

ETHICS AND THE PROFESSIONAL

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ETHICS AND THE PROFESSIONAL

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

ETHICS AND THE LAW

There are always individuals who through ignorance, lack of training, or sheer perversity will not follow the rules. Penalties for rule-breakers make up the basic legal system of a society, backing up customs with force. Every civilized society is founded on law, and none has ever survived without it.

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

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

RISE OF REGULATION

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

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

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

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

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

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

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

STANDARDS DECLINE

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

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.

ETHICS MADE INTO LAWS

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

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 Armstrong Commission, formally the Joint Committee of the Senate and Assembly of the State of New York to Investigate and Examine into the Business and Affairs of Life Insurance Companies Doing Business in the State of New York. The inquiry began in late 1905 when the legislature of New York initiated an investigation of the insurance companies operating in that state. It began when an accumulation of complaints by consumers and other insurers, and was catalyzed by rumors that James Hazen Hyde, a vice president and expected next corporate president of The Equitable Life Assurance Society of the United States, had charged the expense of an immense costume ball that year to the corporate account. Known as "the Armstrong Committee", the New York Legislature Insurance Investigation Committee of 1905 eventually issued a report highlighting a number of questionable practices. The legislature in New York and several other states adopted many of the recommendations, including a restriction on policies with lengthy deferred payouts, including the 19th century version of tontines. The report also recommended a prohibition on political campaign contributions by such corporations. It is credited with launching the political career of future U.S. Supreme Court Chief Justice Charles Evans Hughes.

Investment Plan

A tontine is an investment plan for raising capital in which each subscriber pays an agreed sum into the fund, and thereafter receives an annuity. As members die, their shares devolve to the other participants, and so the value of each annuity increases. On the death of the last member, the scheme is wound up. After an initial introduction in 1868 in the United States, they soon grew in popularity, to the point that by 1905, two-thirds of the life insurance in the United States was in the form of tontines.

The first and largest proponent of tontines was The Equitable Life Assurance Society of the United States. It had grown to be one of the largest insurance companies in the United States, with over \$1 billion in assets around 1900. After continued elaborate activities by the executives at the company, allegations of corruption occurred. An investigation by the New York Insurance Department uncovered a series of corrupt practices used by the company. The report came to the conclusion that "A cancer cannot be cured by treating the symptoms. Complete mutualization, to be paid for at a price only commensurate with its dividends is, in my opinion, the only sure measure of relief." The findings led to the creation of the Armstrong Commission, to investigate such practices across the industry. Spearheaded by William Armstrong, a State Senator, the commission began work in 1905.

The investigation grew out of allegations made by rivals for control of one of the nation's largest life insurers, the Equitable, and came to involve some of Wall Street's biggest names, including Henry Clay Frick, E. H. Harriman, and J. P. Morgan. For months, New York newspapers published shocking details of corporate misconduct; nepotism, self-dealing, questionable stock deals and bookkeeping sleight-of-hand on the part of officers and directors not only of the Equitable, but also of the New York Life Insurance Company and the Mutual Life Insurance Company. Among the revelations were details of reduced-rate lending between executives of one company and those of another and the fact that the companies funneled revenues to political war chests to influence state legislators. One executive explained that this was the way the companies kept from being badgered and harassed to death in every state in the Union by the introduction of bad bills of every kind.

The impact of the disclosures made during the Armstrong Committee investigation, indicating that even some of the most illustrious companies in a major financial industry were being run on an irresponsible and sometimes corrupt basis, were immediate and sensational. Suddenly, just having (and taxing) an insurance industry in the state appeared insufficient. It became clear that this industry, like many others, needed aggressive policing.

Investment banking and insurance

The formation of large vertically integrated manufacturing companies in the late 1890s created a new demand for capital. Huge new equity issues were floated for such industrial giants as US Steel. In addition, the reorganization of railroads brought about the issue of \$1.2 billion of securities between 1900 and 1902. The size and risk of new industrial issues made underwriting by a single investment bank undesirable, leading one firm to take the role of manager, organizing syndicates of underwriting firms that could distribute the securities. Barred by law from holding equities, commercial banks could not be members of an equities syndicate.

In their place, insurance companies became major syndicate members. The rapidly expanding insurance companies had large steady inflows of funds from their policy premiums, making them significant purchasers of securities. Coordination with investment banks was furthered as the insurance industry was highly concentrated with the Mutual, the Equitable and the New York Life Insurance companies garnering half of all policy sales.

New York Life was closely tied to JP Morgan. The Mutual was not tied to any specific bank but had important relationships with First National Bank and Speyer and Co., and the Equitable had an affiliation with the Harriman and the Kuhn Loeb investment banks. New York Life's portfolio was filled with Morgan railroads, US Steel and other Morgan issues, while Equitable's holdings reflected the railroad interests of Harriman and Kuhn Loeb. These insurance companies also gave investment banks loans and other assistance either directly or through their affiliated trust companies, in which they had large deposits.

The primary device for coordinating these combinations of intermediaries were interlocking directorships, where insurance company officers were partners of investment banks and investment bankers served as directors or trustees of insurance companies.

Acutely worried by the potential conflicts of interest involved in these arrangements, progressives described this concentration of activity and power as the 'Money Trust'. New industrial issues followed by a battle for control of the railroads drove the market to its peak in June 1901. Although there is no data for the number or value of new issues, the volume of trading on the New York Stock Exchange is available. Trading on the exchange peaked during the summer of 1901. The declining market hit a plateau until the summer of 1903 when in the 'rich man's panic' it tumbled again, apparently triggered by banks calling in loans to underwriting syndicates forcing them to unload securities. Contemporaries affixed the blame to the over-abundance of new, overpriced securities, and what a leading financial journalist called,

'revelations of fraud, chicanery, and excessive capitalization'. Tumbling stock prices alarmed not only stockowners but also insurance policy holders.

Conflicts of Interest in the Financial Services Industry

In the booming stock market, conflicts of interest received relatively little public attention. The public debate was joined when the stock market collapsed and a struggle over control of the Equitable broke out between its president and the majority shareholder James H Hyde. These events revealed institutional relationships and questionable management practices of which the public had been largely unaware. Disclosures in the press raised questions about whether investment banks had benefited at the expense of life insurance companies and whether insurance officials had personally benefited at the expense of policy owners and stockholders. In the case of the mutual insurance companies, it appeared that officers were in violation of their fiduciary responsibilities.

Insurance companies had sought syndicate participations to get large blocks of securities at reduced prices. They were not, however, treated equally with other syndicate members. Typically, insurance companies were not allowed to buy at the syndicate prices. Most of the securities they acquired for their portfolios were purchased at the public offering price, and they did not participate in the syndicate's profit. Yet, at the same time officers of the insurance companies, like Richard McCurdy, president of Mutual Life, participated as individuals or through private partnerships in the syndicate. In the mutual insurance companies, the directors took considerable risks that they attempted to hide from state regulators. When a Morgan syndicate for the International Mercantile Marine was unable to sell the securities to the public, New York Life and other syndicate members were required to buy their allotments. To hide this transaction, New York Life sold the bonds to Morgan on 31 December 1903 only to repurchase them on 2 January 1904, providing window dressing for its annual report to the New York Superintendent of Insurance.

Some officers appear to have used the insurance companies to protect them from poor private investments. George W Perkins, a vice president of New York Life, belonged to a partnership investing in a syndicate for the Mexican Central Railroad. When the partnership was unable to take its allotment, Perkins arranged for New York Life to acquire the bonds. Similarly, James H Hyde of the Equitable formed a partnership that received the syndicate participations for the Equitable and divided them among the officers, the company and subsidiaries as he deemed appropriate. Some bankers were concerned about the appearance of conflicts of interest implied by interlocking directorates. In 1901, when JP Morgan invited Perkins to become a partner in his firm, he urged him to resign from the insurance company in order to avoid

a possible conflict of interest as New York Life was a regular purchaser of Morgan sponsored securities. Perkins refused and Morgan reluctantly agreed to allow his new partner to continue at New York Life as chairman of the insurance company's Finance Committee.

These revelations in the press led the New York State legislature to convene a special session that created the Armstrong Committee to investigate. Serving as chief counsel, Charles Evans Hughes questioned the bankers focusing on the role they played in determining the investment policies of the companies they were associated with, and demanded to know how they could serve the interests of both. Although the Armstrong Committee found it difficult to measure how investment banks or their managers had profited from their control of financial intermediaries through interlocking directorates, it registered its disapproval of the interlocking directorates and recommended that life insurance companies be prohibited from serving as underwriters.

In response, the New York State legislature passed a reform Bill in 1906 that was quickly copied by 19 other states, effectively making it the law of the land. These laws prohibited life insurance companies from underwriting securities, ordered them to break their interlocking relationships with investment banks, and compelled them to sell off their stocks. While the pre-Armstrong combination of investment banks and insurance companies offered potential benefits to both, the use of interlocking directorates to manage the two firms seems, in retrospect, designed to offer the maximum opportunities to exploit conflicts of interest. Most companies were mutuals, and the few stock companies, like the Equitable, were dominated by one shareholder, diminishing the capacity of the policy owners and shareholders from monitoring the managers. The management structure and the transactions executed by managers on behalf of their companies were opaque to the public. While complete separation was an extreme solution, some reform was necessary. Afterwards when commercial and investment banks began to combine, this poor financial architecture was not repeated. Institutional innovation offered new and improved solutions to the problem of conflicts of interest.

Model Legislation

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 in insurance cases can make a change in liability affecting those in the industry. The legal system in this country is not static, but fluid. Company officials need to keep abreast of such developments and let their agents in the field know about them.

Court Decisions

Suits to recover damages in cases of disputes over insurance coverage are increasingly frequent. The growing tendency to consider insurance practitioners as professional people carries with it increased legal responsibility.

Court decisions in many cases do not take into account any responsibility on the part of the insurance purchaser to be aware of policy provisions, even of easy-to-read policies. The outcome in many liability suits has made the agent or insurance company responsible for providing adequate coverage.

In a Louisiana case a plaintiff, the operator of a Laundromat in a leased building, asked his insurance agent to get as much property damage liability for him as possible. The agent told him \$100,000 was the maximum coverage obtainable, and the plaintiff told the agent to get that amount. Through an error, the policy was written for only \$10,000. A boiler explosion caused \$18,500 in damages at the Laundromat, and the plaintiff sued to recover the \$8,500 that was not covered by the \$10,000 policy.

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.

Professional Responsibility

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.

ETHICS 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.

Guidelines

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.

Claims Defense

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.

Requirements

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.

Proscriptions

The agent MUST NOT do the following in all advertising:

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

- Use misleading words or symbols or imply the material is being sent by a government entity.
- Use the phrase "low cost" without providing disclosures and the caveats associated with the particular plan.

Advertising can be one of the best career enhancing tools, when utilized effectively, legally and ethically.

COMMISSIONS

REBATING

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.

The Concept

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.

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 most states, 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.

Borderline Situations

Rebating, or the attempt to rebate, is an offense not only under the Code of Ethics, but also under state 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.

Representing the Insurance Product

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

Deceptive practices as they pertain to the insurance 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.

Paper Trail

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.

Data Note and Log

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.

Changes Cause Problems

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.

Understanding the Hypothetical

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.

Transparency and Self-Policing

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. Life insurance in force at the end of 1993 was nearly \$11 trillion. 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.

Value Added

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.

Service Essentials

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.
- Annual reviews are extremely important with many policy owners, simply because their needs change. This is particularly obvious with business clients.
- 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.

Part of the Contract

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 forwards 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.

Protect Confidentiality

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 underwriters is illegible applications. Not only does this impair the underwriting process, but it could be grounds for significant dispute during the processing of a claim.

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

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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.

Litmus Test

Labeling a decision as an "ethical decision" may disguise the fact that almost every decision holds some ethical issue or impact. Perhaps a better approach would be to develop an ability to judge the ethical implications. What role do ethics play in this decision? How does one recognize an ethical situation or problem? What are the warning signs that this may be a tougher decision with deeper issues and wider impact? Here are some guidelines. Not all apply every time, but they should raise understanding and improve the decision-making process.

Do I put a monetary value on this decision? Would I make this decision differently if cost were not a factor? Am I putting a monetary value on my ethics?

Do words such as right, fairness, truth, perception, values, or principles appear in my reasoning when I am making my decision?

- Do I feel as if I need to search through a standard policies and procedures or contact a legal representative for help with my decision?
- Do questions of fair treatment arise?
- Do my personal goals or values conflict with my professional ones?
- Could this decision generate strong feelings or other controversy?

- What does my heart tell me? Do I ponder this decision on the way home?
- Do I offer myself excuses such as everybody does it, or no one will find out, or I did it for “The Company”?
- Does this decision really need to be made by someone else? Did I inherit it because someone else doesn't want to make it?
- How am I going to feel tomorrow if I do this?

If an individual faces a tough decision and feels as if some guidance is needed, sometimes there is no place else to turn. One must have an internal compass, a value system for guidance. That is why an ethical standard is important for everyone in the insurance industry.