performance of an insurance contract is an essential part of the "business of insurance." Because the Ohio statute is "aimed at protecting or regulating" the performance of an insurance contract, *National Securities*, 393 U.S., at

460, 89 S. Ct., at 568, it follows that it is a law "enacted for the purpose of regulating the business of insurance," within the meaning of the first clause of § 2(b).

Petitioner, however, also contends that the Ohio statute is not an insurance law but a bankruptcy law because it comes into play only when the insurance company has become insolvent and is in liquidation, at which point the insurance company no longer exists. We disagree. The primary purpose of a statute that distributes the insolvent insurer's assets to policyholders in preference to other creditors is identical to the primary purpose of the insurance company itself: the payment of claims made against policies. .

IV

V

We hold that the Ohio priority statute, to the extent that it regulates policyholders, is a law enacted for the purpose of regulating the business of insurance. To the extent that it is designed to further the interests of other creditors, however, it is not a law enacted for the purpose of regulating the business of insurance. Of course, every preference accorded to the creditors

of an insolvent insurer ultimately may redound to the benefit of policyholders by enhancing the reliability of the insurance company. This argument, however, goes too far: "But in that sense, every business decision made by an insurance company has some impact on its reliability . . . and its status as a reliable insurer." *Royal Drug* rejected the notion that such indirect effects are sufficient for a state law to avoid preemption under the McCarran-Ferguson Act.

We also hold that the preference accorded by Ohio to the expenses of administering the insolvency proceeding is reasonably necessary to further the goal of protecting policyholders. Without payment of administrative costs, liquidation could not even commence. The preferences conferred upon employees and other general creditors, however, do not escape preemption because their connection to the ultimate aim of insurance is too tenuous.... By this decision, we rule only upon the clash of priorities as pronounced by the respective provisions of the federal statute and the Ohio Code. The effect of this decision upon the Ohio Code's remaining priority provisions, including any issue of severability, is a question of state law to be addressed upon remand....

The judgment of the Court of Appeals is affirmed in part and reversed in part, and the case is remanded to that court for further proceedings consistent with this opinion.

It is so ordered.

JUSTICE KENNEDY, with whom JUSTICE SCALIA, JUSTICE SOUTER and JUSTICE THOMAS join, dissenting.

[Dissent omitted]

"Section 1012 reads: "(a) The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business."(b) No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: Provided, That after June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended, shall be applicable to the business of insurance to the extent that such business is not regulated by State Law."



Remember, the purpose of federal anti-trust laws, such as the Sherman Anti-Trust Act, is to prevent a business from willfully acquiring and maintaining monopoly power. The McCarran-Ferguson Act, however, exempts the insurance business from federal anti-trust laws, but only to the extent that such insurance business: (a) is regulated by the state; and (b) does not involve any boycott, coercion or intimidation. Insurance is a business and the insurance transaction is a contractual arrangement whereby one party agrees to

compensate another party for losses incurred. The preceding cases serve as an introduction to this field. However, they only scratch the surface of the subject of insurance law and its relationship to the U.S. economic system.