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.

Document 2nd 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 insurance 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 safe-guarding.

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.

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 under-writers 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.

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 in surer?

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 the 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 potion 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 yen.; 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 insure 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. 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 be policy, Mattson, Jr. was an additional insured. On November 20, 1962, after some investigation, Government Employees wrote Mattson, Sr. 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 I 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 feel 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 1 risk should be assumed. A misstatement of material facts by the applicant takes a. 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 ma- 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 fat, if such answer had been accompanied an explanation, Mattson, Sr. would have been questioned further and an independent investigation might have been made before deciding to issue the policy. Jackson fur 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 ~s. 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 other. wise 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 l as a result of that act suffers an accidental l death, no recovery can be had." On this basis, the court concluded that the case was not governed by § 376.620.

In Ieppert 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, l 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 Ieppert 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. Mangoid 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.

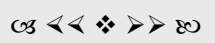
We now consider the reasons offered by the Commissioner to justify a one-year residency requirement for the practice of insurance consulting.

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.



What Constitutes "Insurance" for Regulatory Purposes

An Issue Addressing that which Constitutes "Insurance" for Regulatory Purposes

UNITED HEALTHCARE BENEFITS TRUST v. INSURANCE COMMISSIONER OF PENNSYLVANIA

UNITED HEALTHCARE BENEFITS TRUST v. INSURANCE COMMISSIONER OF PENNSYLVANIA

Pennsylvania Commonwealth Court
620 A.2d 81 (1993)
Pelligrini, Judge
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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 regulation[3] 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

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.