

Case Studies in Property and Casualty Insurance

Course #373

Copyright 2025

RegEd, Inc.

All Rights Reserved

Table of Contents

1.0	Introduction	1
2.0	The History of Property and Casualty Insurance.....	1
3.0	Understanding Risk, Loss, and Hazard	3
3.1	What is Risk?.....	3
3.2	What is Objective Risk?	4
3.3	What is Subjective Risk?	4
3.4	Chance of Loss / Probability.....	4
3.4.1	Chance of Loss: Objective Probability.....	5
3.4.2	Chance of Loss: Subjective Probability	5
3.4.3	Peril and Hazard.....	6
3.4.3.1	Peril.....	6
3.4.3.2	Hazard.....	7
3.4.3.2.1	Physical Hazard.....	7
3.4.3.2.2	Moral Hazard.....	7
3.4.3.2.3	Morale Hazard.....	8
3.5	Categories of Risk	8
3.5.1	Pure and Speculative Risk	8
3.5.2	Static and Dynamic.....	9
3.5.3	Fundamental and Particular	9
3.5.4	Personal Risks	10
3.5.4.1	Risk of Premature Death	10
3.5.4.2	Risk of Old Age	11
3.5.4.3	Risk of Poor Health.....	11
3.5.4.4	Risk of Unemployment	12
3.5.5	Property Risks	12
3.5.6	Liability Risks.....	12

3.6	Burden of Risk on Society	13
3.6.1	Emergency Fund	13
3.6.2	Loss of Certain Goods and Services	13
3.6.3	Worry and Fear	14
3.7	Methods of Handling Risk	14
3.7.1	Avoidance	15
3.7.2	Retention	15
3.7.2.1	Active Retention	15
3.7.2.2	Passive Retention	15
3.7.3	Noninsurance Transfers	15
3.7.3.1	Transfer by Contracts	16
3.7.3.2	Hedging Price Risks	16
3.7.3.3	Incorporation of a Business Firm	16
3.7.4	Loss Control Generally	16
3.7.4.1	Loss Prevention Generally	16
3.7.4.2	Loss Reduction Generally	17
3.8	Risk Management	17
3.8.1	The Risk Manager	17
3.8.2	Risk Management Objectives	18
3.8.3	Risk Management Through Insurance	18
3.8.3.1	Selecting Insurance Coverage	19
3.8.3.2	Selecting an Insurer	19
3.8.3.3	Negotiation of Terms	20
3.8.4	Requirements of an Insurable Risk	20
3.8.4.1	Law of Large Numbers / Homogenous Units	20
3.8.4.2	Accidental and Unintentional	21

3.8.4.3	Determinable and Measurable	21
3.8.4.4	No Catastrophic Loss	22
3.8.4.5	Loss Must Be Calculable	23
3.8.4.6	Affordable Premiums	23
3.8.5	Loss Control Through Insurance	24
3.8.5.1	Pooling of Losses	24
3.8.5.2	Risk Transfer Through Insurance	24
3.8.5.3	Indemnification for Losses	24
3.8.6	Loss Control Regulation	25
3.9	Insurance Risks	25
3.9.1	Spreading Risk Through Reinsurance	26
3.9.2	Insurance Company Equity Holder Assumption of Risk	26
3.9.3	Pooling Risk	27
4.0	The Property and Casualty Industry	31
4.1	Lines of Coverage	31
4.2	Insurance Company Revenue	32
4.3	Insurance Company Expenses / Liabilities	33
4.4	Loss Reserves	33
4.5	Surplus Funds: Capital Counts	36
4.6	Property and Casualty Accounting	36
4.7	The Property and Casualty Market	37
4.8	Property and Casualty Impact on the Economy	37
4.9	Underwriting Cycle in the Property and Casualty Industry	37
4.10	Fiduciary Responsibility and Recordkeeping	38
4.11	Insurance Regulation	38
4.11.1	Rate Regulation	40
4.11.2	Regulation of Policy Forms	40

4.11.3	Licensing of Personnel	40
4.11.4	Trade Practices	41
4.11.5	The Government as an Insurer	42
4.12	Industry Trends	42
4.12.1	Too Much Capacity	43
4.12.3	Mutual Insurers	44
4.12.3.1	Demutualization.....	44
4.12.4	Internet and E-Commerce Offer Opportunities and Challenges	45
4.12.4.1	Uncovering Keys to High Performance	46
4.12.4.2	Technology-Driven Consistency.....	46
4.12.5	Banks and the Property and Casualty Industry	47
4.13	The Changing Property and Casualty Industry	48
4.13.1	The Property and Casualty Customer	49
4.13.2	Customer Demographics	50
4.13.3	Advocacy in the Property and Casualty Industry	50
4.13.3.1	Advocacy Decreases the Less the Carrier Communicates	51
4.13.3.2	Proactive Responses to the Changing Climate Are Essential	51
4.13.3.2.1	Enhancing Current Models and Demographic Focus	52
4.13.3.3	Strengthening Customer Focus to Drive Customer Advocacy	52
4.14	Insurable Interest	53
4.14.1	When Insurable Interest Must Exist.....	54
4.14.2	Insurable Interest Limited by Value	54
4.15	Law of Large Numbers	54
4.16	Insurance Policies Are Contracts	55
4.16.1	Insurance Policies Must Meet Certain Conditions to Be Valid	55
4.16.1.1	Parties to the Contract Must Be Competent	55

4.16.1.2	Contract Must Have a Legal Purpose	56
4.16.1.3	A Valid Offer Must Be Made	56
4.16.1.4	Offer Must Be Accepted as Made	56
4.16.1.5	Consideration Must Be Given	57
4.16.2	Insurance Contracts Have Special Characteristics	57
4.16.2.1	Aleatory Contract	57
4.16.2.2	Contract of Adhesion	58
4.16.2.3	Unilateral Contract	58
4.16.2.4	Conditional Contract	59
5.0	Property and Casualty Insurance	61
5.1	The Basic Policy Format	61
5.1.1	The Declarations Page	61
5.1.2	The Insuring Agreement	62
5.1.3	Exclusions	63
5.1.4	Conditions	64
5.2	Important Property and Casualty Insurance Terms	67
5.3	Property Insurance	68
5.3.1	Types of Property Contracts	68
5.3.2	Property Insurance Declarations	69
5.3.3	Property Insurance Insuring Agreement	70
5.3.4	Property Insurance Exclusions	72
5.3.5	Property Insurance Conditions	73
5.3.5.1	Coinsurance Clauses	74
5.3.6	Deductible Clauses	74
5.3.7	Duties After a Loss	75
5.3.8	Loss Settlement	75
5.3.9	Liberalization	76

5.3.10 Salvage and Abandonment	76
5.4 Casualty Insurance	76
5.4.1 Insuring Agreement	77
5.4.2 Coverages	77
5.4.3 Defense Costs	78
5.4.4 Prejudgment Interest	78
5.4.5 Supplementary Payments	79
5.4.6 Policy Limits	79
5.4.7 Exclusions	79
5.4.8 Conditions	79
5.4.8.1 Duties After Loss	80
5.4.8.2 Other Insurance	80
5.4.8.3 Policy Limits May Apply per Occurrence or per Accident	80
5.4.8.4 Policy Limits May Apply per Person or Also in the Aggregate	81
5.5 Specialty Coverages	81
5.5.1 Earthquake Insurance	81
5.5.1.1 The California Earthquake Authority (CEA)	82
5.5.1.2 Special Earthquake Provisions	83
5.5.1.3 Proximate Cause	83
5.5.1.3.1 Fire	84
5.5.2 Flood Insurance	84
5.5.2.1 History of the National Flood Insurance Program (NFIP)	85
5.5.2.2 Organization	86
5.5.2.3 Flood Programs and Coverage Limits	86
5.5.2.4 Repetitive Loss Properties Program	87
5.5.2.5 Flood Insurance Forms	88

5.5.2.5.1 Dwelling Form	88
5.5.2.5.2 General Property Form	88
5.5.2.5.3 Residential Condominium Building Association Policy (RCBAP).....	89
5.5.2.5.4 Preferred Risk Policy	89
5.5.2.6 Mortgage Portfolio Protection Program (MPPP).....	89
5.5.2.7 Flood Insurance Coverage	90
5.5.2.8 Insuring Agreements	91
5.5.2.8.1 Coverage A: Building	91
5.5.2.8.2 Coverage B: Personal Property	93
5.5.2.8.3 Coverage C: Other Coverages	94
5.5.2.8.4 Coverage D: Increased Cost of Compliance (ICC).....	95
5.5.2.8.5 General Exclusions.....	95
5.5.2.8.6 Increased Cost of Compliance Exclusions	96
5.5.3 Hurricane Coverage.....	96
5.5.3.1 Hurricane Windstorm Insurance Discounts	97
5.5.3.2 Hurricane Deductible.....	97
5.6 The Insurance Premium	98
6.0 Legal Issues in Property and Casualty Insurance.....	105
6.1 Understanding Contracts.....	105
6.2 Contracts and the Law	106
6.3 Types of Contracts	106
6.3.1 Bilateral vs. Unilateral Contracts	107
6.3.2 Executed and Executory Contracts.....	107
6.3.3 Express and Implied Contracts	108
6.3.4 Void and Voidable Contracts	108
6.3.5 Promissory Estoppel	109
6.3.6 Elements of Contracts	109

6.3.6.1 The Offer.....	109
6.3.6.2 Acceptance of an Offer.....	110
6.3.6.3 Capacity to Contract.....	111
6.3.6.4 Consideration.....	111
6.3.6.5 Legal Purpose	112
6.3.7 Statute of Frauds	112
6.4 Rights of Third Parties to Contracts.....	113
6.4.1 Assignment of Rights.....	113
6.4.2 Duties of an Assignee	114
6.4.3 Third-Party Beneficiaries	114
6.4.3.1 Creditor Beneficiary.....	114
6.4.3.2 Donee Beneficiaries.....	114
6.4.3.3 Incidental Beneficiary.....	115
6.5 Agency and Bailment	115
6.6 Tort Liability.....	118
6.6.1 Legal Liability.....	119
6.6.2 Intentional Torts.....	119
6.6.2.1 Interfering With Personal Rights	119
6.6.2.1.1 Battery	119
6.6.2.1.2 Assault.....	119
6.6.2.1.3 False Imprisonment.....	120
6.6.2.1.4 Emotional Distress	121
6.6.2.1.5 Defamation	122
6.6.2.1.6 Invasion of Privacy	123
6.6.2.1.7 Misuse of Legal Proceedings.....	124
6.6.2.1.8 Deceit or Fraud	125

6.6.3 Negligence	125
6.6.3.1 Breach of Duty	126
6.6.3.1.1 Special Duties	126
6.6.3.2 Causation	126
6.6.3.3 Negligence Defenses	127
6.6.3.3.1 Contributory Negligence	127
6.6.3.3.2 Comparative Negligence	128
6.6.3.3.3 Assumption of Risk	128
6.6.3.3.4 Intervening Cause	129
6.6.3.3.5 Statute of Limitations	129
6.7 Civil Litigation:.....	130
6.7.1 Filing a Legal Action.....	130
6.7.2 Discovery	131
6.7.3 Trial.....	131
6.7.4 Right to Appeal	133
6.8 Damages.....	133
6.8.1 Compensatory Damages	133
6.8.2 Punitive Damages	134
6.9 Arbitration and/or Mediation.....	134
7.0 The Players and Their Roles	138
7.1 Types of Agents.....	144
7.2 Career Agents	144
7.3 Brokers.....	145
7.4 Solicitors.....	145
7.5 Mass Marketing.....	145
7.6 Special Arrangements.....	145
7.7 Licensing.....	146

7.8	An Agent's Authority	146
7.9	Agent Responsibilities	147
7.10	Prohibited Sales Practices	148
7.11	Agent Compensation	149
7.12	Agency Law	152
7.12.1	Creation of an Agency	152
7.12.2	Agency Authority	152
7.12.3	Types of Agency	153
7.12.4	Duties of Agent to Principal	154
7.12.4.1	Duty of Loyalty	154
7.12.4.2	Duty of Obedience	155
7.12.4.3	Duty to Act with Care and Skill	155
7.12.4.4	Duty to Notify the Principal	155
7.12.4.5	Duty to Account for Money and Property	156
7.12.5	Duties of Principal to Agent	156
7.12.5.1	Duty to Compensate	157
7.12.5.2	Duty to Reimburse and Indemnify	157
7.12.6	Agency Termination	157
7.12.6.1.1	Termination by Act of the Parties	157
7.12.6.1.2	Termination by Law	157
7.12.6.1.3	How Termination Affects an Agent's Authority	157
7.13	Relationship of Principal and Agent to Third Parties	158
7.13.1	Ratification	158
7.13.2	Contractual Liability of an Agent to Third Parties	158
7.13.3	Tort Liability of a Principal to Third Parties	159
7.13.3.1	Respondeat Superior	159

7.13.3.2 Direct Liability	160
7.13.3.3 Liability for Acts of General Contractors	161
7.13.3.4 Liability for Agent’s Misrepresentation	161
7.13.3.5 Tort Liability of the Agent	161
7.13.3.6 Suits Against the Principal and Agent	162
8.0 The Current State of the Property and Casualty Industry.....	164
9.0 Conclusion	168

1.0 Introduction

This course will discuss the property and casualty industry, property and casualty insurance, and the role and responsibility of the property and casualty insurance professional through examples and case studies. Upon completion of this course, you should:

- Understand risk, the root of the industry;
- Have a thorough understanding of the property and casualty industry as a whole;
- Have an understanding of property and casualty insurance;
- Understand the law regarding property and casualty insurance; and
- Understand the role of a property and casualty agent.

To understand your role, you must first understand your industry, so we will start with a brief and interesting history.

2.0 The History of Property and Casualty Insurance

Let's start this course with a look at the long and interesting history of the property and casualty insurance industry. For as long as it was documented, people were searching for protection from catastrophic losses. Through the years, the one consistent goal was to find a way to transfer the risk of loss from the individual to the group as a whole.

Initially, property and casualty insurance dealt solely with the loss of ships and their cargos. In the 1600s, the British spawned a commercial shipping industry that opened mercantile markets around the world. Unfortunately, the commercial shipping industry carried with it much risk—ranging from weather to bandits. The loss of a ship and its cargo could be a financial disaster for a single ship owner. As a result, the ship owners sought ways to minimize exposure to these risks. First, they realized that most ships arrived safely and on time, while others never arrived. Some determined that if they could average their losses or spread the loss of a few ships among many ship owners who were exposed to the risk, the cost of economic security for each ship owner was small in comparison to the potential loss.

Near the end of the 17th century, a man named Edward Lloyd was the owner of a London coffee shop near the shipping docks. Each day, Mr. Lloyd would post the latest shipping information on the coffee shop bulletin board. This practice attracted both ship owners and merchants to the coffee shop. It was here that they would meet in the hopes of finding other shippers willing to share the potential loss, as well as the potential for profit. In 1771, a group of these men moved from the Lloyd's Coffee House to the London financial district. This group was known as "Lloyd's of London."

This venture then grew to include individuals outside the shipping industry who were willing to help the owners defray part of their risk in exchange for part of their profits. They were the original "underwriters." The underwriters, unfortunately, soon found themselves in the same risk-reward situation and, as a result, began to band together in syndicates. They became known as "Lloyd's of London Syndicates Structure."

Of Interest:

Many of the practices implemented by the Syndicates Structure are still used today by Lloyd's of

Eventually, these underwriters realized that the profits they were making from underwriting shipping could also be gained from other endeavors that did not involve shipping. At that time, one of the biggest disasters facing most people was the threat of fire. Soon the underwriters began offering manufacturers, storeowners, and wealthy homeowners the possibility of offsetting a part of any loss to their property occurring from fire. Eventually, other perils followed, including floods, wind damage, and human-made perils such as robbery and theft.

During this same time, the shipping industry expanded to a new harbor: New York. Eventually, the industry moved westward to San Francisco. Unfortunately, The Lloyd's underwriters, for various reasons, did not wish to underwrite risks in America. The void created by this lack of interest gave way to a new breed of independent insurers. The difference was that rather than asking for a part of the owner's profits, American underwriters demanded a specific fee in exchange for their risk assumption. From this came the concept of charging an insurance premium, and the insurance industry, as we know it today, was born.

Today, the property and casualty insurance industry offers products that protect against the risk of loss of most types of property, as well as the liability that can result from the use of that property. Nearly all property or liability losses that can be measured can be insured against that loss—in return for a stated premium.

Section Review:

1. The earliest form of property and casualty insurance was: Refer to Section 2.0, page 1

A. Marine **[Your answer is correct. Marine was the earliest form of property and casualty insurance.]**

B. CGL **[Your answer is incorrect. CGL was not the earliest form of property and casualty insurance.]**

C. Fire **[Your answer is incorrect. Fire was not the earliest form of property and casualty insurance.]**

D. Theft **[Your answer is incorrect. Theft was not the earliest form of property and casualty insurance.]**

2. Where did Lloyd's insurance come to fruition? Refer to Section 2.0, page 1

A. America **[Your answer is incorrect. Lloyd's did not originate in America.]**

B. France **[Your answer is incorrect. Lloyd's did not originate in France.]**

C. England **[Your answer is correct. Lloyd's originated in England.]**

D. Japan **[Your answer is incorrect. Lloyd's did not originate in Japan.]**

3. From where did the current concept of insuring risk in exchange for paying premiums come? Refer to Section 2.0, page 2

A. American underwriters **[Your answer is correct. American underwriters pioneered the concept of insuring risk in exchange for premiums.]**

B. British underwriters **[Your answer is incorrect. The concept did not come from British underwriters.]**

C. French underwriters **[Your answer is incorrect. The concept did not come from French underwriters.]**

D. Italian underwriters **[Your answer is incorrect. The concept did not come from Italian underwriters.]**

4. **True or False.** Nearly all property or liability losses that can be measured can be insured against that loss—in return for a stated premium. Refer to Section 2.0, page 2

A. True **[Your answer is correct.]**

B. False **[Your answer is incorrect. Nearly all property or liability losses that can be measured can be insured against that loss—in return for a stated premium.]**

3.0 Understanding Risk, Loss, and Hazard

As you learned, risk is at the root of the insurance industry. To understand the industry, you must understand risk. It is with this in mind that we move on to a look at risk, together with loss and hazard and how they each compare.

3.1 What is Risk?

In insurance, risk can best be defined as the uncertainty of a loss occurring. Keep in mind, risk is not the actual loss itself but rather the uncertainty that the loss may occur. Risk does not include certain losses of value, such as those resulting from wear and tear on a physical object, as these are certain to eventually occur. On the other hand, losses such as damage or injuries resulting from events such as a lightning bolt or an industrial accident are not predictable or certain and would be considered risks. To further illustrate, risk could include things such as:

- Lung cancer for smokers;
- An automobile accident for drivers; or
- A plane crash for airline travelers

At the basic level, risk is broken down into two categories: objective risk and subjective risk.

Let's take a look at the difference.

3.2 What is Objective Risk?

Objective risk is the relative variation of actual loss from expected loss. Insurance companies can only make a profit if they understand a risk and the frequency of its occurrence. In order to understand this type of risk, insurers study the actual number of losses versus the total possible losses.

For Example:

ABC Insurance is conducting a study for fire losses. It starts with a sampling of 10,000 houses that were built many years ago. In this study, the expected frequency of fires can be calculated by learning how many houses burned each year, then averaging those numbers. For instance, if this average is 10, then this is the expected loss (10/10,000 or 0.1%). The relative variation occurs because obviously, it will be rare that exactly 10 houses burn each year -- there may be years when none, 20, 30, or 100 of them burn.

In our example, this relative variation of actual loss from expected loss is the objective risk. As you can see, objective risk declines as the number of exposures increases. Specifically, objective risk varies inversely with the square root of the number of cases under observation.

3.3 What is Subjective Risk?

Subjective risk is what one might perceive to be a possible unwanted event. Most people realize, for instance, that it is possible for them to have an accident, a heart attack, or some other health problem—or even that they will likely lose money if they buy lottery tickets. How much subjective risk people experience depends on their history and their expected possibility of its occurrence (the subjective probability).

For Example:

An individual that has lost a lot of money in the stock market will likely feel more risk in investing in the market than someone who has profited handsomely.

Subjective risk typically alters the behavior of the risk taker, whether it is a very undesirable risk or one that has a good chance of occurring if a particular action is taken. A perfect example would be someone who was in a serious auto accident who, as a result, is much more careful driving than someone who has never been in a serious accident.

3.4 Chance of Loss / Probability

The classic demonstration of probability is the "balls in the bag" experiment favored by school teachers. The "balls in the bag" goes like this:

A bag contains 50 red balls, 40 white ones, and 10 black ones. James puts his hand in the bag and picks a ball. What is the probability that the ball he chooses is black? The answer is 0.1.

In insurance, chance of loss is the probability that a loss will occur. Chance of loss can be distinguished from objective risk in that objective risk is dependent upon actual losses and chance of loss is the probability that an event will occur.

For Example:

10,000 homes in Florida might have the same chance of loss as 10,000 similarly situated homes in Georgia, but there could be greater differences from the average in most years in Florida over Georgia or vice versa.

Just like risk, chance of loss (probability) can be both objective and subjective.

3.4.1 Chance of Loss: Objective Probability

Objective probability is the likelihood of something happening based on either reasoning or by actual observations of a large number of similar events taking place under similar conditions.

For Example:

- There is a 50% chance that a perfectly balanced coin will come up heads if flipped.
- There is a 1/6 chance that a 2 will come on top of a rolled, perfectly balanced and shaped die.

Insurers typically use more complicated scenarios than the examples given. An insurer can assess objective probability through a large number of observations under a given set of conditions.

For Example:

The probability that a 50-year-old man will live to 65 cannot typically be calculated, but insurers can assess the objective probability based on the proportion of 50-year-old men who have lived to 65 in the past.

3.4.2 Chance of Loss: Subjective Probability

Subjective probability is an individual's perception (or personal estimate) of the likelihood of an event occurring. Typically, subjective probability differs significantly from objective probability, either because the individual cannot calculate the actual probability or because the individual feels lucky or unlucky.

There is a wide variety of factors that may influence subjective probability, including:

- Age
- Sex
- Intelligence
- Education
- Alcohol Use

For Example:

Alcohol might influence someone's subjective probability by causing them to overestimate their physical skills and abilities and get behind the wheel of a car, even though in reality they should not be driving at all.

A little bit later in this course we will take a look at how insurers address and/or control loss.

3.4.3 Peril and Hazard

Although you might think that peril and hazard are synonymous, **peril** is the direct cause of a loss and **hazard** is the condition that creates or increases the chance of loss. Let's start with peril.

3.4.3.1 Peril

In Insurance, the term "peril" typically means:

- The cause of an injury,
- The reason something is damaged or destroyed, or
- The way something was lost or is no longer in your possession.

A peril may include things such as:

- Fire
- Earthquake
- Windstorm
- Flood
- Theft

In addition, most Insurance policies break down perils into "named" or "all-risk" categories. Named peril policies only cover the causes of loss specifically stated in the policy. They are sometimes referred to as "specified peril policies."

For Example:

A standard fire policy will cover only the two specifically named perils of fire and lightning.

Fortunately, additional perils may be added to a policy by endorsement, such as theft, vandalism, and malicious mischief. Other common named perils include earthquake and flood insurance if the risks of these perils are high. Named peril policies generally offer the lowest premium; however, the fewest risks of loss will be covered.

All-risk insurance (also known as comprehensive or open peril) policies cover losses and pay claims for damages to personal property when the peril is direct, sudden, and accidental and is not excluded in the policy. All-risk policies typically cover all perils unless they are specifically

excluded the policy. With an all-risk policy, the premium is generally higher than a named peril policy, but the coverage is broader. Keep in mind that careful review of the "excluded" causes of loss in an all-risk policy is important for an insured to ensure that all potential loss scenarios are addressed and covered.

For Example:

Even the most comprehensive homeowners policy does not cover losses caused by flooding, and it may not include earthquake coverage, absent an endorsement, which could be catastrophic for a client.

3.4.3.2 Hazard

A hazard is anything that either causes or increases the likelihood of a loss. For instance, gas furnaces are a hazard for carbon monoxide poisoning. Three common hazard categories are physical hazard, moral hazard, and morale hazard. Let's take a look.

3.4.3.2.1 Physical Hazard

A physical hazard is a physical condition that increases the possibility of a loss. Some examples include:

- Smoking is a physical hazard that increases the likelihood of a house fire and illness.
- Owning an older building with defective wiring is a physical hazard that increases the chance of a fire.
- Driving on an icy road is a physical hazard that increases the possibility of you losing control of your car and colliding with another vehicle.

3.4.3.2.2 Moral Hazard

Moral hazards are losses that result from dishonesty. Insurance companies often suffer losses from these hazards due to fraudulent or inflated claims. Dishonest insureds often justify their actions (such as arson) or a false claim by adapting the attitude that insurance companies have a "lot of money" and, therefore, they are entitled to cheat a little.

For Example:

Bob Smith Building has recently suffered a downturn in business due to economic conditions in his state. He stores all of his tools and supplies in a warehouse away from his office. Bob will go out of business if he does not raise capital soon. Bob comes up with the idea that if all of his tools and supplies were to be "lost" in a fire at his warehouse, he could collect the insurance proceeds.

These individuals would never steal from a neighbor as it is against their morals; however, they do not view this type of behavior as "stealing" from an insurance company or, for that matter, from other insureds. The problem with this attitude is that insurance companies must pass these costs on to other, more honest insureds in the form of premium hikes.

For Example:

Arlo has recently obtained health insurance from his employer. Because Arlo no longer bears the cost of medical services, he has an added incentive to ask for pricier and more elaborate medical service (a full body MRI, just to be safe) which would otherwise not be necessary. In this instance, Arlo has an incentive to over-consume, simply because he no longer bears the full cost of his medical services.

Sometimes moral hazard is so severe it makes insurance policies impossible. Coinsurance, copayments, and deductibles reduce the risk of moral hazard by increasing the out-of-pocket spending of consumers, which decreases their incentive to consume. Thus, the insured has a financial incentive to avoid making a claim.

3.4.3.2.3 Morale Hazard

A morale hazard in insurance is best described as an attitude of indifference to loss. An insured may worry less about losses simply because they have insurance, so they may take fewer precautions and engage in riskier activities, thus increasing the possibility of loss.

For Example:

An individual that remains in the hospital merely to collect health insurance benefits, rather than return to work.

3.5 Categories of Risk

Risk is typically categorized according to why the risk exists and, to a greater extent, whom the risk affects. The major categories include:

- Pure and Speculative
- Static and Dynamic
- Fundamental and Particular

3.5.1 Pure and Speculative Risk

Pure risk is one that involves only the possibility of loss. In addition, there is no profit from pure loss.

For Example:

Pure risk includes:

- Premature death
- Occupational and nonoccupational disability
- Catastrophic medical expenses
- Damage to property from fire, lightning, flood, or earthquake

In the above scenarios, none involve an individual actually profiting from the loss.

Speculative risk differs from pure risk because it involves both the possibility of profit and loss. This type of risk is most common in financial investments. Speculative risks have more varied conditions that make estimating future losses difficult or impossible. In addition, speculative risk will generally involve a greater frequency of loss than a pure risk. For instance, people do many things to protect their lives, or their property, but people willingly engage in speculative risks, such as investing in the stock market, to make a profit; otherwise, a person can avoid most speculative risks simply by avoiding the activity that gives rise to it.

Speculative risks that can affect an organization are usually subdivided into strategic risk, operational risk, and financial risk. Strategic risk results from goal-oriented behavior. A business may want to try to improve efficiency by buying new equipment or trying a new technique, but these efforts may result in more losses than gains.

Most speculative risks are uninsurable because they are undertaken willingly for the hope of profit. Pure risk, on the other hand, is insurable because the law of large numbers can be applied to forecast future losses, thus allowing insurance companies to calculate what premium to charge based on expected losses.

3.5.2 Static and Dynamic

Static risks are connected to losses caused by the irregular action of nature or by the mistakes of human beings.

Note:

Most static risks are pure risks.

Dynamic risks are risks associated with a changing economy. Examples include the changing tastes of consumers, technological changes, new methods of production, and investments in capital goods used to produce new and untried products.

Note:

Dynamic risks are always speculative, meaning that it is possible to realize either a profit or a loss.

3.5.3 Fundamental and Particular

Risk can also be classified by whether it affects many people or only a single individual (fundamental risk and particular risk).

Fundamental risks are risks, such as earthquakes or terrorism, that can affect many people at once. These include economic risks, such as unemployment, because they affect many people. In the case of fundamental risks that are insured, insurance companies help to reduce their risk of great financial loss by limiting coverage in a specific geographic area and using reinsurance (the purchase of insurance from other companies to cover their potential losses).

In addition to the fundamental risks that typically affect individual members of society, fundamental risks can also affect organizations. For instance, enterprise risk is the set of all

risks that affects a business enterprise. Operational risks arise from the operation of the enterprise, such as the risk of injury to employees or the risk that customers' data can be leaked to the public because of insufficient security. Financial risk is the risk that an investment will result in losses. Because most enterprise risk is a speculative risk, and because the enterprise itself can do much to lower its own risk, many companies are learning to manage their risk by creating departments and hiring people with the express purpose of reducing enterprise risks.

Note:

While private insurers will insure fundamental risks such as hurricane or wind damage, they generally do not insure fundamental risks like unemployment. These risks are typically insured by the government. This is because the government has some control over economic risks through specific policies, such as monetary policy and law.

Particular risk, on the other hand, is a risk that affects particular individuals, such as robbery or vandalism. Insurance companies typically insure most particular risks. Both fundamental and particular risks can be either pure or speculative.

3.5.4 Personal Risks

Personal risks are those that affect an individual directly and can involve the possibility of a complete loss or reduction of earned income and the depletion of financial assets. There are four major categories of personal risks, all of which are insurable:

- Risk of premature death
- Risk of old age
- Risk of poor health
- Risk of unemployment

Let's take a closer look.

3.5.4.1 Risk of Premature Death

A sampling of the life expectancy of an individual in the United States in 2021 according to the National Vital Statistics System looks like this:

LIFE EXPECTANCY BY AGE AND SEX, UNITED STATES, 2021

Age	YEARS		
	Total	Male	Female
40	38.8	36.6	41.1
50	30.1	28.2	32.1
60	22.1	20.5	23.7
70	14.9	13.7	16.0
80	8.7	7.9	9.4
90	4.4	3.9	4.6
100	2.2	1.9	2.2

As the table illustrates, the life expectancy of a 50-year-old male is 28.2 years, that is to age 78.2, and a 50-year-old female is 32.1 years, that is to age 82.1. Regardless of whether we die “on schedule” or before our time (or even after our time), individuals may leave obligations and people who depend on them. The human life value of a head of household is lost forever whenever death occurs.

Note:

The actual or potential human life value of most college graduates can easily exceed a million dollars.

3.5.4.2 Risk of Old Age

The primary risk associated with old age is the possibility that an individual will not have sufficient income for retirement. Obviously, when you retire, you lose normal earnings, like that weekly paycheck you have grown to rely on. Unless an individual can accumulate sufficient financial assets to draw from during retirement, they will have to access other sources of retirement income, such as Social Security, a pension, or, for those lucky enough to retire from their profession, both.

3.5.4.3 Risk of Poor Health

A common personal risk to most individuals is that of poor health. Catastrophic medical expenses, as well as loss of earned income, could happen as the result of any unexpected illness or accident.

Note:

Consider that the cost of a heart or kidney transplant can easily exceed \$100,000, or the cost of a crippling automobile accident requiring major operations and rehabilitation could also easily exceed \$100,000.

A long-term disability and the lack of any insurance coverage is a common scenario that can also create a heavy financial burden. Suffering a disability is more likely to occur during any one year than being in an auto accident, dying, or having a fire in your home. This brings us to our last consideration: the cost of long-term care in a skill nursing facility, which can easily exceed \$125,000 a year.

Scenario:

Bob Smith was a very successful insurance agent, specializing in health insurance products, and was careful to maintain a quality disability insurance policy on him. After moving up in the ranks, he started his own company, working with insurance companies and marketing firms by streamlining their recruiting programs. Bob had it all and nothing was going to stand in his way, or so he thought.

While being so busy with his endeavors of working with insurers, he made the oversight of letting his own personal disability policy lapse. Unfortunately, his insurance agents assumed he was protected and neglected to contact him about a disability insurance plan. As a smart

businessperson, Bob consistently put away money in mutual fund nest eggs for his retirement. However, Bob was not medically destined to reach age 53 before stroke after stroke and other severe medical conditions struck. Disability insurance is meant to pick up a large part of income when you can no longer work, like what happened to Bob.

You might think that Bob was fortunate, because he had a sizable retirement fund he could dig into. Social Security is a poor excuse for true assistance to a formerly hard-working person. Further mishap blew in like a hurricane when the economy went into a landslide. Bob's mutual fund values were suddenly cut by more than half, and his house value was substantially slashed. Bob lived the American Dream; however, he made one small slipup in letting his policy lapse.

Question: How would his situation be different had Bob kept his disability income insurance?

Answer: If he had kept his disability income insurance, he would right now have a much-needed steady check coming in monthly.

3.5.4.4 Risk of Unemployment

In tough economic times such as those facing the world today, the risk of unemployment is a major threat to an individual's financial security. Depending on the length of unemployment, an unemployed worker could exhaust any rainy-day fund or other replacement income they have accumulated in preparation for such an event either because they were ill prepared or because there is no other source available to replace that lost income.

3.5.5 Property Risks

Property risk can affect either personal or real property. Thus, a house fire or car theft are examples of property risk. A property loss often involves both a direct loss and consequential losses.

A direct loss is the financial loss from physical damage, destruction, or theft of property. A consequential loss (or indirect loss) is a loss that is created by the direct loss.

Note:

If a car is stolen, that is a direct loss; if an individual has to rent a car because of the theft, then they have incurred some financial loss—a consequential loss—from renting a car.

3.5.6 Liability Risks

Liability risk (also referred to as legal risk) is the type of personal risk where an individual may be sued because of neglect, malpractice, or causing willful injury either to another person or to someone else's property. The legal risk aspect is the possibility of financial loss if the individual is subsequently found liable. It also includes the financial loss incurred from defending the action, even if they are not found liable.

Liability risks are important for several reasons. First, there is no cap on the limit with respect to the amount of loss.

For Example:

Consider that you are in an automobile accident resulting in \$5,000 in damage to your vehicle. The actual physical damage is \$5,000. Now consider that the driver of the other vehicle is severely injured in the accident and sues. The liability risk in this instance can be any amount from \$50,000 or \$1 million, or more, dependent upon the severity of the injuries.

3.6 Burden of Risk on Society

The mere presence of risk can result in undesirable social and economic risks. The three typical burdens on society include:

- In the absence of insurance, individuals would have to maintain large emergency funds.
- The risk of a liability lawsuit may discourage innovation, depriving society of certain goods and services.
- Risk causes worry and fear.

Let's start with emergency funds.

3.6.1 Emergency Fund

Both businesses and individuals need an emergency fund. Moreover, if a business or an individual does not have insurance to cover unexpected emergencies, the size of their fund must grow exponentially.

For Example:

A home is valued at \$100,000. In the absence of insurance to cover loss from fire, hail, windstorm, or other perils, an individual would have to save approximately \$20,000 annually to build an adequate emergency fund. Moreover, even given this, that amount likely would not be sufficient to cover the loss.

3.6.2 Loss of Certain Goods and Services

At any given time, society may be deprived of certain goods and services. The presence of any risk associated with goods and services ultimately means that the cost is passed on to society. A good example of these costs are professional liability policies for physicians and surgeons who can pay upwards of \$50,000 annually in medical malpractice premiums. These costs are then passed on to patients who pay for the risk associated with the practice of medicine.

For Example:

In 1976, the swine flu broke out at a military base in Fort Dix, New Jersey. As the last major flu outbreak (in 1918-1919) resulted in the loss of 548,000 lives, President Gerald Ford recommended a national vaccine program. Initially, because of the risks associated with the vaccine, major drug manufacturers were unwilling to produce the vaccine and professional liability insurers were unwilling to offer complete liability coverage for those offering the vaccine. Obviously, the flu vaccine was eventually manufactured, with relatively few adverse reactions;

however, had the government not stepped in, society would have been deprived of the vaccine.

3.6.3 Worry and Fear

The final "burden" for individuals (society) is the presence of worry and fear. Some worries come and go with the news cycle; others are always with us. A 2024 poll by the Gallup organization showed the following as the top worries of Americans in response to a question about how often the respondents worry about these issues:

Issue	A great deal (%)	A fair amount (%)	Only a little/ Not at all (%)
Inflation	55	24	21
Crime and violence	53	26	21
Hunger and homelessness	52	28	20
The economy	52	26	22
The availability and affordability of healthcare	51	27	21
Federal spending and the budget deficit	51	26	22
Illegal immigration	48	18	34
Drug use	45	25	29
The Social Security system	43	24	32
The possibility of future terrorist attacks in the U.S.	43	23	33
The availability and affordability of energy	37	32	30
The quality of the environment	37	31	32
Race relations	35	29	36
Unemployment	33	25	43

Other polls and surveys have different results but have many issues in common. Insuring against or alleviating all of these worries or fears would be nearly impossible. No one insures against war or a bad economy. But insurance does have a place in relieving some of these worries.

3.7 Methods of Handling Risk

Because risk involves the possibility of loss, people, organizations, and society typically attempt to avoid risk, or in cases where risk is not avoidable, then they attempt to manage risk. There are five typical methods of handling risk:

- Avoidance
- Loss control
- Retention
- Noninsurance transfers
- Insurance

3.7.1 Avoidance

Avoidance is the elimination of risk. For instance, you can avoid the risk of a loss in the stock market by not buying or shorting stocks; the risk of divorce, by not marrying; the risk of having car trouble by not having a car; or the risk of crashing in an airplane by not flying. In the manufacturing arena, many manufacturers avoid legal risk by not manufacturing particular products.

Obviously, not all risks can be avoided, notably the risk of death. By adapting to a lifestyle built around avoiding risk, individuals may actually be avoiding many pleasures of life, or the potential profits that result from taking risks.

3.7.2 Retention

Risk retention involves handling the unavoidable risk internally. This is typically either because insurance cannot be purchased for the risk because it costs too much or because retention is much more cost-effective. Usually, retained risks occur with greater frequency but have a low severity.

For Example:

An insurance deductible is a common example of risk retention used to save money, since a deductible is a limited risk that lowers the insurance premiums for larger risks.

Risk retention typically takes on one of two forms: active retention or passive retention.

3.7.2.1 Active Retention

Active risk retention means that an individual or business is aware of the risk and, nevertheless, plans to retain all or part of it. Many businesses actively retain risks (e.g., self-insurance) because of the cost or unavailability of commercial insurance. Individuals often actively retain risks in the form of an insurance deductible since a deductible is a limited risk that will lower their insurance premiums.

3.7.2.2 Passive Retention

Passive risk retention involves retaining risk either because the risk is unknown or because the risk taker does not know the risk exists or does not give the risk the proper level of consideration (i.e., they think the level of risk is smaller than it actually is). Some examples include:

- **Smoking cigarettes.** Smoking cigarettes can be considered a form of passive risk retention, since several people smoke without knowing the many risks of disease—and those that do know the risks do not think it will happen to them.
- **Speeding.** Many people think they can handle speed, and that there is no risk involved with driving fast. However, the risk is always greater when speeding, since it always takes longer to stop, and, in a collision, higher speeds will always result in more damage and the added risk of serious injury or death.

3.7.3 Noninsurance Transfers

Risk can also be managed by noninsurance transfers. The three major forms of noninsurance risk transfer are by contract, hedging, and, for business risks, by incorporating.

3.7.3.1 Transfer by Contracts

A typical transfer of risk by contract is by purchasing the warranty extension that many retailers offer for the items that they sell. The warranty itself transfers the risk of manufacturing defects from the buyer to the manufacturer.

There are times, however, when transfers of risk through contract are prevented by a hold-harmless clause, which may limit liability for the party to whom the clause applies. For instance, if the manufacturer of a scaffold inserts a hold-harmless clause in the contract with the retailer, the retailer agrees to hold the manufacturer harmless in the event the scaffold collapses and injury occurs. (We will discuss contracts in more detail later in the course.)

3.7.3.2 Hedging Price Risks

Hedging is a method of reducing portfolio risk or some business risks involving future transactions. Thus, the possible decline of a stock price can be hedged by buying a put for the stock. A business can hedge a foreign exchange transaction by purchasing a forward contract that guarantees the exchange rate for a future date. Investors can reduce their liability risk in a business by forming a corporation or a limited liability company. This prevents the extension of the company's liabilities to its investors.

3.7.3.3 Incorporation of a Business Firm

Incorporation is another form of risk transfer for businesses. An example might be a sole proprietorship. This type of business formation typically puts the owner's personal assets at risk of attachment by a creditor to satisfy debts. If that individual incorporates their business, those personal assets are typically protected from attachment.

3.7.4 Loss Control Generally

Loss control works by either **loss prevention**, which involves reducing the probability of risk, or **loss reduction**, which minimizes the loss. Losses can be prevented by identifying the factors that increase the likelihood of a loss, then either eliminating the factor or minimizing its effect.

Most businesses actively control losses because it is a cost-effective way to prevent losses from accidents and damage to property. Loss control generally becomes more effective the longer the business has been operating.

3.7.4.1 Loss Prevention Generally

Loss prevention is typically aimed at reducing the probability of loss, thereby reducing the frequency of loss. Let's take a look at examples of loss prevention.

For Example:

Personal loss prevention examples might include:

- Automobile accidents can be reduced if motorists take safe driving courses.
- The number of heart attacks can be reduced if individuals lose weight, quit smoking, and follow good health habits.

Business loss prevention examples might include:

- A boiler explosion can be prevented by periodic inspections by a safety engineer.
- Occupational accidents can be reduced by eliminating unsafe working conditions.
- Fires can be prevented by forbidding employees to smoke in an area where highly flammable materials are stored.

3.7.4.2 Loss Reduction Generally

Although loss prevention efforts are the typical method for handling risk, it is inevitable that losses will occur. It is in these instances that loss reduction measures come into play.

For Example:

A plant constructed with fire resistant materials would obviously minimize the loss of fire. Further, firewalls and fire doors can prevent a fire from spreading.

3.8 Risk Management

Now that you have a basic understanding of risk and perils, let's discuss risk management. Risk management is the process of identification and evaluation of pure loss exposures and for the administration of the most appropriate measures for addressing such exposures.

3.8.1 The Risk Manager

Most large corporations, governmental units, and educational institutions have some form of formal risk management program or department. Additionally, many firms have an appointed risk manager. The risk manager is the individual responsible for managing an organization's risks and minimizing the adverse impact of losses on the achievement of the organization's objectives. Traditionally, risk managers have focused on event risks, but some organizations have expanded the role to include other types of risk (e.g., operational risks). It is the responsibility of the risk manager to:

- Identify risks
- Evaluate risks
- Select the best techniques for treating identified risks
- Implement the chosen risk management techniques
- Regularly evaluate and monitor the program

The risk manager is also involved in the managerial processes of planning, organizing, leading, and controlling those activities in a business that deals with various types of risk.

3.8.2 Risk Management Objectives

The objective of a typical risk management program includes both pre-loss and post-loss objectives.

Prior to a loss occurring (pre-loss objectives), goals typically are focused on:

- The economic impact (e.g., preparation for potential losses in the most economical way)
- The reduction of anxiety (e.g., alleviating worry and fear of executives and stockholders)
- Complying with externally imposed obligations (e.g., government regulations)

Once a loss has occurred (post-loss objectives), however, the goals change and include:

- Survival of the business (e.g., the firm can resume at least partial operations after loss)
- Continued operations (e.g., a public utility continuing operations after a storm)
- Stability of earnings (e.g., maintaining earnings per share after a loss occurs)
- Continued growth (e.g., the ability to enter into acquisitions and mergers)
- Social responsibility (e.g., minimizing the impact of a loss on society)

Once all of these objectives are set, the risk management process begins. This process typically involves:

- Identifying potential losses
- Evaluating potential losses
- Selecting the appropriate technique or combination of techniques for treating loss exposures
- Administering the program

Although insurance is only one component of the risk management process, it is the most widely used and we will focus our attention on the insurance component of risk management next.

3.8.3 Risk Management Through Insurance

Insurance is the primary (and most practical) method that most individuals and businesses alike use to transfer pure risks by paying a premium to an insurance company in exchange for payment of a possible large loss.

By using the law of large numbers, an insurance company can estimate, fairly and reliably, the amount of loss for a given number of customers within a specific time. An insurance company can pay for losses because it pools and invests the premiums of many subscribers to pay the few who will have significant losses. Not every pure risk is insurable by private insurance companies. Private insurers do not insure events that are unpredictable and that could cause extensive damage, such as earthquakes. Nor are most speculative risks insured—risks taken in the hope of making a profit.

From the viewpoint of risk management, insurance is essentially a contractual transfer of risk. Insurance is an even more important risk management tool when the chance of loss is low and the severity of a potential loss is high. Both individuals and firms meet these two criteria. For

small firms, insurance is typically the foundation of their risk management program. Larger firms typically face circumstances requiring commercial coverage, and, in some cases, the law requires this insurance.

Once insurance is chosen as the method to address certain loss exposures, there are key areas to explore, such as:

- Selection of insurance coverage(s)
- Selection of an insurer
- Negotiation of terms

The work of the risk manager does not stop with merely selecting insurance. The risk manager must make sure that all terms of the insurance contract are adhered to.

For Example:

The insurance contract may be conditioned on the company employing a security guard or maintaining a particular fire sprinkler system. It is the job of the risk manager to make sure these conditions are met.

3.8.3.1 Selecting Insurance Coverage

This step in the process should be fairly obvious. The key is assessing importance of coverage and then determining which insurance is appropriate to address these needs. This process typically involves classifying need into three categories:

- Essential insurance
- Desirable insurance
- Available insurance

Using these categories, specific coverages might include:

- Essential insurance: Workers' compensation or liability insurance
- Desirable insurance: Coverage for financial difficulty
- Available insurance: Coverages for losses that may merely inconvenience a firm

It is in this step of the process that such things as assessing deductibles would occur. The decision on a deductible would fall in line with the risk retention discussion we had earlier.

3.8.3.2 Selecting an Insurer

In selecting an insurer, a risk manager typically looks at the financial strength of the insurer, risk management services provided by an insurer, and the cost of insurance offered. A knowledgeable insurance agent or broker typically assists in this selection.

Note:

It is the cost of insurance that typically drives a risk manager to choose or not choose a particular coverage, or, for that matter, a particular insurer.

3.8.3.3 Negotiation of Terms

Negotiating an insurance contract is one of the primary roles of a risk manager. They will have to review all printed policies, endorsements, and forms to ensure that the insurance contract formed will provide the best coverage for their firm.

For large firms, this stage of the process may also include negotiation of premiums or, in the event the premium is non-negotiable, pointing the insurer to the fact that the firm is part of a different underwriting classification, resulting in lower premiums being assessed.

3.8.4 Requirements of an Insurable Risk

As you learned earlier in this course, insurers typically will only insure pure risks. However, not all pure risks are insurable. Certain requirements usually must be fulfilled before a pure risk can be privately insured. From the viewpoint of the insurer, there are (ideally) six requirements of an insurable risk.

- There must be a large number of homogeneous exposure units.
- The loss must be accidental and unintentional.
- The loss must be determinable and measurable.
- The loss should not be catastrophic.
- The chance of loss must be calculable.
- The premium must be economically feasible.

3.8.4.1 Law of Large Numbers / Homogenous Units

One basic requirement to induce insurance companies to insure a risk is that the total payout would have to be fairly predictable in a large sample of the population. Obviously, there will be some variation in total losses from year to year; however, these losses should not deviate too much from the mean over time. In order to be predictable, both the frequency and the severity of losses should be calculable.

Because these calculations rely on the law of large numbers, there would have to be a large number of exposure units, the basic items that are insured. Without accurate forecasting, an affordable premium cannot be calculated. The law of large numbers is based on the observation that the greater the number of events that have a given or observed probability, the less the observed frequency will deviate from the expected frequency.

For Example:

To better understand the law of large numbers, let's revisit our earlier example of the coin toss. The chance, in any one toss, that it will come up heads or tails is 50/50, but if the coin were tossed 10 times, there is a small possibility that all 10 flips will yield heads. Even if it is not all heads or all tails, there is a very good chance that the observed frequency will deviate significantly from the expected 50/50 chance. However, if the coin were flipped 1 million times, then heads and tails will be more nearly equal.

Let's apply the law of large numbers to catastrophic losses, such as floods, earthquakes, and war. Given the fact that these events often occur erratically, and typically with great destruction, both the frequency of occurrence and the severity of losses cannot be accurately forecasted, and, thus, catastrophic losses are usually not insured by private companies.

Put another way, insurable risk requires the existence of a large number of homogeneous exposure units. As we noted earlier, this means there is a large group of roughly similar exposure units that are exposed to the same peril or group of perils.

For Example:

A large number of frame dwellings can be grouped together in one underwriting class for purposes of providing fire insurance on the dwellings.

It is important to keep in mind, however, that a large number of heterogeneous or substantially different exposure units do not fulfill this requirement. The exposure units must be roughly similar to each other in terms of loss-producing characteristics. If substantially different exposure units were grouped together, it would be difficult for the insurer to predict accurately the average frequency and severity of claims. It is for this reason that frame dwellings, manufacturing plants, churches, schools, office buildings, and other structures are not typically grouped together in one class. Because of their dissimilar nature, the chance of loss would be difficult to calculate accurately.

3.8.4.2 Accidental and Unintentional

In addition, to keep premiums in line, most policies require that covered losses must be accidental and unintentional. If losses were not accidental or unintentional, then the issue crops up of people causing losses to collect insurance. These acts raise premiums to unaffordable levels, and make payouts by the company unpredictable, since the losses would not occur by chance. Further, people would stop paying premiums if they knew that the premiums were used to enrich dishonest people. When a loss is accidental and unintentional, it means that, ideally, it should be fortuitous and outside the insured's control. Obviously, this means that if an individual deliberately causes a loss, it should not be paid.

The requirement of an accidental and unintentional loss is necessary for two reasons. First, if intentional losses were paid, moral hazard would be substantially increased, and premiums would rise as a result. The substantial increase in premiums could result in relatively fewer people purchasing the insurance. The insurer may not then have a sufficient number of homogeneous exposure units to predict future losses.

Secondly, the law of large numbers is based on the random occurrence of events. A deliberately caused loss is not a random event since the insured knows when the loss will occur. Consequently, since prediction of future losses is based on past loss experience, the prediction of future experience may be highly inaccurate if a large number of intentional or non-random losses occur.

3.8.4.3 Determinable and Measurable

A third requirement is that the loss should be both determinable and measurable. This means the loss must be definite as to cause, time, place, and amount. Life insurance in most cases meets this requirement easily. The cause and time of death can be readily determined in most cases, and if the person is insured, the face amount of the life insurance policy is the amount paid.

From an insurer's perspective, loss must be determinable because an insurance company will only pay for a loss if the loss was for a covered reason. The loss must be measurable so the insurer can determine what to pay out, as insurance companies will only pay to cover the actual loss, and typically no more than that. The reason is that if insurance companies paid more than the actual loss, then insureds could, in theory, make a profit by causing partial losses, then collecting the entire amount from the insurance company. These actions would not only increase premiums because of the larger payout but would also create a moral hazard (as discussed earlier in the course) by motivating some people to cause losses to profit from insurance, raising premiums to an even higher level. Some losses, however, are difficult to determine and measure.

For Example:

Under a disability-income policy, the insurer promises to pay a monthly benefit to the disabled person if the definition of disability stated in the policy is satisfied. Some dishonest claimants may deliberately fake an illness or injury in order to collect from the company. Even if the claim is legitimate, the company must still determine whether the insured satisfies the definition of disability as stated in the policy.

Sickness and disability are highly subjective, and the same event can affect two persons quite differently.

For Example:

Two accountants who are insured under separate disability-income contracts may be injured in an automobile accident, and both may be classified as totally disabled. One accountant, however, may be stronger willed and more determined to return to work. If they undergo rehabilitation and return to work, the disability-income benefits are terminated. Meanwhile, the other accountant would still continue to receive disability-income benefits according to the terms of the policy.

In short, it is difficult to determine when a person is actually disabled.

Note:

The basic purpose of this requirement is that the insurer must be able to determine if the loss is covered under the policy, and further, if it is covered, how much the company will pay. For example, Mary may have a fur coat insured under her homeowners policy. It makes a great deal of difference to the insurer whether a thief breaks into her home and steals the coat or the coat is missing merely because her husband stored the coat in a dry-cleaning establishment but forgot to tell her. The loss is covered in the first example but not in the second.

3.8.4.4 No Catastrophic Loss

Still another requirement is that the loss should not be catastrophic. This means that ideally a large proportion of exposure units should not incur losses at the same time. As we will discuss later in this course, pooling is the essence of insurance. If most or all of the exposure units in a certain class simultaneously incur a loss, then the pooling technique breaks down and becomes unworkable. Premiums must be increased to prohibitive levels, and insurance is no longer a viable arrangement by which losses of the few are spread over the entire group.

Insurers ideally wish to avoid all catastrophic losses, but in the real world, this is impossible, as catastrophic losses commonly result from floods, hurricanes, tornadoes, earthquakes, forest fires, and other natural disasters.

Fortunately, two approaches are available for meeting the problem of a catastrophic loss. The first, reinsurance, can be used by which insurance companies are indemnified by reinsurers for catastrophic losses. Reinsurance is the shifting of part or all of the insurance originally written by one insurer to another insurer. The reinsurer is then responsible for the payment of excess losses that exceed a maximum limit.

Secondly, insurers can avoid the concentration of risk by dispersing their coverage over a large geographical area. The concentration of loss exposures in some areas exposed to frequent floods, tornadoes, hurricanes, or other natural disasters can cause periodic catastrophic losses. If loss exposures are geographically dispersed, the possibility of such a catastrophic loss is reduced.

3.8.4.5 Loss Must Be Calculable

Another requirement is that the chance of loss must be calculable. This means that the insurer must be able to calculate both the average frequency and the average severity of future losses with some accuracy. This is necessary so that appropriate premiums can be charged to sufficiently pay all claims and expenses, yet yield the insurer a profit during the policy period.

Certain losses, however, are difficult to insure because the chance of loss cannot be accurately estimated, and the potential for a catastrophic loss is present.

For Example:

Floods, war, and cyclical unemployment occur on an irregular basis, and prediction of the average frequency and the severity of losses is difficult. Thus, without government assistance, these losses are difficult for private carriers to insure.

3.8.4.6 Affordable Premiums

If premiums are not affordable, too few people would want or be able to buy insurance. Here is where this aspect of risk management through insurance becomes a bit more complicated. For instance:

- If too few people buy the insurance, then the risk is spread among fewer people; the fewer the people, the higher the premium would have to be to cover potential losses.
- If the premium is not considerably less than the policy coverage, individuals would simply self-insure.

3.8.5 Loss Control Through Insurance

The simple definition of insurance is the pooling of money from a group of people or organizations to pay for the fortuitous losses that any of them may suffer. This pool of money (premiums paid) is exchanged for a promise from the insurer to indemnify any of its customers for covered losses. The insurer may also provide risk management services.

Let's take a look at the following distinct characteristics of loss control through insurance:

- Pooling of losses
- Risk transfer
- Indemnification

3.8.5.1 Pooling of Losses

This characteristic of insurance, as the name (and definition of insurance) implies, involves the pooling of losses among its customers. In return for losing a little money in the form of a premium, customers are indemnified against a large loss. As a result, the average loss among a group of people is substituted for actual losses.

For Example:

Consider a sample of 1,000 farms, and suppose that each farm was identical and had the same value of \$300,000 for the house and barn. Over the years, it was discovered that one farmer would have a total loss every year. If a farmer's buildings burned completely, the farmer would be out \$300,000, but if each farmer paid into a fund every year to pay for the fires, then each would only have to pay $300,000/1,000 = \$300$ per year. Thus, for \$300 per year, each farmer can avoid a loss of \$300,000 if they suffer a fire that destroys both house and barn.

3.8.5.2 Risk Transfer Through Insurance

Risk transfer is another essential element of insurance. With the exception of self-insurance, a true insurance plan always involves risk transfer. Risk transfer means that a pure risk is transferred from the insured to the insurer, who typically is in a stronger financial position to pay the loss than the insured. From the viewpoint of the individual, pure risks that are typically transferred to insurers include the risks of premature death, poor health, disability, destruction, theft of property, and liability lawsuits.

3.8.5.3 Indemnification for Losses

A final characteristic of insurance is indemnification for losses. The insured is indemnified if a covered loss occurs. Indemnification means that the insured is restored to their approximate financial position prior to the occurrence of the loss.

For Example:

If a home burns in a fire, the homeowners policy will indemnify or restore the insured to their previous position. If an insured is sued because of the negligent operation of an automobile, that automobile liability insurance policy will pay on behalf of the insured those sums that the

insured is legally obligated to pay. Similarly, if an insured is seriously disabled, a disability-income policy will restore part or all of the wages lost.

3.8.6 Loss Control Regulation

In addition to what we have discussed, it should be noted that loss control is regulated on the commercial level in some states. In Texas, for example: the Insurance Code, specifically Sec. 1952.058, entitled “Loss Control Information and Services Required” provides:

(a) An insurer must provide loss control information as a prerequisite to writing commercial automobile liability insurance in this state.

(b) The insurer shall provide to the insurer's policyholders loss control information reasonably commensurate with the risks, exposures, and experience of the insured's business. To provide loss control information or services, the insurer may:

- (1) employ qualified personnel;
- (2) retain qualified independent contractors;
- (3) contract with the policyholder to provide qualified loss control personnel and services; or
- (4) use a combination of methods described by this subsection.

(c) If there is evidence that an insurer is not providing reasonable loss control information or is not using that information in a reasonable manner to reduce losses, the commissioner shall order a hearing to determine whether the insurer is in compliance with this section. If the commissioner determines that the insurer is not in compliance, the commissioner may impose any sanction authorized by Chapter 82.

(d) An insurer or an agent or employee of the insurer is not liable, and a cause of action does not arise against the insurer, agent, or employee, for any accident based on the allegation that the accident was caused or could have been prevented by a program, information, inspection, or other activity or service undertaken by the insurer for the prevention of accidents in connection with operations of the insured. The immunity provided by this subsection does not affect the liability of an insurer for compensation or as otherwise provided in an insurance policy.

(e) Loss control information an insurer provides to an insured under this section is not subject to discovery and is not admissible as evidence in any civil proceeding.

(f) The commissioner, after holding a public hearing on the proposed rules, may adopt reasonable rules for the enforcement of this section.

(Source: <https://codes.findlaw.com/tx/insurance-code/ins-sect-1952-058.html>)

3.9 Insurance Risks

One way that the insurance industry encourages economic activity is by pooling the risks of many policyholders. Pooling risk reduces the amount of resources necessary to provide a given

level of protection and thereby frees up resources that can be used for other purposes.

Insurance protects a policyholder from loss by spreading the policyholder's risk among the other policyholders and the owners of the insurance company. Policyholders pay premiums to insurance companies for protection during a specific period of time. These premiums add to the reserves of insurance companies, which are then used to finance payments to policyholders.

For Example:

When a policyholder suffers an insured loss and files a claim for loss with their insurer, the insurer pays for the loss by drawing down its reserves by the amount of the claim. Because not all policyholders typically suffer losses at the same time, the insurer can lower the amount of reserves it needs to hold against the potential losses of policyholders.

3.9.1 Spreading Risk Through Reinsurance

An insurer can also effectively spread these risks among policyholders of other insurers using "reinsurance." Insurance companies buy reinsurance to guard against the risks they have insured. Like individuals and businesses that wish to lower their exposure to the various risks of everyday life, an insurance company may wish to lower its exposure to the risks it has insured. This is particularly true in the case of a large risk relative to the insurance company's capital and surplus and when many of its risks have similar chances of occurring. An insurance company can spread some of its risks by paying other insurers, known as reinsurers, to assume these risks.

The reinsurance transaction is straightforward. A primary insurance company—one that writes life, health, property, or casualty insurance—pays for the reinsurance by giving or ceding a portion of the associated premium receipt to the reinsurer, which is willing to assume the risk. The reinsurer in turn pays the primary insurer a ceding commission as a payment for originating the policy and agrees to pay the primary insurer a portion of the loss associated with the risk. Note, however, that the primary insurer remains liable for paying all losses to insured parties in the event that the reinsurer does not pay.

A risk insured by a primary insurer can be spread among a large number of reinsurers. After the primary insurer cedes the risk, the reinsurer may reinsure some of the risk with other insurance companies called "retrocessionaires," which in turn also may reinsure some of the risk with other insurers, and so on. In the terminology of the insurance industry, a reinsurer may "retrocede" its risks to other reinsurers.

Reinsurance not only spreads risks more widely but also increases the supply of insurance. A primary insurer cannot write policies beyond its underwriting capacity, the amount that its capital and surplus can support. By ceding risks to reinsurers, a primary insurer essentially frees up a portion of its surplus that can be used to support more insurance policies.

Because property and casualty risks are generally more difficult to estimate than life and health risks, reinsurance is more prevalent among property and casualty insurers than among life and health insurers.

3.9.2 Insurance Company Equity Holder Assumption of Risk

Apart from policyholders, the owners or equity holders of insurance companies also assume some of the insurance risks. In particular, they assume some of the risk of abnormally large losses by policyholders because the chances and the magnitudes of losses are not known with certainty. When insured losses are abnormally large, but not large enough to cause the insurance company to fail, the equity holders of the company must bear some of the burden of paying for the abnormal losses through lower dividends and a drop in the market value of the insurers' equity.

The protection given to a single policyholder arises because losses are spread widely, not because losses are eliminated for the whole economy. When a natural disaster destroys property, for example, this destruction is a permanent loss for the economy, which lowers the productive capacity of the economy. Property insurers pay policyholders for the insured losses they have suffered, but they do so by withdrawing funds from their resources: reserves, capital, and surplus. The total loss of property to the economy is not changed. The lost property is replaced by reducing the financial capital of insurers.

3.9.3 Pooling Risk

When insurers pool risk, it enhances social welfare. This means that it makes individuals and businesses better off not only because they generally do not like certain risks but also because pooling risk makes a wider assortment of goods and services available to individuals and businesses. Individuals are more willing to own houses and cars, for example, when they can buy insurance against costly accidents to, or created by, these items. Businesses are more willing to supply products such as medical drugs when they can buy product liability insurance. The larger supply of goods and services from these risky activities does not necessarily come at the expense of a smaller supply of low-risk activities. Risk pooling promotes a greater level of economic activity than would exist without insurance. By pooling many risks, insurance companies can economize on the amount of resources necessary to provide a given level of risk pooling, and thereby free up resources that they can use for other purposes.

Now that you have a thorough understanding of risk, let's take a look at a case study outlining a failure to appropriately address the potential for risk and the failure of their risk management system.

Scenario:

In 1992, the City of Chicago sustained approximately \$1 billion in damage when its business area was flooded. This flood resulted from a hole punched into the roof of one of the city's tunnels beneath the Chicago River. This tunnel was part of a maze of tunnels used earlier in the century to deliver coal and other materials beneath the busy city streets.

This flood caused a maximum probable loss because a series of steps in the risk management process were not followed. First, this source of loss was never considered by city managers, although there was a procedure in place for securing city approval before beginning construction projects in the affected area. Next, the initial leaks were detected approximately three months before the disaster occurred; however, there were no clear lines of communication to a central risk management authority. This communication is essential in any risk management program. Because the loss potential was not realized, no risk management

control procedures were used, and no prevention or reduction techniques were in place. Upon closer examination, it was determined that strategically placed bulkheads (at a cost of \$15,000 each) could have greatly lessened the scope of the damage.

Question: Why did this catastrophic risk occur?

Answer: This catastrophic loss arose because of a series of breakdowns in the risk management process. If the potential loss had been identified, greater supervision near the tunnels may have taken place, and loss reduction measures could have been taken before the loss. Additionally, risk-financing techniques, such as catastrophic insurance coverage, may have been put into place.

Section Review:

1. The variations in a study, such as the number of houses that have burned versus those likely to burn in any year in a random sampling of 100, is referred to as _____ risk. Refer to Section 3.2, page 4

A. Subjective **[Your answer is incorrect. Variations in a study are not subjective risk.]**

B. Objective **[Your answer is correct. Objective risk involves the study of the actual number of losses versus the total possible.]**

C. True **[Your answer is incorrect. Variations in a study are not true risk.]**

D. Random **[Your answer is incorrect. Variations in a study are not random risk.]**

2. Which of the following is likely to influence an individual's subjective probability by causing them to overestimate their physical abilities? Refer to Section 3.4.2, page 5, Key Point

A. Age **[Your answer is incorrect. Age does not typically affect subjective probability in this manner.]**

B. Intelligence **[Your answer is incorrect. Intelligence does not typically affect subjective probability in this manner.]**

C. Sex **[Your answer is incorrect. The sex of an individual does not typically affect subjective probability in this manner.]**

D. Alcohol Use. **[Your answer is correct. Alcohol influences an individual's subjective probability by causing most individuals to overestimate their physical skills and abilities.]**

3. What risk aspect involves the possibility of financial loss if the individual is subsequently found liable, or the financial loss incurred just defending an action, even if not found liable?

Refer to Section 3.5.6, page 12

A. Legal **[Your answer is correct. The legal risk aspect is the possibility of financial loss if the individual is subsequently found liable, or the financial loss incurred just defending an action, even if not found liable.]**

B. Personal **[Your answer is incorrect. Personal risk is not the aspect involving the possibility of financial loss.]**

C. Property **[Your answer is incorrect. Property risk does not involve financial loss if an individual is not found liable.]**

D. Subsequent **[Your answer is incorrect. Subsequent risk does not involve the possibility of financial loss if the individual is subsequently found liable, or the financial loss incurred just defending an action, even if not found liable.]**

4. Which of the following is not a typical burden on society as a result of risk? Refer to Section 3.6.3, pages 13-14

A. The need for large emergency funds **[Your answer is incorrect. The need for large emergency funds is a typical burden.]**

B. Deprivation of goods and services **[Your answer is incorrect. Deprivation of goods and services is a typical burden.]**

C. Worry and fear **[Your answer is incorrect. Worry and fear are burdens on society.]**

D. Sudden death **[Your answer is correct. Although sudden death is obviously a personal concern, the three typical burdens on society include:**

- **In the absence of insurance, individuals would have to maintain large emergency funds**
- **The risk of a liability lawsuit may discourage innovation, depriving society of certain goods and services**
- **Risk causes worry and fear]**

5. **True or False.** All risk can be avoided. Refer to Section 3.7.1, page 14

A. True **[Your answer is incorrect.]**

B. False **[Your answer is correct. Obviously, not all risks can be avoided, notably the risk of death. By adapting to a lifestyle built around avoiding risk, individuals may actually be avoiding many pleasures of life, or the potential profits that result from taking risks.]**

6. Which of the following would not be considered a loss reduction measure? Refer to Section 3.7.4.2, pages 16-17

A. Fire resistant materials used to construct a building **[Your answer is incorrect. Using fire resistant materials is a loss reduction measure.]**

B. Firewalls installation **[Your answer is incorrect. Firewalls installation is a loss reduction measure.]**

C. Fire door installation **[Your answer is incorrect. Fire door installation is a loss reduction measure.]**

D. Landscaping with trees and bushes in a wildfire area **[Your answer is correct. Loss reduction measures might include a plant constructed with fire resistant materials which would obviously minimize the loss of fire. Further, firewalls and fire doors can prevent a fire from spreading.]**

7. Insurance companies typically use _____ to estimate the amount of loss for a given number of customers within a specific time. Refer to Section 3.8.4.1, page 20

A. A single insured's past claims history **[Your answer is incorrect. Insurers do not use past claims to estimate the amount of loss for a given number of customers.]**

B. The law of large numbers **[Your answer is correct. By using the law of large numbers, an insurance company can estimate, fairly and reliably, the amount of loss for a given number of customers within a specific time.]**

C. Accountants **[Your answer is incorrect. Insurers do not use accountants to estimate the amount of loss for a given number of customers.]**

D. Graphing **[Your answer is incorrect. Insurers do not use graphing to estimate the amount of loss for a given number of customers.]**

8. **True or False.** When insurers pool risk, it has no impact on social welfare. Refer to Section 3.9.3, page 27

A. True **[Your answer is incorrect.]**

B. False **[Your answer is correct. Pooling risk enhances social welfare, which means that it makes individuals and businesses better off not only because they generally do not like certain risks but also because pooling risk makes a wider assortment of goods and services available to individuals and businesses.]**

Let's move on to a look at the "industry" as a whole.

4.0 The Property and Casualty Industry

The property-casualty insurance industry can best be described as a risk-bearing enterprise. That means that in the event of a loss, insurance is the means by which the burden of that loss — whether related to the destruction of property or an incurred liability — is shared. Typical property and casualty policies include auto coverage, workers' compensation coverage, homeowners' coverage, and others.

In the property and casualty industry, there are two kinds of ownership structures: mutual and stock. The mutual insurance ownership structure is a type where those protected by the insurance (policyholders) also have certain "ownership" rights in the organization. These "ownership" rights typically consist of the ability to elect the management of the organization and to participate in a distribution of any net assets or surplus should the organization cease doing business. Interestingly, insurance began in the U.S. through the mutual (or cooperative) structure.

A stock insurance company, on the other hand, is one for which investors (that is, shareholders) are issued stock as evidence of their ownership interest, which is represented by shareholders' equity.

Recently, some insurance companies have gone through demutualization (a topic we will discuss later in this course) and became public companies in an effort, among other things, to improve their ability to acquire capital.

4.1 Lines of Coverage

Although property-casualty insurance is available on a wide variety of coverages, several lines constitute the bulk of industry premium volume. These lines of coverage include:

- **Automobile coverage.** This is the largest property and casualty line; it covers both physical (property) damage and car owners' liability. Automobile coverage (both personal and commercial) has long dominated the industry's product mix. Its growth has been fueled by the adoption of mandatory automobile insurance in most states and by escalating litigation and medical care costs.
- **Workers' compensation.** Another common line of business for the property and casualty industry is workers' compensation. This business line insures organizations that are required by state laws to compensate employees who are injured or disabled because of an occupational hazard. It also helps compensate families of employees killed on the job. During the 1960s and 1970s, the growth in this business line was helped by changes in certain state laws that increased mandated coverage and by the general upgrading of benefit levels. However, in the past several years, this market has contracted as corporations and local governments have sought less costly means of providing this coverage, such as self-insuring.

Some insurers have also withdrawn from this line of business in response to poor underwriting results.

- **Other lines.** The remaining share of the market comprises a variety of types of coverage, including homeowners' multi-peril coverage, commercial multi-peril coverage, and an array of liability coverages.

Insurance companies distribute their personal and commercial policies either through direct selling systems or agency systems. In a direct selling distribution system, the insurance company (sometimes referred to as a direct writer) contacts its customers ("insureds") through its own employees. Within this framework, the insurer sells policies through a number of outlets, including direct mail and company-run agencies.

Under an agency system, the insurer contracts outside agents to sell its policies in exchange for a commission. Some agents may sell only a single insurer's policies ("exclusive agents"), while others ("independent agents") may offer policies from various insurance companies.

While there are advantages and disadvantages to both systems, the tradeoff is between costs and control. A direct selling system can be expensive to establish and operate, but it gives an insurer more control over the distribution process. The agency system reduces the amount of control an insurer has over each aspect of the distribution system, but it usually offers an established network through which the insurer can distribute its products. This is especially helpful to small and regional insurers without the means to establish their own distribution network.

4.2 Insurance Company Revenue

Regardless of an insurance company's ownership structure, the insurance business is one of shared risk. Insurers collect payments in the form of premiums from people who face similar risks. A portion of those payments is set aside to cover policyholders' losses. Therefore, earned premiums are typically an insurer's primary revenue source.

This means that at the time a policy is issued, it is recorded on the insurer's books as a written premium. Then, over the life of the policy, the premium is "earned," or recognized as revenue, on a fractional basis. These premiums are classified as deferred revenues and assigned to an unearned premium reserve, which is classified as a liability on an insurer's financial statement.

For Example:

There is a typical lag of approximately 12 months between the time a policy is written and the time the full premium is recognized as revenue. For example, a \$600 premium for a year of auto insurance coverage would be "earned" by the insurer at the rate of \$50 a month for 12 months.

After premiums, the second-largest component of insurer revenues is investment income. This revenue is realized from investing the funds set aside for loss reserves and unearned premium reserves and from policyholders' surplus or shareholders' equity.

The last, and typically smallest, revenue component an insurer realizes is investment gains.

This is the most volatile and hardest-to-predict component. Realized investment gains typically arise from the sale of securities (usually stocks and bonds) held in an insurer's investment portfolio. The timing and magnitude of the gains depends on conditions in the securities markets, which by their nature are dynamic, making it difficult to forecast realized investment gains.

4.3 Insurance Company Expenses / Liabilities

An insurer's revenue covers a variety of expenses. These include commissions, losses, and other operating expenses.

The commission paid to the insurance agent or salesperson for selling a policy is usually deducted immediately from the collected premium. The insurance company generally accounts for this commission by deducting it from its policyholders' surplus account and crediting it to the unearned premium reserve.

After commissions are paid, premium dollars are used to cover a variety of expenses. The largest expense facing a property-casualty insurer is losses (typically referred to as policyholder claims). Insurer's funds are also used to pay claims-related expenses and loss adjustment expenses, including insurance adjusters' fees and litigation expenses. Additionally, insurers face expenses related to the underwriting process, such as salaries for actuarial staff. The underwriting profit (or loss) is determined by subtracting these expenses from earned premiums.

Like most other companies, insurers incur various other operating expenses and interest costs. Pretax profits are calculated by subtracting these expenses from underwriting profits. Finally, after-tax (or net) income is derived by taking pretax profits and subtracting dividends and federal and state income taxes.

Many property-related insurance claims are settled relatively quickly. They are often referred to as "short-tail" liabilities because the time period between the incident causing the loss — such as a storm that damages a home — and the claim settlement is relatively short. Because of their liability profile, property and casualty insurers maintain the vast majority of their assets in highly liquid investments that can be quickly converted to cash. This liquidity ensures that policyholders can be paid promptly in the event of a loss.

4.4 Loss Reserves

An insurer derives funds for investment from three primary sources: its loss reserves, its unearned premium reserve, and its policyholders' surplus. Loss reserves — the funds set aside to pay claims — are by far the largest component of the property-casualty industry's liabilities.

The second-largest liability on an insurer's books, and a principal source of investment income, is the unearned premium reserve. The unearned premium reserve represents the liability for that portion of a written premium that has been charged to the policyholder but hasn't yet been used.

For Example:

Recalling our earlier example of the \$600 annual auto insurance premium, the unearned

premium reserve would total \$550 at the end of the first month, because \$50 (or 1/12th) of the annual premium had been “earned,” or accounted for as an earned premium on the insurer’s books.

As the largest component of an insurer’s liabilities, loss reserves play a significant role in an insurer’s financial results. An insurer’s prosperity depends largely on its ability to accurately quantify the ultimate cost of the losses from the risks it assumes.

When reserve levels are too high — that is, when an insurer sets aside too much money to pay future claims — profits appear lower than they actually are. As a result, premium rates might not appear high enough to cover losses, causing the insurer to unnecessarily raise its rates. On the other hand, if reserves are too low, profits will be inflated, leading an insurer to lower its rates inappropriately. Either way, once losses develop, inaccurate reserve levels will ultimately have to be adjusted. Unfortunately, use of such erratic accounting adjustments can make an insurer’s financial position seem unstable.

For insurers, reserving for losses and setting premium levels involve estimating the ultimate value of future losses. This is, however, a complicated and difficult process. In addition to the unpredictability of natural disasters, forecasts of future losses are subject to several other variables, including real economic growth, inflation, interest rates, sociopolitical trends, judicial rulings, and voter initiatives.

Making the reserving process even more difficult is the trend, in recent years, toward a greater proportion of the insurance business being written in casualty lines. This is because it is considerably harder to estimate the ultimate losses from casualty lines than from property lines such as homeowners’ coverage, because casualty lines have “long tails.” Long tails are the period between the origination of the policy, the event leading to a claim and the subsequent payment of that claim, which could take years — or even decades. Additionally, inflation can have a highly negative impact on the insurer’s eventual costs as the liability’s “tail” lengthens. On the plus side, however, this characteristic of casualty lines lets the insurer invest those premium dollars for a longer time.

The calculation of loss reserves involves considering four different kinds of losses, each with differing levels of uncertainty.

- **Losses that have been incurred, reported, and settled but not yet paid.** These losses are the most certain of the four loss types. Because the size of the ultimate loss has been established, setting aside an accurate reserve level is easiest here.
- **Losses that have been incurred and reported but not settled.** These carry a slightly increased level of uncertainty. Here, the insurer is aware that a loss has occurred, but final payment terms have not yet been established.
- **Losses that have been incurred and reported but not settled due to liability.** Because such losses usually involve longer-tail liabilities, calculating the ultimate cost of settlement is more difficult.
- **Losses that have been incurred but not reported (IBNR).** These losses carry the most uncertainty. In some cases, insurers know about IBNR losses and try to make preliminary loss estimates.

For Example:

Suppose an earthquake hit a certain area on December 30 and a local property and casualty insurer ends its fiscal year on December 31. In its year-end statements, the insurer could estimate its earthquake-related IBNR loss based on its experience in prior earthquakes.

In other cases, however, IBNR losses emerge years after the damage first occurs. Such losses are very difficult to predict. For example, the various asbestos lawsuits that plague property and casualty insurers relate to injuries incurred many years ago but reported much later.

The task of establishing appropriate loss reserve levels is typically assigned to an insurer's actuarial staff. Actuaries (specialists trained in mathematics, statistics, and accounting) are responsible for calculating premium rates, reserves, and dividends. They use a variety of quantitative methods to establish loss reserves. The five most common methods used by actuaries are the following:

- **Claim-file estimates plus.** This method establishes the estimated liability for reported losses by aggregating pending claim-file estimates (such as estimates being prepared by the claims department), from which payments that have already been made are deducted. To this total are added formula calculations for additional payments on closed claims that will be reopened and payments for IBNR losses. The sum of the component parts constitutes the full loss liability as of the end of the accounting period. This method, considered the least sophisticated, is appropriate for property lines in which claim frequency is low and the range of loss costs is sizable. Furthermore, its dependence on claims department estimates exposes it to a degree of subjectivity.
- **Extrapolation from accumulated paid losses.** This method indirectly estimates the liability by extrapolating it from losses paid to date. Although this method is regarded as simple to apply, its use is limited to coverages where payment patterns are relatively consistent. The percentage of losses paid to ultimate incurred losses is calculated for various stages of development for prior years. From this history, percentages paid are selected for each stage of development. The amount of losses paid to date for the period under review is then divided by the appropriate percentage, to arrive at the estimated ultimate loss cost. The amount of losses paid to date is subtracted from this figure to produce the estimated loss liability.
- **Counts and average costs of incurred losses.** This method indirectly establishes the liability for losses from loss counts and average costs. The estimated number of loss units is obtained by projecting the number of loss units received to date, based on percentages reported in prior years at the same stage of development. The average cost of loss units closed to date is calculated and compared with average closed costs of prior years at the same stage of development. The projected ultimate number of loss units derived is then multiplied by the estimated ultimate average cost, to arrive at the total estimated ultimate loss. Losses paid to date are then subtracted to obtain the estimated liability.
- **Counts and average values of unpaid losses.** This method directly establishes the liability from loss counts and average values of unpaid losses. In this case, a selected average value is applied to the number of loss units. If the data are based on reported losses, the selected average value is applied to the number of open loss units, and a separate calculation for IBNR losses is necessary. If the data are based on accidents incurred, the selected average value is based on the total number of open and IBNR losses.

- **Loss ratio.** This method estimates the ultimate loss by using an estimated loss ratio. Selected for whatever period of coverage is involved, the ratio is applied to the applicable earned premiums, producing the estimated ultimate losses incurred for that period. Losses paid to date on accidents occurring during the period are deducted from this total to derive the estimated total loss liability.

4.5 Surplus Funds: Capital Counts

After investment assets and loss reserves, the third-largest component of an insurer's balance sheet is policyholders' surplus, similar to shareholders' equity.

Policyholders' surplus is one of the indicators that state regulators use to monitor and control insurers' solvency and growth. Industry surplus (sometimes referred to as capital or equity) appreciates or depreciates through retained earnings or losses, unrealized gains or losses from investment portfolios, and additions to investors' capital.

Typically, regulators permit a certain amount of leverage of the surplus, generally letting companies underwrite business equal to two to three times the amount of their surplus. Regulators tend to give insurers more leeway on the short-tail property lines than on the long-tail casualty lines, because of the proper line's relatively greater predictability of underwriting performance.

As a result, as the industry has increased its exposure to casualty lines, its leverage has declined. Industry leverage has also declined due to overcapacity.

4.6 Property and Casualty Accounting

Property-casualty insurers generally account for their surplus by using statutory accounting principles (SAP), rather than generally accepted accounting principles (GAAP). SAP requires that all costs related to writing business be expensed immediately. GAAP attempts to match an insurer's income and expenses by prorating the costs of an insurance policy over its assumed life.

Many insurers report their financial results using both accounting systems. They report their results to regulators using SAP; for investors, they use GAAP. (Many analysts, however, also use SAP financial statements when analyzing an insurer.) This difference largely reflects the disparate priorities of shareholders, investors, and regulators. Shareholders and investors are likely to be most interested in a company's ability to earn a profit, while regulators' primary concern is the company's solvency — its ability to meet policyholder obligations.

The primary difference between GAAP and SAP lies in an accounting concept known as the matching principle. Under GAAP accounting, an insurer charges expenses to the period in which they were used to generate revenues. Under SAP accounting, expenses are recognized as soon as they occur.

For Example:

When an insurer uses SAP, any expenses associated with writing an insurance policy, such as

commissions and other underwriting expenses, are immediately deducted from income. Under GAAP accounting, these same charges are treated as assets, referred to as “deferred policy acquisition costs,” and are amortized over the insurance policy’s life.

For this reason, the more conservative SAP emphasizes a company’s solvency. An insurer’s income and surplus tend to be lower under SAP than under GAAP, emphasizing a firm’s ongoing profitability.

4.7 The Property and Casualty Market

There are literally hundreds of insurers within the U.S. property and casualty market; however, a handful of companies still dominate. According to the National Association of Insurance Commissioners, net premiums written in the property-casualty market were \$932 billion in 2024. Auto insurance was the largest component of the property-casualty market with \$344 billion in direct premiums written, representing 35% of the market share.

In recent years, several large property-casualty insurers have sought to offset their slowing premium growth in the mature U.S. market by increasing their presence in certain overseas markets. For the most part, however, most U.S.-based property and casualty insurers operate solely in the United States.

4.8 Property and Casualty Impact on the Economy

The insurance industry has a major impact on the nation’s economic well-being as an employer, taxpayer, and investor. Let’s take a closer look.

As employers. Insurance companies employ around 3 million individuals in various capacities, with nearly 680,000 in the property-casualty sector. Over a million more are employed in insurance agencies and brokerages. More than 380,000 additional people are employed as claims adjusters, third-party administrators, and other service personnel needed to conduct business.

As a taxpayer. The insurance industry is a major source of revenue for both the federal government and the individual states. Premium taxes paid to the states totaled over \$32 billion in 2023. The amount of income taxes paid to the federal government fluctuates depending on changes in tax rules and operating results.

As an investor. Without the investments made by the insurance industry, private companies and governments at all levels would have a harder time finding the money required to finance their operations. The insurance industry had over \$8.5 trillion in total cash and invested assets in 2023, with property and casualty insurers holding nearly \$2.7 trillion of this amount. Of that \$2.7 trillion, about \$1.3 trillion was allocated in bonds, and over \$900 billion was carried in common stocks. The remainder was held in other types of investments, such as mortgages and real estate.

4.9 Underwriting Cycle in the Property and Casualty Industry

The underwriting cycle refers to the periodic rise and fall in the net underwriting income of the property and casualty industry. The number of insolvencies in the industry varies inversely with this cycle — rising when income falls and vice versa. The cycle gets its name from the fact that swings in net income from underwriting activities — rather than swings in the income earned on asset holdings (net investment income) — create the cycle.

In recent years, the industry's underwriting cycle appears to have changed in that the periods of falling net income seemed to have lengthened, while those of rising net income appear to have shortened. Moreover, the industry, as a whole, has lost money on its underwriting activities and has relied more heavily on investment income to remain profitable.

Unfortunately, this shift of sources of income has exposed the industry to greater risks. Large underwriting losses indicate that this insurance is underpriced; in other words, the property and casualty industry charges too little for the risk it assumes. At the same time, the industry's reliance on investment income for profitability has increased its exposure to risks in asset markets. These greater risks are reflected in the drop in the industry's profit rates, resulting in an increase in insolvencies of property and casualty insurers. Continued low profitability could lead insurers to undertake even greater risks in hopes of returning to profitability, and thus result in additional insolvencies.

4.10 Fiduciary Responsibility and Recordkeeping

Each individual or agency insurance producer has fiduciary responsibility for all premiums and related insurance proceeds received on behalf of insurers. Funds must be remitted to the appropriate insurer or consumer in a timely manner. The law prohibits misappropriation or theft of insurance funds collected from or owed to a consumer. A licensee may be disciplined administratively or be subject to criminal or civil prosecution for fiduciary violations.

Commingling of client or insurer funds with the monies of a producer or agency is strongly discouraged. Insurance commissioners recommend that client and insurer funds be kept separate from the funds owned by the producer or agency.

Most financial restrictions and requirements and recordkeeping requirements are set forth by the agency in the insurer-agency contract agreed to at the time of appointment of a producer. Some insurance codes require that a producer uses reasonable accounting methods to record funds received in a fiduciary capacity and state that a producer shall not accept payment of a premium in the form of a check or money order made payable to the producer instead of the insurer.

Note:

Most states require that a licensee make records available to the insurance commissioner or regulatory staff. For instance, the State of Michigan recommends that all licensee records be maintained for three (3) years. The insurance commissioner typically reserves the right to audit the records of a producer or agency to determine compliance with a particular state's statutory requirements. Additionally, licensees who do not maintain records in a manner that meets the state statutory requirements may be subject to discipline including fines, suspension, or revocation.

4.11 Insurance Regulation

From its beginnings, the individual states have regulated insurance industry activities within their respective borders. Current law generally permits the federal government to intervene only when state regulation proves to be inadequate. This gives the various state governments an incentive to make sure they do a good job. While the federal government can influence these activities, it is generally up to the states to enact and enforce the laws that regulate the insurance business.

The insurance industry is regulated on a state-by-state basis. Each of the 50 states and the District of Columbia have an insurance commissioner, who grants insurers operating licenses allowing them to conduct business within that state.

State regulators serve three primary functions. First, they monitor the financial condition and claims-paying ability of each insurance company operating in their state. Second, they serve as consumer “watchdogs,” ensuring that policyholders aren’t overcharged or discriminated against. Finally, regulators try to ensure that essential insurance coverage is readily available for all consumers.

The National Association of Insurance Commissioners (NAIC) based in Kansas City, Missouri, coordinates the activities of state insurance commissioners. Founded in 1871 as the National Convention of Insurance Commissioners, the NAIC undertook the formulation of uniform accounting procedures as one of its first actions. Today, one of the NAIC’s main functions is to develop and improve insurance reporting and accounting standards and practices. These actions are intended to improve state regulators’ knowledge of the financial condition of insurers in their jurisdiction.

Insurance companies are required to file a set of financial statements each year with regulators in every state in which they operate. These records, called annual statements, use statutory accounting terms to outline the company’s profits, losses, and overall financial condition.

Other forms of regulation and control also govern the insurance industry. For instance, publicly held insurance companies — those that issue stocks — are subject to regulation by the Securities and Exchange Commission (SEC).

Finally, the intense level of competition among industry participants in all lines also serves as a measure of control. Competition helps keep pricing in line and prevents any one participant from becoming too powerful.

Each state legislature is responsible for enacting the state's insurance laws, and the insurance department of each state administers them. The head of the insurance department is known as the Insurance Commissioner, although this individual is referred to as the Director or Superintendent of Insurance in some states.

One of the ways states regulate the insurance business is by deciding which insurance companies (often simply called “insurers”) are authorized to conduct business within their borders. If an insurance company meets the state’s requirements, the insurance department issues it a certificate of authority, and it becomes an authorized insurer, also known as an admitted insurer.

A company that does not have a certificate of authority to operate in a given state is known as an unauthorized, or nonadmitted, insurer in that state.

In its home state, or state of domicile, a company is known as a domestic company. If it is admitted to other states, it operates in those states as a foreign company.

4.11.1 Rate Regulation

Insurance departments may also regulate an insurer's rates — the amounts they charge the public for insurance. One purpose of rate regulation is to help ensure that insurers stay solvent: Rates must be high enough to cover an insurer's expected losses and expenses. Other purposes include making sure that insurers don't make rates too high compared to the value that consumers receive and that rates don't unfairly discriminate against certain people or groups.

The methods insurance departments use to regulate rates vary from state to state and by line of insurance. In some cases, where plenty of insurers are competing for a particular line of business, the insurance department may allow competition among the insurers to establish the level of rates. In other cases, companies may have to file their rates and have them approved by the insurance department before they may use them. For some coverages, certain states determine what rates companies must use.

There are variations in between: For example, insurance departments may require companies to file their rates for particular lines of business but may allow companies to use those rates without waiting for the department's approval. But even where rates are set by competition among companies, the insurance department may ask companies to justify the rates they are using and may disapprove any rates that are inadequate (too low) or excessive (too high), or that discriminate unfairly because they are based on something other than risk-related characteristics.

4.11.2 Regulation of Policy Forms

Although insurance is not a simple product, insurance regulators have taken a number of approaches to keep it from becoming overly complex.

- **Standard Policies.** For certain types of coverage, the law may prescribe the wording of the entire policy.
- **Mandatory Provisions.** In some cases, the law may prescribe only the wording of certain provisions that must be included in certain types of policies.
- **Policy Filing.** The law may require companies to file certain types of policies with the insurance department and receive its approval before using them.
- **Easy-to-Read Policies.** Regulators may require that insurers write their policies using simplified wording, make certain provisions appear separately from other copy, and use at least a certain size or style of type.

While such requirements limit the variety and flexibility of coverages available to consumers, they also help make policies easier for people to understand and to compare.

4.11.3 Licensing of Personnel

Insurance departments also regulate the insurance business by requiring people in certain positions to be licensed. By establishing licensing requirements—such as that an individual be

of a certain age, have no history of criminal wrongdoing, and pass a qualification exam— insurance departments help ensure that persons in those positions are of good character and possess a minimum level of competence.

All states require those who represent insurance companies in sales situations with consumers to be licensed as agents, brokers, or producers. Some states also require claims representatives to be licensed as adjusters.

4.11.4 Trade Practices

The insurance department also regulates the manner in which companies and their representatives conduct themselves in dealings with the public. Certain practices are prohibited by law. For example, agents and brokers must avoid any type of deceptive sales practice, particularly any misrepresentation of policy features, terms, or benefits. There is also a list of unfair claim settlement practices that adjusters must avoid. These include:

- **Insurers cannot misrepresent a policy.** Under most Unfair Claims Settlement Practices Acts, an insurance company may not knowingly misrepresent material facts or relevant policy provisions in connection with a claim. It may not attempt to enforce policy provisions that were altered by the company without notice to policyholders or without policyholders' knowledge or consent.
- **Insurers cannot influence other policy settlements.** Typically, insurers may not drag out the settlement of a claim under one portion of a policy where liability and the amount of the loss are reasonably clear, so as to influence settlements under a different portion of that same policy.

For Example:

An auto insurer cannot refuse to pay an insured's bills under the medical coverage in the policy so that the insured will settle an uninsured motorist claim. Usually, this prohibition only applies if the insured is filing a claim under their own policy, not if the insured is pursuing a third-party action against someone else .

- **Insurers must acknowledge an insured's claim.** An insurance company should acknowledge and act promptly in response to an insured's communications about claims. The NAIC model act for property and casualty claims settlement recommends that the insurance company acknowledge a claim within 15 days.
- **Insurers must process claims promptly.** Insurers must implement standards for promptly investigating and processing claims. An insurance company should complete its investigation of a claim within a reasonable amount of time. The model recommends that it be completed within 30 days after notification of a claim, unless the investigation cannot be reasonably completed within that amount of time. Otherwise, unethical insurance companies could endlessly stonewall insureds by indicating that it is still investigating the claim.
- **Insurers cannot force insureds to settle for less.** Insurance companies may not insist an insured take a cash settlement that is less than the amount the insured paid for repairs. The exception is for cars that are a total loss or if the insured agrees to the lesser amount.

- **Insurers cannot force an insured to travel.** An insurance company may not force an insured to travel an unreasonable distance to have an automobile repaired at a specific repair shop, to inspect a replacement automobile or to obtain a repair estimate.
- **Insurers cannot refuse or delay claims without good reason.** An insurance company may not refuse to pay a claim or delay payment without a valid reason. It must provide the insured with a reasonable explanation why the claim was denied or why a compromise settlement was offered. If the insured claim is denied, the insurer must provide the denial in writing and reference specific provisions, conditions or exclusions in the policy that allow for denial. The insurer is required to make a good faith attempt to process a prompt, fair, and equitable settlement of claims in which liability is reasonably clear.

The goal of trade practice regulation is to establish minimum standards of fair dealing with the public. Those who violate these rules are subject to penalties ranging from censure, to fines, to loss of their licenses. The companies they represent may also incur fines and other sanctions if they were negligent in supervising those individuals' activities.

4.11.5 The Government as an Insurer

There are instances when the federal or state government might become involved in the insurance business, not as a regulator but as an insurer. This occurs when the public needs some type of coverage that the private insurance industry cannot provide, or cannot provide as effectively, as the government.

The federal government operates several property-casualty insurance programs. Probably the most well-known are the National Flood Insurance Program, which makes flood insurance available to property owners, and the Federal Crop Insurance Program, which offers farmers protection against crop damage from drought, insects, hail, and other perils. Some private insurers aid the government by providing coverage under these programs or by helping to administer them.

Additionally, many state governments are active in workers' compensation. In some states, the law requires employers to buy their workers' compensation coverage from the state. In others, employers can buy coverage from either the state program or private insurers.

4.12 Industry Trends

Historically, the property and casualty industry operated in three-year cycles or trends of rates and profits. Although most businesses ride a cycle of some sort, few have cycles as predictable as those that once affected the property-and-casualty insurance business. The difference between insurance and other industries, such as manufacturing, is that the carriers that do the selling and set the prices never really know for sure exactly what it will cost them to deliver their product. Those who sell insurance coverage have no way of knowing how much they will pay out in claims until after the fact.

Starting around the end of World War II, property and casualty companies tended to spend three years on the upside, enjoying higher profits enabled by higher rates. Then, for three years, rates would fall and profits would all but vanish. On and on it went, three years up and three years down. Today, these cycles are much smoother, longer, and less predictable. This means increasingly competitive rates for property and casualty insurance coverage, especially commercial policies.

Additionally, in recent years, a number of insurers have consolidated in an attempt to offset the historically sluggish premium growth and to become more cost-efficient. The results are not always entirely positive, and many companies suffer from post-merger integration pains.

Other property-casualty insurers, especially personal lines carriers, expanded into the retirement savings market as a way to offset slowing premium growth. Others, primarily commercial lines insurers, expanded overseas in an attempt to offset slower domestic growth with what they hoped would be more robust growth in somewhat less mature and faster-growing foreign markets. These strategies, however, have also yielded mixed results.

Among other efforts, many insurers have focused on improving their distribution systems as a means of offsetting slowing growth and regaining a competitive edge. Most insurers are publicly committed to maintaining their traditional agency distribution but are exploring other means of getting the product to the customer in a more economical fashion. Some are exploring direct marketing, including internet advertising and sales, while others have joined forces with banks to expand their distribution channels by selling insurance products through bank branch networks.

Let's take a look at issues and trends affecting the industry.

4.12.1 Too Much Capacity

A key condition affecting the property-casualty insurance industry today is excess underwriting capacity. This "excess" capacity means that the policyholders' surplus (or capital) base is underleveraged, measured by the ratio of net written premiums to policyholder surplus. Simply put, too many insurers with too much capital are chasing too little business.

Based on data provided by the National Association of Mutual Insurance Companies, the net premiums written-to-surplus ratio for the insurance industry in 2023 equaled 1.28-to-1. In other words, insurers gained \$1.28 in surplus for every \$1 of net premium.

4.12.2 Expanding Overseas as an Option

A handful of companies have addressed the need to ramp up growth by expanding overseas. Traditionally, most insurance companies have tended to limit their scope of operations to their home turf, with U.S.-based insurers writing insurance primarily in the United States and their European counterparts remaining largely in their own domestic markets. However, two factors — the globalization of U.S. businesses and a faster rate of economic growth in many areas outside the United States — have led a number of insurers to venture abroad.

Despite the opportunities for faster growth afforded by overseas markets, not all primary insurers are eager to expand abroad in the near future. This is due in part to the regional and national thrust of most primary insurers, especially those that write such personal lines as homeowners' and personal auto insurance. Moreover, concerns over language and cultural differences, plus differing consumer attitudes and customs, have left many insurers wary of expanding into unknown markets. Making these concerns worse is the fear of corruption, especially in developing countries where growth opportunities are the greatest.

4.12.3 Mutual Insurers

The concept of a mutual insurance company originated in England in 1696 and migrated to America in 1735, when Benjamin Franklin created the Union Fire Co. in Philadelphia. As stated earlier in this course, mutual insurance companies are owned by their policyholders, who are entitled to vote for members of the company's board of directors. Mutual policyholders may also receive special dividends in the form of capital contributions. The capital base of a mutual insurer is called policyholders' surplus (or statutory capital).

Simply put, a mutual insurance company exists solely to serve the needs of its policyholders. Consequently, the priorities of these companies are to provide low-cost policies and high-quality service to policyholders. This contrasts with stockholder-owned insurance companies, which must juggle the often-conflicting interests of their policyholder clients and shareholder owners. The largest property-casualty insurer in the United States (based on written premium volume) is a mutual insurer.

Insurance companies often have the word "mutual" in their name, when they are mutually owned by their policyholders as a group. In the past, there has been a strong trend for these companies to demutualize, converting to a shareholder ownership base. Under this trend, policyholders are offered either shares or money in exchange for their ownership rights. Because shares can be traded or sold – in contrast to ownership rights, which cannot – demutualization increases the possibility of profit for those involved, and tends also to benefit the economy. Let's take a closer look at demutualization.

4.12.3.1 Demutualization

There are three general methods in which an organization might demutualize: full demutualization, sponsored demutualization, and into a mutual holding company (MHC). In any type of demutualization, insurance policies, outstanding loans, etc., are not directly affected by the organization's change of legal form.

- In a **full demutualization**, the mutual completely converts to a stock company and passes on its own (newly issued) stock, cash, and/or policy credits to the members or policyholders. No attempt is made to preserve mutuality in any form.
- A **sponsored demutualization** is similar; the mutual is fully demutualized and its policyholders or members are compensated. The difference is that the mutuality is essentially bought by a stock corporation. Instead of receiving stock in the former mutual company, stock in the new parent company is granted instead.
- A **mutual holding company** is a hybrid concept: part stock company and part mutual company. Technically, the members still own over 50% of the company as a whole. Because of this, they are generally not significantly compensated for what would otherwise be viewed as loss of property. The core participants are isolated into a special segment of the company, still viewed as "mutual." The rest is a stock company. This part of the business might be publicly traded or held as a wholly owned subsidiary until such time that the organization should choose to go public.

Mutual holding companies are not allowed in New York, where attempts by mutual insurance to pass permissible legislation failed. Opponents of mutual insurance holding companies referred to the establishment of mutual holding companies in New York as “Legalized Theft.”

Some MHC demutualizations have been planned as the first of a two-stage process. The second stage would be full demutualization once the transition pains into MHC status are complete. In other cases, the MHC is the final stage.

Note that some mutual companies own stock companies and are listed on a stock exchange. These are not MHCs, however; they are simply mutual companies that have majority control over one or more stock companies. Other mutual companies may own some of another company's stock, but as simply an asset, not something they actually control. Finally, many mutual companies have wholly owned subsidiaries. The subsidiaries may technically be stock companies, but the mutual owns all the stock. A person may purchase an insurance policy from either company, but only those who own participating policies are mutual members. Other policyholders are customers.

The forces behind the demutualization trend in the insurance industry in the past ten years differed from those that drove a number of companies to demutualize in the late 1980s. Back then, insurers needed access to the capital markets to sell equity and debt securities in an attempt to boost their sagging capital levels. At that time, many companies were saddled with illiquid and underperforming real estate loans and assets, which eroded the strength of their capital bases and threatened their solvency. They needed to raise capital in order to survive.

Demutualization has several implications for the overall property-casualty industry. Probably most significant is the potential impact on pricing. Some industry watchers have speculated that demutualization increases competition in an already soft market. Some experts argue, however, that it may actually help pricing. This is because the change in accountability — from policyholders to shareholders — may force some of the mutuals to take a more conservative stance with regard to pricing. In addition, as demutualizations occurred, more companies became potential participants in the M and A scene.

This trend seems to be once again reversing back to mutual insurers, given the current state of the economy, and we will discuss this reversal later.

4.12.4 Internet and E-Commerce Offer Opportunities and Challenges

Historically, insurers have relied on agents (independent and captive) as their primary distribution channel. However, changing consumer preferences and technological innovations have forced insurers to rethink this strategy.

Many insurers still lag behind their banking and brokerage peers in their online presence, though. Although virtually every insurer has a website, most of these are no more than online brochures offering general product information and instructions on how to contact a local agent. Some firms that primarily use direct-marketing techniques like toll-free phone numbers have such information available for visitors to their websites.

Many in the industry view personal lines insurance products like auto and homeowners' coverage as relatively well suited to online or direct distribution because they are fairly simple commodity products (versus more complicated commercial lines coverage). Among the

obstacles facing insurers seeking to distribute such products online is the need for a customer to sign an insurance policy to make it binding, or effective. Legislation covering electronic signatures offers a solution to this dilemma. In addition, many consumers find buying insurance daunting enough when done face to face, let alone online. Nonetheless, as consumers have become comfortable making simple transactions on the Internet (like buying toys or books), they are also becoming more willing to go online for insurance purchases.

While agency systems can be expensive to maintain, many insurers still view them as an effective means of distributing their products, especially for those insurers that subscribe to the paradigm “insurance is sold, not bought.” In addition, in the past many insurers have built sizable market shares by relying on this network of independent and captive agents. Most are hesitant to introduce other distribution channels that would compete directly with their agents.

It is not a stretch to say that fluctuations of every sort ultimately affect the fate of insurers: changes in economies and in government regulations, weather-related catastrophes, and the new breed of business-related catastrophes. The underwriting function has traditionally steered insurers through these market fluctuations, navigating the peaks and valleys of hard and soft market conditions. In soft markets, underwriting rules are relaxed and prices drop to compete and gain new business. In hard markets, as demand increases, terms can again be tightened and prices raised for greater profitability.

In the past, insurers have enjoyed the profitability that comes with these hard markets. Unfortunately, they often overlooked the opportunity to prepare for the soft markets that inevitably followed. Today's insurance executives are increasingly eager to maintain high levels of growth and profitability, regardless of changing market conditions. This calls for investments in new capabilities that can help insurers sustain high performance even as the market shifts.

4.12.4.1 Uncovering Keys to High Performance

Results from recent Accenture reports suggest a way toward consistently positive bottom-line results. Accenture identified critical trends and issues in the insurance industry and assessed the impact that technology has had – and could have – on insurers' ability to perform more efficiently and more effectively. Here are some highlights:

- In one report, Accenture found that 56% of insurers have significantly updated their processes by implementing new technologies and sales methods.
- Accenture discovered in another survey that 52% of insurance respondents that invest in data and artificial intelligence (AI) do so for the primary benefit of new growth opportunities. And, 87% plan to incorporate new data, AI, or other technological initiatives, such as hiring, training, or acquiring, in their operations.
- Ninety-one percent of property and casualty insurers surveyed by Accenture reported financial benefits from using AI.

However, even personal lines insurers and small account commercial insurers continue to operate with suboptimal technologies and have yet to apply technology to several processes that could benefit from automation.

4.12.4.2 Technology-Driven Consistency

The findings add up to an industry that is under-prepared for responding to evolving market

conditions. Applying technology to key areas of property and casualty insurance underwriting brings the discipline needed to sustain the alignment of pricing, terms, and exposures even under the pressure to grow. Establishing coherent underwriting practices has the greatest potential for achieving the transformation that so many insurance executives envision for their companies in the very near future.

Technology plays an important role in engendering consistent underwriting behaviors regardless of market circumstances, underwriter experience, management variations, and geographic diversity. Automating processes and procedures builds in the rigor and discipline to staunch the leaks in underwriting and elevates every underwriter's performance to the level of an organization's very best.

Technology is becoming necessary to build the next generation of underwriters by preserving the depth and wisdom of the organization's experience while institutionalizing that knowledge for new hires and trainees. In fact, the coming crop of best and brightest workers expects up-to-date technology in the workplace. They are eager to focus on the value-added activities of analyzing, selling, negotiating, and creating and managing relationships—not on pushing paper, re-keying data, or chasing information in several different locations.

4.12.5 Banks and the Property and Casualty Industry

Life insurers have long waged a turf war with banks over the sale of life insurance products through bank branches. In recent years, it looks as though property-casualty insurers might also square off with banks. This is not necessarily a bad thing, however, as the result could be a new distribution channel for insurers.

In several overseas markets, banks already have a fairly well-established presence in personal lines such as life and property-casualty insurance. Additionally, in several countries, a number of large insurance companies and banks have formally teamed up through mergers to create bank-insurance powerhouses.

Proponents claim that such arrangements benefit both banks and insurers. Banks, they say, get the opportunity to offset slowing loan growth with new sources of fee income, while insurers can widen their distribution channels. Moreover, for insurers, distributing their products through banks offers a low-cost means of reaching the underserved middle-class market.

Savings-oriented products — including individual annuities, ordinary life insurance, and credit life insurance (which pays off certain debts in the event of the insured's death) — currently constitute the bulk of insurance sales made through banks. However, sales of some property and casualty products — like personal auto coverage and homeowners' policies — are growing. Because these products are like commodities, they're well suited to the banking distribution channel.

The ability to discover and leverage alternative distribution channels is a critical success factor for property-casualty insurers. In fact, one leading insurer has joined forces with a number of large banks to provide personal automobile and homeowners' insurance coverage to the banks' retail and credit card customers.

Unfortunately, there are losers in this scenario: independent insurance agents. In fact, many insurers have become reluctant to disclose the level or scope of their distribution agreements

with banks for fear of jeopardizing their relationships with their independent agents. Nevertheless, as more and more insurers team up with banks, independent agents will have no choice but to carve out other niches, such as focusing on the high-end insurance market for wealthy individuals or selling insurance to lower-income individuals.

For companies that recognize that the lines separating the various sectors of the financial services industry are blurring, this could be a positive trend and a means of expanding their distribution systems. For those that refuse to acknowledge the presence of banks in the insurance marketplace, the consequences could be disastrous for the company.

4.13 The Changing Property and Casualty Industry

The property and casualty industry is facing significant changes. Shifting demographics, evolving consumer expectations, and the just-discussed new distribution channels are dramatically impacting how policyholders think, interact, and work with their insurance companies. Recommendations for providers include methods to be used to effectively respond to and proactively improve their policyholder's experiences to help build policyholder advocacy for their company and their products.

To accomplish this, providers might ask themselves the following questions:

- Who are our advocates?
- How do we confirm that our products and services meet or exceed policyholder expectations?
- How do we assess and verify that our distribution models are attracting and retaining the policyholders that contribute to our success?

The ability to grow policyholder advocacy can be one of the most effective strategic weapons that an insurance company can use to help build a sustainable competitive advantage.

At this time, the insurance environment is facing evolutionary change. The policyholder base is becoming increasingly segmented, with existing policyholders who are aging and comfortable with traditional insurance models. In contrast, younger, newer policyholders tend to be internet savvy and expect instantaneous interactions and tailored selections.

Insurance providers continue to see changes to their distribution channels, with the consolidation of independent agencies and demands for quicker quotes and streamlined claims processing. Providers must work to balance the increasing demands of policyholders, while supporting the growth of their agents. Striking a successful balance requires a different approach designed to improve the customer experience.

Improving customer experiences and enhancing service delivery are not new concepts. However, without a clear approach, many companies (both within insurance and other industries) have responded in a narrow fashion addressing distinct operational needs, often focusing on cost reduction and streamlining, rather than fully addressing their customers' needs in a more integrated way. An effective and practical approach is needed to incorporate policyholder perspectives into the evaluation of programs and improvements intended to drive

service delivery, product innovation, and, subsequently, profitability.

The IBM Institute for Business Value conducted a global survey of 1,100 insurance executives across 34 countries and over 10,000 policyholders from nine countries (1,800 participants were from the U.S.) regarding their customer experience. Trends across key interactions were examined to determine what insurance providers ought to be doing to elevate the experience they provide to their policyholders. Key findings from the survey include:

- Despite 49% of policyholders placing importance on websites for customer engagement, only 5% of insurers are using this method. Same with direct contact: 50% of policyholders value this communication method, but only 17% of insurers are personally engaging with their customers.
- Although 85% of insurers have adopted customer-experience initiatives, 42% of customers are distrustful of their insurer.
- Insurers utilizing AI tools have reported higher levels of customer satisfaction, retention, and cost saving.

To deal with such significant changes, providers must find ways to intelligently evolve and differentiate their business by understanding and incorporating ways to enhance the policyholder's experiences. Continued reliance on traditional values and methods will likely contribute to a slow erosion of business value for today's leading insurance providers.

In the near future, the growth rate for insurers is expected to decline in line with global industry trends. The expected decline is on the back of the cessation of price increases in most business lines and price declines in several product areas. Additionally, the maturity of the property and casualty insurance product sets and value propositions that may not be clearly understood are increasingly driving policyholders to make their choices based on price.

Despite commoditization of insurance products, some companies have been successful at differentiating themselves. Visible examples include direct-to-consumer companies with their strong media campaigns targeting an evolving demographic.

Additionally, price-sensitive policyholders are continuously surfing the Web to access multiple insurance quotes to find the best deals. While the local, family insurance agent is far from extinct, the presence of younger customers and a range of sales models will continue to tax traditional business models.

4.13.1 The Property and Casualty Customer

Depending on the distribution model employed, insurance companies may consider agents to be the primary customers, others consider policyholders, and still others take a hybrid approach. Often the definition of the primary customer changes, such as focusing on the carrier-agent relationship during the sales process, and then the carrier-policyholder relationship for administration and claims.

Insurers relying primarily on their agents for customer interactions will benefit by understanding the attitudes of the policyholder. These insurers should and do understand that managing the policyholder experience will be a delicate and complex process, one that requires a careful design, integration of disparate channels, and the ability to influence the experience even when the carrier has little direct contact with its policyholders.

4.13.2 Customer Demographics

Young policyholders coming of age are both price-sensitive and technology-savvy. They are more likely than other demographics to access a variety of distribution channels and have expectations formed by broader access to information, multiple product choice options, and, in many cases, little human assistance.

In the short term, though, it would appear that not all customers are ready to move completely to virtual transactions. Today's older consumers demand service and quality, are more brand loyal, and may be more likely to continue their agent relationships. Baby boomers, on the other hand, continue to redefine the market as they age, forcing suppliers to accommodate their needs and develop customized products. They are also becoming increasingly comfortable with technology and alternate channels.

Trends indicate that the traditional market will continue to evolve, and not just across younger demographics. Older demographics will continue to expand their use of a broader range of channels to support their research and buying of insurance products. While traditional models will continue to provide value, changing demographics will require companies to provide a variety of flexible channels and sales models to stay relevant and competitive.

Demographics provide a first step toward thinking about customers and their attitudes. If insurers accept that any particular channel or sales model will eventually be copied and widely adopted, the end battleground for growth will reside with the customer experience.

Approached proactively, this insight can enable insurers to make important decisions about how they compete, even if they can't predict how the market is going to change in the future. In other words, a loyal and advocating customer base will likely be the foundation for growth, as all players perpetually adjust their sales and delivery models for insurance products.

4.13.3 Advocacy in the Property and Casualty Industry

Insurers can better align their operations, customer experiences, and investments for growth if they clearly understand customer attitudes toward their companies. A view that focuses on whether customers are advocates (those who embrace and promote the company), apathetic (those who are indifferent or passive toward the company), and antagonists (those who harbor negative feelings and can adversely influence business economics and other customers) can provide new insight into customer attitudes and behavior. Understanding advocacy provides the support for more targeted customer experience strategies and improvements.

As we all know, a happy customer is not always necessarily one who automatically converts into new sales or even stays as your customer. The three statements advocates agree with are:

- I would recommend my insurance agent/carrier to friends and family.
- I would buy my next product from my agent/carrier.
- If another insurance carrier offered me a competitive insurance product, I would remain with my insurance agent/carrier.

One of the key components of converting a policyholder into an advocate is trust. According to J.D. Power, "when customers have a high level of trust in their insurer, customer satisfaction and brand advocacy increase considerably, even in the face of rate increases." In its 2024 U.S.

Auto Insurance Study, J.D. Power found that 90% of policyholders who highly trust their insurers are likely to renew their policies. Only 30% of low-trust policyholders stated they are likely to renew.

Another important factor for policyholder advocacy is communication. J.D. Power's 2024 U.S. Home Insurance Study reported that effective communication from an insurer can help prevent unhappy insureds from switching to a new insurer, specifically following a premium increase. When an insured fully understands why their premium increased, they are 14 percentage points less likely to search for a new policy than those who don't understand the cost increase. Insureds who fully understand the reason are also 21 percentage points more likely to view their insurer as putting its customers' interests first.

4.13.3.1 Advocacy Decreases the Less the Carrier Communicates

Having trust and communication as the foundation of insured-insurer (or insured-agent) interactions is a common theme across the insurance industry. McKinsey's 2023 North American Insurance Customer Experience Survey also stressed how an insurer communicates with its policyholders can make or break the customer experience—from the sales process to account management—and can lead to significant challenges.

According to McKinsey's survey, approximately one in six customers reported that their insurer didn't follow up after an initial interaction. Forty percent of those who did hear back interacted with two or more people, leading to a fragmented, and likely frustrating, experience.

The survey also found that customers are split fairly evenly in their preference between speaking with an agent or company representative and using online tools to update their account or research and learn about insurance. However, over 70% prefer in-person interactions when it comes to purchasing a policy or solving a problem. These preferences, of course, can vary for each individual policyholder, meaning insurers cannot apply a one-size-fits-all approach but should rather offer solutions for diverse customer types.

Plus, a customer's preference may switch based on how their insurer's digital channels operate and how their agent, if they have one, communicates and manages their account. For example, despite half of McKinsey's respondents stating they prefer using their insurer's online offerings, more than 30% found the available digital tools unsatisfactory. When it comes to agent communication, only half reported having interactions on an annual basis. Likewise, around 40% considered canceling their insurance policy altogether because they believed it wasn't necessary or didn't provide sufficient value.

But, when customers are satisfied with the experience their agent provides, they are more likely to switch insurance companies if their agent left. In fact, McKinsey's survey revealed that agents and advisers are the highest-rated channel for customer satisfaction.”

4.13.3.2 Proactive Responses to the Changing Climate Are Essential

While there is no direct path for any one company to find success in building advocacy, the data and its implications highlight some key areas to address. Most importantly, finding the right mix of experiences and operations will come from increased focus on a combination of activities,

including:

- Enhancing current models and demographic focus
- Strengthening customer focus to drive customer advocacy

Let's take a closer look.

4.13.3.2.1 Enhancing Current Models and Demographic Focus

The correlation between demographics and distribution models suggests there may be initial, near-term actions that can be taken by insurers. These actions include implementation of any of the following distribution models:

- **Affinity model – Grow wallet share:** Affinity-based insurers need to focus on product and channel innovations to drive wallet share across their existing demographics while implementing strategies to attract younger customers. Measuring and understanding the lifetime value of policyholders should help to shape product strategies to attract younger policyholders.
- **Captive agent model – Shift the balance:** Captive agents can enhance the Internet channel by integrating highly valued policyholder experience attributes that appeal to advocates 25 to 44 years old, while creating new products for older segments that are marketed through agent/employee-based channels.
- **Independent agent model – Make it easier to do business:** Advocates love their agents, and agents need insurance companies that make it easy for them to understand their policyholders and to deliver personalized service. Insurance companies need to continue to invest in advocacy and efficiency improvements to support agents as well as to help them better understand policyholder needs and wants. Successful carriers will reward agents based on the levels of advocacy that they provide for the company.
- **Direct/Over-the-phone model – Provide more bundles and offers:** Insurers need to appeal to this growing population of young, price-driven, technically savvy group by increasing site appeal and providing discounted bundles to capture wallet share. Focus on improving "stickiness" by implementing innovative interaction approaches and improving product relevancy.

4.13.3.3 Strengthening Customer Focus to Drive Customer Advocacy

Customer focus is an overarching discipline of understanding customers' wants and needs, aligning operations to meet customer needs, and improving the effectiveness of operations. Insurers need to begin to build a basic foundation that will enable them to move to a more customer-focused organization by increasing the relevance and attractiveness of their products and services.

Given the velocity of change in the marketplace, insurers should develop approaches that are flexible enough to adapt to an industry likely to remain in flux. Some industry experts recommend a focus on five key areas:

- **Build a deeper understanding of what is important to the policyholder.** This involves creating or repurposing customer research and applying those techniques to capture and analyze customer data from key interactions across the policyholder experience and

distribution channels. Leveraging the Internet, blogs, feedback, and other tools to better understand policyholders' attitudes and perspectives on key insurance interactions involves use of focus groups and ethnographic research (that is, observe clients in real settings trying to assess insurance product options, obtaining help with billing questions, and the like) to help define the desired client experience outcomes. Lastly, it may be beneficial for insurers to correlate operational and financial performance factors to movement in customer advocacy scores to understand how to best drive value.

- **Design customer experiences based on an understanding of customer expectations and perceptions of operational performance.** This might include using customer advocacy and demographic data to drive improvements at key "moments of truth" across distribution channels, such as when a policyholder calls to file a claim, integrating customer advocacy metrics into daily operations and performance compensation, within the company and across agencies.
- **Communicate and transact with customers intelligently during key interactions, on a customer-by-customer basis, making them feel that "you know me."** This might mean that an insurer encourages customers to provide feedback and rewards them for sharing information through personalized service and relevant offers. The insurer could then find methods to share information (two-way) about policyholders through the agencies.
- **Improve the coordination of key activities across the delivery channel to improve effectiveness and quality of the overall policyholder experience.** This includes providing agents and direct-based channels with real-time access to key customer data to increase visibility into customer needs and wants.
- **Increase policyholder involvement in the development and customization of insurance products.** This could involve collaboration with both advocates and antagonists (for example, through Internet surveys, blogs, "Customer Jams," and the like) in the development of products and services. Additionally, an insurer could consider the development of full-lifecycle, lifestage, and product bundles that address the needs of specific policyholder groups and that work to migrate policyholders to appropriate products and services as they mature. Lastly, develop and deploy easy-to-use product selection/configuration tools to support customization of insurance products based on need, risk, price, and service assumptions for all customers, employees, and agents.

4.14 Insurable Interest

An important concept affecting the availability of insurance of all types is the requirement that the person who will receive the benefit from the insurance policy has an insurable interest. An insurable interest exists when the occurrence of the event insured against would result in a loss to that individual or entity. Although financial loss is the principal type of loss envisioned in the case of property insurance, other types of loss could cause a person to have an insurable interest, depending on the type of insurance. (An insurable interest may exist in the case of life insurance, for example, based solely on love and affection between the person whose life is insured and the person who will receive the death benefit.)

Thus, an insurable interest requires that the person who would receive the insurance benefit after a covered event must have an expectation of:

- Benefit or advantage from avoidance of the event; or
- Loss or detriment from the occurrence of the event.

For Example:

Consider the fact that if a person's house is damaged by fire, its value is reduced. Regardless of whether the owner's intent is to sell the fire-damaged house at a lower price or have the damage repaired, they have suffered a financial loss as a result of the fire. Clearly, the homeowner has an insurable interest in the house.

However, suppose it was your neighbor's house that was damaged by the fire. Although you may sympathize with your neighbor's plight, their damaged house has not caused you to suffer a financial loss. Since you have not suffered the loss, you do not have an insurable interest in your neighbor's home.

4.14.1 When Insurable Interest Must Exist

Although insurable interest must exist in order for insurance to be available, just when such interest must exist depends on the type of insurance. In the case of life insurance, an insurable interest need exist only at the time the insurance contract is entered into; insurable interest is not required at the time of the insured's death. Thus, the person receiving a life insurance death benefit is not required to have an insurable interest in the insured when they pass away.

However, the need for insurable interest in property and casualty insurance works differently. In property and casualty insurance, an insurable interest need only exist at the time of loss in order for a benefit to be payable. Such interest does not have to exist at the time of inception of the property and casualty insurance contract.

4.14.2 Insurable Interest Limited by Value

A person's insurable interest in property is also affected by the nature of property insurance.

Property insurance is a type of indemnity insurance. Insurance that is deemed "indemnity insurance" limits payment to beneficiaries to the lesser of:

- The beneficiary's economic loss; or
- The policy limit.

Accordingly, a property insurance beneficiary's insurable interest—and their benefit payment—is limited to the amount of the provable loss even if the insured amount shown in the policy is higher. In contrast, life insurance is not a contract of indemnity; thus, in the case of a life insurance death benefit, the beneficiary's economic loss occasioned by the insured's death is irrelevant to the payment, and the insurer must pay the entire policy death benefit to the beneficiary.

4.15 Law of Large Numbers

Insurance offers individuals and organizations the opportunity to transfer to an insurance company risks whose economic impact may be enormous. Although the cost of such a transfer varies depending on many factors, it is often no more than a few cents for each dollar of risk transferred.

For example:

Insuring a house for \$500,000 under homeowners insurance may cost as little as \$1,500 annually. Even though the cost to the insured is relatively small, the insurer may be required to pay the full \$500,000 of benefits if the house is destroyed by fire, earthquake, or other covered cause. An important question relates to how the insurer can afford to pay such a potentially large claim settlement after receiving only a small premium payment. The answer lies in the law of large numbers.

As you learned earlier in this course, in mathematical terms, the law of large numbers is a probability theorem used to describe the stability of the mean of a random variable. In less complicated language, it demonstrates that as the number of observations increases, their mean (or average) will tend to approximate the average for the population. Thus, the greater the amount of data used to develop a statistic, the more reliable it will tend to be in predicting actual results.

Insurers rely on the law of large numbers to predict the number of losses likely to occur among a given population of insureds. Based on that prediction, they can establish proper premium levels that enable them to accumulate the needed funds to pay any and all claims made.

4.16 Insurance Policies Are Contracts

When an applicant purchases insurance, they normally receive an insurance policy containing various provisions that detail the coverage, its premium cost, etc. These policies are contracts—agreements that are enforceable in a court of law—and are subject to the rules of contract law. In other words, they create binding promises on the part of the insurer for which the law mandates a duty of performance.

4.16.1 Insurance Policies Must Meet Certain Conditions to Be Valid

In order for an insurance policy to be valid, it must meet many of the same requirements as other contracts. Those requirements include:

- Competence of the parties to the contract;
- A legal purpose of the contract;
- A valid offer;
- An acceptance of the offer precisely as made; and
- Consideration.

Let's briefly consider each of these requirements for a valid contract.

4.16.1.1 Parties to the Contract Must Be Competent

Contract law requires that, for a contract to be valid, the parties to the contract must be competent. The parties to the contract are those persons who are bound by its terms. In the case of an insurance contract, the parties to the contract are the insurer and the applicant. If the insurer is authorized under the laws of the state in which the insurance transaction occurs to engage in the insurance business, it is deemed to meet the competence requirement.

The issue of competence, however, is one that principally involves the applicant for insurance. An applicant for insurance is generally not deemed to be competent if, at the time of application,

they are:

- A minor;
- Adjudged insane; or
- Under the influence of drugs or alcohol.

4.16.1.2 Contract Must Have a Legal Purpose

In general, parties may enter a contract for almost any purpose. The overriding consideration, however, is that the contract must have a purpose that is legal. Thus, an enforceable contract cannot be:

- In violation of the law; or
- Against public policy.

The simplest example of a contract that would be unenforceable as being in violation of the law and against public policy might be a contract between a property owner and an arsonist under which the arsonist agreed to set fire to the property owner's house in order to enable him or her to collect insurance proceeds. Despite the property owner's advance payment for services to be rendered, they could not sue the arsonist for a failure to perform.

4.16.1.3 A Valid Offer Must Be Made

A valid offer, in the case of contracts in general, is one that expresses a willingness to enter into an agreement and contains sufficient information such that the other party may conclude the contract by their acceptance and the giving of agreed-upon consideration.

For Example:

Cliff might make the following offer to Donna: "I hereby offer to sell you my blue 2007 automobile for \$1,200 cash." By agreeing to the offer and paying the requested \$1,200, Donna will have entered into a contract with Cliff to purchase his car.

When an applicant completes an application for insurance and pays the initial premium, they have made an offer to the insurer to purchase the requested coverage.

4.16.1.4 Offer Must Be Accepted as Made

When a person receives a valid offer, their options are to accept the offer or reject it. As we will see, in the parlance of contract law, an offeree's attempt to change the offer is really a rejection of it.

For Example:

Suppose Donna, the offeree in our previous example, had wanted to change the offer. In attempting to negotiate price or terms, she might have offered Cliff \$1,000 for the car or offered

to pay him \$100 each month for the next 12 months. In terms of contract law, Donna's attempt to negotiate rather than accept Cliff's offer constitutes a:

- Rejection of the offer; and
- Counteroffer.

Similarly, an insurer that receives an application for insurance along with the initial premium from an applicant may accept the offer as made by issuing the requested coverage at its standard premium. However, the insurer may decline to write the insurance under any circumstances and reject the application, or it may modify the coverage or increase the premium.

If an insurer issues an insurance policy in any way other than as applied for, such action constitutes a rejection of the applicant's offer (evidenced by their application) and the making of a counteroffer. The applicant then becomes the party who may accept or reject the insurer's counteroffer. If the applicant chooses to reject the counteroffer, they simply refuse delivery of the policy. If the applicant accepts policy delivery and pays any premium due, the counteroffer has been accepted and coverage provided by the policy commences.

4.16.1.5 Consideration Must Be Given

The final element that must be present to form a valid contract is consideration. In contract law, consideration is defined as something of value that is bargained for and given by one party to the other in exchange for the other's performance promised in the contract.

For Example:

Revisiting Cliff and Donna, Cliff offered to sell his used car to Donna for \$1,200. Donna's agreement to the terms of the offer constitutes acceptance; her payment of \$1,200 is the consideration she has given, which, along with her acceptance of the offer, creates a valid contract.

In an insurance sales transaction, the applicant's consideration is their premium payment. The insurer's consideration is its promise to pay a specified benefit for stipulated covered losses.

4.16.2 Insurance Contracts Have Special Characteristics

Although insurance contracts are contracts in the traditional sense and subject to general contract law, they have certain special characteristics that affect their interpretation and enforcement. Specifically, insurance policies are:

- Aleatory contracts;
- Contracts of adhesion;
- Unilateral contracts; and
- Conditional contracts.

Let's examine the meaning and consequences of these special characteristics.

4.16.2.1 Aleatory Contract

An insurance policy is an aleatory contract. An aleatory contract is a contract under which the promised performance by one of the parties to the contract is conditioned on the occurrence of an uncertain event. To better understand the implications of an aleatory contract, we need to consider the promises made by each of the parties to a contract other than an insurance contract.

Contracts other than insurance contracts are considered commutative contracts. In a commutative contract, each party to the contract anticipates receiving from the other party something that is of approximately equivalent value.

For Example:

Back to Cliff and Donna: When Donna agreed to pay \$1,200 for Cliff's used car, she entered into a commutative contract since the value of what she expected to receive (i.e., Cliff's used car) was approximately equal to her \$1,200 in cash.

The fundamental characteristic of an aleatory contract is the element of uncertainty. Since an insurance policy is an aleatory contract, both the insurer and the applicant understand that, depending on the occurrence of the uncertain event specified in the policy, the applicant may receive a benefit whose value greatly exceeds the total premiums paid for the coverage. In fact, an insured who has made only a single premium payment may receive the entire benefit promised in the insurance policy. In contrast, an insured who does not suffer a covered loss during the term of the policy will receive no benefit—other than the peace of mind such protection may provide—from the policy.

4.16.2.2 Contract of Adhesion

Insurers are generally required to file their insurance policies with the insurance regulators of the states in which they transact insurance business and receive their approval before offering the policies for sale. Once approved, insurers have a limited ability—usually limited solely to policy endorsements—to change policy provisions.

Thus, insurance policies are sold to applicants on a take-it-or-leave-it basis. In legal language, an insurance policy is a contract of adhesion, which means that there is no room for the applicant to negotiate with the insurer over its terms; instead, the applicant may only accept the policy as written by the insurer or reject it. In other words, the applicant may reject the policy or “adhere” to it.

From a legal enforcement perspective, the adhesive nature of an insurance contract has significant implications deriving from the fundamental principle of contract construction that any contract ambiguity is interpreted against the party that drafted the contract. Accordingly, since the insurer drafted the insurance contract, any ambiguity is interpreted in a manner most favorable to the insured (and least favorable to the insurer).

4.16.2.3 Unilateral Contract

The overwhelming majority of contracts, other than insurance contracts, are bilateral contracts under which each party to the contract makes enforceable promises. An insurance policy, in contrast, is a unilateral contract.

A unilateral contract is a contract under which only one party to the contract makes an enforceable promise. The contract in such a case is created by the non-promising party's performance of their part of the agreed-upon bargain before the contract is formed. In an insurance policy, the non-promising party is the insured who makes a premium payment which obligates the insurer to pay for any covered loss under the terms of the policy.

An insured is not required to pay premiums and cannot be forced to do so by the insurer. However, if the insured fails to pay the required premiums, the insurer may cancel the coverage.

4.16.2.4 Conditional Contract

An insurance policy is a conditional contract. A conditional contract is a contract under which the insurer's obligation is contingent on the insured's meeting certain conditions (i.e., the performance of specified acts).

For Example:

In order for a property insurance claim to be paid, the insured is generally required to:

- Give prompt notice of the claim to the insurer;
- Protect the property from additional damage;
- Provide a detailed inventory of damages;
- Permit the property to be inspected; and
- Assist the insurer during the claim investigation.

In addition, an insured may be required to submit to an examination under oath.

Section Review:

1. Which is the largest property and casualty line? Refer to Section 4.1, page 31

A. Automobile coverage **[Your answer is correct. Automobile coverage is the largest property and casualty line; it covers both physical (property) damage and car owners' liability.]**

B. Commercial general liability **[Your answer is incorrect. Commercial general liability is not the largest line.]**

C. Flood insurance **[Your answer is incorrect. Flood insurance is not the largest line.]**

D. Earthquake insurance **[Your answer is incorrect. Earthquake insurance is not the largest line.]**

2. **True or False.** GAAP accounting requires that all costs related to writing business be

expensed immediately. **Refer to Section 4.6, page 36**

A. True **[Your answer is incorrect.]**

B. False **[Your answer is correct. GAAP requires that all costs related to writing business be expensed immediately.]**

3. Commingling of client or insurer funds with the monies of a producer or agency is strongly discouraged and is a breach of what duty? Refer to Section 4.10, page 38

A. Fiduciary **[Your answer is correct. One fiduciary duty of an insured is to ensure that there is no commingling of client or insurer funds with the monies of a producer or agency.]**

B. Ethical **[Your answer is incorrect. Although unethical, it is not the duty referred to.]**

C. Moral **[Your answer is incorrect. Morality is not a duty.]**

D. Basic **[Your answer is incorrect. Commingling of funds is not a basic duty.]**

4. **True or False.** The Federal government never has the right to intervene in state insurance matters. Refer to Section 4.11, page 38

A. True **[Your answer is incorrect.]**

B. False **[Your answer is correct. Current law generally permits the federal government to intervene only when state regulation proves to be inadequate.]**

5. Under which of the following instances might the government provide insurance coverage? Refer to Section 4.11.5, page 41

A. When a natural disaster occurs **[Your answer is incorrect. The government doesn't provide insurance coverage when a natural disaster occurs.]**

B. During a terrorist attack **[Your answer is incorrect. The government doesn't provide insurance coverage during a terrorist attack.]**

C. If the insurance industry cannot provide coverage **[Your answer is correct. This occurs when the public needs some type of coverage that the private insurance industry cannot provide, or cannot provide as effectively, as the government.]**

D. When a death in the family occurs **[Your answer is incorrect. The government doesn't provide insurance coverage when a death in the family occurs.]**

6. Who typically provides workers' compensation insurance? Refer to Section 4.11.5, page 42

A. Employers **[Your answer is incorrect. Employers do not typically provide workers' compensation insurance.]**

B. Employees **[Your answer is incorrect. Employees do not typically provide workers' compensation insurance.]**

C. Private insurers **[Your answer is incorrect. Private insurers do not typically provide workers' compensation insurance.]**

D. State governments **[Your answer is correct. Many state governments are active in workers' compensation. In some states, the law requires employers to buy their workers' compensation coverage from the state.]**

Now let's look at property and casualty insurance.

5.0 Property and Casualty Insurance

Of the broader category of property and casualty insurance, the line of insurance more easily defined is property insurance. Property insurance is designed to cover property losses. Such covered losses may involve:

- Actual loss of the covered property caused by its destruction;
- Loss of income resulting from the insured's inability to use the covered property that has been damaged or destroyed; and
- The additional expenses incurred by the insured due to their loss of the covered property.

5.1 The Basic Policy Format

Nearly all standard insurance policies are constructed the same way. They have five general parts:

- The Declarations,
- The Insuring Agreement,
- The Exclusions,
- The Conditions, and
- The Endorsements.

Obviously, insurers can and will use somewhat different presentations of one or more of these policy parts, but the content and purpose of each is always consistent from insurance company to insurance company.

5.1.1 The Declarations Page

The declarations page is what makes a particular insurance policy for one insured different from all other policies issued by the insurer. It is here that the insured's name is indicated, along with their address and other identifying information.

The declarations page contains the policy number. Universally, each policy issued by a particular insurance company bears an identifying policy number. The policy numbers bear no similarity from one company to another:

- Some may use only numbers.
- Others will use a combination of numbers and letters.
- Some may use a specific letter or number prefixes to identify the type of policy being issued.
- Some may use a suffix number to indicate such things as the number of renewals this policy has gone through.

Although every company has its own method of sequencing the policy numbers, all companies use some numbering system to identify the specific policy issued.

Also on the declarations page, the general coverages being provided are listed. Again, companies may vary on how they display this information; however, the coverages being purchased by the insured are shown here in one form or another.

If a policy contains a deductible provision, for one or more of the coverages being provided, the deductible information should be shown on the declarations page.

Similarly, the identity of any loss payees under the policy, and/or additional named insureds under the policy, may also be shown on the declarations page. The term of the policy, or length of time the policy will be in effect, from inception date to expiration date is shown here.

Also on the declarations page, the specifics of the property being insured are identified by address, physical description, etc.

Although the specific endorsements to a policy are contained in, or affixed to, the policy, and spell out the parameters of the endorsement language, the existence of the endorsements related to a particular policy are generally identified on the declaration page by listing the endorsements names and/or numbers.

Finally, the declarations page shows the premium being charged for the coverage being provided. The premium may appear as a single inclusive number, or it may be broken down to show the charges related to specific coverages contained in the policy.

Since the declarations page is often the only thing that changes from one policy period to the next, many carriers merely issue a new declarations page at renewal, rather than reissuing the entire policy contract.

5.1.2 The Insuring Agreement

The main body of the insurance policy is the insuring agreement. It is here that the perils being insured against are set forth and defined. The type of policy being issued determines whether

the perils include those that are usually associated with damage to one's own property, to property of others, or to acts the insured might commit which could damage other people or property.

In policies covering the insured's own property, the type of property is often elaborated upon. Although certain property may be specifically identified in the declarations page, the description contained in the insuring agreement is usually only general in nature. It may indicate the location of certain real property, the geographical boundaries of certain operations being covered, the description of a particular piece of property, or the activities for which the insured is being insured.

The insuring agreement will generally explain what the duties, rights, and responsibilities of the parties will be in the event of a claim under the policy. It may cover the time frame in which a claim must be presented, whether the insured will be required to present a "proof of loss" form, or whether the insured may sue the company in court if disputes arise or if they must seek redress through the arbitration process.

In liability policies, the Insuring agreement generally states that the company has the duty and the obligation to defend the insured from all claims filed against them, even if those claims are without merit, and to indemnify or pay for any judgment rendered against the insured in such claim or lawsuit. The company usually has the right (but not the obligation) to investigate any claim submitted by the insured or by a third party.

There is generally a cooperation clause within the insuring agreement that requires the insured to assist the insurer in all reasonable ways toward resolution of any loss sustained and covered by the policy.

After providing in the insuring agreement what the insurance policy covers, the policy then limits some of those broad promises in the exclusions section of the policy. While the insuring agreement is usually general in nature, the exclusions are usually quite specific.

It is necessary to limit the coverage being provided for a number of reasons. Most specifically, if coverage is normally provided in other types of policies, the exclusions will attempt to eliminate that article, activity, or result from the coverage. The intent is to avoid double recovery wherever possible.

5.1.3 Exclusions

Exclusions in a first-party or property policy might indicate that the property being insured will not be covered for such things as wear and tear, inherent vice, latent defects, etc. Coverage for real property might have limitations for damage arising out of settling, shifting, bulging of foundations, walls, etc. Damage resulting from earth movement (such as earthquakes) is typically not covered, unless it is specifically addressed elsewhere in the policy. Flood damage, or damage from other surface water, may be excluded. Although theft may be a covered peril, any "mysterious disappearance" of an article may not be recoverable under the policy, unless it is specifically described and mentioned as being covered. (That is to say the coverage would not be in effect unless it can be shown the article was specifically taken from a known place at a known time.) Since there may be a substantial increase in the risk of damage to property that is unoccupied for long periods of time, many policies covering buildings contain an exclusion for damage to alienated premises.

In general liability policies, there is usually an exclusion for injury to a third party arising out of the loading or unloading of a motor vehicle. Injuries of this type are usually covered by the automobile policy, and the general liability policy exclusion attempts to avoid duplicating that coverage.

General liability policies often exclude damage arising out of professional services rendered by the insured, since such coverage is better provided by professional liability insurance contracts, such as an errors and omissions policy or some specific professional malpractice policy. Similarly, since providers of alcoholic beverages can purchase liquor legal liability coverage, the general liability policy usually excludes liability arising out of such activities.

Since the insured may purchase first-party coverage to provide for perils to property that the insured may own, or be holding for some reason, the general liability and automobile liability policies generally exclude damage to property in the care, custody, or control of the insured.

Workers' compensation coverage is available to almost all employers, so the automobile and general liability policies exclude injuries to employees of the insured if they are injured during the course and scope of their employment. This is an important exclusion because many automobile liability policies, and premises liability policies, contain Medical Payments coverage. This pays certain medical costs incurred by anyone injured while in the insured automobile, or on the insured premises, regardless of whether or not the injury was caused by the negligence of the insured.

Note:

Without a workers' compensation exclusion, an injured worker, under certain circumstances, might be able to collect under workers' compensation and also under the automobile or premises policies of his employer.

5.1.4 Conditions

The final section making up the basic insurance policy is the Conditions. Here the insurance company sets forth the contract terms. There may be certain limitations to the coverage being provided, not to be confused with specific exclusions. There is usually a "liberalization" clause, which, in effect, says if the insurance company issues the same type of policy that broadens or expands the coverage, the existing (previously issued) policy will be broadened to provide the revised degree and type of coverage.

This allows the company to conform, for instance, to court directed interpretations of certain policy terms and conditions without the need to recall and reissue all existing policies that might be affected by the court's ruling. The clause can also be used by the company on a voluntary basis for marketing purposes to enhance the coverage being provided to its current policyholders.

The conditions section will specify how, and for what reasons, either party may cancel the policy. Generally, the insured may cancel the policy at any time and for any reason. The only question that arises in such circumstances is how much, if any, of the unearned but paid premium will be returned to the policyholder. The insurance company, on the other hand, does not have the luxury of such a broad escape route from an unprofitable or high-risk contract.

Once the policy is issued, the insurer normally can only cancel the contract for failure of the insured to pay the premium, or if the insurer can show that fraud was committed by the insured in the purchase of the policy. Such restrictions are often similar for the insurers' rights to not renew a policy that is expiring, although some policies and state insurance laws only deal with "mid-term" cancellations. A number of states, through their insurance laws and regulations, have imposed restrictions regarding the insurer's rights to cancel and/or non-renew policies.

Since laws and customs may vary dramatically in other countries, insurance companies in the United States may often limit, in the conditions section, the geographical territory where the policy will be in effect. This may not be pertinent to stationary, real property; however, many things are mobile and may be physically situated in an area where the risk is substantially higher than was contemplated by the insurer when the policy was written.

The same is true for liability policies that cover the insured's actions. While certain activities may be relatively risk free in some parts of the world, other countries may impose harsh legal or civil penalties for those same actions. The territory conditions attempt to limit the insurance company's liability to the risks in known territories that they considered when the policy was issued.

As with most contracts, the parties entering into the agreement do not want the rights or obligations given over to some other party without full mutual agreement to do so. This is called a contract assignment, and the conditions section of the policy restricts the insured from assigning their rights and obligations unless the insurer agrees. An insurance policy is an agreement for the insurer to protect (monetarily) the property and/or actions of the insured and is based on what the insurer knows and is told about the insured. If the insured's character or makeup changes materially after the policy is issued (i.e., the insured entity is sold to another owner) the risk to the insurer could be substantially altered. In those situations, the Assignment Clause would allow the insurer, in effect, to renegotiate the terms and price of the policy to better reflect the changed risk factors.

In many types of policies, the insurer pays for loss to the insured's property, even though the damage may have been caused by the negligent actions of some other party. The person whose property was damaged (in this case the insured) would have the right to seek compensation for the damage from the negligent party. However, they may opt to collect from their own insurance company and give the insurer the right to proceed against the wrongdoer to collect some or all of what the insurer paid to its insured. This is called subrogation, and the right of the insurance company to step into the shoes of its policyholder to recoup their loss is found in the Conditions Section of the policy.

For commercial policies, the insurance company obtains the right, in the conditions section, to inspect and audit certain aspects of the companies they agree to insure. This is in the Inspection and Audit clause of the Condition Section. As mentioned above, it is possible that the entity originally insured may have materially changed since the inception of the policy. Those changes could alter the risk that the insurance company thought it was taking. The right to periodically take another look at what was insured is given to the insurer in this clause.

Note:

One of the most important, and most frequently used, clauses in the conditions section of liability policies is the Other Insurance Clause. As was discussed earlier, insurance companies

attempt to avoid (in most circumstances) the duplication of payment to an injured or damaged party, whether that party is the insured or a third party. In addition to some of the specific exclusions in the policy that seek to eliminate such overlapping payments, the Other Insurance Clause is designed to deal with two or more policies which provide substantially the same coverage to the same person or entity for the same incident. Such situations can arise not only because an entity may have bought duplicating policies, but also from having coverage extended under someone else's policy (as when the named insured under one policy is also entitled to coverage as an additional insured under someone else's policy).

When such potentially duplicative coverage arises, the other insurance clause attempts to set forth how the co-existing policies will each respond to the claim. Generally speaking, there are three types of other insurance clauses: pro-rata, equal shares, and exculpatory.

In a **pro-rata clause**, the policy says that if more than one policy provides coverage for a specific claim or loss, the policies will share the loss on the basis that their individual limits of liability bear to the total of all applicable limits of liability.

For Example:

If there are two policies that will share the loss, and one has a limit of liability of \$100,000 while the other has a \$200,000 limit, the first carrier will pay one third of the loss and the other will pay two thirds.

The **equal shares clause** says that if there are two or more policies providing coverage for the same loss, the policies will each respond equally, up to the limits of their respective limits of liability. In the example above with two policies, one at \$100,000 and the other at \$200,000 limits of liability, each would pay an equal amount up to a maximum of \$100,000 each (the limits of the lower policy), and then the remaining carriers would respond to the additional payments necessary to settle the loss.

An **exculpatory clause** says that if there is other viable insurance that will address the loss, the coverage under this policy shall be excess to all other collectible insurance. In other words, if the insured has other coverage available to them, whether in a policy they purchased or one purchased by someone else in which they qualify as an insured, the policy with the exculpatory language would not respond at all until all other insurance was exhausted.

Any of these three clauses works well, so long as all policies that are being called upon to respond to a loss contain compatible types of other insurance clauses. Certainly, if all the policies contain pro-rata clauses or equal shares clauses, the sorting out of the respective responsibilities is relatively simple. Things get a little less clear when the responding policies have conflicting wording, or where all policies have exculpatory clauses.

The laws governing the interpretation of these conflicting clauses vary somewhat from state jurisdiction to jurisdiction. There are, however, some generally accepted rules for solving these apparent conflicts:

- If one or more of the policies has a pro-rata clause and one or more has an equal shares clause, the coverage will generally be allocated by equal shares.

- When one policy has a pro-rata or an equal shares clause, with the other policy having an exculpatory clause, the pro-rata policy will be primary and the exculpatory policy will be excess.
- If both (all) policies have exculpatory clauses, the insured cannot be left without primary coverage, and the usual interpretation is for the policies with exculpatory language to share the loss on a pro-rata basis.

Since there is much in an insurance policy to be interpreted, the conditions often include definitions on certain terms found in the policy.

A general rule to remember when reviewing an insurance policy is that it is a legal contract. As with any contract, it is important to read the entire form, rather than reading only one particular clause or paragraph that may appear to cover the aspect in which you are interested. As has been seen from the foregoing information, the construction of the policy may very well provide coverage in one place and then remove it in another.

5.2 Important Property and Casualty Insurance Terms

Knowledge of certain terms specific to the property and casualty insurance industry—in addition to those already discussed—can help facilitate your understanding of the insurance products we will be examining in the balance of the course. Accordingly, although many terms are used in connection with property and casualty insurance, we will define the following common terms:

- **Additional insured** – a natural or non-natural person listed in the policy’s declarations page in addition to the named insured. An example is a lien holder who has an insurable interest in the insured property.
- **Hazard** – something that increases the likelihood of loss.
- **Certificate of insurance** – a written form providing a summary of coverage provided under a policy that is frequently used to verify that a policy has been written.
- **Indemnity** – the insurance principle stating an insured after suffering a loss should be restored to the approximate condition existing before the loss, no better or worse.
- **Coinurance** (property insurance) – the policy condition requiring an insured to pay part of a covered loss if the amount of insurance coverage on the insured property is less than a specified percentage of the property’s value at the time of loss.
- **Insuring agreement** – the provision of an insurance policy describing what is covered and the perils insured against.
- **Conditions** – provisions in an insurance policy that describe the rights and duties of the insured and insurer under the policy.
- **Limitations** – the provision of an insurance policy eliminating or reducing coverage under certain circumstances or when specified conditions exist.
- **Declarations** – the page of an insurance policy that describes the insured, the risk or property covered, the term of coverage, and applicable limits.
- **Named insured** – the natural or non-natural person named in the policy declarations to whom the policy is issued.
- **Deductible** – the dollar amount of each covered loss payable by the insured.
- **Peril** – the cause of a loss.

- **Endorsement** – a document added to an insurance policy that changes the policy in some fashion by adding or limiting coverage.
- **Policy limit** – the maximum amount the insurer will pay under the policy, either for a particular loss or for all losses sustained during the policy period.
- **Exclusions** – the policy provisions identifying the property, perils, persons, or situations not covered under the policy.
- **Policy period** – the date and time coverage begins and ends under the policy specified in the declarations page.
- **Exposure** – a condition or situation presenting a possibility of loss.
- **Proof of loss** – a form that provides an inventory of damages completed by the insured following a loss.
- **Floater** – an insurance policy covering property wherever located.
- **Subrogation** – the transfer to the insurer of an insured's right to collect damages from a third party.

Let's now take a look at both property and casualty coverages and what they mean.

5.3 Property Insurance

For the purpose of this course, we are going to define property insurance as the line of insurance designed to protect against the risk of financial loss if physical property or its income-producing ability is damaged or destroyed.

Many types of coverage are included under “property insurance.” The principal property coverages include:

- Dwelling insurance;
- Homeowners insurance;
- Commercial property insurance;
- Inland marine insurance;
- Ocean marine insurance; and
- Crime insurance.

5.3.1 Types of Property Contracts

Since the nature of physical property varies, so must the types of property insurance contracts.

One variation deals with the location of the property to be insured. Some property, by nature, is fixed to a specific location, such as your house. Other property, such as your automobile, is designed to be mobile. As a result, property insurance contracts can be issued on a fixed coverage or on a floater coverage basis.

Fixed coverage policies generally protect property that is located at a specific or fixed location.

For Example:

The best example of fixed coverage is property insurance protecting buildings, houses, detached garages, barns, office buildings, apartment buildings, etc.

Floater coverage policies provide protection for property at various locations. The protection follows the property around, or floats.

For Example:

The best example of floater coverage is automobile insurance, which insures the car whether it is in the driveway, in the next town, or in another state.

The territory in which the coverage is valid may vary. A typical floater policy clause might define the coverage territory as the U.S., Puerto Rico, and Canada.

Most property insurance contracts indemnify the policyholder for the loss of property on either a replacement cost or actual cash value (ACV) basis, as described in the policy.

There are, however, certain types of property that are difficult to value. This means that the policyholder and insurance company agree in advance on the value of the property, and this is the amount of insurance stated on the policy's declarations page.

For Example:

Examples include jewelry, valuable collections (coins, stamps, etc.), and artwork. In these cases, the property contract will be issued on a stated value basis.

Finally, some risks or exposures are easier than others to determine in advance. For example, numerous statistics exist that enable an insurance company to accurately evaluate the risk of providing insurance coverage for property such as homes and automobiles. These property insurance contracts are issued on a non-reporting basis, which means that a known, stated premium is charged each time the policy is renewed.

Other types of property fluctuate in value, making it difficult to determine in advance the amount of coverage needed at any given time.

For Example:

A good example of this situation is business inventory. As the inventory fluctuates in size, so does the risk of loss. This type of situation can be insured on a reporting basis.

With a reporting policy, the policyholder pays a deposit and then periodically submits reports of property values to the insurance company, instead of paying a flat premium at the beginning of the policy term. These reports, commonly submitted monthly, are then used by the insurance company to calculate the premium for the actual risk exposure. At the end of the reporting period, this premium is then charged against the initial deposit made by the policyholder. If it exceeds the deposit, the policyholder must pay the difference. Otherwise, the policyholder receives a refund.

5.3.2 Property Insurance Declarations

You earlier learned about the function of the declarations page. Let's take a look at some specifics of a property insurance declaration page to gain a better understanding of this coverage.

The declarations page of a property insurance contract will first state the name and address of the person or business who is insured (e.g., the property owner). It will also describe the property that is covered by the policy.

For Example:

This policy description can appear in one of two ways:

- **Specific Insurance** – The description of the property can be very specific, such as: "Dwelling located on Lot 31, Section 2, Rolling Meadows Subdivision, Riverview, New Jersey."
- **Blanket Insurance** – Alternatively, the description can be broad, such as: "Personal property located at 136 Oak Street."

Any deductible is shown on the declarations page, together with the policy term (date and time), the premium, and the policy number. Finally, the declarations page describes the limits of coverage.

In the case of a stated value contract, the limit of coverage shown is the amount that will be paid if the property is destroyed. Otherwise, the amount of insurance that appears on the declarations page is the maximum the company will pay in the event of a loss. Based on the principle of indemnity, the policyholder will be indemnified for any losses on a replacement cost or actual cash value basis, but never to exceed the limit of coverage shown on the declarations page.

For Example:

The limits of coverage found on the Declarations Page can be expressed in one of two ways:

- **Scheduled Coverage** – The limit is shown for each specific item of insured property, such as: "\$10,000 Furs"
- **Unscheduled Coverage** – The limit applies to all property, such as: "\$50,000 Contents"

Scheduled and unscheduled coverage are the same as specific and blanket insurance, respectively.

5.3.3 Property Insurance Insuring Agreement

The Insuring Agreement explains exactly what coverage is provided by the policy.

We previously described a peril as the cause of a loss. For instance, if a house burns down, fire is the peril. The Insuring Agreement states exactly what perils are insured.

If the policy specifically lists the perils it covers, it is called a named peril or specified peril contract. These contracts insure property against only the perils named in the policy. If a loss is caused by a peril not named in the policy, the policyholder is not covered and cannot collect

from the insurance company.

For Example:

A standard fire insurance policy covers against loss by fire, lightning, and removal from premises endangered by fire and lightning. If the property is damaged by flood, however, there is no coverage.

In contrast to a named peril contract, some property contracts are written on a special form basis. A special form contract does not list or specify the perils covered. Instead, it states that coverage against direct cause of loss is provided. Other terms for direct cause of loss are "open perils" or "all risks." The latter term has fallen out of use somewhat but is still the best explanation of special coverage. It means that the policy insures against "all risks" of loss except causes that are specifically excluded.

For Example:

A special form property policy usually excludes nuclear hazard. This means that if the covered property is destroyed by radioactive contamination, for example, the loss is not covered by the special form policy.

In addition to specifying the perils covered, the Insuring Agreement will state whether it covers direct loss, indirect loss, or both.

Direct loss is direct physical damage to covered property by the perils insured against, without an intervening cause.

For Example:

An apartment building that is destroyed by an explosion.

Indirect loss or consequential loss is a loss that results from a hazard or peril but is not directly caused by the hazard or peril. Instead, it is a result or consequence of the original loss.

For Example:

Lost rental income from the destruction of an apartment building by an explosion is an indirect loss.

Closely related to direct and indirect loss is proximate cause, which refers to an unbroken series of events leading from a cause to an end result. In our earlier example, explosion was the proximate cause of the direct loss of the apartment building. If following an explosion, damage to the building was instead caused by looters, explosion would no longer be the "proximate" cause of loss and the loss to the building would not be covered unless damage by looters was also included in the policy.

Note:

The general rule is that the proximate cause of a loss must be proven by the insured if the policy is on a named perils basis. Otherwise, the insurance company must prove the proximate cause of the loss.

Most property contracts cover direct losses only, with indirect losses being covered by adding endorsements to the policy. In addition, certain commercial property policies allow the insured to elect certain extensions of coverage. Generally speaking, these extensions of coverage often provide additional insurance. As the wording indicates, these extensions "extend" the policy coverage beyond the basic insuring agreement and, in many situations, add additional coverage to the policy.

For Example:

The XYZ Company has a manufacturing plant insured for \$1 million and is in the process of constructing a storage building on their property when it burns down. Using the "Newly Acquired or Constructed Property" extension of coverage, the company has additional coverage beyond the \$1 million policy limit it can apply to the loss to the storage building.

5.3.4 Property Insurance Exclusions

All property insurance contracts contain exclusions—losses not covered by the policy. In a named or specified peril contract, any perils that are not specifically covered are automatically excluded from coverage. In addition, these contracts usually list certain exclusions in order to emphasize or explain losses that are not covered.

In a special form policy, exclusions are especially important because any loss that is not specifically excluded is covered.

Note:

Because of the doctrine of concurrent causation, most property policies very specifically describe what is and is not covered by the policy.

Concurrent causation states that if two or more perils cause a loss, the entire loss is covered if any one of the perils is covered.

For Example:

A property policy covers losses caused by fire but excludes those caused by earthquake. During an earthquake, the covered property is severely damaged by cracks in the building's foundation. There is also a small fire that causes minor damage. Without a specific exclusion to the contrary, the entire loss would be covered under the doctrine of concurrent causation.

While exclusions vary from policy to policy, we will review the types of exclusions most commonly found in property insurance contracts.

The first of these general exclusions is non-accidental losses. Since wear and tear, electrical or mechanical breakdown, rust, corrosion, and deterioration are all certainties, they cannot be insured against and are excluded. Included in the category of exclusions are conditions or defects that exist in a product naturally. This is referred to as inherent vice, another non-accidental loss.

For Example:

Since rubber tends to deteriorate with age, tires cannot be insured against loss from deterioration.

Another general exclusion is catastrophic losses. These are losses that are so broad in scope that they would bankrupt an insurance company if they became a reality.

For Example:

Catastrophic losses excluded from coverage typically include war and nuclear hazard.

Other risks are considered extremely hazardous. They could be covered, but to do so, the insurance company would have to charge a substantially higher premium.

For Example:

Losses caused by earthquake are generally excluded, especially in a state such as California. Another example of an extremely hazardous exclusion is flood. For those individuals or businesses wanting this coverage, it can be obtained through a separate policy, or by endorsement to the basic policy, for which they must pay an extra premium.

Another general category of exclusions is losses controllable or preventable by the policyholder. Losses that the policyholder can prevent or control with extra effort are not covered. As a result, the policyholder is encouraged to be responsible in the use of property. Under this exclusion, losses such as marring, scratching, breaking, or chipping of objects are generally not covered. Illegal acts by the policyholder also fall under this exclusion.

Finally, property that is customarily covered in other available insurance policies is generally excluded. For this reason, a homeowners policy would generally not cover a car, since automobile insurance is available.

5.3.5 Property Insurance Conditions

The Conditions section of the property insurance contract serves to describe the rights and responsibilities of both the policyholder and the insurance company.

Two clauses commonly found in property insurance contracts are the coinsurance clause and the deductible clause. While each operates differently, they have a common objective: to reduce the premiums by requiring the policyholder to share in the risk. Let's take a closer look.

5.3.5.1 Coinsurance Clauses

Coinsurance is used by insurance companies to encourage policyholders to insure property for its full value. Since partial losses are much more common than total losses, some policyholders might purchase only enough insurance to cover any smaller partial losses, taking the chance that a total loss will not occur. If done frequently enough, insurance companies would then not be able to collect enough premiums to pay for actual losses. Coinsurance is the solution to this problem.

With a coinsurance clause, the insurance company is able to require that the policyholder carry insurance equal to a specified percentage of the property's value in order to receive full reimbursement for any loss.

Note:

The most commonly used coinsurance percentage is 80%. This means that the policyholder must insure at least 80% of the property's value in order to receive full reimbursement. If, for example, a house is worth \$100,000, the policyholder must carry at least \$80,000 of insurance to satisfy the coinsurance requirement.

If the policyholder does not satisfy the coinsurance requirement and suffers a loss, the insurance company will usually pay only a percentage of what the full reimbursement would otherwise have been.

Scenario:

Let's assume that a policyholder with a home valued at \$100,000 carries only \$60,000 of insurance, rather than the required \$80,000. This means that the policyholder is carrying only 75% of the required insurance (\$60,000 divided by \$80,000).

Question: If the policyholder suffers a \$10,000 loss, how much will the insurance company reimburse?

Answer: The insurance company will reimburse only 75% of that amount, or \$7,500.

Question: If the policyholder suffers a total loss, how much will the insurance company reimburse?

Answer: In the event of a total loss of the home, the company would pay its full limit of liability, or \$60,000.

As you work with property insurance coinsurance requirements, do not confuse them with health insurance coinsurance. In health insurance, a coinsurance clause requires that the insured pay a specified percentage of medical expenses incurred, such as 20% or 30%, with the insurance company paying the balance.

5.3.6 Deductible Clauses

A deductible clause requires that the policyholder pay the first part of each loss, up to the

amount of the deductible. Usually, the deductible is either a flat amount or a percentage of the loss.

For Example:

If the deductible is a flat \$250 and the policyholder suffers a \$200 loss, the insurance company would pay nothing. If, however, the loss is \$1,000, the policyholder would pay the first \$250, with the insurance company paying the remaining \$750.

Deductibles serve two purposes. They reduce the cost of insurance by serving to eliminate the cost of paying small claims. In addition, by sharing in the cost of a loss, policyholders are encouraged to avoid or minimize losses.

Generally speaking, the higher the deductible selected by the policyholder, the lower the premium.

5.3.7 Duties After a Loss

Most property insurance contracts contain a clause called **duties after a loss**. This clause specifies what the policyholder must do when a loss does occur. These duties include:

- Notifying the company within a certain time period after the loss
- Protecting the property from further loss
- In the case of theft, notifying the police
- Completing a detailed proof of loss
- Making the property available for the company's examination
- Submitting to examinations under oath

Failure to comply with these duties can relieve the insurer of its liability for indemnifying the loss.

5.3.8 Loss Settlement

The duties of the insurance company following a loss are contained in a loss settlement or valuation clause. This clause explains the basis on which the policyholder will be reimbursed. Assuming that insurable interest in the property exists at the time of loss, a typical loss settlement clause provides that the policyholder will receive the lesser of:

- The actual cash value of the property at the time of loss;
- The cost of repairing or replacing the property; or
- The limits of liability of the policy.

Scenario:

Let's assume that Eli's stereo system, for which he originally paid \$5,000, is damaged in a fire. Subtracting depreciation, the actual cash value of the stereo system at the time of loss is \$2,500. The cost to replace the stereo system today is \$4,000, and Eli's homeowners policy has a \$30,000 limit of liability on personal property.

Question: How much will Eli receive from the insurance company for this loss?

Answer: In this scenario, Eli will receive \$2,500 (minus the deductible, if any), the stereo system's actual cash value, since this figure is less than the cost to replace (\$4,000) or the policy's limit of liability (\$30,000).

If the policyholder and the insurance company cannot agree on the amount of the loss, the appraisal clause provides that each party can select an independent appraiser. If the two appraisers cannot agree on an amount, they then submit their differences to an umpire. The decision agreed to by any two of these three parties then sets the amount of the loss.

5.3.9 Liberalization

Property contracts contain a liberalization clause, which makes a change that broadens coverage without an additional premium charge. The change will apply to all existing policies for the same type. This is true even if the policy or endorsement was issued prior to the change that broadened coverage. This clause applies only when legislation or rulings broaden coverage, not when they restrict coverage.

5.3.10 Salvage and Abandonment

Finally, many property insurance contracts contain salvage and abandonment clauses.

A salvage clause provides that the insurance company can take title to any damaged property after paying for the loss. Sale of salvaged property can help reduce the cost of the claim to the insurance company.

An abandonment clause states that the insurance company need not accept any property abandoned by the policyholder. This means that the company retains the right of salvage, and property cannot be relinquished at the policyholder's option.

5.4 Casualty Insurance

Unlike property insurance which has a clear and straightforward definition, the definition of casualty insurance is somewhat "elastic." Casualty insurance is a term used to refer to a wide range of insurance coverages other than life, health, or property insurance. The principal casualty insurance policies are:

- Liability insurance; and
- Automobile insurance.

More specifically, casualty insurance (also referred to as liability insurance) covers losses and liabilities which are a result of unforeseen accidents. This category of insurance is quite broad, encompassing a range of situations and fields within the insurance industry. Generally, casualty insurance excludes life, health, and fire insurance policies; it is designed for things like burglary, terrorist attacks, and fraud.

Typically, casualty insurance covers both damages to property and people. For example, if someone purchases a casualty insurance policy for a boat and someone is injured on board, the insurance company will bear that person's medical costs. Likewise, if part of the boat is damaged as a result of something like a burglary attempt, the insurance company will also

cover this unforeseen event. This type of insurance is very useful for things like replacing broken plate glass or handling the aftermath of criminal acts.

Casualty insurance that includes personal liability can be very useful for business owners, as it ensures that the business will be able to take care of people who are injured on site. Homeowners can also take advantage of casualty insurance to help them replace items stolen during robberies, as can renters. A casualty insurance policy may also cover the people who visit a home in the event of an accident.

For Example:

Imagine that a business has just been destroyed in a natural disaster. Picture an irate customer creeping out from under a pile of wreckage, standing shakily erect, waving a fist, and shouting, "I'm gonna sue you for everything you've got!" Who knows: Perhaps the irate citizen would win the suit and leave the business in absolute financial ruin.

This happens more than you are probably aware. To help protect against such occurrences, insurance companies provide liability insurance.

An individual can incur legal liability as a result of actions or inactions toward other people or their property, and the financial consequences can be severe. Such losses are called liability losses. A liability loss occurs when it is determined that an individual or business is responsible, or liable, for loss to another person or another person's property and is required to make financial restitution.

Liability insurance is designed to protect an insured's overall assets. Although a homeowners policy might pay to rebuild or repair a house after fire damage, the amount of the loss cannot exceed the value of the property. When a third party is injured and it is the insured's fault, there might not be any limit on the amount of loss. The loss could wipe out savings and investments, cause the sale of owned property, and even involve the attachment of future earnings.

When casualty insurance is purchased for a home or a business, it should be viewed as supplemental insurance. It will not cover things like fires and floods, which need to be separately insured. People should also read the terms of casualty insurance carefully because certain things may not be covered, and this could become an issue when a claim is made.

Let's take a look at the terms of a sample casualty policy.

5.4.1 Insuring Agreement

Insuring agreements describe the coverage being provided but also describe a number of related provisions, such as defense costs, interest payments on judgments, and other supplementary payments.

5.4.2 Coverages

Most liability policies agree to pay on behalf of the insured all sums for which the insured becomes legally liable to pay as damages because of bodily injury and property damage.

Terms are always defined in the policy, but in general, bodily injury (BI) means injury, sickness, disease, and death arising out of injury, sickness, or disease. Property damage (PD) means damage to or destruction of property, including loss of use of the property. Some liability policies also cover the insured's liability for personal injury (PI), such as slander, libel, false arrest, and invasion of privacy. (In the insurance business, "bodily injury" and "personal injury" have different meanings and are not used interchangeably.)

Although insurance companies pay "on behalf of the insured," the injured party must file a claim against the insured or sue the insured, not the insurance company. In fact, third parties usually have no right to sue the insurance company directly.

5.4.3 Defense Costs

In addition to paying for bodily injury or property damage, liability policies promise to defend the insured in any suit seeking BI or PD damages, even if the charges are totally groundless or false. Defense costs are generally paid in addition to payments for amounts awarded against the insured. The insurer pays for the defense, but its duty to defend ends once the amount it pays for damages equals the policy limit.

For Example:

Let's say an insured's policy has a \$100,000 liability limit. If the insurer has spent \$50,000 defending the claim and has also paid \$100,000 in partial settlements, the insurer's obligation to defend ends completely, as does its obligation to pay any additional amounts of the claim that remain in dispute. Once the policy limit is exhausted, any additional defense costs and amounts awarded against the insured are fully the insured's responsibility.

Potential defense costs paid by the insurer are typically unlimited until the insurer's obligation to defend ends. Under most policies, these costs are paid outside of the policy limits for liability and in addition to any liability amounts ultimately awarded. For example, if an insured has a \$250,000 policy limit and the insurer has spent \$75,000 while defending the claim, the full \$250,000 limit of insurance remains available to pay any judgments.

Settlements are not always determined by a court. Although the insurance company will provide a legal defense, in some cases it might not want to. In theory, an insurer could pay more defending a claim than the limit of insurance. In reality, that is not likely. When it appears that defense costs will be excessive or that the liability of the insured is clear and the defense cannot win the case, the insurer will usually try to cut its losses by negotiating a settlement out of court in order to avoid the additional expenses of defending the claim.

5.4.4 Prejudgment Interest

A court will sometimes award a third-party interest on an award for damages to compensate for the interest the third party might have earned if they had received compensation at the time of injury or damage, rather than at the time of judgment. Most liability policies cover this prejudgment interest. Some policies cover it in the insuring agreement along with the actual

damages, up to the policy limits. Other policies might include it as a supplementary or additional payment that is not subject to the limit of liability.

5.4.5 Supplementary Payments

Liability policies usually provide a number of supplementary payments that are all paid in addition to the policy's regular limit of liability. These coverages vary from one type of liability policy to another. We already mentioned defense costs, but in general the complete list of additional payments typically includes:

- Defense costs
- Expenses incurred in the investigation of a claim
- Premiums for certain types of bonds, such as bail bonds, appeal bonds, and release of attachment bonds
- First aid to others at the time of an accident
- Reasonable expenses incurred by the insured at the company's request in the investigation or defense of a claim
- Loss of earnings (such as when the insured is required to miss work for court appearances)
- Prejudgment interest (when it is not included in the insuring agreement as a part of damages)
- Post judgment interest (interest accruing on the judgment after an award has been made, but before payment is made by the company)

5.4.6 Policy Limits

Even though the purpose of liability insurance is to protect the insured from financial loss by shifting the burden of payment from the insured to the company, there is a limit beyond which the company will not go. The maximum amount the company will pay on behalf of the insured is stated in the policy limits, which are shown in the declarations.

The policy might stipulate separate limits for BI and PD (split limits), or there might be one limit that applies to both BI and PD (single or combined single limit).

5.4.7 Exclusions

All liability policies contain certain exclusions. In general, there is no coverage for:

- Damage to property owned by the insured
- Damage to property in the insured's care, custody, or control
- Bodily injury to an insured
- Losses covered under workers' compensation laws
- Losses covered under Nuclear Energy Liability policies
- Injuries or damages caused intentionally by the insured

5.4.8 Conditions

A number of conditions are commonly found in liability policies – many of which we've already discussed, such as cancellation, assignment and misrepresentation, concealment, and fraud.

But let's review two conditions that have some special provisions applicable to liability insurance.

5.4.8.1 Duties After Loss

The Duties After Loss condition has some unique requirements in liability policies. The insured must notify the insurance company in writing of all losses. In addition, the insured is required to forward all applicable demands, notices, or summonses and give any necessary assistance to the case, such as testifying as required. The insured cannot voluntarily assume any liability or make any restitution to another party without the knowledge and consent of the insurer.

5.4.8.2 Other Insurance

Like property policies, liability policies contain Other Insurance clauses. In addition to the methods we've already discussed for handling other insurance – such as pro-rata liability under which multiple insurers will share a loss proportionally based on their respective limits of insurance – liability policies can provide for contribution by equal shares.

Under contribution by equal shares, all insurers pay equal amounts regardless of their limits of coverage, up to the limit of the policy having the smallest limit. Then that company, having paid its policy limit, stops paying and the other companies share in the remainder of the loss. This continues until each company has paid its policy limit or the loss is paid in full.

For Example:

An insured's \$24,000 liability loss is covered by two policies: one issued by company XYZ with a \$5,000 limit and one issued by company PDQ with a \$25,000 limit. Company XYZ would pay \$5,000; company PDQ would pay \$19,000 (\$5,000 + \$14,000). If the loss had been \$4,000, company XYZ would pay \$2,000 and company PDQ would pay \$2,000.

5.4.8.3 Policy Limits May Apply per Occurrence or per Accident

Whether a liability insurance policy's limit is stated as a single policy limit or as split limits, the limits stated in the policy may apply:

- Per occurrence; or
- Per accident.

The policy coverage limits generally apply per occurrence. Limits that apply per occurrence can refer to a loss that occurs:

- At a specific time and place; or
- Over a period of time.

Some liability insurance policy coverage limits apply per accident, which is an older and more restrictive approach to policy limits. Limits that apply per accident limit covered losses to losses that occur at a specific time and place, rather than also to losses that occur over a period of time. Despite the difference in terminology, however, liability insurance policies whose coverage limits are stated on a per-accident basis may actually define the coverage limit such that it is

virtually identical with a per-occurrence coverage limit.

5.4.8.4 Policy Limits May Apply per Person or Also in the Aggregate

Liability insurance policies may impose policy coverage limits on a per-person basis. When a **per-person** limit applies, the policy states the maximum amount that will be paid for an injury to any one person.

Other liability insurance policies may also impose aggregate limits. When an aggregate limit applies, the limit stated in the policy is the maximum the insurer will pay for all losses that occur during the policy period.

Except for aggregate limits, a liability insurance policy's coverage limits are generally restored following the payment of a loss.

For Example:

Suppose a liability insurance policy provides for a \$5,000 per person limit and a \$250,000 aggregate limit. Following the insurer's \$3,000 claim payment, the per-person limit will be restored to \$5,000; however, the remaining aggregate limit will be \$247,000.

5.5 Specialty Coverages

As you have learned, typical property and casualty policies do not cover losses as a result of disasters such as earthquakes, flooding, and certain damages sustained in a hurricane. Let's take a look at these coverages.

5.5.1 Earthquake Insurance

While it is difficult to surpass the natural beauty of California, some say that all this beauty exacts a price. Natural disasters are part of the price to pay for living in beautiful California. Fires, mudslides, floods, and earthquakes are a few of the natural disasters common to the state. Earthquakes in particular send a tremor of fear through most Californians. Impossible to predict, earthquakes can cause major damage to home and personal property, not to mention the loss of human life that can occur in severe earthquakes. Earthquake insurance is one way to protect one of your most valuable assets: your home.

Many property owners utilize earthquake insurance to help defray the expense of costly earthquake repairs. Residential property insurers (insurance companies that sell homeowners policies and policies for qualifying condominiums and apartments) are required under California Insurance Code (CIC) Section 10081 to offer earthquake coverage for the peril of earthquake. The mandatory earthquake offer must:

- Be made in writing
- Describe coverage amounts
- List the deductible offered
- State the policy premium

You have 30 days from the date of mailing from the insurance company to accept the offer of earthquake coverage. If your homeowners insurance company does not receive a response from you, then they consider the offer rejected. Your insurance company is only required to make the offer of earthquake coverage every other year. The law prohibits an insurer from canceling, rejecting, or refusing to renew a residential property policy solely because the policyholder has accepted the offer of earthquake coverage.

Every offer of earthquake insurance must provide coverage for your dwelling (matches the limit on your homeowners insurance), for your personal property (limits ranging from \$5,000 to \$25,000), and for any additional living expense (ALE) of at least \$1,500. You may waive ALE coverage if you or your family do not occupy the dwelling you wish to insure.

ALE coverage, which is also called loss of use, is designed to pay for the cost associated with living somewhere else while repairs are being made to your home. Typically, your insurer will cover increases in your normal living expenses to help you maintain the standard of living you had before an earthquake damaged your home and personal property. ALE coverage can include costs for the following:

- Temporary rental home, apartment, or hotel room
- Restaurant meals
- Telephone or utility installation in a temporary residence
- Relocation and storage
- Furniture Rental
- Laundry

Payment on ALE coverage is limited to the reasonable time required to repair or rebuild your home or for you to permanently settle in another residence. It is important to note that ALE only covers the extra amount you have to pay in order to maintain your normal standard of living while outside your home. ALE coverage can also pay costs you may incur due to the police or other civil authority denying access to your home in the event of an evacuation.

CIC Section 10089(b) states that the maximum deductible that can be charged under earthquake insurance is 15% of the policy dwelling limit. It is common for the deductible to be the maximum 15%.

If you desire earthquake insurance offering more than the minimum limits and a deductible less than the maximum established by law, then you may contact your current residential property insurer or earthquake insurer to see if higher limits or lower deductibles are available. (Please see the "California Earthquake Authority" section of this course.) Also, you may want to contact a broker or agent to assist you with securing a monoline "stand-alone" policy. Stand-alone policies are offered by a few specialty insurance companies who do not require you to purchase your homeowners insurance from them in order to offer you earthquake coverage. They offer a stand-alone policy, which is referred to as a monoline policy (one line of insurance) by the insurance industry.

5.5.1.1 The California Earthquake Authority (CEA)

The CEA was formed to provide earthquake insurance to residential property owners including homeowners, individual condominium unit owners, mobile homeowners, and renters. Under the CEA plan, the CEA member insurance company is required to offer earthquake coverage

subject to the minimum dwelling and personal property requirements as outlined in CIC Section 10089 and as discussed in the "Earthquake Coverage" section of this course. Your dwelling must be covered according to the CEA policy guidelines; however, other structures such as outbuildings, swimming pools, and masonry fences are specifically excluded (as is the case with the majority of earthquake policies). The CEA has more recently offered broader coverage in response to growing claim reserves and positive reports of plan solvency.

You cannot purchase earthquake coverage directly from the CEA. The CEA does not offer stand-alone earthquake policies. Only licensed California insurers who are CEA member companies can sell CEA policies. You must have a residential property policy in force or be purchasing a new residential property policy from a CEA member insurer in order to be offered a CEA policy. The same insurer that provides your homeowners policy will also provide your earthquake coverage.

The residential insurance companies participating in the CEA insure nearly 1 million homes as of January 2025. For more information on the CEA, contact a CEA member residential property insurance company or access the CEA website at www.earthquakeauthority.com.

5.5.1.2 Special Earthquake Provisions

Insurance companies are required to offer earthquake coverage even if your property does not meet current Building Code and Health and Safety Code requirements relating to foundation anchor bolting and water heater bracing. However, your insurer may charge additional premium and/or an increased earthquake deductible if this is the case with your dwelling. Also, your insurance company must disclose any available discounts (such as retrofitting) for earthquake hazard reduction to your property in writing.

Retrofitting acts to strengthen your home to minimize future earthquake damage. Many consumers have utilized earthquake retrofitting as another way to be as prepared as possible for an earthquake. Look into retrofitting your property. In some cases, taking simple steps such as bolting your wood frame home to the foundation can save your home from severe earthquake damage and can reduce your earthquake insurance premium. Residential retrofitting includes, but is not limited to the following:

- Anchoring a dwelling to its foundation through seismic bolting
- Reinforcing and/or bracing the fireplace chimney
- Securing and bracing the water heater to the dwelling frame
- Installing automatic gas shut-off valves
- Installing bracing for sheer walls

CEA policies also include \$10,000 of coverage for reconstruction costs to bring your dwelling up to current building codes as required for approval of the reconstruction permit after an earthquake. This is called **building code upgrade coverage**, and you can purchase an additional \$10,000 or \$20,000 of coverage (for a total limit of \$20,000 or \$30,000, respectively).

5.5.1.3 Proximate Cause

Sometimes an earthquake and/or its aftershocks can cause other events to occur that result in damage to your property. When an earthquake triggers other property losses (such as a

bursting water pipe), the earthquake is referred to as the "proximate cause" of the damage, not the "direct cause." CIC Section 10088 states that unless earthquake coverage is in force at the time of an earthquake, the resulting loss is not covered, even if the direct cause is a covered peril under your residential property policy. This section does not prevent an insurance company from specifically providing coverage for direct loss due to explosion, theft, or glass breakage resulting from earthquake when an endorsement or earthquake policy does not exist. Read your policy and contact your insurance company whenever you experience a property loss due to an earthquake. Do not assume that the damage to your property is not covered.

5.5.1.3.1 Fire

Fires in the aftermath of an earthquake can often pose just as much threat to property damage as an earthquake itself. CIC Section 10088.5 provides that your residential fire insurer covers all fire losses that are caused by or follow an earthquake, regardless of whether you have earthquake coverage. Fire is the only exception to the proximate cause law.

5.5.2 Flood Insurance

Since standard homeowners insurance doesn't cover flooding, it's important to have protection from the floods associated with hurricanes, tropical storms, heavy rains, and other conditions that impact the U.S.

Because of frequent flooding of the Mississippi River during the 1960s and the rising cost of taxpayer-funded disaster relief for flood victims, Congress created the National Flood Insurance Program (NFIP) in 1968. It has three mandates: to provide residential and commercial insurance coverage for flood damage, to improve floodplain management, and to develop maps of flood hazard zones.

While the comprehensive section of an auto insurance policy covers flood damage to vehicles, there is no coverage for flooding in standard homeowners, renters, or commercial property insurance policies. It is available in a separate policy from the NFIP and from a few private insurers. Despite efforts to publicize this, many people exposed to the risk of floods still fail to purchase flood insurance.

It was the widespread flooding associated with Hurricane Katrina in 2005 that drew attention to the NFIP and put the program into a deficit. This set in motion debate about how to improve the program. The Biggert Waters Flood Insurance Reform Act of 2012 attempted to put the program on a better financial footing by phasing out subsidized premiums. This led to complaints about premium increases to existing policyholders, so Congress passed the Homeowner Flood Insurance Affordability Act of 2014 to place limits on the increases enacted in 2012. It is generally agreed that more work is needed on the program, but so far Congress has not acted further. As we have all seen either in person or on our television, flooding can happen anywhere, and at any time. Floods can cause hundreds of thousands of dollars' worth of damage, leaving people unhoused and in need of assistance. Are you making sure your clients are prepared for the next big flood?

Hurricane Katrina drew the public's attention to how a hurricane can lead to major flooding.

Don't let this mislead you though. Flooding can be caused by many other sources. Between May 1953 and March 2025, the United States has had 5,050 declared disasters, with fires, severe storms, and floods as the top three incident categories. Around 75% of disasters declared by the president involve flooding. The number of flood claims paid by the NFIP between 1980 and 2024 is over 1.9 million.

While there is a myth that certain areas of the country are immune to flood losses, the reality is that no state is immune and no locality within a state is immune. Anyone can suffer a flood loss. In fact, the Federal Emergency Management Agency (FEMA) reports that 40% of flood insurance claims originate in low-to-moderate-risk areas.

Do you know who provides flood insurance coverage? Some insurers provide flood coverage in certain inland marine policies and there are insurers who will provide flood coverage for large insureds in customized property insurance policies. For most of us, however, the only source for flood insurance is the National Flood Insurance Program (NFIP) underwritten by the Federal Government and we can only purchase flood insurance if we live in a participating community.

5.5.2.1 History of the National Flood Insurance Program (NFIP)

It used to be that people at risk from flood loss had only their neighbors and charitable organizations to help them during their time of need. At that time, Insurance companies avoided providing flood coverage because the risk was not considered to be commercially insurable for two reasons. First, a requirement for commercial insurability is spread of risk, being able to spread the risk over a sufficiently large number of policyholders so that the cost of insurance is affordable. But, originally, the only people who wanted flood coverage were those who lived in floodplains. As a result, adverse selection meant that insurers would not be able to spread the risk. A second requirement for commercial insurability is that the insurer not be faced with an undue catastrophe hazard, meaning no risk that would threaten the financial solvency of the insurer. Unless an insurer limited the amount of flood insurance it wrote, a large flood could easily bankrupt it. But there again, the insurer would be limiting its spread of risk. Sort of a vicious cycle. Notice that these restrictions applied to risks that are not commercially insurable. Many otherwise uninsurable risks can be and are insured by the Federal Government, which can spread risk through mandating insurance and, theoretically, cannot go bankrupt.

After considerable debate, Congress decided that disaster relief for victims of floods was both inadequate and expensive and, in 1968, it passed the National Flood Insurance Act. The objectives of the Act were to:

- Transfer the costs of private property flood losses from the taxpayers to flood insurance policyholders through flood insurance premiums.
- Provide floodplain residents and other property owners with financial aid after floods, especially smaller floods that do not warrant federal disaster aid.
- Guide development away from flood hazard areas.
- Require that new and substantially improved buildings be constructed in ways that would minimize or prevent damage in a flood.

Responsibility for administering the program was given to the Federal Insurance Administration (FIA), which at that time was operating under the Department of Housing and Urban Development. FIA now reports to FEMA, which in turn reports to Homeland Security.

5.5.2.2 Organization

There are two channels of distribution for flood insurance under the NFIP. One channel is the National Flood Insurance Program itself, also referred to as the direct side. The second distribution channel is "WYO" or "Write Your Own". As a title, "Write Your Own" is a little misleading since the buyer does not actually write their own insurance policy. Instead, the WYO option lets the buyer purchase insurance from an insurance company of their choice. All participating WYO Companies issue standard flood insurance policies using the same rules, rates, and regulations. National Flood Services is a Third-Party Administrator, or vendor, contracted to provide application and policy administration, claims management, data processing, accounting, customer phone support, statistical and financial reporting, production printing/notification, and marketing assistance to more than 80 WYO companies. NFIP flood insurance coverage is underwritten by the Federal Government, meaning it (and, therefore, the taxpayer) bears the initial risk of loss. However, excluding the extraordinary claims experienced in the 2005 claims season, the program has historically sustained itself by offsetting claims with premium payments. Unlike other insurance products, NFIP does not include an expense variable in the premium rate calculation. NFIP chooses instead to pay WYO Companies an expense reimbursement equal to a rolling five-year average of actual insurance company expenses on five insurance lines reported through A.M. Best.

The NFIP offers many benefits to the insured when compared to what a flood victim might receive from disaster assistance programs.

Flood Insurance	Disaster Assistance
Flood insurance claims are paid even if a disaster is not declared by the President.	Most forms of federal disaster assistance require a Presidential declaration.
More than 40% of all claims paid by the NFIP are outside of high-risk flood zones.	Federal disaster assistance declarations are awarded in less than 50% of flooding incidents.
There is no indemnity payback requirement.	The most typical form of disaster assistance is a loan that must be repaid with interest
Flood insurance policies can be renewed annually and are not non-renewed or cancelled for repeat losses.	The duration of a Small Business Administration (SBA) disaster home loan is approximately 30 years.
Flood insurance reimburses you for all covered losses up to \$250,000 for homeowners and \$500,000 for businesses.	The average Individuals and Households Program award is about \$4,000.
As of August 2023, 37% of NFIP policies had annual premiums of \$1,000 or less. Thirty-two percent had premiums between \$1,000 and \$2,000 per year.	Repayment on a \$50,000 SBA disaster home loan is \$240 a month or \$2,880 annually at 4% interest.

The NFIP also benefits local economies. Without flood insurance, lenders might be reluctant to loan money to home buyers with the result that the building and real estate industries would suffer. New buildings must comply with local zoning requirements which, in participating communities, must be in compliance with FEMA's floodplain management guidelines.

5.5.2.3 Flood Programs and Coverage Limits

The National Flood Insurance Program (NFIP) itself contains two programs: the Emergency Program and the Regular Program. The Emergency Program was established to provide access to limited amounts of flood insurance until a community meets the requirements for full participation in the Regular Program. Participation in the Emergency Program is either at a community's request or upon receipt by the community of notification from FEMA that the community contains one or more Special Flood Hazard Areas. A Special Flood Hazard Area (SFHA) is one that has a 1% chance of being flooded in any given year. FEMA then initiates a Flood Insurance Study to determine base flood elevations and flood risk zones. These make up the community's Flood Insurance Rate Map (FIRM). The community must adopt any mandated regulations by the FIRM effective date. Failure to do so results in the suspension of the community, meaning flood insurance is no longer available to the properties located within the community.

Once a community has met the requirements, FEMA places it in the Regular Program. More than 20,000 communities currently participate in the National Flood Insurance Program.

The amount of flood insurance that is available under NFIP depends on the type of building to be insured and whether the community is in the Emergency or Regular Program. Note that these limits do not apply to condominiums.

BUILDING OCCUPANCY	EMERGENCY PROGRAM	
	Maximum Building Limits	Maximum Contents Limits
Single Family	\$35,000*	\$10,000
Two-to-Four Family	\$35,000*	\$10,000
Other Residential	\$100,000**	\$10,000
Non-Residential/Small Business	\$100,000**	\$100,000
*In Alaska, Guam, Hawaii, and the U.S. Virgin Islands, the maximum amount is \$50,000.		
**In Alaska, Guam, Hawaii, and the U.S. Virgin Islands, the maximum amount is \$150,000.		

BUILDING OCCUPANCY	REGULAR PROGRAM	
	Maximum Building Limits	Maximum Contents Limits
Single Family	\$250,000	\$100,000
Two-to-Four Family	\$250,000	\$100,000
Other Residential	\$500,000	\$100,000
Non-Residential/Small Business	\$500,000	\$500,000

Congress passed the Flood Insurance Reform Act in 2004. Title I of the act established a severe repetitive loss properties program for properties that have suffered multiple losses and targets them for FEMA-sponsored mitigation actions to reduce the risk of future flood damage. Title II provides for policyholder education regarding the insurance coverage and the claims process.

5.5.2.4 Repetitive Loss Properties Program

The primary objective of the repetitive loss properties strategy is to eliminate or reduce the damage to property and the disruption to life caused by repeated flooding. A target group of approximately 11,000 repetitive loss properties' policies was initially transferred to the NFIP Servicing Agent's Special Direct Facility (SDF). Additional policies are transferred to the SDF as they meet the loss criteria. The purpose of transferring these policies to the SDF is so that mitigation assistance can be offered to the policyholders that meet this criteria.

5.5.2.5 Flood Insurance Forms

The NFIP Standard Flood Policy consists of three forms, depending on the type of property insured. All are written for one-year terms. To be eligible for coverage under any flood policy, the property must be located in a community that is participating in Flood Plain Management and appear in the National Flood Insurance Program (NFIP) master file as an active, participating community.

5.5.2.5.1 Dwelling Form

As the name implies, The Dwelling Form is designed to insure individual homes. It provides coverage for building and/or contents coverage on:

- Detached, single-family, non-condominium residence with incidental occupancy limited to less than 50% of the total floor area;
- Two- to four-family, non-condominium building with incidental occupancy limited to less than 25% of the total floor area;
- Dwelling units in residential condominium building;
- Residential townhouse/rowhouse.

5.5.2.5.2 General Property Form

The General Property form provides building and/or contents coverage for these and similar "other residential" risks:

- Hotel or motel with normal guest occupancy of 6 months or more;
- Tourist home or rooming house with five or more lodgers;
- Apartment building;
- Residential cooperative building;
- Dormitory;
- Assisted-living facility.

It can also be used to insure owners or lessees of the following types of non-residential buildings:

- Hotel or motel with normal guest occupancy of less than 6 months;
- Licensed bed-and-breakfast inn;
- Retail shop, restaurant, or other business;
- Mercantile building;
- Grain bin, silo, or other farm building;
- Agricultural or industrial processing facility;
- Factory;

- Warehouse;
- Poolhouse, clubhouse, or other recreational building;
- House of worship;
- School;
- Nursing home;
- Non-residential condominium;
- Condominium building with less than 75% of its total floor area in residential use;
- Detached garage;
- Tool shed;
- Stock, inventory, or other commercial contents.

5.5.2.5.3 Residential Condominium Building Association Policy (RCBAP)

The RCBAP is used to insure all residential condominium buildings (i.e., those buildings wherein at least 75% of the total floor area within the building is residential) and which is located in Regular Program communities. It covers the common elements and all structural items of the units within a building. It also covers contents owned in common with the purchase of contents coverage.

5.5.2.5.4 Preferred Risk Policy

Preferred Risk Policies (PRPs), which were a lower-cost Standard Flood Insurance Policy option written under the Dwelling Form or General Property Form, are no longer available for flood policies effective October 1, 2021 or later. They were discontinued with FEMA's adoption of Risk Rating 2.0 since the revised methodology is able to identify property-specific flood risks in non-Special Flood Hazard Areas.

Many PRPs had premiums insufficient for the risk the insured properties posed. As a result, some policyholders with existing PRPs have seen gradually rising premiums each year, subject to the 18% annual cap set by Congress.

5.5.2.6 Mortgage Portfolio Protection Program (MPPP)

The Mortgage Portfolio Protection Program (MPPP) is not a separate insurance form. Rather, the Mortgage Portfolio Protection Program was introduced on January 1, 1991, as an additional tool to comply with flood insurance requirements.

Both building and contents coverage are available under the MPPP, subject to the same maximum limit rules that apply to other properties in the Emergency and Regular programs. A \$1,000 deductible is applicable for policies written under the MPPP.

When a mortgagee or a mortgage servicing company discovers at any time following the granting of a loan that one or more of the loans in its portfolio is located in a Special Flood Hazard Area (SFHA), and there is no evidence of flood insurance in such property(ies), then the MPPP may be used by the mortgage company to obtain (i.e., force place) the required flood insurance coverage. In order to participate in the MPPP, the lender (or its authorized representative, which will typically be the WYO company providing the coverage through the MPPP) must notify the borrower of the following, at a minimum:

- The requirements of the Flood Disaster Protection Act of 1973 (which created MPPP),

- The flood zone location of the borrower's property,
- The requirement for flood insurance,
- The fact that the lender has no evidence of the borrower's having flood insurance,
- The amount of coverage being required and its cost under the MPPP, and
- The options of the borrower for obtaining conventionally underwritten flood insurance coverage and the potential cost benefits of doing so.

If the mortgagor fails to voluntarily obtain flood insurance, the mortgage company or lender may do so through a WYO insurer at the mortgagor's expense. Flood insurance rates through the MPPP are typically higher than the rates available through voluntary insurance. The mortgagor may replace the MPPP with insurance through the voluntary program at any time provided the building or occupancy remains otherwise eligible.

5.5.2.7 Flood Insurance Coverage

The Flood Program is a single-peril policy that insures against all "Direct Physical Loss By or From Flood" (including mudflow) to the insured building (Coverage A) or personal property (Coverage B) while insured property is located at:

- The address shown on the application form.
- Property is also covered for a period of 45 days at another location if it has been removed to another place other than the described location that contains the property in order to protect it from flood or the imminent danger of flood and placed in a fully enclosed and roofed structure.

Direct physical loss by or from flood to your insured property can be covered if you:

- Have paid the correct premium.
- Comply with all terms and conditions of your policy; and
- Have furnished accurate information and statements.

FEMA has the right to review the information provided by the policyholder at any time and to revise the policy based on its review.

But, what is a flood? The Standard Flood Policy defines it very specifically as:

I. A general and temporary condition of partial or complete inundation of two or more acres of normally dry land area or of two or more properties (at least one of which is your property) from:

- Overflow of inland or tidal waters;
- Unusual and rapid accumulation or runoff of surface waters from any source;
- Mudflow;
- Collapse or subsidence of land along the shore of a lake or similar body of water as a result of erosion or undermining caused by waves or currents of water exceeding anticipated cyclical levels.

The first part of the definition specifies that it must be a general and temporary condition. If your land subsided as the result of a sinkhole that created a low-lying area filled with water, you would not have had a flood. Next, the flood must involve two or more properties or two or more acres of normally dry land (if only one person's property is involved). If you own 20 acres of land that are

normally dry, then flood waters must inundate at least two of the acres owned. Flood can also involve two or more properties of any size as long as one of them belongs to the insured and results from overflow of waters or unusual and rapid accumulation of water. During a construction project in 1974, the bottom fell out of the Erie Canal near Rochester, NY, releasing 200 million gallons of water that damaged 69 homes. One lady was actually doing laundry in her basement when the rush of water tore out a corner of her house and carried her into the trees beyond. She survived but neither she nor any of the other homeowners had flood insurance. While this was not a flood in the sense that we usually think of one, it did meet the above definition.

This last part of the definition, which involves the collapse or subsidence of land along a lakeshore or similar body of water, covers situations such as levees failing as occurred in New Orleans during Hurricane Katrina.

5.5.2.8 Insuring Agreements

Flood policies contain four insuring agreements.

- Coverage A — Building
- Coverage B — Personal Property
- Coverage C — Debris Removal and Loss Avoidance
- Coverage D — Increased Cost of Construction (ICC)

Let's take a closer look.

5.5.2.8.1 Coverage A: Building

Insurance can only be written on walled and roofed buildings that are principally above ground and are permanently affixed to sites. Also eligible are silos and grain storage buildings. Buildings in the course of construction and mobile homes are also eligible, subject to certain special conditions.

The following structures are also eligible subject to conditions:

- **Mobile Homes:** This includes a manufactured home built on a permanent chassis transported to its site in one or more sections and affixed to a permanent foundation or a travel trailer without wheels built on a chassis and affixed to a permanent foundation according to the community's flood plain management and building ordinances or laws. The mobile home must be anchored to a permanent foundation to resist flotation, collapse, or lateral movement in a Special Flood Hazard Area.
- **Buildings in Course of Construction:** Until the structure has two rigid walls and a roof, should a loss occur, the claim is paid using double the deductible shown on the application form.
- **Detached Garages:** A detached garage at the described location is covered as an appurtenant structure. Coverage is limited to no more than ten percent of the limit of liability on the dwelling. Use of this insurance is at your option but reduces the building limit of liability. Garages used for any purpose other than garaging must be separately insured. Detached garages are paid based on ACV.

Structures not eligible for coverage include:

- **1316 Listed Properties:** Section 1316 – Section of the National Flood Insurance Act of 1968, as amended, states that no new flood insurance coverage shall be provided for any property that FEMA finds has been declared by a duly constituted state or local zoning authority or other authorized public body to be in violation of state or local laws, regulations, or ordinances that are intended to discourage or otherwise restrict land development or occupancy in flood-prone areas.
- **Coastal Barrier Resources Act Properties:** The Coastal Barrier Resources Act (1982) designated certain areas as ineligible for direct or indirect Federal financial assistance that might support development, including flood insurance, except for emergency life-saving activities.
- **Buildings In Violation Of Floodplain Management Laws:** Coverage may not be available for buildings that are constructed or altered in such a way as to place them in violation of state or local floodplain management laws, regulations, or ordinances. Contents and personal property contained in these buildings are ineligible for coverage.
- **Container-Type Buildings:** Gas, water, and chemical tanks are not insurable.
- **Buildings Entirely Over Water:** If constructed on or after October 1, 1982, buildings entirely over water are not insurable.
- **Buildings Partially Underground:** If 50% of the ACV of the building, including machinery & equipment used to service the building, is below ground level, the building is not insurable.

The following types of property are also covered under Coverage A - Building:

- Awnings and canopies
- Blinds
- Built-in dishwashers
- Built-in microwave ovens
- Carpet permanently installed over unfinished flooring
- Central air conditioners
- Elevator equipment
- Fire sprinkler systems
- Furnaces and radiators
- Garbage disposal units
- Hot water heaters, including solar water heaters
- Light fixtures
- Outdoor antennas and aerials fastened to buildings
- Permanently installed cupboards, bookcases, cabinets, paneling, and wallpaper
- Permanently installed wall mirrors
- Plumbing fixtures
- Pumps and machinery for operating pumps
- Ranges, cooking stoves, and ovens
- Refrigerators
- Walk-in freezers

Examples of Ineligible Building Risks:

- Boat repair dock

- Boat storage over water
- Camper
- Cooperative unit within cooperative building
- Drive-in teller unit (located outside walls of building)
- Football stadium
- Gasoline pump
- Gazebo (unless it qualifies as a building)
- Pavilion (unless it qualifies as a building)
- Pole barn (unless it qualifies as a building)
- Pumping station (unless it qualifies as a building)
- Storage tank – gasoline, water, chemicals, sugar, etc.
- Swimming pool bubble
- Swimming pool (indoor and outdoor)
- Tennis bubble
- Tent
- Time share unit within multi-unit building
- Travel trailer (unless converted to a permanent onsite building meeting the community's floodplain management permit requirements).
- Water treatment plant (unless 51% of its actual cash value is above ground level)

5.5.2.8.2 Coverage B: Personal Property

The flood policy covers property owned by the insured or, if a condominium, owned by the unit owners or condominium association.

Examples of Covered Property include:

- Air conditioning units, portable or window type
- Carpets, not permanently installed, over unfinished flooring
- Carpets over finished flooring
- Clothes washers and dryers
- "Cook-out" grills
- Food Freezers, other than walk-in, and food in any freezer
- Portable microwave ovens and portable dishwashers

If the insured is a tenant, both the General Property and Dwelling forms also provide coverage for improvements the tenant has made to the building for up to 10% of the Coverage B limit.

Examples of Property Not Covered:

- Automobiles, motorcycles, and self-propelled vehicles (except self-propelled vehicles not licensed for road use and used mainly to service the insured location, e.g., lawn mowers);
- Bailees customer goods – including garment contractors, cleaners, shoe repair shops, processors of goods belonging to others, and similar risks;
- Contents located in a structure not eligible for building coverage;
- Contents located in a building not fully enclosed;

- Aircraft, watercraft, trailers, and recreational vehicles including their furnishings or equipment;
- Accounts, bills, coins, currency, deeds, evidences of debt, medals, money, scrip, stored value cards, postage stamps, securities, bullion, manuscripts, or other valuable paper.
- Underground structures and equipment, including wells, septic tanks, and septic systems;
- Walks, walkways, decks, driveways, patios, and other surfaces (e.g., tennis courts) located outside the perimeter, exterior walls of the insured building
- Hot tubs and spas that are not bathroom fixtures, and swimming pools and their equipment such as heaters, filters, pumps, and pipes.

In addition, personal property in a building that is not fully enclosed must be secured to prevent flotation out of the building. If the personal property does float out during a flood, it will be conclusively presumed that it was not reasonably secured. In that case, there is no coverage for such property.

5.5.2.8.3 Coverage C: Other Coverages

Coverage C contains three additional insuring agreements. These coverages do not increase the limit of liability, so any loss paid reduces the amount of insurance available under Coverage A — Building or Coverage B — Personal Property.

- Debris removal, which pays the cost to remove debris from the insured location.
- Loss avoidance measures, which pays up to \$1,000 for costs incurred to protect the insured property from imminent danger of flooding. Expenses covered are costs for:
 - Sandbags, including sand to fill them;
 - Fill for temporary levees;
 - Pumps;
 - Plastic sheeting and lumber used in connection with these items;
 - Moving and storing insured items off premises for up to 45 days; and
 - The value of work, at the Federal minimum wage, that you or a member of your household perform.

To be considered in imminent danger of flooding, one of the following must occur:

- A general and temporary condition of flooding in the area near the described location must occur, even if the flood does not reach the insured building; or
- A legally authorized official must issue an evacuation order or other civil order for the community in which the insured building is located, calling for measures to preserve life and property from the peril of flood.

The policy will also pay up to \$1,000 for the reasonable expenses you incur to move insured property to a place other than the described location that contains the property in order to protect it from flood or the imminent danger of flood. The insured property needs to currently be in a Special Flood Hazard Area and be moved to a Non-Special Hazard Area.

The Pollution Damage coverage pays up to \$10,000 for pollution damage to covered property if it is caused by flooding. It does not pay for costs to test for pollutants or for the cost to remove them from an insured location.

5.5.2.8.4 Coverage D: Increased Cost of Compliance (ICC)

Coverage D pays up to \$30,000 for the insured to comply with a state or local floodplain management law or ordinance affecting repair or reconstruction of a structure suffering flood damage. Compliance activities eligible for payment are:

- Elevating the insured structure;
- Floodproofing (for non-residential buildings and residential buildings with basements that meet FEMA's standards);
- Relocating the structure to another place at the insured location;
- Demolition; or
- Any combination of these activities.

Coverage applies only to repetitive loss structures or where the cost to repair the structure equals at least 50% of its market value. In addition, there is no coverage until the insured building has been elevated, floodproofed, demolished, or relocated within no more than two years from the loss.

Although the ICC coverage limit is paid in addition to Coverage A – Building, the total of the two coverages together cannot be greater than the NFIP's statutory maximums for building coverage. Premiums for ICC coverage cannot exceed \$75 per year and are typically calculated as 1.9% of the policy's premiums for building and contents coverage.

5.5.2.8.5 General Exclusions

All three policies – Dwelling, General Property, and Residential Condominium Building Association Policy (RCBAP) – cover only loss directly resulting from flood. Indirect loss, such as loss of income, is specifically excluded.

The same general exclusions are found in all three policy forms. They are:

- Pressure or weight of ice
- Freezing or thawing
- Rain, snow, sleet, hail, or water spray
- Theft, fire, explosion, or wind
- Intentionally caused loss
- Losses in progress when coverage is requested
- Earth movement – including earthquakes, landslides, land subsidence, and sinkholes – even if caused by flooding
- Destabilization or movement of land that results from accumulation of water in subsurface land area
- Gradual erosion
- Water, moisture, mildew, or mold damage that results primarily from any condition that is within the insured's control, including but not limited to failure to inspect and maintain the property after a flood recedes
- Water or waterborne material that backs up through sewers, drains discharges, or overflows from a sump pump or related equipment
- Seeps or leaks on or through the covered property

- Unless there is a flood in the area and the flood is the proximate cause of the sewer or drain backup, sump pump discharge or overflow and seepage of water.
- The pressure or weight of water (hydrostatic pressure), unless there is a flood in the area and the flood is the proximate cause of the damage
- The failure of power, heating, or cooling, unless it results from direct physical loss from flood to equipment at the insured location
- Any loss to property on Federal land where the flooding was initiated by the government and the insured has given the government a hold-harmless agreement for damage from flooding (e.g., the government intentionally releases pent-up water from behind a dam and the resulting flood damages property on land leased from the government)
- Expenses incurred for the testing or monitoring of pollutants, unless required by law – as previously mentioned, the General Property Form also permits up to \$10,000 of the limit of insurance to be applied to pollutant damage to insured property caused by flooding
- Any additional living expenses incurred while the insured building is being repaired or is unable to be occupied for any reason

5.5.2.8.6 Increased Cost of Compliance Exclusions

In addition to the general exclusions just discussed, Coverage D — Increased Cost of Compliance has its own set of additional exclusions.

- The cost of compliance incurred while the insured's community is participating in the Emergency Program.
- Costs mandated by law to clean up, remove, test for, etc., pollutants.
- Any loss in value to an insured building as the result of compliance.
- Any loss in the residual value of a building that has been partially demolished because of the enforcement of floodplain management laws.
- Any Increased Cost of Compliance, unless and until the building is elevated, floodproofed, demolished, or relocated within two years.
- The cost of any code-mandated upgrade not related to local floodplain management laws.
- Any cost incurred to bring additions or improvements into compliance after a loss has occurred.
- Loss due to the insured's failure to comply with any law before the current loss occurred.
- Any rebuilding activity that does not comply with NFIP minimum requirements.
- The increased Cost of Compliance for a garage or carport.
- Any structure insured under an NFIP Group Flood policy.
- Assessments made by a condominium association on individual condominium unit owners to pay increased costs of repairing commonly owned buildings after a flood in compliance with State or local floodplain management ordinances or laws.

Lawmakers considering legislation to renew authorization of NFIP in 2007 and 2008 proposed many changes that would have increased the NFIP's future income, including making owners of property subject to repetitive flooding pay premiums that more closely reflect the true cost of their losses and gradually eliminating the flood insurance subsidy for vacation and second homes. In addition, they would have allowed premium increases of up to 15 percent from the current 10 percent.

5.5.3 Hurricane Coverage

In many cases, the damage caused by hurricanes will be covered by a basic homeowners insurance policy. That being said, an increasing number of policies actually exclude hurricane-related damage, in which case additional coverage will need to be purchased.

Let's take a look at how the State of Florida treats such coverage. Florida law requires insurers issuing residential property insurance policies to include hurricane windstorm coverage in the policies. Residential policies include both personal lines (i. e., coverage provided by homeowners, mobile homeowners, dwelling, tenants, condominium unit owners, cooperative unit owners, and similar policies) and commercial lines (i. e., coverage provided by condominium association, cooperative association, apartment building, and similar policies, including policies covering the common elements of a homeowners' association).

“Hurricane coverage” is coverage for loss or damage caused by windstorm during a hurricane. It includes ensuing damage to the interior of a building, or to property inside a building, caused by rain, snow, sleet, hail, sand, or dust if the direct force of the windstorm first damages the building, causing an opening through which rain, snow, sleet, hail, sand, or dust enters and causes damage.

“Windstorm” means wind, wind gusts, hail, rain, tornadoes, or cyclones caused by or resulting from a hurricane that results in direct physical loss or damage to property. “Hurricane” means a storm system that has been declared to be a hurricane by the National Weather Service's National Hurricane Center. A hurricane includes the time period (1) beginning when the National Hurricane Center issues a hurricane watch or warning for any part of Florida, (2) continuing for the time period during which the hurricane conditions exist anywhere in Florida, and (3) ending 72 hours after the National Hurricane Center terminates the last hurricane watch or warning issued for any part of Florida.

5.5.3.1 Hurricane Windstorm Insurance Discounts

A Florida law effective June 1, 2002 requires insurance companies to provide discounts on the hurricane windstorm portion of insurance premiums for residents who install wind resistant features on their homes. However, few homeowners were aware of the requirement and have not received the discounts. As a result, the legislature passed and the governor signed into law Senate Bill 1486, effective October 1, 2005. It requires insurers to notify insurance applicants and policyholders of the premium discounts available for installation of fixtures or construction techniques demonstrated to reduce the amount of loss in a windstorm. The Florida Office of Insurance Regulation developed the required notice form and must post online the discounts it has approved for each licensed insurer.

Available discounts range up to 42% of the hurricane windstorm portion of insurance premiums. To qualify for discounts, insurers typically require a certified inspector to examine a home for the necessary wind resistant features. The homeowner pays the inspection cost, but often it is offset by the accrued premium savings. Discounts are offered for things such as hurricane shutters, impact rated glass, roof-to-wall connections, roof deck fastening, building code equivalent roof covering, and hip roof shape.

5.5.3.2 Hurricane Deductible

Property insurance policies may include a separate deductible specific for hurricane losses. Specific requirements apply by law.

A hurricane deductible is a percentage of the insurance coverage on the dwelling or a dollar deductible higher than those for other causes of loss. By Florida law, the hurricane deductible provision is triggered by windstorm losses resulting from a storm system declared to be a hurricane by the National Hurricane Center. They remain in effect during the duration of the hurricane (from when the watch or warning is issued and continuing until 72 hours after its termination). Wind damage from storm systems other than declared hurricanes is not subject to the hurricane deductible but to the policy's general deductible.

Hurricane deductibles for a mobile home property insurance policy may not exceed (1) 5% of the property value if the property is subject to any liens and (2) 10% of the property value if the property is not subject to any liens.

Homeowners pay the deductible only once during a hurricane season. Policies that contain hurricane deductibles must include a statement stating that the policy contains a separate hurricane deductible for hurricane losses, which may result in high out-of-pocket expenses.

Finally, let's take a look at an important piece of the insurance policy puzzle: the insurance premium.

5.6 The Insurance Premium

The charge that an insurance company assesses when it agrees to assume part or all of a risk is called the **premium**. The premium is meant to cover the anticipated losses associated with the policy coverage, plus expenses, and a reasonable profit. This does not always turn out to be the case.

Obviously, since insurance deals with what might occur in the future, it is impossible to predict precisely what the losses will be. To enable them to come closer in their projections, insurance companies use actuaries who look at past trends and patterns and make predictions as to what will happen in the future. The actuarial calculations are based on statistics from other similar kinds of policies and the losses sustained under those policies. In its purest sense, the proper amount of a premium assessment is the amount the insurance company will pay for:

- All losses sustained by the insured
- Outside expenses related to the insurance
- Internal costs such as salaries
- A reasonable profit

That type of formula, however, is not actually used for most premium calculations.

On any given individual insurance policy, the probabilities of being correct in the assumptions about future losses is very low; however, the insurance industry uses what is called "The Law of Large Numbers." What this means is that with a large enough group of policies, they are able to predict with some accuracy that a certain percentage will suffer certain types of losses. While they cannot guess as to which specific policy may encounter the loss, by insuring large groups, they can spread their risk so they will have sufficient premium from the policies that do not

sustain a loss to cover those that do.

For many types of insurance, the various Departments of Insurance in the states where the policies will be sold regulate the premium charges. The insurance department's attempt to control the premium amounts that may be charged is an effort to assist the insurance buying public, and to guard against companies developing a monopolistic type of price fixing. In effect, most states themselves do the price fixing by regulating what a company can charge as premium for a specific type of policy.

In the early days of insurance, there was much more speculation required on loss frequency and severity. As the industry matured and prospered, formulas and patterns were developed to enable the underwriters to assign classifications to certain groups. For these risk classifications, a basic premium is calculated. The underwriter may then add additional charges to increase the premium on a specific policy so as to reflect a risk greater than the norm of the general class – or offer credits to reduce the premium for a risk in the class that has below average risk potential.

Insurance companies desiring to conduct business in a particular state must file certain information on what types of coverage they will be providing and the premium levels they will charge. It is quite possible that some companies will willingly charge less than the amount approved by the state Department of Insurance in order to capture a larger share of the market. It is also possible that a given company may be able to obtain approval from the state to charge more than some other company for substantially the same coverage. A company cannot, however, merely decide unilaterally to increase their premium charges. They must petition the state to increase their fees. The justification for such increases is usually accomplished by showing extraordinary claims costs and/or higher-than-normal expenses. When this occurs over a number of years, an insurance department may grant a carrier the right to increase their premium fees.

If the fee increase is requested and granted to a number of companies, the rates in that state go up and the insurance companies continue to forage for their respective shares of the available insureds. If the rate increase is brought about because an individual company is unable to function at the current rate structure, while other companies seem to be functioning within the standard parameter, the company receiving the right to raise their rates may well be unable to compete with the other carriers who continue to charge a lower rate.

State insurance departments do not want insurance companies to go out of business or to withdraw from their state's markets, since that decreases the number of insurers for selection by residents of the state. At the same time, the insurance departments have a built in need to attempt to maintain the pricing structure at reasonable and existing rates to provide insureds in their states with affordable insurance.

Most states require that every insurance company writing business in their state contribute to some sort of a Guaranty Fund, which is organized to meet the financial obligations of any insurer that becomes insolvent and is unable to pay their losses. Although the state insurance departments attempt to keep close watch over the dealings of insurers operating within their states, periodically an insurance company is unable to continue to do business and these Guaranty Funds allow the policyholders and others to obtain at least a portion of the claim payment they might have been owed from the now insolvent insurer.

Premium rates may differ widely from state to state and can even show vast differences from one area of a state to another in that same state. The same rationale as is discussed above generally holds true whether the rates are being regulated for a given state, or for specific locales within a state.

Earlier in this course, it was noted that an insurance company must be licensed in a particular state in order to do business in that state. An exception to this general rule is what is known as **non-admitted insurance companies**. A company that is fully licensed in a state, and therefore allowed to write business for which it has been granted such permission, is an **admitted carrier**. These companies may sell directly to the insureds via their own sales force, or they may offer their products through a network of agents and brokers who market and sell the policies for them.

Some insurance companies may not be fully licensed to do business in a particular state but are nevertheless allowed to provide their policies under certain specific situations. These are called **non-admitted carriers**. Under most circumstances, a policy cannot be written by a non-admitted carrier unless the same coverage is unavailable from admitted carriers, or highly restricted in the scope of the coverage being offered by the admitted carriers.

When a prospective insured is unable to find an admitted carrier in his state who can offer the type of coverage desired, the business may be placed with a non-admitted carrier. While non-admitted carriers are not subject to the same degree of scrutiny as admitted carriers are, the state departments of insurance nevertheless still control much of the non-admitted carriers activities and actions.

The premium ultimately charged by an insurance company, admitted or non-admitted, very often does not include any specific profit ingredient. In fact, many times the cost to the insurance company, for losses plus expenses, exceeds the premium charged. This does not mean, however, that in the long run the insurer is actually operating at a loss.

Unlike the cost for most other goods and services, charges for insurance protection (premium) are usually paid in advance. Insurance premiums are charged for the entire policy period and are payable when the policy goes into effect. This is actually a form of prepayment whereby the insurance company receives money for services (protection) to be rendered in the future. As a result, insurers have large funds of capital from the premiums collected that they are able to invest.

A policy written for a one-year period will usually have an annual premium that is fully owed when the coverage goes into effect, even though the protection that is being purchased will actually accrue one day at a time over the life of the policy. As a result, the insurance company has the use of the premium payment for the entire time the policy is in effect. This "pot" of money is, of course, invested by the insurer, and the investment profit is a crucial ingredient in the insurer's bottom line profit margin. This investment profit, however, is not one of the ingredients that is usually considered in establishing premium rates. Therefore, a carrier, anticipating this investment income, might charge rates that will actually produce income less than the losses plus expenses.

Depending on the investment climate at any given time, the profits gained by the insurance companies from these investments can add large gains to their bottom-line profitability.

The amount of premium that an insurance company charges for a policy, or a group of policies, is called the Written Premium. This is the gross premium figure. Since the premiums are charged in advance, the company has not actually earned the premium until they perform the services to which they agreed in the policy – that is, to provide protection as indicated in the Insuring Agreement.

In other words, the day the policy takes effect, the entire premium cost is the written premium. The earned premium would be zero, since nothing would have yet been earned. The unearned premium would be the same amount as the written premium, since the entire policy period would still be ahead. After the first day (on a one-year policy), 1/365 of the written premium would be earned, and 364/365 would be unearned. On day two, earned premium would be 2/365, and the unearned would be 363/365. This is admittedly an oversimplification but should provide a better understanding of these terms and how they relate to one another.

Not all premiums are assessed at the inception of a policy. Some policies are written with what is called a Retro Premium. In such cases, there is usually a portion of the anticipated premium that is charged "up front", as with all other policies; however, the policy is then reassessed at the end of the policy term and the premium is adjusted. This means the insurance company may be entitled to additional premium, or may be required to return some of the premium to the insured.

Retro-premium accounts are usually large and complex insureds where determining the scope of the future losses is very difficult. In some cases, the amount of the premium may be tied to the amount of sales the insured will have during the policy period, to the amount of their payroll reflecting the size of their work force, or to any other factor that may vary during the policy term.

Instead of paying the entire premium at the inception of the policy, the insured and the carrier agree that the insurance will be provided, and the insured will reimburse the company for all losses, all expenses, and a reasonable profit. In these cases, the insurance company is not able to use the entire premium for investment purposes, since the majority of the premium will not be paid until the policy expires. On the other hand, the carrier is often guaranteed a profit in the retro-premium calculations.

Insurance companies are required to set aside certain amounts of money to cover their anticipated losses. Out of the total amount of premiums the company collects from its policyholders, they must establish a monetary "loss reserve" for each claim reported. This is the claims handler's best estimate of the cost to settle the loss. In addition, an amount must also be established to cover the cost of the direct expenses related to the claim, such as adjustment expenses, legal expenses, etc. These claims expenses are "Allocated Loss Adjustment Expenses" (ALAE).

In addition to the direct expenses (ALAE) that are anticipated and can be allocated to a particular policy, there are other expenses that will be incurred but which do not relate directly to an individual policy. These "Unallocated Loss Adjustment Expenses" (ULAE) include such things as employee salaries, transportation allowances, training costs, etc.

Finally, the reserves must include an additional factor to cover claims that history has told us have probably already happened (incurred) but which have not yet come to the attention of the insurance company. These claims are referred to as "incurred but not reported" (IBNR). The amounts set aside for these IBNR reserves are established by actuaries who develop models of

future loss frequency based on past loss history.

The remainder of the total premiums collected, after all these mandatory reserves are set aside, is the "surplus," or "underwriting surplus," of the company. Understandably, the surplus fluctuates almost constantly; however, with a large enough base number of claims, gross written premium, etc., the fluctuations are somewhat flattened and a general surplus can be calculated, which remains relatively constant.

The underwriting surplus is an important calculation for an insurance company, since the amount of new premium they will be able to write is somewhat determined by the amount of this surplus. Financial organizations which rate insurance companies as to their financial stability and their ability to pay anticipated claims (such as Best's Rating Systems), carefully watch the ratio between the amount of premium any company writes and the amount of surplus held by that company. If a company is writing new premiums at a rate of two or three times their surplus, it is generally considered sound business. If a carrier writes five, six, or seven times its surplus, most state insurance departments would be concerned that their writings were too large to be reasonably covered by the carrier's assets. The financial rating bureaus that monitor the carriers also become concerned when an insurance company's writings grow too large in comparison to their existing policyholders' surplus.

Section Review:

1. Property insurance protects against the risk of financial _____ if physical property or its income-producing ability is damaged or destroyed. Refer to Section 5.3, page 67

A. destruction **[Your answer is incorrect. Property insurance does not protect against the risk of financial destruction if physical property or its income-producing ability is damaged or destroyed.]**

B. ruin **[Your answer is incorrect. Property insurance does not protect against the risk of financial ruin if physical property or its income-producing ability is damaged or destroyed.]**

C. gain **[Your answer is incorrect. Property insurance does not protect against the risk of financial gain if physical property or its income-producing ability is damaged or destroyed.]**

D. loss **[Your answer is correct. Property insurance protects against the risk of financial loss if physical property or its income-producing ability is damaged or destroyed.]**

2. Property insurance for a specified amount agreed to by the policyholder and insurance company in advance is known as: Refer to Section 5.3.1, page 68

A. fixed coverage. **[Your answer is incorrect. Property insurance for a specified amount agreed to by the policyholder and insurance company in advance is not known as fixed coverage.]**

B. Stated value coverage **[Your answer is correct. Property insurance for a specified amount agreed to by the policyholder and insurance company in advance is known as stated value coverage.]**

C. replacement value coverage. **[Your answer is incorrect. Property insurance for a specified amount agreed to by the policyholder and insurance company in advance is not known as replacement value coverage.]**

D. floater coverage. **[Your answer is incorrect. Property insurance for a specified amount agreed to by the policyholder and insurance company in advance is not known as floater coverage.]**

3. The limit of coverage shown on the Declarations Page of a replacement value property insurance contract is the amount that will automatically be paid for any loss. Refer to Section 5.1.1, pages 61-62

A. True **[Your answer is incorrect.]**

B. False **[Your answer is correct. The limit of coverage shown on the Declarations Page of a replacement value property insurance contract is the not the amount that will automatically be paid for any loss.]**

4. A contract that insures only the perils listed in the policy is called a: Refer to Section 5.3.3, page 70

A. special form policy. **[Your answer is incorrect. A contract that insures only the perils listed in the policy is not called a special form policy.]**

B. named peril policy. **[Your answer is correct. A contract that insures only the perils listed in the policy is called a named peril policy.]**

C. risk policy. **[Your answer is incorrect. A contract that insures only the perils listed in the policy is not called a risk policy.]**

D. property policy. **[Your answer is incorrect. A contract that insures only the perils listed in the policy is not called a property policy.]**

5. You have a fire in your home which causes \$25,000 of damage. While your home is being repaired, you have to stay in a hotel costing \$100 per day. Assuming that the fire is a covered peril, the cost of the hotel room is: Refer to Section 5.3.3, page 71

A. a direct loss. **[Your answer is incorrect. The cost of the hotel room is not a direct loss.]**

B. proximate cause. **[Your answer is incorrect. The cost of the hotel room is not proximate cause.]**

C. a consequential loss. **[Your answer is correct. The cost of the hotel room is a consequential loss.]**

D. none of the above **[Your answer is incorrect. One of the options is a correct statement.]**

6. In a named or specified peril contract, any perils that are NOT specifically covered are automatically _____ from coverage. Refer to Section 5.3.4, page 71

A. left out **[Your answer is incorrect. In a named or specified peril contract, any perils that are NOT specifically covered are not automatically left out from coverage.]**

B. removed **[Your answer is incorrect. In a named or specified peril contract, any perils that are NOT specifically covered are not automatically removed from coverage.]**

C. eliminated **[Your answer is incorrect. In a named or specified peril contract, any perils that are NOT specifically covered are not automatically eliminated from coverage.]**

D. excluded **[Your answer is correct. In a named or specified peril contract, any perils that are NOT specifically covered are automatically excluded from coverage.]**

7. A loss that the policyholder can prevent or control with extra effort is called a loss controllable or preventable by the policyholder. Refer to Section 5.3.4, pages 72-73

A. True **[Your answer is correct. A loss that the policyholder can prevent or control with extra effort is called a loss controllable or preventable by the policyholder.]**

B. False **[Your answer is incorrect.]**

8. Mary's homeowners policy contains an 80% coinsurance requirement. Mary, however, only carries \$40,000 of insurance on her home, valued at \$100,000. If Mary suffers a \$10,000 loss, how much will her insurance company reimburse her? Refer to Section 5.3.5.1, page 73

A. \$10,000 **[Your answer is incorrect. Mary's insurance company will not reimburse her \$10,000.]**

B. \$8,000 **[Your answer is incorrect. Mary's insurance company will not reimburse her \$8,000.]**

C. \$5,000 **[Your answer is correct. Mary's insurance company will reimburse her \$5000.]**

D. none of the above **[Your answer is incorrect. Mary's insurance company will reimburse her.]**

9. Jane's homeowners policy has a deductible of \$250. If Jane suffers a \$300 loss, how much will the insurance company pay? Refer to Section 5.3.6, page 74

A. \$50 **[Your answer is correct. Jane's insurance company will pay \$50.]**

B. \$250 **[Your answer is incorrect. Jane's insurance company will not pay \$250.]**

C. \$300 **[Your answer is incorrect. Jane's insurance company will not pay \$300.]**

D. \$0 **[Your answer is incorrect. Jane's insurance company will pay on this claim.]**

10. Property insurance that insures property at the various locations to which it is moved is known as _____ coverage. Refer to Section 5.3.1, page 68

A. mobile **[Your answer is incorrect. Property insurance that insures property at the various locations to which it is moved is not known as mobile coverage.]**

B. fixed **[Your answer is incorrect. Property insurance that insures property at the various locations to which it is moved is not known as fixed coverage.]**

C. floater **[Your answer is correct. Property insurance that insures property at the various locations to which it is moved is known as floater coverage.]**

D. exposure **[Your answer is incorrect. Property insurance that insures property at the various locations to which it is moved is not known as exposure coverage.]**

6.0 Legal Issues in Property and Casualty Insurance

We said earlier in this course that we would take a closer look at contracts. Let's do so now.

6.1 Understanding Contracts

All legal and binding contracts are comprised of three basic ingredients:

1. An offer by one party to do or refrain from doing something (the offer);
2. An agreement or acceptance by another party of the offer (the acceptance); and
3. The conveying of something of value (the consideration) from one party to the other in order to bind the contract and make it a legal and enforceable document.

There must also be "a meeting of the minds" (i.e., a mutual understanding of what is involved).

Note:

An insurance policy is a contract entered into between a person wishing to be protected from certain monetary losses (the insured) and an insurance company (the insurer) that agrees, for a price (the premium), to accept part or all of the insured's risk.

In the case of an insurance policy, an insurer offers to accept certain potential risks which are foreseeable, and for which the insured wishes to be insulated. These offers take the form of advertisements, solicitations by the companies themselves, and/or solicitations by agents, brokers, or sales representatives. Generally speaking, these offers by the insurance industry and their representatives cover basic risks, which most people face in their day-to-day personal and business lives.

An individual or company wishing to take advantage of these insurance company offers will usually contact the company or the agent and be provided with an application form. The form will request details about the individual or entity that is to be insured, the type of insurance being requested, and certain historical data regarding past insurance and claims activity. This information is necessary for the underwriters and actuaries to determine if this person or company fits into the insurer's anticipated universe of prospective insureds, and to determine the appropriate premium to be charged for the coverage being written.

If the insurer feels comfortable with the information obtained from the insurance buyer, and if the prospective insured likes what the company is offering and the premium being charged, the two parties will enter into a contract. The contract is the policy itself, and the consideration to bind the contract is the premium.

As indicated above, there must also be a meeting of the minds of the parties as to what each party is to do or not do, and each party will have specific duties, rights, and obligations under the terms of the contract. It is expected that each party will honor their respective obligations and will perform their duties under the covenant of good faith and fair dealing that all contracts require.

Let's take a closer look.

6.2 Contracts and the Law

Insurance agents may find themselves responsible for injury to others for basically one of two reasons: breach of contract or commission of a tort (a wrongful act). What follows is an exploration of both types of exposures an agent can face. Agents should be knowledgeable about these aspects of the law not only because they, as individuals, are as subject to them as anybody else, but also because agents occupy a unique position relative to the law. Agents are in the business of selling contracts and many of these contracts cover tort liability. Therefore, agents have more exposure to issues of contract law generally, and to issues of tort liability specifically, than most people.

6.3 Types of Contracts

Contracts are agreements between two or more people or entities. Contracts can be:

- Bilateral or unilateral
- Executed or executory
- Express or implied
- Voidable or void

6.3.1 Bilateral vs. Unilateral Contracts

A bilateral contract is one in which each party promises to do something.

For Example:

Melvin says to a contractor, "I will pay you \$200,000 if you will build my house." If the contractor agrees, the contractor's agreement creates a bilateral contract because each party is committed to doing something.

Insurance contracts, on the other hand, are unilateral. A unilateral contract is one in which only one party is required to do something.

For Example:

Melvin says to an insurer, "I will pay you \$500 if you promise to replace my house should it burn." If the insurer agrees, only Melvin is required to do something: pay the premium. The insurer isn't required to do anything until the house burns, which may never happen.

Ambiguities in unilateral contracts are typically resolved in favor of the party that did not draw up the agreement.

Scenario:

Phil's Insurance Agency stated in a local newspaper ad that each person who sent in an accurate estimate of the number of dots in the ad would receive a free certificate, which could be applied to the purchase of a TV set at a local store. Ralph mailed his estimate to Phil's and was notified that he had won one of the certificates. The certificate he received stated that it could be used only in the purchase of certain models. The newspaper ad had not contained this restriction. Orwell objected to this restriction.

Question: Must Ralph abide by the restriction?

Answer: No. The ad constituted an offer which was accepted when Ralph mailed in an estimate that was a "winner." This unilateral contract was based upon the terms of the ad. The limitation found in the certificate was not binding on Ralph since it was not a term of the contract between the parties.

6.3.2 Executed and Executory Contracts

An executed contract is one that has been completed. In our previous example, Melvin's

insurance policy is not an executed contract because only Melvin has done anything. Melvin's policy is an executory contract, one that has not been fully completed by all parties.

6.3.3 Express and Implied Contracts

Express contracts contain the terms of the parties' agreement. They may be oral or in writing.

For Example:

An insurer and insured who agree on a \$500 premium for a homeowners policy create an express contract.

In contrast, an implied contract is one in which the evidence of the agreement is not shown by words but by the acts and conduct of the parties.

For Example:

If a contractor who sincerely believes he will be paid for his work proceeds to repair a homeowner's roof and the homeowner stands aside and lets the contractor do the repairs, an implied contract has been created between them.

Implied contracts are sometimes referred to as quasi-contracts.

Scenario:

Terrence and Ursula decided to work together as agents in the sale of insurance. Although they never officially formed a partnership, they represented themselves to the community as one. They pooled their assets in a joint account and rented an office as joint tenants with right of survivorship. Ursula left the arrangement to join another agency and received only a few dollars from her and Terrence's joint assets with Terrence retaining the balance. Ursula filed suit against Terrence, arguing that he had breached their agreement to share assets equally. In her deposition she said: "Everything we did and purchased, whether it is a computer or a box of pencils, we did as partners. It was just something that we agreed on, that is how we were going to do it."

Question: Did a contract exist between Ursula and Terrence?

Answer: Yes. Two parties may, by their course of conduct, express their agreement, though no words are ever spoken. From their conduct alone, Ursula and Terrance created an agreement.

6.3.4 Void and Voidable Contracts

A voidable contract is one that is enforceable but which, because of circumstances surrounding it, may be rejected at the option of one of the parties. An insured who obtains a policy by virtue of a material misrepresentation of information to the underwriter has a voidable contract. The insurer has the option of paying a claim or voiding the policy. A void contract, on the other hand,

has no effect. It doesn't exist legally. It is a non-contract.

6.3.5 Promissory Estoppel

Promissory estoppel is a rule of contract law that was developed to prevent injustices. When one person (the promisee) relies on the promise of another (the promisor) under circumstances where one or more elements for an enforceable contract is missing, an injustice could arise if the promisor was allowed to argue that no contract exists. Under such circumstances, the promisor may be required to perform as if a contract existed. The promisee must show:

- that there was a promise;
- on which the promisee relied to his detriment;
- in a way the promisor expected or should have expected; and
- resulting in an injustice which only enforcement of the promise could cure.

6.3.6 Elements of Contracts

To be enforceable, a contract must have all of the following elements:

- An agreement
- The capacity to contract
- Consideration
- A legal purpose

6.3.6.1 The Offer

An agreement consists of an offer and an acceptance of the offer. Seems pretty straightforward, right? But problems can occur.

Sharon ran an ad in a local paper stating that her average client saved \$500 on auto insurance. Landau agreed to purchase an auto insurance policy but, when delivered, the policy only saved Landau \$100 from his prior coverage. Landau sued for the remaining \$400.

Question: Should Landau be awarded the value of his claim?

Answer: No. The ad was merely an invitation to purchase and not an offer that could be accepted by Landau. Landau's submission of an application for insurance constituted the offer and the insurance company's issuance of the policy constituted the acceptance, creating the contract.

A valid offer must meet three requirements:

1. It must evidence an intent to create a contract,
2. It must contain definite terms, and
3. It must be communicated by the person making the offer.

Lucy's advertisement failed to meet the first and second requirements. Other statements that are not considered offers are social invitations, predictions, and offers made in jest or excitement.

For Example:

Someone says “Wow! If I win the lottery, I’ll buy everyone a new car.”

In insurance, the submission of an application by a prospective insured constitutes the offer. Within reason, an offer is good until it is accepted or rejected, but it may be terminated in several ways, such as the death or insanity of the person making the offer. Other ways include:

- **Lapse of time:** The offer may specify when it expires. If no period is specified, then it expires when a reasonable amount of time passes. Of course, what is reasonable depends on the circumstances surrounding the offer.
- **By operation of law:** When the Volstead Act (Prohibition) took effect, it immediately made all offers to sell alcoholic beverages illegal.
- **A counteroffer:** Generally speaking, a counteroffer constitutes a rejection of the original offer and the making of a new one.
- **A rejection by the offeree:** If the person to whom an offer is extended rejects the offer, the offer is terminated. Once rejected, the offeree may not later accept the offer and form a binding contract.

Scenario:

Marshall, an insurance agent, wished to expand his agency by purchasing land for an office in another town. Theodore, the owner of the land, agreed to sell for \$10,000 plus a promise of “suitable” employment in the agency that he, Theodore, was “able to do.” Marshall did not employ Theodore after the new office was built and Theodore sued Marshall for breach of contract.

Question: Should the court decide in favor of Theodore?

Answer: No. Any agreement as to employment was too vague to be a binding contract because it could not be determined what kind of employment was intended or what was suitable.

6.3.6.2 Acceptance of an Offer

Just as an offer must be communicated to the offeree, an acceptance must be communicated to the offeror. As a general rule, an acceptance that uses the same method of communication as the offer is good when it is made. An acceptance that uses a different method is good when it is received. In all cases, an offer that specifies a particular type of acceptance (i.e., a reply by mail) must be accepted in accordance with instructions to form a contract.

Scenario:

Horatio mailed an application for liability insurance to his agent, Gamma. Gamma looked it over and forwarded it to Cardwell Indemnity, the insurer. Cardwell subsequently issued the policy and sent it by return mail to Gamma who forwarded it by mail to Horatio. Before receiving the policy, Horatio called Gamma to say that he found a better deal with another agent and would not be accepting the policy. When Cardwell cancelled the policy and applied a short-rate penalty to the return premium, Horatio sued for the full return premium, claiming that his phone call to

Gamma constituted a revocation of his offer to purchase the policy.

Question: Should the court rule in favor of Horatio?

Answer: No. The rule is that communication of an acceptance using the same medium that the offer was communicated constitutes an acceptance and completes the contract. Since the offer was made by mail when Horatio sent in the application, the mailing of the policy by the insurer was a valid acceptance. Horatio's phone call revoking his offer had no effect.

6.3.6.3 Capacity to Contract

Offers can only be made or accepted by people who are competent to do so. Parties presumed to lack competency include:

- Minors
- Insane persons
- Intoxicated persons
- Artificial entities such as insurers that may be restricted by law or corporate charter from entering into certain contracts.

A contract made with a minor, an insane person, or one who is intoxicated is voidable by that person if they do not ratify the agreement when they come of age, regain sanity, or sober up. However, certain exceptions, such as contracts to purchase necessities of life (food, housing, etc.) are not voidable. On the other hand, if an insurer issues a policy that it is not permitted to issue under state regulations or its charter, that contract is voidable by the insured.

6.3.6.4 Consideration

A contract must have consideration to be enforceable. Consideration is something of value exchanged by the parties to the contract. Most consideration consists of money or property but it doesn't have to be that. Consideration can also include a promise to do something in the future or a promise not to do something in the future. Past consideration (something that has already been done before an offer is made) is insufficient to form a contract. A promise to do something one has already agreed to do is also insufficient consideration. Example: Harry agrees to construct a house for Sam but stops halfway through construction and tells Sam that he will finish the house for another \$10,000 on top of the original contract price. If Sam agrees to pay the extra money, Harry will not be able to collect it because there was no consideration for Sam's promise.

In insurance, the insurer's consideration is its promise to pay for a loss. The insured's consideration is the payment of the premium (or the promise to pay it).

Scenario:

Kendall, an insurance agent, leased a building from Don. Kendall transferred his right to receive payments on all claims to Phillip, to whom he, Kendall, was in debt. When Don complained that the rent was not paid, he was assured by Phillip that the rent would be paid to him. Don did not sue Kendall for the overdue rent but later sued Phillip.

Question: Does Don have a valid claim?

Answer: No. The promise of Phillip was not binding because there was no consideration for it.

6.3.6.5 Legal Purpose

A contract must have a legal purpose. A contract that does not is void and cannot be enforced by either party. Illegal contracts include those that are:

- **Agreements that violate statutes.** These include usury statutes (laws governing allowable rates of interest) and gambling statutes (in some states).
- **Agreements that violate public policy**, including agreements to commit a crime (arson, murder, etc.) and otherwise legal transactions that are entered into for an illegal purpose. Example: Tom sells a gun to Bob knowing that Bob intends to use the gun to rob a store. Tom will not be allowed to sue Bob for the cost of the gun.
- ~~Agreements to commit crimes or torts (murder, arson, etc.)~~
- **Agreements that harm the public interest** (promises to make illegal contributions to political campaigns, bribery, etc.). Agreements to transfer liability for one's own negligence can also fall into this category. Example: A landlord rents an apartment and includes a clause in the lease that says the landlord is not responsible for injuries to the tenant from any cause whatsoever. This type of clause (called an exculpatory clause) is not normally enforceable as it is against the public interest. Note that insurance policies form an exception to this rule in the sense that an insurance policy transfers the financial consequences from the party at fault to the insurer.

6.3.7 Statute of Frauds

Besides satisfying the four elements, some contracts must also comply with the Statute of Frauds to be enforceable. Every state has a Statute of Frauds law on its books. The Statute requires that certain types of contracts must be in writing to be enforceable. These types include:

- Contracts for the sale of land or an interest in land
- Contracts that cannot be performed within one year
- Contracts to pay for the debt of another
- Contracts in consideration of marriage
- Contracts by an executor to pay the debts of an estate from the executor's own funds
- Contracts for the sale of personal property for \$500 or more.

While these contracts may be perfectly valid agreements, they must be in writing to be enforceable.

Scenario:

Samantha alleges that her employer, an attorney, agreed to pay her \$1 million (and a shiny, new luxury car to the tune of \$65,000) for her work in starting up a class action lawsuit. The background facts are that, after the attorney (and his cohorts) received their respective share of the class action settlement, Samantha and her husband met with the attorney to discuss how

much she would be paid on their agreement. The attorney ultimately agreed to pay Samantha the above sums at a rate of \$10,000 per month and agreed to reduce it to writing. The attorney never signed the agreement but did make total payments of \$165,000 before refusing to pay any more. What the attorney did not realize was that Samantha had secretly tape-recorded their conversation and soon filed suit to enforce their contract. The jury ultimately found that the attorney had agreed to pay Samantha a bonus once the class action settlement was received and awarded her \$900,000. The attorney filed a motion to set aside the jury verdict on the basis that the Statute of Frauds renders the agreement unenforceable. Samantha counter-argued that the writing requirement of the Statute of Frauds was satisfied here through the combination of the tape-recorded conversation and the checks the attorney did write for the required monthly installments before refusing to pay more. Samantha further argued that the contract could have been completed within one year by the attorney making a single lump sum payment.

Question: Who is right?

Answer: Judgment for the attorney. The court merely had to refer to the written agreement prepared by Samantha's attorney clearly stating that the payments would be stretched over 107 months and Samantha's own admission that the parties did not contemplate performance in less than one year. The fact that it could be completed in one year by a voluntary act of one of the parties does not render the Statute of Frauds inapplicable when the parties specifically agree that the contract will extend beyond one year.

6.4 Rights of Third Parties to Contracts

The general rule is that only the contracting parties have rights under a contract (called privity of contract) but sometimes other parties acquire rights as well. This can arise in two situations: assignment of rights and third-party beneficiaries.

6.4.1 Assignment of Rights

Most rights under a contract can be assigned to someone. A buyer can assign delivery to a third person or a seller can assign payment to someone (the assignees). The mortgagee clause in the standard homeowners policy states that the policyholder will be assigned full rights under the mortgage if they pay off the mortgagor. Some rights, however, are not assignable. These include:

- When laws prohibit assignment (as with prior assignment of wages, disability benefits, workers compensation payments).
- When the contract itself prohibits assignments.
- When the contract is a personal service agreement (such as an agreement by a painter to create a mural or an agreement with an author to write a book).
- When an assignment materially changes the obligations of a party to the contract. For example, if Marcus agrees to buy corn from Wallace, he cannot assign the right to receive the corn to Lee Fong in Beijing unless Wallace agrees.
- When the contract requires the personal approval of the buyer, the buyer cannot substitute another person's judgment.

- When damages for personal injury are pending, the claimant cannot assign the right to a potential court award to another. A final judgment by the court, however, is assignable as is the right to sue for damages caused by another. This is where an insurance company obtains the right to sue a third party for a claim it has paid to an insured.

The general rule is that an assignee does not acquire greater rights than the assignor has. Example: Terry agrees to sell his car to Harold and assigns the right to collect payment to Martha. If Terry fails to deliver the car, Harold can raise the defense of breach of contract against Terry or Martha.

6.4.2 Duties of an Assignee

Although an assignment usually involves the transfer of rights under a contract, it may include the transfer of obligations (called a delegation) as well.

For Example:

Sarah agrees to purchase two tons of gravel from Turner. Turner assigns (delegates) the responsibility to the Deep Hole Gravel Co. Deep Hole has the right to receive payment for the gravel and the obligation to deliver it. But note, a transfer of an obligation does not automatically relieve the assignor of the duty to perform. If Deep Hole does not deliver the gravel, Turner still has the obligation to do so. The assignment makes the assignee (Deep Hole) directly responsible. If Deep Hole fails to deliver, Sarah can proceed directly against them, against Turner, or against both. An assignor can be released from the obligation, though, if the party to the original contract (Sarah, in this case) agrees.

6.4.3 Third-Party Beneficiaries

A third-party beneficiary is one who benefits from a contract between other parties either directly or indirectly. These include:

- Creditor beneficiaries
- Donee beneficiaries
- Incidental beneficiaries

6.4.3.1 Creditor Beneficiary

A creditor beneficiary is created when the performance of the agreement is intended to satisfy a legal duty owed to a third party.

For Example:

A man buys a car on credit from a used car dealer. The man later sells that car to a third party, who agrees to pay the balance due on the car to the used car dealer. In this case, the used car dealer is a creditor beneficiary of the contract between the original purchaser and the third party and has the right to sue either of them directly for payment.

6.4.3.2 Donee Beneficiaries

When the purpose of the agreement is to make a gift of the contract's performance to a third party, the third party is called a donee beneficiary. A donee beneficiary may sue the promisor in the event of a contract breach but not the promisee.

For Example:

Byron buys a life policy from Delta Life Insurance and names a friend as the beneficiary. If Byron (the promisee) dies and Delta (the promisor) fails to pay, the friend may sue Delta for breach of contract but not Byron's estate.

6.4.3.3 Incidental Beneficiary

A contract between two parties may benefit a third party even though that was not the intent of the contract. Incidental beneficiaries are not entitled to sue in the event of a breach of contract.

For Example:

Alpha owns a drug store next to vacant land. Thalia contracts with Unger to build a shopping center on the vacant land. The shopping center will increase the value of Alpha's property, making him an incidental beneficiary to the contract between Thalia and Unger. Alpha will not have standing to sue if either Thalia or Unger breaches their agreement.

6.5 Agency and Bailment

Two legal concepts with which the insurance industry deals on a regular basis are "agency" and "bailment." The legal term "agency" should not be confused with the term describing a person or company that sells insurance (an insurance agency). The individual who earns their living working at an insurance agency selling insurance may or may not be a legal agent of an insurance company or some other entity. The term "agent" has somewhat different meanings in these two contexts and we will discuss them later in this course.

It is easier to understand the concept of legal agency, and the process by which someone acts as an agent for another, if the word "agent" is replaced by the word "servant." The concept of legal agency reverts back to older times when many people did engage servants to do their bidding. These employees were often the personal representatives of their "masters," and the earliest mention of the agency theory of liability was termed the "master-servant doctrine."

In effect, the theory of agency says that if a person is functioning at the direction of, and for the primary purpose of, another, the first person is the agent of the other, who is referred to as the principal. In such situations, the principal is held accountable, under the law, for the actions of the agent. The principal may not shield himself from responsibility by asserting the actions were done by another, if that other person was the principal's agent.

Note:

The agency relationship exists most frequently in matters of employment. When a company hires an employee, that employee is in an agency relationship with the employer so long as his actions are confined to the functions for which he was hired. The employee, as the agent of the employer, may do something, or refrain from doing something, which will impose a legal liability

on the employer, even though the employer may have been totally unaware of the specific action or lack of action taken by the employee.

The theory that the principal (or master) will be held accountable for the actions of the agent (or servant) is called respondeat superior. In many jurisdictions, when the principal is held to be responsible in these agency relationships, the courts have allowed the principal to seek redress from the agent if the actions were not the type that the principal should have reasonably foreseen, or if the agent's actions were beyond the scope of the agreement between the agent and the principal.

At times, the court will hold a principal accountable for the acts of his agent even if those actions are well beyond the principal's directions, or even if the agent's actions were contradictory to the instructions of the principal. This is allowed to happen if the agent has the appearance of functioning as the agent of the principal, and a third party relies on that appearance. This is called "ostensible authority," and means that the general public may have the right to assume an agency relationship exists if a person reasonably appears to be functioning as the agent of someone else, and if there seems to be evidence of this agent-principal relationship.

A second legal relationship, which, at times, exists between people, is a bailment.

Note: Unlike an agency relationship, a bailment is created when the relationship comes into existence not for the primary purpose of helping one of the parties (as with an agency relationship) but for a mutual benefit of both parties. This distinction is not always clear.

Often a bailment arises when one party entrusts another with property for a specific purpose, such as a dry cleaner accepting someone's clothing or an automobile mechanic being given a person's car to service. In these types of situations, although the owner of the property is deriving some value from the temporary conveyance of the property, it is actually for the mutual benefit of both parties. Certainly, an employee is benefiting from his employment; however, the primary benefit falls to the employer who is reaping the harvest of the employee's labor.

Unlike an agent-principal relationship, a person in a bailment relationship with another cannot be held accountable for the acts of the other party. While a dry cleaner may possess the clothes of someone in order to clean them and return them to the owner, and is therefore in a bailment with the clothing owner, a person who is given clothing to sell by a clothing manufacturer would probably be functioning in an agency relationship with the manufacturer.

For Example:

One of the classic scenarios in which insurance companies need to determine agency vs. bailment involves someone driving the automobile of another. In almost all automobile insurance policies, so long as the driver of a vehicle is operating the vehicle with the permission of the owner, the policy will cover the actions of that driver. Nevertheless, there are situations that arise when it is critical to determine if a person, even though driving with the owner's permission, was an agent of the owner.

If an accident occurs under these circumstances, so long as the damages are within the limits of

liability of the insurance policy, the insurer will respond (all other facts being non-contested in our example.) The claim should be disposed of whether the injured or damaged party brings the claim against the owner, driver, or both.

The question of agency does come into play, however, if the policy limits are insufficient to satisfy the total damages caused by the permissive user of the vehicle. In that situation, the owner may well have an exposure beyond the limits of his insurance policy if the driver was in an agency relationship with him at the time of the accident. On the other hand, if the driver was operating the vehicle with the owner's permission, but not on any errand or purpose for the owner's benefit (thus failing to meet the standard for establishing agency), then the owner should not be responsible for any of the damages whatsoever. The owner's insurance policy would still respond to the claim against the permissive user of the vehicle, and to the claim against the owner. However, under the law, in the absence of agency existing, the absentee owner of the vehicle should not be held accountable.

Another common situation where the question of agency and bailment comes into play with insurance claims involves the question of subrogation. Under the provisions of most insurance policies, if an insurer is called upon to pay for certain damages to property of their insured, the insurer obtains the rights to proceed against any other party who may have caused the damage. In other words, had the property owner not possessed insurance on the property, or opted to not collect for their damage under the policy, the property owner would have the right to proceed against whoever damaged their property. By choosing to have the insurance company repair or pay for the damaged property, the property owner agrees to allow the insurer to proceed against the other party in order to recoup their loss payment. The insurance company is said to be subrogated to the rights of their insured.

In subrogation claims, as with all others, the issues of contributory negligence or comparative negligence, discussed later in this chapter, come into play. These issues deal with the question of who was at fault and to what degree. If the owner of the damaged property was totally or partially at fault in causing the damage to their own property, the ability of the insurance company to recover their payment from some other party may be severely limited.

Therefore, if the property was in the possession of someone other than the owner, it is critical to know the relationship between the owner and the person possessing the property at the time of the damage.

Under an agency relationship, the negligence of the agent is imputed to the principal. Therefore, if the property was in the possession of someone who was functioning as the agent of the owner, that agent's negligence can be used against the owner (and the subrogating insurance company) in defeating or mitigating the claim against the negligent party. On the other hand, if the person possessing the property at the time it was damaged was in a bailment situation with the owner, any negligence on the part of the bailee cannot be imputed to the owner, so the bailee's negligence should have no bearing on the claim by the owner (or their insurance company) against the other party who caused or contributed to the damage.

A person who is given property to care for, or on which to perform a specific function, is usually in a bailment situation with the owner of the property. As such, the accepting party is expected to exercise reasonable care and diligence in protecting the property from damage.

For Example:

A dry cleaner accepting a customer's clothes is in a bailment situation. A veterinarian accepting a pet to groom would be in a bailment. The driver of the car in our previous example would be expected to take reasonable precautions to protect the car from damage while in a bailment situation.

While in an agency relationship, it might be hoped the agent would exercise a high degree of care. The law generally does not recognize the liability for any failure to care for the property, because if the agent were negligent in caring for the property, the principal would be equally responsible for that negligence. It would be as if the principal would have damaged the property himself. (Recourse does exist in some jurisdictions between agent and principal. Under the interpretation of the doctrine of respondeat superior, some courts have ruled a principal has the right to expect the agent to exercise the same degree of care over the principal's property as he would otherwise show to his own.)

It is possible for two individuals to be involved in an agency relationship, which will evolve into a bailment, then back to agency, and so on.

For Example:

Using the automobile scenario again, a permissive user of an automobile may be given a car to use by the owner to run a specific errand for the owner. While the driver is going from point A to point B to accomplish the owner's errand, he would most probably be in an agency relationship with the owner. Let us then suppose the driver decides to not return directly back to the owner's location, but instead (with the owner's permission) detours to pick up his own laundry. During this side trip the driver would still be covered by the owner's automobile policy because he was operating the vehicle with the owner's permission; but since the side trip has no apparent benefit to the owner, the driver would be operating the vehicle under a bailment. The owner should not be held personally accountable if the driver causes an accident during this personal detour.

Continuing the scenario, if the driver runs a second errand on behalf of the owner, after picking up his laundry, and is in the process of returning the vehicle to the owner following this second errand for the owner, the driver most probably would be back into an agency relationship, with the owner being held accountable for the driver's actions. It should be noted that legal jurisdictions differ as to whether or not the driver would enter into the agency relationship as soon as he completed his personal errand and began to proceed to the owner's second errand, or if the agency relationship would not reattach to the relationship until after the driver had actually begun the second errand, rather than just traveling to it.

6.6 Tort Liability

The imposition of money damages is the principal means through which compensation is made to persons whose rights have been violated in a civil wrong known as a tort. Such torts may be either intentional or unintentional. As the language suggests, an intentional tort is a violation of another's rights that is intended by the individual violating those rights. Liability arising out of such intentional torts is not covered under liability insurance.

Unintentional torts are civil violations of another's personal or property rights resulting from the negligence of an individual. Negligence involves the failure to exercise reasonable care required to protect others from an unreasonable chance of harm. Liability arising out of unintentional torts

is covered under liability insurance.

6.6.1 Legal Liability

Agents can also find themselves responsible for injury to others through their legal liability. In this section, we look at the basics of liability from intentional and unintentional (negligence) torts. Torts are wrongs against a person as opposed to wrongs against society (crimes). Some acts, such as murder, are both torts and crimes. Torts are always moral wrongs, but not all moral wrongs are torts. A person who sees another in danger has a moral but not a legal duty to warn that person.

6.6.2 Intentional Torts

Let's take a closer look at intentional torts. Intentional torts come in three flavors:

- Interfering with personal rights,
- interfering with property rights, and
- business or competitive torts.

6.6.2.1 Interfering With Personal Rights

6.6.2.1.1 Battery

Battery is the intentional harmful or offensive touching of another without consent. The key here is "intent." The accidental touching of another would not be considered battery even if it resulted in injury or offense, though it still might be considered negligence. An offensive touching also results if the defendant causes contact with something attached to the plaintiff's person. Tom and Dick are in an argument and Tom knocks Dick's hat off without actually touching Dick. Tom's action would still be considered a battery.

6.6.2.1.2 Assault

Assault is the attempt or offer to cause a harmful or offensive contact with another. Unlike battery, there is no actual contact, merely the threat of one. In order for there to be an assault, the plaintiff must have an expectation of contact or harm and that expectation must be a reasonable one.

For Example:

Frank is hunting in the woods and someone fires a rifle at him. If Frank only learns about the shot sometime later, there was no expectation of being hit on his part and, therefore, no assault. If Frank was on a hill and saw someone shoot a pellet gun in his direction from 400 yards away, there would be no assault because it isn't reasonable to expect a pellet gun to carry that distance (Frank would have to know that it was a pellet gun, though, and not a regular rifle).

Scenario:

Pop's Bar was a tavern insured by Beta Insurance for Liquor Liability. Pop's Bar was assured by its insurance agent that the policy included coverage for liability arising out of assault and battery if the event was in connection with the sale of alcoholic beverages. Preston was a patron of the tavern. An altercation between Preston and employees of Pop's Bar resulted in Preston being punched and kicked. Preston sued Pop's Bar for assault and battery and Pop's Bar looked to Beta Insurance for protection under the Liquor Liability policy. When Beta Insurance denied coverage, Pop's Bar sued the insurer. The court held that Preston's injuries did not result from the sale of alcoholic beverages and that there was no coverage under the policy.

Question: Was the basis of Preston's claim injuries from assault or injuries from battery?

Answer: Since battery is the non-permissive touching of another, the basis for Preston's claim was injury from battery.

6.6.2.1.3 False Imprisonment

False imprisonment is the intentional and unprivileged detaining of someone without their consent. The detention must be for an appreciable amount of time, meaning that the plaintiff knows that they have been detained, and it must be complete in that there is no reasonable means available for the plaintiff to have escaped detention. Detention can be permitted (privileged) if the plaintiff has given consent or if the law allows it. Most states now have statutes that allow stores to detain suspected shoplifters so long as the store acts reasonably, even if subsequent information reveals that the customer did not take anything.

Scenario:

One evening, Vernon presented three prescriptions, along with his new prescription insurance card, to the pharmacy in a Local store.

While the pharmacy filled his prescriptions, Vernon spent 20 to 25 minutes shopping for groceries. Vernon picked up his prescriptions from the pharmacy, signed the pharmacy log, and told the pharmacist that he would pay for his groceries at the front of the store. Vernon and the pharmacist did not discuss the amount due on Vernon's prescriptions. At his deposition, Vernon testified that he believed his insurance covered the entire cost of his prescriptions and that he was not required to make a co-payment.

Vernon proceeded immediately to the check-out lanes at the front of the store, where the cashier rang up Vernon's groceries, and Vernon wrote a check for the amount due. The cashier questioned Vernon about the absence of a paid sticker on his prescription bag, and Vernon responded that his insurance covered the prescriptions. Vernon admits that he left the Local store without paying any co-payment toward his prescriptions.

Shortly after Vernon left the Local store, Springer, a Store loss prevention employee, telephoned Vernon's home and left a message that Vernon had not paid for his prescriptions and would need to return to the store to resolve the situation. The store contends that Vernon owed co-payments totaling \$119.71 on his prescriptions. Vernon returned Springer's telephone call and attempted to explain that the bagger checked with the pharmacy to be sure the prescriptions were paid for. Nevertheless, Vernon told Springer that he would be driving through Columbus on his truck-driving route late that evening and would return to the store.

Vernon returned to the Local store around midnight. Two police officers at the Local store on an unrelated matter followed Vernon into the store. At Vernon's request, a cashier led Vernon, followed by the officers, to Springer's office. Vernon introduced himself, and Springer told the police officers that he wanted Vernon arrested, even though one of the officers suggested that the situation sounded like a misunderstanding that could be rectified. One of the officers arrested Vernon, and, with Vernon's consent, the officers searched Vernon's truck and recovered the prescriptions. Vernon subsequently sued the store for false arrest and malicious prosecution. The court granted the store summary judgment on the false arrest charge because the statute of limitations on it had expired.

Question: Will the store prevail on the malicious prosecution charge?

Answer: Yes. To sustain an action for malicious prosecution, a plaintiff must establish: (1) malice in instituting or continuing the prosecution; (2) lack of probable cause; and (3) termination of the prosecution in his favor. If probable cause exists, no action for malicious prosecution will succeed, even if the plaintiff can demonstrate actual malice. While Vernon's belief that he owed nothing for his prescriptions may have been relevant to create a reasonable doubt as to his guilt in a criminal trial, it does not dispel the store's reasonable suspicion, based on the facts and circumstances known to them or reasonably within their contemplation, that Vernon was guilty of theft. Vernon pointed to no other evidence to overcome the presumption that the store had probable cause to initiate criminal proceedings against him. Judgment for the store.

6.6.2.1.4 Emotional Distress

Historically, courts did not recognize claims of emotional distress for fear of encouraging trivial claims and the difficulty of proving harm. Today, however, most courts will allow recovery for emotional distress provided that the defendant's actions were outrageous and the result of those actions was severe emotional harm. Some courts add that the harm must be such that an ordinary person with normal sensibilities would suffer. In those states, people who are unusually emotionally susceptible would not be able to recover.

Scenario:

Lucy Leisure, a church-going woman in her late 40s, was employed at the Epsilon Insurance Agency. While working in the office, she and another employee were asked to move some supplies to another room. After an hour had passed, Ethan Epsilon, the son of the agency owner and the office manager, noticed that the supplies had not been moved. He launched into a profane one-minute tirade directed at Lucy and her co-worker and threatened to "show them the gate." At this, Lucy became upset and began to experience pain in her chest, pounding in her head, and difficulty in breathing. Her family physician met her at the hospital where he admitted her, fearing that she was having a heart attack. She was later diagnosed as having had an acute anxiety reaction. Lucy later sued Epsilon Jr. and the agency for intentional infliction of emotional distress.

Question: Was Epsilon Jr. responsible for Lucy's injury?

Answer: No. The one-minute outburst of profanity did not amount to such extreme and outrageous conduct as to give rise to recovery for intentional infliction of emotional distress, even though the conduct was crude, rough, and uncalled for. Although Lucy was a decent

person and a diligent employee who would not condone the use of vulgar language and who would be upset at being unjustifiably berated at her place of work, there was no evidence that she was particularly susceptible to emotional distress, or that Epsilon Jr. had knowledge of any such susceptibility. There was no evidence that he intended to inflict emotional distress of a severe nature or that he believed such a result was substantially certain to follow from his conduct. Judgment reversed in favor of Epsilon.

6.6.2.1.5 Defamation

Defamation involves comments that are harmful to one's reputation. It must be:

- unprivileged,
- false, and
- published or communicated.

Defamation can take the form of libel (written or printed defamation) or slander (oral defamation).

Unprivileged: Privilege, the right to issue an otherwise defamatory statement, can take one of two forms: absolute or conditional. Absolute privilege includes statements made during judicial proceedings, between spouses, and by certain executive officials made in the course of their duties. Absolute privilege is a complete shield against a charge of defamation.

Conditional: A conditional privilege provides a defense unless the privilege is abused. Examples of conditional privilege include:

- Statements made to advance the maker's legitimate interests.

For Example:

Paul accuses Mary of stealing money. Mary calls Paul a liar. Mary's statement carries a conditional privilege.

- Statements made to protect the interests of another.

For Example:

Leslie tells Susan that the man she is dating has a sexually transmitted disease. Leslie's statement is a conditional privilege even if he doesn't know it to be true for a fact as long as he believes it to be true. However, Leslie would lose his privilege if he makes the statement knowing it to be false.

- Statements made in the process of fair and accurate media reports.

Scenario:

Belle Winslow was general manager of an Eye Care Vision retail optical store. Three Eye Care employees met with Winslow to discuss a \$4,000 deficit in her store's petty cash account.

Winslow refused to cooperate with the investigation and was officially fired for that reason. The three investigating employees made some allegedly defamatory statements about Winslow's situation to two other Eye Care employees, Harlow and Reiker, whom they were investigating. Later in April, Winslow's successor as store manager told Cathy Bein, a friend of Winslow's who was not an Eye Care employee, that Winslow "is no longer here" and "is in big trouble."

Winslow sued Eye Care for slander. Her three claims were that: (1) the investigating employees' statements to Harlow and Reiker defamed her, (2) she would be required to engage in defamatory self-publication when asked about her previous employment in subsequent job applications, and (3) the new manager's statements to Bein defamed her. The court granted Eye Care's motion for summary judgment on all three claims and Winslow appealed.

Question: Will Winslow prevail in the appeal?

Answer: Yes, in part. In this matter, the court held that publication is the communication of defamatory matter to a third person, and neither agents nor employees of a company are third persons in relation to the corporation because they are part and parcel of the corporation itself. [The corporation] is but communicating with itself. Winslow contended that she has been, and will continue to be, forced to reveal the accusations surrounding her termination when applying for other positions. Eye Care's stated reason for terminating Winslow was that she failed to cooperate with a company investigation. Thus, Winslow would not publish a defamatory statement by informing third parties [of this], because [it] is a true statement. The court believed that further evaluation of the statement "she's in big trouble" in the context of the new manager informing Bein that Winslow no longer worked at the [store] was in order. Whether this comment imputes the commission of a crime or tends to injure the victim's professional reputation—and therefore constitutes slander per se—is a question for the fact finder. A claim of slander per se renders irrelevant the absence of evidence that a comment actually sullied the victim's reputation. Summary judgment in Eye Care's favor affirmed, except on Winslow's claim that the new manager's statement to Bein defamed her. Case returned to the district court for proceedings consistent with the court of appeals' decision.

6.6.2.1.6 Invasion of Privacy

There are four types of invasion of privacy.

- **Intrusion on Personal Solitude:** Any intentional intrusion on one's solitude is an invasion of privacy if the intrusion would be offensive to an ordinary person and if there is a reasonable expectation of privacy.
- **Public Disclosure of Private Facts:** This can constitute an invasion of privacy if the publication of the facts would be offensive to a normal person. Because this is different from defamation, truth of the facts disclosed is not a defense. Also, a mere repeating of the facts to a third person would not constitute an invasion of privacy. The disclosure must be public (i.e., disclosed to a number of persons). There is no liability if the facts disclosed are a matter of public record. In addition, there is no liability if the facts have to do with public officials and is reasonably related to their public lives.
- **False Light:** Information that misrepresents a person to the public in a way that is highly objectionable (not necessarily offensive) can be an invasion of privacy. Saying that someone supports a racist organization may not be offensive in the traditional sense of the word, but it might be highly objectionable, especially if the person targeted occupies a position sensitive to such charges, such as a teacher. However, like defamation, the truth is an absolute defense.

- **Appropriation of Name or Likeness:** Liability arises when a defendant uses someone's name or likeness to imply an endorsement of a product or service or issue or connection with the defendant's business when no such relationship exists. This raises the question to what extent public figures have control over the use of their names. Insurance agents often occupy very visible public positions as members of church organizations, volunteer committees, etc. Considerable disagreement exists from state to state over the extent of a public person's right of privacy.

There are several defenses that might be available against a charge of invasion of privacy.

- The plaintiff previously published the information.
- The plaintiff consented to publication.
- The plaintiff is a public figure or the information is public knowledge.
- The information was part of a news event.
- The publication would not offend an individual of ordinary sensibility.
- Matters were disclosed in judicial proceedings.
- The information is of public interest, such as the public's right to know.

6.6.2.1.7 Misuse of Legal Proceedings

An agent, or anyone for that matter, can be libel through the misuse of legal proceedings. There are three forms this liability might take:

- Malicious prosecution,
- Wrongful Use of Civil Proceedings, and
- Abuse of process.

Misuse of legal proceedings involves the wrongful initiation of criminal proceedings against the plaintiff. The plaintiff must show:

- that the defendant started the proceedings without probable cause,
- that the defendant did so for an improper purpose, and
- that the criminal proceedings were eventually resolved in the plaintiff's favor.

Note:

District attorneys are much more likely to be the subject of this type of suit than other people.

On the other hand, anybody can be charged with Wrongful Use of Civil Proceedings. This cause of action is intended to protect people against wrongfully initiated civil suits. The elements plaintiffs must prove are similar to those for misuse of legal proceedings.

When someone starts legal proceedings, criminal or civil, for reasons other than the ones for which the proceedings were designed, they may be libel for abuse of process. Abuse of process most frequently comes about when someone initiates legal activity in order to achieve an outcome that is unrelated to the lawsuit.

6.6.2.1.8 Deceit or Fraud

Fraud consists of six elements, all of which must be proven by the plaintiff.

- That there was a false representation.
- That the misrepresentation involved a material fact.
- That the misrepresentation was knowingly made by the defendant.
- That the defendant intended to deceive the plaintiff.
- That the plaintiff justifiably relied on the misrepresentation.
- That the plaintiff was injured as a result of that reliance.

Scenario:

Mr. Rogers applied for life insurance with Omega Life on October 7, 2022. Question 12 of the application required him to provide information as to his past and present smoking habits. In answer to the question, he represented that he had not smoked in the past 12 months and that he had never smoked cigarettes. Just above Mr. Rogers's signature at the end of the application is the statement that "all of the statements which are part of the application ... are complete and true to the best of the knowledge and belief of those persons who made them."

The true facts were that Mr. Rogers had smoked for 13 years and that, during the month that he applied for the policy, he was smoking approximately 10 cigarettes per day. Both Mr. Rogers and his father, Mr. Stanley, were aware of the facts. Had Omega Life known these facts, it would have offered a life insurance policy to Mr. Rogers, but the premium it would have demanded would have been substantially higher.

Mr. Rogers died on July 17, 2024, within two years of the application for insurance, for reasons unrelated to smoking. Mr. Stanley, the beneficiary, filed a claim for the proceeds of the policy. Omega Life investigated and learned of the misrepresentations. It denied the claim and sought to effect rescission by tendering to Mr. Stanley a check for the premiums paid under the policy. The tender was refused and Omega Life commenced a declaratory judgment action to have the policy declared null and void.

Question: Will Omega Life prevail in this action?

Answer: Yes. Under the state law where the case was tried, an insurance policy is void for misrepresentation when the insurer establishes three elements: (1) that the representation was false; (2) that the insured knew that the representation was false when made or made it in bad faith; and (3) that the representation was material to the risk being insured. The first two elements are not in dispute. The key question, then, was whether the misrepresentation was material. The court rules that a misrepresented fact is material if, being disclosed to the insurer, it would have caused it to refuse the risk altogether or to demand a higher premium. Since Omega Life could clearly point to its published actuarial tables that required a higher rate for smokers, this last element was met.

6.6.3 Negligence

Although a person may be deemed liable for damages based on strict liability—a type of tort liability not requiring evidence of negligence—an award of damages by a court of law generally

requires that a finding of negligence be made.

Negligence comes about, legally speaking, when our actions fail to rise to the level needed to protect others from harm and that failure is deemed unreasonable under the circumstances. To recover in a lawsuit for negligence, a plaintiff must prove:

1. That the defendant breached a duty owed to the plaintiff,
2. That the plaintiff suffered an injury,
3. And that the injury was caused by the defendant's breach of duty.

6.6.3.1 Breach of Duty

While the precise duty owed by a defendant may depend on the circumstances surrounding a case, the general rule is that one should act in a reasonable and prudent manner (the "reasonable person" standard). A reasonable person is not required to foresee all possible risks of harm to another or to take unreasonable steps to protect others. When determining what is reasonable under the circumstances, a court will consider the foreseeability of harm, the potential seriousness of the foreseeable harm, the difficulty of the plaintiff avoiding harm, and the social value of the defendant's actions. The greater the social value, the less likely that the court will find that there has been a breach of duty.

6.6.3.1.1 Special Duties

When determining what constitutes "reasonable," a court will also consider any specialized knowledge or skills the defendant may have or the defendant's relationship to the plaintiff. For example, doctors and other professionals are held to a higher standard than the ordinary person insofar as their specialty is concerned. Similarly, an insurance agent may be held to a higher standard of care than an ordinary person when it comes to insurance portfolios. The standard applied to owners of premises may change depending on the status of the defendant in relationship to the property. A plaintiff may be a trespasser, a licensee (one who is permitted entry for their own benefit), or an invitee (one who is invited onto the premises by the owner). Most customers are considered to be invitees of a merchant. Traditionally, the duties owed by the owner of a premises are:

- **Duty owed to a trespasser:** Not to harm them intentionally. There is no duty to make the premises safe for them. A trespasser basically takes the premises as he/she finds it.
- **Duty to a licensee:** To warn them of any known hazards that the licensee is unlikely to discover on his own.
- **Duty to an invitee:** to take all reasonable steps to make the premises safe for them.

6.6.3.2 Causation

There are three elements to consider when determining if a defendant's breach of a duty caused a plaintiff's injury:

- Would the injury have occurred without the defendant's breach?

- Was there an unbroken chain of events starting with the defendant's breach and ending with the plaintiff's injury (proximate cause)?
- Was there any intervening force after the breach that helped to cause the injury? (An intervening force will generally relieve the defendant of liability unless it is one that could reasonably have been foreseen by the defendant.)

Scenario:

A vehicle driven by Fletcher collided with a vehicle driven by Grace at an intersection in the parking lot of a shopping mall leased and operated by The Realty Trust. The accident occurred because Fletcher failed to stop at the intersection. A stop sign previously placed at the crossing had been vandalized the day before the accident, and The Realty Trust had not yet replaced it. However, the word stop was painted in yellow on the asphalt of the lane followed by Fletcher. After the initial collision, Grace left her car to check it for damage. In the meantime, Fletcher's car continued in a circular fashion, struck a parked car, and then headed toward Grace, eventually pinning her against her own car and causing her serious injury. Grace sued The Realty Trust for its negligent failure to maintain proper traffic signs in the mall's parking lot. The Realty Trust moved for summary judgment on the basis that Fletcher's car was an intervening force.

Question: Should the judge uphold The Realty Trust's motion?

Answer: No, The Realty Trust's argument is not a good one. While Fletcher's car indeed may have been an unforeseeable intervening force, the result in this case – Grace's injury – was an all-too-foreseeable result of The Realty Trust's breach.

6.6.3.3 Negligence Defenses

In addition to being able to prove the essential elements of negligence, the plaintiff must also be able to overcome the defenses offered by the defendant. Traditionally, these are:

1. Contributory negligence
2. Assumption of risk
3. Comparative negligence

6.6.3.3.1 Contributory Negligence

In states that follow the rule of contributory negligence, a defendant has a complete defense against a negligence claim if it can be shown that the plaintiff's own actions substantially contributed to the injury or if the defendant can show that the plaintiff had a last clear chance to avoid injury and failed to take reasonable steps. Of course, the same condition is true for the defendant.

For Example:

Hannah pulls out in front of Irene's speeding car without looking and is struck in the side. When Hannah sues, Irene argues that Hannah was contributorily negligent. But if Hannah can show that Irene had a last clear chance of avoiding the accident, perhaps by showing that Irene had time to change direction, she may be able to overcome Irene's defense.

Although some states retain the claimant's contributory negligence as a complete defense against liability, other states have moved to a comparative negligence approach. Under comparative negligence laws, a finding that the claimant contributed to the loss through their own negligence would result in an award based on the degree of negligence of each party. Thus, comparative negligence laws may mitigate the extent of any liability when a claimant is contributorily negligent, but such contributory negligence would not eliminate the liability as it would under contributory negligence laws.

6.6.3.3.2 Comparative Negligence

Contributory negligence sometimes results in inequitable court decisions. Assume that someone was only 10% at fault for their own injury. They would be barred from any recovery even though the other party had the majority of the blame for the accident. Juries recognized this inequity long before the law did. When faced with a case where the plaintiff's degree of fault was small relative to the defendant, juries might find for the plaintiff but for a reduced amount.

For Example:

If a plaintiff's claim was for \$100,000 and the jury felt the plaintiff was 10% at fault, they would find for the plaintiff but only award them \$90,000.

Many states have now recognized the logic of this approach by enacting comparative negligence statutes, which reduces a party's recovery by the amount of their own negligence. Some states have a mixed system that requires the defendant's degree of fault be at least 50% or the contributory negligence rule will apply.

6.6.3.3.3 Assumption of Risk

Assumption of risk means the plaintiff voluntarily consented to a known danger.

For Example:

Justin accepts a ride from Kam, knowing that Kam is intoxicated and unfit to drive. If there is an accident and Justin sues Kam, Kam can argue that Justin knowingly and voluntarily accepted the risk.

Sometimes, contracts will include exculpatory clauses in which a party to the agreement seeks to be relieved of potential liability. Courts generally do not favor exculpatory agreements but will uphold them where the agreement was entered into fairly with language that is clear and unambiguous.

Scenario:

Lance, an expert skier and certified ski instructor, entered a competition held at a local Ski Resort, which was owned and operated by the LMN Corporation. The competition was held for fun rather than profit. It consisted of several events, including swimming five pool laps, bowling one line, drinking a quart of beer, throwing darts, and skiing in both downhill and cross-country races. The downhill ski race was the first event in the competition. It was held early in the morning before the resort was opened to the public. Prior to the race, Lance and all of the other

downhill contestants were required to sign a document entitled "General Release of Claim." The Release provided, in part:

"In consideration of my being allowed to participate in the competition at the Ski Resort, I irrevocably and forever hereby release and discharge any and all of the employees, agents, or servants and owners of the Resort and the other sponsors of the competition officially connected with this event of and from any and all legal claims or legal liability of any kind involving bodily injury or death sustained by me during my stay at the Resort. I hereby personally assume all risks in connection with said event and I further release the aforementioned resort, its agents, and operators, for any harm which might befall me as a participant in this event, whether foreseen or unforeseen and further save and hold harmless said resort and persons from any claim by me or my family, estate, heirs, or assigns"

About 10 minutes after the race began. Lance was found unconscious approximately three-quarters of the way down the mountain. He died a few hours later. No one witnessed the incident that caused his death, but it was speculated that he lost control of his skis and hit a tree. The personal representative of Lance's estate filed a wrongful death action against LMN on behalf of Lance's son.

Question: Do you think the Resort is liable in this scenario?

Answer: No. The trial court granted a summary judgment in favor of LMN on the grounds that the exculpatory agreement (The General Release) signed by Lance released LMN from all liability.

One of the areas in which assumption of risk has been successfully used in defense of a liability claim is in sporting events during which spectators are injured. For example, a spectator at a hockey game who is hit in the face by a flying puck may be prevented from maintaining a successful liability claim on the basis that their voluntary attendance at the game was tantamount to an assumption of the risk of such an injury.

6.6.3.3.4 Intervening Cause

We noted earlier that, in a negligence claim, a defendant's negligent actions must have been the proximate cause of the claimant's loss in order for the defendant to be liable. In the case of an intervening cause, another action—one which is independent of the defendant's negligence—intervenes and becomes the proximate cause of the claimant's loss.

Since the intervening cause has displaced the defendant's negligent actions as the proximate cause of the loss suffered by the claimant, the chain of causality between the negligent actions and the claimant's loss is broken. Since the defendant's negligence is no longer the proximate cause of the loss, no liability applies.

6.6.3.3.5 Statute of Limitations

As time passes following a loss, memories concerning the circumstances surrounding it often dim, witnesses to an act may die or move away, and evidence may be lost. For these and for other reasons, the laws of the various jurisdictions contain a statute of limitations—a statute specifying a period of time following an individual's wrongful conduct—during which a legal

remedy may be pursued.

In fact, a statute of limitations is really multiple statutes of limitation that impose various time periods applicable to the pursuit of a legal remedy based on whether the matter is civil or criminal and, generally, on its seriousness. (For some crimes—crimes against humanity, for example—no statute of limitations applies.) A claimant's failure to bring an action within the period required is an important defense against negligence.

6.7 Civil Litigation:

Let's take a brief look at the civil litigation process, one which many property and casualty insurance professionals might encounter at one point in their career.

6.7.1 Filing a Legal Action

When an accident occurs, the first contact the injured party has is typically with a representative from the insurance company. The vast majority of claims that occur, and for which insurance coverage exists, are settled between the injured party and the insurance company prior to litigation being instituted. Although the number of claims that are not amicably settled (without resorting to any type of legal action) varies greatly, experience shows this number to be relatively small. Nevertheless, there are times when the parties absolutely cannot agree on issues of liability or damages and the injured party must either withdraw their claim or resort to other available avenues. This will typically be either hiring a lawyer to intervene on their behalf or filing a lawsuit on their own behalf, without the assistance of a lawyer. As the legal system is a difficult one to navigate, hiring a lawyer is typically the chosen path.

Once an attorney is hired, one choice available for further remedy is to file a lawsuit in the appropriate venue (i.e., the court area that has jurisdiction over the matter). A lawsuit may be filed by an attorney licensed to represent others, or it may be filed on one's own behalf. This is said to be "in pro per" (in propria persona), or "in one's own person."

The filing of a legal action must be done timely. In all court jurisdictions, there are legislative statutes governing the time, following an incident that gives rise to the lawsuit, in which the legal proceedings must begin. Typically, each type of incident – property damage, bodily or personal injury, contract disputes, medical or legal malpractice, financial transactions, etc. – has a specified time period in which the action must be filed. These time periods are called the Statute of Limitations and differ from jurisdiction to jurisdiction, and for the different types of incidents.

The commencement of a lawsuit usually involves filling out a summons and/or complaint. It is in this document that the plaintiff will make all allegations of wrongdoing and negligence by the defendant. The complaint usually contains a section where the plaintiff indicates the means and amount of relief (money damages or other court action) being sought in the lawsuit.

After the complaint is filled out, it must be filed with the clerk of the court, and the plaintiff must ensure that the party being sued is presented with (served) a copy of the complaint, along with a summons to appear in court to answer the charges.

Once the defendant is served with the summons and complaint, they must file an answer to the charges within a specified period of time or request an extension of that time to answer. This

may also be done by the defendant hiring an attorney to represent them, or the defendant may appear in pro per.

6.7.2 Discovery

After the complaint is filed and served by the plaintiff, and answered by the defendant, a trial date is set. In today's somewhat complex legal world with which civil litigation deals, the ultimate trial date may be months or, in some cases, years after the original complaint is filed. During this interim, the parties attempt to determine precisely what transpired in leading up to and following the incident with which the lawsuit deals. This process is called the Discovery Process. Each party is allowed to file a series of written questions (interrogatories) that the other party must answer under oath. Each party may command witnesses, or parties to the lawsuit, to appear before a court reporter and, under oath, provide a sworn statement (a deposition) as to their knowledge of the circumstances.

In addition to the discovery process going on to determine the factual issues, there is also the opportunity to file motions with the court pertaining to specific items of the law which are felt to be advantageous to one party or the other. The motions can address very small, almost insignificant, issues dealing with trial procedure. They also may be as central to the underlying issues of the case as to call for an immediate determination by the judge to either dismiss the lawsuit in favor of the defendant, or rule in favor of the plaintiff as a matter of law, thus forgoing the necessity of a trial. Understandably, neither of these somewhat drastic results is successfully arrived at very often.

While the discovery phase and the motion phase are going on, thus moving the case toward disposition at trial, there is often activity by one or both parties to continue to try to resolve the matter without going to trial. While it was indicated earlier that only a very small percentage of cases wind up in the litigation process, an even smaller number are actually tried before a judge and jury. The vast majority of the cases are resolved by mutual agreement. In those situations, the claimant signs a release that discharges the defendant from any further claim being brought in the matter. The defendant pays the agreed upon amount (assuming it is a monetary settlement), and the lawsuit is dismissed.

6.7.3 Trial

In the few cases that cannot be resolved via a mutually agreeable settlement, the case is ultimately assigned to a judge for trial. Either party has the right to request a jury trial; however, if neither party makes that request, the case will be held before, and ruled upon, by the judge. This is called a Bench Trial. In jury trials, it is the jury's function to consider all matters of fact, while the judge is responsible for ruling on all matters of law. In a bench trial, the judge will rule on both matters of law and matters of fact.

In jury trials, prospective jurors are called and each party, along with the judge, asks a series of questions to determine if the prospective juror has any bias or prejudice which would render that individual unable to provide a fair and impartial verdict. This is called voir dire, from the Latin meaning to speak the truth. If a juror is found to have such bias or prejudice, the juror may be dismissed "for cause." Each side generally has an unlimited number of challenges to jurors for cause, so long as the judge agrees the cause is reasonable.

When a full jury is impaneled, the trial begins with each party (or their legal representative) making an opening statement to the jury. It is here that the case to be presented by both parties is laid out for the jury to hear. The parties will indicate what they intend to prove and outline, for the jury, certain matters they deem to be important.

During the trial each side is allowed to call witnesses to testify before the jury. The witnesses generally are the same group of people who were deposed during the discovery stage of the pretrial activity. When one side calls a witness to testify, the other side then is allowed to cross-examine the witness on testimony given. When the opposing side finishes their cross examination, the side which called the witness may reexamine the witness to attempt to correct any confusion or miscommunication given by the witness.

In some cases, expert witnesses are called to testify for one or both sides. Experts are people who possess certain specific knowledge of aspects in question in the trial, and whom the court agrees will shed additional light on certain subjects to benefit the jury in their quest for a verdict.

After all witnesses have been heard and evidence introduced, each side again gets to address the jury. This is called the Summation or Closing Arguments. This time, the parties sum up what they have introduced and what certain witnesses said. The jury is asked to consider certain items and to disregard others. Each side attempts to win the jury to their position.

When the parties or their lawyers have completed their final arguments, the judge then provides the jury with specific instructions on the law. This is often called the Jury Charge or the Charge to the Jury. Since the jury is made up of laymen, generally unschooled in legal matters, they are not expected to know the law regarding the case at hand. The judge, at this time, informs the jurors as to what they must do under the law, and what they cannot do under the law. He advises them that if they find certain things to be true, a particular verdict must be brought back, while other findings on their part must result in some other verdict being rendered. Although these instructions are delivered by the judge in open court to the jury members, they are usually the product of an earlier arrived-at agreement between the judge and the lawyers trying the case.

After this "charge" to the jury, the jurors are taken to a jury deliberation room to consider what they have heard and determine what they wish to do in the way of rendering a verdict. Although in a criminal trial the defendant is protected by the issue of reasonable doubt, no such legal restrictions apply in civil matters. The jurors are allowed to believe any portion of what they heard as testimony, and to disregard any or all other testimony. They may accept evidence or disregard it. They are allowed to accept the "preponderance of the evidence," which means they are able to accept what they believe to be true based on what they heard as jurors. They cannot use their own personal knowledge or backgrounds or rely on anything other than what they heard or saw in the courtroom. Also, unlike a criminal trial, the jury's verdict need not be unanimous. A simple majority is all that is required in most jurisdictions.

When the jury has decided on the issues of liability, and (if appropriate) damages, they return to the courtroom and their verdict is announced. The trial phase, except in very few circumstances, is completed at this point. That does not mean, however, that the matter is finalized.

The party that did not prevail may ask the court to throw out the verdict, thus ignoring the jury's

deliberations and decision. This is a "verdict N.O.V." (non obstante verdicto.) While possible, this is rarely done. Either party can also ask the judge to change the amount of the damages assessed by the jury's verdict. The plaintiff may feel the evidence and the verdict were incompatible, and that a finding in their favor should have resulted in a higher damages award. This would be asking the judge for an Additur. Likewise, the defendant against whom the verdict has been rendered may feel the damage assessment was too high, given the evidence presented. They may ask the judge for a Remittitur, thus reducing the amount of damages associated with the verdict.

6.7.4 Right to Appeal

After a verdict is rendered, and officially entered by the court, thus making it binding, either party has the right to appeal to a higher court, so long as there are some issues that allow such action. That is to say, it is not sufficient to merely be unhappy with the outcome of the lower court proceedings. There must be some issue of law on which the side seeking the appeal can base their plea for further redress. With the complexities of the law today, and the civil court proceedings, it is a rarity to be unable to find some point that cannot be argued as an appealable issue.

The appellate process is somewhat different from the lower court proceedings. Generally speaking, the appeals courts are presented with written documents (called briefs, which are usually anything but brief) prepared by the parties that set forth the issues that the appeals court is asked to decide. Witnesses are almost never heard at this level. The appeals court can:

- Affirm the lower court decision, thus telling the appealing party the verdict was correct;
- Overturn the lower court decision and render a different verdict; or
- Find an error in the lower court trial and remand the case back to the previous court to be tried again in light of the appeals court ruling on the legal issue presented.

Beyond the appeal to the appellate courts, the parties may ask the State Supreme Court or the United States Supreme Court to review the case. However, in order to reach these levels, it is necessary to have a question of a constitutional issue, rather than merely a matter of legislative or common law.

6.8 Damages

The legal remedy applied to the finding of liability is the payment of money damages. Thus, when a person has been found liable for a claimant's loss due to negligence, damages are normally awarded. Such damages may be:

- Compensatory damages; and/or
- Punitive damages.

6.8.1 Compensatory Damages

Compensatory damages are those damages awarded to a claimant for the losses they actually sustained; they are designed to provide reimbursement. Two types of compensatory damages may apply. They are known as:

- Special compensatory damages; and
- General compensatory damages.

Special compensatory damages are damages to pay the claimant for their actual expenses and may include:

- Hospital and medical expenses;
- Lost wages;
- Expenses incurred to repair or replace property damaged by negligence attributed to the defendant; and
- Funeral expenses.

General compensatory damages are damages paid to a claimant to compensate them for disfigurement, pain, and suffering.

6.8.2 Punitive Damages

Punitive damages are damages awarded to a claimant, designed to punish the defendant and make an example of them. Punitive damages—also called **exemplary damages**—are often awarded when the defendant has acted willfully or wantonly in causing the claimant's loss.

6.9 Arbitration and/or Mediation

At times, and under certain circumstances, it is possible to resolve differences related to a claim by use of a forum other than the courts. One alternative dispute resolution method is Arbitration. Since this form of resolution process is generally less formal than the court system, almost any type of ground rules is possible, so long as they are agreeable to all parties. Nevertheless, the American Arbitration Association (AAA) has established guidelines for many of the possible procedures, and most parties agree to be bound by the rules and procedures established by the AAA.

A second similar method of dispute resolution is Mediation.

This method is also used to resolve disputes, by agreement, without resorting to litigation and normal court proceedings. Instead, the matter is resolved by appointed, or agreed upon, individuals to hear evidence and render a decision.

Arbitration and mediation may be either Binding or Non-Binding. Binding Arbitration or Mediation will commit all parties to accept the decision of the arbitration or mediation panel, and no further action can be taken to pursue or resist the claim. The arbitration or mediation decision will resolve the matter at that point.

If the arbitration or mediation is non-binding, then either party may choose to ignore any or all of the findings. While this may not resolve the entire matter, even non-binding arbitration or mediation can show each side the possible weaknesses in their respective positions, and very often will lead to some negotiated resolution, usually based loosely on the arbitration/mediation findings.

While the litigation process is commenced via the use of the Summons and Complaint process,

arbitration and/or mediation is usually initiated by one party or the other merely giving notice of its intent to follow this route.

The availability of these alternative processes often emanates from a contractual clause contained in some type of previously signed agreement between the parties. Such a pre-arranged agreement to arbitrate or mediate is not, however, necessary. Even in the absence of such a contract clause or other earlier agreement, the parties may still decide to settle their differences by arbitration or mediation, rather than through the courts, merely by agreeing to do so.

The advantages of arbitration and mediation are that they are usually much faster than the court process and, as a result, are usually also substantially less expensive. Either party can be represented by an attorney, just as with litigated proceedings, and there may be the opportunity to conduct much of the same type of pretrial discovery that was discussed previously dealing with court litigation.

The arbitration or mediation process between the parties is usually accomplished by one party selecting an arbitrator/mediator and the other party selecting a second similar individual. Those two selected representatives then agree on a third person. As indicated, there is much greater latitude in these types of proceedings, and if both parties agree, a single arbitrator or mediator may be selected to hear the case.

The arbitrators or mediators examine the facts submitted by each side and resolve whatever points are in contention. While the arbitration and mediation processes may be less structured than court proceedings, there will generally still be some type of formal hearing with the arbitrators or mediators acting as judge and jury. Witnesses may be called, evidence may be submitted, and the parties may have the opportunity to present oral arguments in favor of their position.

Section Review:

1. An insurance policy is an example of what type of contract? Refer to Section 6.3.1, page 106

A. Bilateral **[Your answer is incorrect. An insurance contract is not a bilateral contract.]**

B. Unilateral **[Your answer is correct. An insurance policy is a unilateral contract because only the insured is required to do anything when the policy is issued.]**

C. Executed **[Your answer is incorrect. An insurance policy is not an executed contract.]**

D. Implied **[Your answer is incorrect. An insurance policy is not an implied contract.]**

2. Which of the following statements about insurance policies is true? Refer to Section 6.3.4, page 107

A. An insurance policy may be both an executed and an executory contract. **[Your answer is incorrect. A contract cannot be both executed and executory by definition.]**

B. An insurance policy may be both void and voidable. **[Your answer is incorrect. A contract cannot be both void and voidable by definition.]**

C. An insurance policy may be both executory and voidable. **[Your answer is correct. An insurance policy is an executory contract and may be voidable in certain situations.]**

D. An insurance policy may be both executed and bilateral. **[Your answer is incorrect. An insurance policy may be an executed contract (particularly after policy expiration), but it is a unilateral and not a bilateral contract.]**

3. The purpose of promissory estoppel is to: Refer to Section 6.3.5, page 107

A. Make promissory notes binding contracts. **[Your answer is incorrect. The purpose behind the rule of promissory estoppel is not to make promissory notes binding contracts.]**

B. Protect someone who relies on the promise of another. **[Your answer is correct. The purpose behind the rule of promissory estoppel is to protect people who innocently rely on the promise of another to their detriment.]**

C. Protect someone who makes a promise that can't be kept. **[Your answer is incorrect. The purpose behind the rule of promissory estoppel is not to protect someone who makes a promise that can't be kept.]**

D. Make contracts voidable. **[Your answer is incorrect. The purpose behind the rule of promissory estoppel is not to make contracts voidable.]**

4. An agreement where one party has not given or promised to give anything of value is missing _____ . Refer to Section 6.3.6.4, page 110

A. An intent to contract. **[Your answer is incorrect. If nothing of value has been exchanged, the agreement is not missing an intent to contract.]**

B. The capacity to contract. **[Your answer is incorrect. If nothing of value has been exchanged, the agreement is not missing the capacity to contract.]**

C. Consideration. **[Your answer is correct. Consideration requires the exchange of something of value.]**

D. A legal purpose. **[Your answer is incorrect. If nothing of value has been exchanged, the agreement is not missing legal purpose.]**

5. Tom says: "If I could get \$100,000 for my house, I'd sell it." Jason replies: "I'll give you \$100,000." Has a contract been created? Refer to Section 6.3.6.2, page 109

A. Yes, assuming both Tom and Jason have the legal capacity to contract. **[Your answer is incorrect. A contract has not been created just because Tom and Jason both have the legal capacity to contract.]**

B. Yes, because there is consideration and a legal purpose. **[Your answer is incorrect. A contract has not been created just because there is consideration and a legal purpose.]**

C. No, because the agreement is not in writing. **[Your answer is incorrect. The agreement does not need to be in writing.]**

D. No, because there has not been an acceptance. **[Your answer is correct. Jason made an offer to buy the house for \$100,000, but Tom has not accepted it. There can be no contract without both an offer and acceptance.]**

6. Which one of the following contractual rights may not be assigned to a third party? Refer to Section 6.4.1, page 112

A. The right to accept delivery of goods. **[Your answer is incorrect. A buyer may assign the right to accept delivery of goods to anyone they wish.]**

B. The right to accept payment for performance of a service. **[Your answer is incorrect. A seller may assign the right to receive payment for a service to anyone they wish.]**

C. The right to assign payment to a third person. **[Your answer is incorrect. A seller may assign the right to receive payment for a service to anyone they wish.]**

D. The right to assign payment of workers' compensation benefits. **[Your answer is correct. Workers' compensation payments are a type of benefit that may not be assigned to a third person.]**

7. A creditor beneficiary is someone who: .Refer to Section 6.4.3.1, page 113

A. Borrows money under a contract. **[Your answer is incorrect. A creditor beneficiary is not someone who borrows money under a contract.]**

B. Loans money under a contract. **[Your answer is incorrect. A creditor beneficiary is not someone who loans money under a contract.]**

C. Obligates a third party to perform something under a contract. **[Your answer is incorrect. A creditor beneficiary is not someone who obligates a third party to perform something under a contract.]**

D. Receives a benefit from a contract but is not a party to it. **[Your answer is correct. A creditor beneficiary receives a benefit from a contract to which they are not a party.]**

8. Which one of the following torts requires physical contact or the threat of physical contact? Refer to Section 6.6.2.1.1, page 113

- A. Assault **[Your answer is incorrect. No physical contact is needed for the tort of assault.]**
- B. Battery **[Your answer is correct. Battery is a tort that results from the intentional and objectionable contact with another.]**
- C. Defamation **[Your answer is incorrect. The tort of defamation does not require physical contact.]**
- D. Invasion of privacy **[Your answer is incorrect. The tort of invasion of privacy does not require physical contact.]**

9. In order to prove negligence, a plaintiff must prove all of the following EXCEPT: Refer to Section 6.6.3, page 124

- A. That there was a breach of a duty. **[Your answer is incorrect. Proving breach of duty is an essential part of proving negligence.]**
- B. That the defendant intended the breach. **[Your answer is correct. Intent is not an element in proving negligence.]**
- C. That the plaintiff suffered an injury. **[Your answer is incorrect. Proving an injury is an essential part of proving negligence.]**
- D. That the injury was caused by the breach of duty. **[Your answer is incorrect. Proving causation is an essential part of proving negligence.]**

7.0 The Players and Their Roles

Insurance is generally sold by three sources: company sales personnel, insurance agents, and insurance brokers. At times, the differentiation among these individuals can be difficult to see or understand.

A company salesperson is someone employed by the insurance company to generate "direct" sales to the customer. In most instances, these individuals are truly employees of the company, receiving the same employment benefits as any other company employee. They are generally paid a salary with some sort of sales volume bonus. In almost all situations, the direct sales personnel can only sell insurance for one company: the company by whom they are employed.

Direct sales people are most often found at mutual insurers.

In addition to mutual insurers, reciprocals and captives often hire direct employees to market their policies. Since neither of these specialized insurers offers their coverages to the general public, the marketing focus is quite specific and seems to lend itself to having direct employees selling their products.

The vast majority of insurers enlist independent agents to sell their services. These agents are individuals or companies established primarily or exclusively to sell insurance. The people engaged in this endeavor often wear two hats: as agent and as broker.

The insurance agent is usually a company or individual that enters into an agreement with one or more insurance companies to sell the policies of those insurers. The agent is generally at liberty to sell a policy of any of the insurers with whom he has a sales agreement, and they may have dozens of such agreements with all manner of different insurance companies.

Note:

Most large stock companies use independent agents to market and sell their policies.

One exception to the independent agent is the company-sponsored agency. In this situation, the insurer establishes an insurance agency for the purpose of advancing sales of its own insurance policies. Usually, the agent operating under such an agreement is not truly an "independent" agent and is committed to attempt to sell the policy of the company that has set up and/or sponsored the agency.

Generally, these special agents are allowed to sell the policies of other companies, but only if the sponsoring insurance company does not offer a specific type of policy needed by the customer, or if the sponsoring company declines to accept the prospective insured. In effect, the sponsoring company has the right of first refusal.

As can be seen, the insurance agent (in its truest sense) is associated with one or more insurance companies. As such, they have certain rights and responsibilities with, and to, the companies they represent.

The insurance broker, on the other hand, generally represents the customer who is seeking insurance. A person or company needing insurance will contact a broker, who will agree to attempt to find an insurance company that will issue the proper type of policy at a price acceptable to the customer. In its purest form, the broker would contact an insurance agent (who represents the insurance companies). They would agree on an insurance company, the proper type policy, and the correct price (the premium). The agent receives a commission from the company for the sale of the policy, and a part of that commission is then passed on to the broker as his payment – a type of "finder's fee."

In many instances, the agent and broker are one and the same – or at least two individuals both working for the same agency / brokerage firm. In these situations, the lines of responsibility and authority often become blurred, and at times are not visible at all.

In the purchasing of insurance, it may not seem overly important to specifically determine if the person providing this middleman function is an insurance agent or an insurance broker. The difference can become important if and when problems develop and it is necessary to determine to whom the sales person was primarily responsible: the insurance company or the customer.

Whether or not the policy is sold by a company sales representative, a company-sponsored agency, an independent agent, or a broker, the person with the responsibility to accept or decline a prospective customer is the company underwriter. This is an employee of the insurance company who is familiar with insurable risk, the types of policies the company wishes to write, and the types of insureds they wish to protect. The underwriter has the responsibility to accept or decline a prospective customer as an acceptable risk and set the premium needed to insure the risk for the desired coverage.

Since many individuals and companies seek the same basic types of policies and coverages, it is not necessary that the underwriter personally review each and every application for a policy. The insurance companies provide manuals and guidelines, so many of the agents know what types of risk the individual company is willing to insure, what general exceptions might be pertinent, and the price (premium) that will be charged.

In a number of instances, insurance companies provide some of their agents with underwriting authority; that is, the agent can actually accept a risk and bind the company to insure the person or company applying for the policy, without the prior approval of the insurance company. Where the application for insurance does not fit neatly into a predetermined template, the application may need to be submitted to the company underwriter to make the necessary decisions. Except in rare instances, the insureds seldom come into direct contact with the insurance company underwriters.

Another person with whom insureds seldom come into contact is the actuary. The actuary may be an employee of the insurance company or an independent person or firm hired by the insurer for specific functions. The actuary is the person primarily responsible for establishing the premium rates that everyone will pay for their insurance protection. The rates are established through a series of relatively complex calculations based on the probabilities of a certain type of risk suffering a certain type of loss and sustaining a certain degree of damage. Much of the calculations are based on reviewing past history for identifiable groups of insured types and extrapolating the past claims history into the future. The anticipated expenses and operating costs are factored into the equations, and it is thereby determined what amount of money will be needed for each type of risk being insured, at various monetary levels of coverage.

Once a policy of insurance is issued, the customer (now the insured) may have little or nothing to do with the insurance company or their representative until the policy expires or is renewed, unless there is a claim to be submitted under the policy. When this occurs, the insured or their representative will deal with the claims adjuster. The adjuster may be an employee of the insurance company or an employee of a separate company established to assist the insurance company in handling its claims. These independent adjusters will perform many of the same functions as does a company employee adjuster. The adjuster will gather estimates of the damage, or may personally appraise the damage, to determine how much money will be needed to return the insured, or the damaged third party, back into the same position they were before the loss.

The function of the claims adjuster, either company employee or independent adjuster, will vary

somewhat depending upon the type of claim being submitted, the magnitude of the claim, and the geographical location (and legal jurisdiction) where the claim will be handled. Nevertheless, the basic function of the adjuster is to gather the facts surrounding the loss, determine if the situation is one covered by the policy that was purchased by the insured, determine the value of the loss, and settle the matter (if warranted) for a reasonable amount in light of all the above considerations.

The insurance company employee adjusters are paid a salary, as are their other company counterparts. They do not receive compensation based on the amount of the claim or the amount for which the claim is settled. To do so might unduly influence their objectivity and impartiality, with which they are charged in the exercise of their duties. Technically, there is no personal incentive for the adjuster to attempt to reduce the amount of the loss beyond its fair and reasonable size, nor to interpret the coverage provisions of the policy in such a restrictive way as to unreasonably confine the insured's recovery process.

Realistically, one must realize that overzealousness by the adjuster may, however, come into play in trying to please their employer, to the possible detriment of the policyholder. The laws in most states forbid the adjuster from being paid on any contingency basis that might act to offer the adjuster an incentive to view the adjustment process as one of possible personal monetary gain.

Where the insurance company chooses to employ an independent adjuster, rather than use a company employee, this individual also is generally prohibited from working on a contingency basis. As with the company employee, the adjuster should not be tempted to minimize the amount owed to the policyholder or the claimant in order to increase the amount of compensation earned by the adjuster. These independent adjustment companies rely on the insurance companies to hire them to assist in these activities. Again, being realistic, the independent adjuster wishes to please the insurance company with their efforts. This can lead to abuses, and the insurer must be vigilant to see that the involved parties do not receive less than they are owed.

Many states have laws that attempt to further strengthen the requirements that adjusters, whether company employees or independent adjusters, act fairly and impartially when investigating and resolving claims. These laws and requirements are generally referred to as "Fair Claims Practices" and come under the responsibility of the individual state's Department of Insurance.

On the opposite side of the equation from the insurance company employees is the person or company being insured, or their representative. For most of us purchasing personal insurance for our homes, automobiles, lives, etc., we have only ourselves, our friends, or some knowledgeable acquaintance to help us through this seemingly convoluted maze.

Companies seeking to purchase insurance, especially the larger corporations, may have a Risk Manager who is responsible for such decision making. Risk Managers are generally individuals with extensive insurance backgrounds and experience, who are able to compare the various similarities and differences between premium quotes, coverages, etc.

In many cases the claims adjustment experience is an easy and almost effortless process. It is never fun, but it can be relatively painless if everything goes right and is not complicated by one or more of the large number of possible pitfalls. In some instances, the process breaks down.

When this occurs, the matter may be moved to a legal or quasi-legal forum (i.e., litigation or arbitration).

When an insured or claimant is not satisfied with the position being taken by the insurance company, or disagrees with the amount being offered to resolve the claim, they may seek outside assistance. If the claim is one involving a loss of personal or commercial property, such as a fire, theft, vandalism, etc., the unhappy property owner may engage the service of a Public Adjuster. This should not be confused with an Independent Adjuster, discussed earlier. Although Public Adjusters are also independent, in the sense they are not affiliated with the insurance company, they represent only the insured, while the Independent Adjuster represents the insurance company.

A Public Adjuster is retained almost exclusively in matters of property damage. They seldom, if ever, are used in matters of injury claims. They will re-evaluate the damage, the coverage, and the law that is involved with the particular claim being disputed. The Public Adjuster will generally conduct their own investigation and will do their own appraisal of the amount and scope of the damage being claimed. Unlike the company adjuster and the independent Adjuster, the Public Adjuster does usually work on a contingency basis. The higher the Public Adjuster can get the claim amount, generally the more their fee will be. While this can lead to some unscrupulous behavior on the part of some public adjusters, most are only interested in obtaining the full, fair amount that is owed to their clients. In the spirit of today's consumerism, the contingency fee arrangement for a Public Adjuster is seen to be an incentive to attempt to maximize the return to the insured/claimant.

The involvement of a Public Adjuster may not be sufficient to resolve a disputed claim. If the Public Adjuster cannot convince the insurance company to settle the matter, there are still some other options available. Most insurance policies contain Appraisal and Arbitration Clauses. These mandate that the insured will submit any first party, irresolvable claim to an appraisal process, and ultimately, if necessary, to arbitration. In some instances, when arbitration cannot resolve the issues, the dispute may become a matter to be heard by the courts.

Some insurance companies and self-insured organizations hire a third-party administrator (TPA) to handle their claims for them. These independent firms are usually under contract to the insurance company or self-insured group to perform many of the same functions as would the insurance company claims adjuster.

The TPA adjuster functions basically the same as the company adjuster described previously but is the employee of an independent firm representing the interests of the self-insured entity or the insurance company.

Another insurance company employee with whom the insured may come into contact is the Loss Control Specialist. The dealings between the insured and the Loss Control Specialist are generally much less adversarial than the interaction with the claims adjuster.

The Loss Control Specialist is someone with knowledge of the insurance aspects and experience in areas such as engineering. A more appropriate term for these individuals might be "loss prevention specialist." Their job is to work with the insured to attempt to minimize the frequency and severity of accidents suffered by the insured. Obviously, this usually only involves those larger companies that have a number of claims and/or the potential for large or catastrophic losses.

Since the premium large corporations are charged for their insurance is very often related to their loss history, the task of reducing the size of the losses or the number of claims may have a corresponding reduction in what the insured pays for its insurance. Obviously, most companies are eager to receive such help from these insurance company representatives. Entire loss prevention programs are installed in some companies that can have a dramatic impact on the losses suffered by the company and/or their employees.

In the discussion above, relating to disputes between insureds and their insurers, involving claims adjusters, public adjusters, and arbitrators, the issues involved in the settlement of claims are related to the insured's own property or damages (a first-party loss). On occasion, the dispute does not involve a disagreement between the insured and their insurance company, but rather it involves a third party, someone alleging damages caused by the insured, and for which the insured is protected under a liability insurance contract. Such a claim is a third-party claim and involves someone alleging to have been damaged or injured by the insured and seeking a monetary settlement as compensation for those damages or injuries.

An injured third party, alleging negligence on the part of the insured that caused the damages, will submit a claim to the insured or directly to the insured's insurer. The insurance company will, in effect, "stand in the shoes of the policyholder." The insurance company will analyze the coverage provided under the applicable insurance policy, and if coverage exists, will initiate the adjustment process.

Generally, a third-party claimant submits their damages to the company or independent adjuster assigned by the company to handle the loss. The adjuster investigates the circumstances of the accident, determines if the facts fit within the confines of the coverage afforded by the insured's policy, and then verifies the validity of the submitted damages. In the vast majority of situations, the adjuster is able to resolve the claim directly with the claimant for an amount of money with which both parties are satisfied.

Unfortunately, there are occasions when an amicable settlement is not possible and the third-party claimant retains a lawyer and ultimately files a lawsuit or other legal proceeding against the insured.

Depending on the type of insurance policy written by the company for the insured, there is generally coverage for legal fees in almost all primary liability type insurance policies. (Note there are also excess liability type policies, many of which do not provide for legal expenses in all cases.)

The primary insurer generally has an obligation to provide (and pay for) a defense of the insured if the allegations of the lawsuit fall within the parameters of the policy coverage language. Under such circumstances, the insurance company refers the lawsuit to an attorney to file the necessary appearance on behalf of the insured, and to defend the matter. The attorney may be an employee of the insurance company (referred to as "house counsel") or may be an independent attorney or law firm which the insurance company engages to defend their insured for this specific lawsuit.

Although the lawyer is generally hired and paid for their services by the insurance company, the attorney's responsibility is to the insured, not to the insurance company. On occasion, a conflict will arise between the insured and the insurer. Under those circumstances, the attorney hired to defend the insured has a clear and specific duty to represent only the position of the insured,

even if that position may be contrary to the best interest of the insurance company that is paying them.

Nevertheless, there are certain instances in which the insured may be entitled to separate counsel selected by the insured but paid for by the carrier to specifically represent the interests of the insured in matters that may or may not be covered under the policy.

7.1 Types of Agents

There are many systems insurance companies use to distribute (sell) their products. These distribution systems can typically be divided into five broad categories, including:

1. Career Agents
2. Brokers
3. Solicitors
4. Mass Marketing
5. Special Arrangements

Let's explore each of these.

7.2 Career Agents

The majority of career agents are recruited, trained, and supervised by the management of career agencies. These agencies are branches or general agencies of insurance companies organized to sell and service the company's products. Career agents are usually expected to sell a company's products exclusively, unless the primary company does not have a particular product or is unable to underwrite the business.

A career agency can be headed by a:

- manager, who is an employee of the company and has no ownership interest in the agency; or
- general agent, who has a vested right in the business written by the agents hired.

General agents usually spend more time in the personal sale of insurance than do managers, although this general statement is not universally true. There are different types of career agents, including:

- **Ordinary agents**, who are typically trained to tap the middle- and upper-income markets. This type of agent may be an independent contractor, not an employee of the company. Many ordinary agents are not required to sell the primary company's products exclusively. Rather, they are encouraged to sell the primary company's products through the compensation, incentive, and benefit programs the company offers to its career ordinary agents.
- **Personal-Producing General Agents (PPGAs)**, who typically do not develop career agents but primarily sell insurance. The PPGA is paid a commission, as well as general agent compensation on their own business, and is responsible for their own office and support staff expenses. PPGAs may have contracts with a number of companies, or they may deal primarily with one company.

- **Combination, debit, or home service agents**, who are given an assigned territory. They are expected to service the company's policyowners in that territory. This type of agent is also expected to sell additional products, both inside and outside this assigned territory. The home service agent is an employee of the company and is typically required to sell the company's products exclusively.
- **Multiple-line agents**, who represent companies that sell various lines of insurance, including auto, homeowners, life, and health. These agents can be exclusive (selling one company's products) or independent (representing a number of companies). With major life companies having property and casualty subsidiaries, many ordinary and home service agents can also sell multiple lines of coverage.

7.3 Brokers

In the brokerage system, an insurance company typically has a home office and field staff responsible for soliciting business from agents who are not the company's career agents. Thus, an agent can be a career agent with one company and a broker with another company.

Career agents generally "broker" business to take advantage of a product, price, or underwriting specialty that the primary company does not have available.

7.4 Solicitors

A solicitor is like an agent in that they prospect for insurance sales. A solicitor generally works with or for an agent or broker, soliciting sales on the agent's or broker's behalf. Unlike an agent, however, a solicitor has no authority to bind risks. To bind a risk, an agent collects premium to provide temporary coverage until a policy can be issued or denied.

7.5 Mass Marketing

Some companies deal directly with potential insureds using their own licensed salaried employees. These companies, which do not use "agents," are known as direct writers. Direct writers use the internet, direct mail, and/or advertising campaigns to reach large numbers of consumers. Application requirements are completed online or by mail. Historically, the amounts of coverage offered were small, but this is changing rapidly, with many direct writing companies offering as much as \$1 million of coverage through these channels.

7.6 Special Arrangements

Insurance products can be sold through special arrangements, generally not involving the use of an agent or broker. For example, credit life insurance can be sold by a variety of lenders, typically through a corporate agent.

Example: After considering all of my options, I decided to go to work in a career agency of the All Purpose Life Insurance Company, for whom I am a career ordinary agent. While I am an agent of All Purpose Life and primarily sell their products, I also am a broker with three other companies offering specialty products my clients occasionally need.

In addition to its life, health, and annuity products, All Purpose Life owns a property and casualty subsidiary and a securities subsidiary. As a result, I can also offer my clients property and casualty and investment products. In this sense, I'm a multiple-lines agent as well.

7.7 Licensing

A license is an authorization from the State Insurance Department allowing an agent or broker to sell a particular type of insurance in that state. The agent or broker must sit for and pass an examination to qualify for this privilege.

Licenses to sell investment products are required by the federal government and are obtained through The Financial Industry Regulatory Authority (FINRA). Some states also have additional licensing requirements for the sale of investment products. For insurance products, there are two types of licenses administered by the state:

1. Life and Health (including annuities)
2. Property and Casualty

An agent must pass the required licensing exam in order to obtain a permanent license. Pre-licensing study may be required by the state, and most states have continuing education requirements that must be satisfied before an agent may renew a license.

An agent's license is subject to renewal at specific intervals. A license is terminated at the death of the agent or cancellation of the appointment by the insurer. If terminated by death, some states issue an estate certificate of convenience to the heirs in order to carry on the agent's business until a permanent license is issued or the agent's business is wrapped up or sold.

Unlike an agent's license, a broker's license is not terminated at death but may be revoked by the state insurance commissioner or be cancelled by the insurer.

7.8 An Agent's Authority

An individual who legally represents another is called an agent. At one time or another, we've all dealt with a variety of agents, such as a real estate agent or a purchasing agent. These individuals represent another person or organization, known as the principal.

The relationship between an agent and the company they represent (the principal) is governed by agency law, which provides:

1. The acts of the agent, within the scope of their authority, are the acts of the principal.

The authorities granted include:

- express authority – defined in the agent's contract;
- implied authority – customary and necessary for the agent to conduct business; and
- apparent authority – the authority a third party can reasonably expect the agent to have.

For Example:

An agent informs a beneficiary that a life policy was in effect at the death of the insured, even though it is unknown to the agent that the policy had lapsed. It would be reasonable for the beneficiary to expect the agent to know whether the contract was in effect. The company, in this example, could very well be forced to pay the death benefit as if the policy were in full effect.

2. A contract completed by an agent on behalf of the principal is a contract of the principal.

For Example:

An agent issues a written binder, granting immediate protection for an automobile insurance application even though the agent had no authority to issue the binder. The proposed insured has an accident before the binder is cancelled by the company. The company is required to provide insurance protection for the accident because their agent issued a binder, thus completing a contract on their behalf. **The company has ratified the binder and is liable to provide the coverage it represents.**

3. Payments made to an agent on behalf of the principal are payments made to the principal.

For Example:

If an agent accepts a premium payment and then does not submit it to the company, the company must credit the premium payment as though it had been received directly by the company. Payment to the principal's agent is recognized as payment to the principal itself.

4. Knowledge that the agent obtained in the course of the principal's business is presumed to be knowledge of the principal.

For Example:

An applicant for health insurance tells the agent about a heart condition he had three years ago, but that information is not included on the application. The company issues the policy, which it cannot later cancel for concealment of a material fact since the agent's knowledge is the company's knowledge.

7.9 Agent Responsibilities

Agents are considered fiduciaries, someone in a position of trust. As a fiduciary, you are liable to your clients for your actions. To protect yourself and best serve your clients, you can assist them in identifying and evaluating their needs by:

- Using a thorough data-gathering process to identify their goals and objectives.
- Analyzing all of the financial information obtained in light of the client's goals and objectives.
- Recommending product solutions that will best meet the client's needs and ability to pay premiums and by explaining all of the coverages to the client.
- Submitting all applications and premiums promptly and correctly.
- Promptly delivering the policy to the client, including reviewing all policy terms and conditions.
- Periodically reviewing the client's policies and circumstances to determine if any changes or additions must be made in order to continue meeting the client's needs.

Which of the following is the first step in identifying and evaluating needs? Refer to Section 7.9, this page)

- A. analyzing information [Your answer is incorrect.]
- B. identifying goals and objectives [Your answer is correct. You should use a thorough data-gathering process to identify clients' goals and objectives.]
- C. recommending and explaining products [Your answer is incorrect.]
- D. submitting applications and premiums [Your answer is incorrect.]

7.10 Prohibited Sales Practices

Certain sales practices are prohibited, both by many insurance companies and by the states in their licensing of agents and regulation of insurance sales. These violations of ethical selling are punishable, possibly by dismissal or even criminal penalty.

The first of these prohibited sales practices is rebating. A rebate can be thought of as a kickback. Rebating occurs if an agent offers anything of significant value, including part of the agent's commission, to induce a buyer to purchase a policy. In nearly all states, an agent caught rebating is subject to serious punishment, as may be the person receiving a rebate.

For Example:

An agent who gives an applicant 25 percent of his commission earned on the sale is guilty of rebating, as is the agent who gives a gift of significant value.

The next prohibited sales practice is misrepresentation, a broad category of untrue or misleading statements, whether intentional or unintentional, committed or omitted. Policy misrepresentation occurs when an agent makes any written or oral statements that do not tell the exact truth about a policy's terms or benefits. Misrepresentation also occurs when an agent makes derogatory comments about a competing policy, agent, or company.

For Example:

An agent who states that dividends are guaranteed, whether done intentionally or unintentionally, is guilty of misrepresentation. An agent who falsely tells a prospect that a competing company does not pay its claims is also guilty of misrepresentation and possible defamation.

The best way to avoid misrepresentation is to:

- become thoroughly familiar with the products you sell;
- use only company-approved sales illustrations and literature; and
- concentrate on the merits of your products, company, and services when you are facing competition.

A third prohibited sales practice is known as twisting. This is the act of persuading a policyowner to drop a policy solely for the purpose of selling that person another policy, through misrepresentation or distortion of the facts.

For Example:

An agent persuades a policyowner to drop one permanent insurance policy and purchase another by understating the cash value schedule of the existing policy.

Keep in mind that the act of twisting should not be confused with policy replacement. The replacement of one policy with another is not prohibited, provided the policyowner is given a complete and accurate comparison of the two policies and specific requirements of the state are met. Replacement can frequently be to the policyowner's advantage. A new policy might provide the same benefits for a lower cost or more benefits for the same cost.

For Example:

When an existing disability income policy is compared with a new one, it is found that the new policy provides a higher monthly income benefit with a more liberal definition of disability for the same premium as the existing policy. In this case, replacement may be to the policyowner's advantage and may be appropriate.

State regulations concerning an agent's handling of premiums are also very strict. Diverting premiums for an agent's personal use is prohibited. Premium dollars should not be commingled (mixed) with an agent's personal funds in any way, and accurate records of premium money should be kept. Agents who mishandle premium funds face possible criminal penalties and/or loss of license.

7.11 Agent Compensation

In an insurance sales career, earnings are determined by sales results. The higher an individual agent's initiative, drive, and performance, the higher their income will usually be.

The two basic forms of compensation that agents receive from insurance companies are:

1. Commissions
2. Bonuses

Let's review each in detail.

Commissions are payments made to agents for transacting business or performing a service, usually paid as a percentage of the premium generated. There are two types of commissions and a service fee that generally make up an agent's compensation.

1. **First-Year Commissions:** A percentage of the first-year's premium paid for the policy, generally ranging from 15 percent to 55 percent depending on the type of policy and the company.

For Example:

1st-yr premium	\$2000
----------------	--------

1st-yr commission rate	<u>x 55 percent</u>
1st-yr commission to agent	\$1100

The policy must be paid-for. That means it is accepted by the policyowner and the first premium is paid. Only then is the first-year commission payable. Written policies, policies that have been issued but not yet accepted and paid-for by the policyowner, generally do not yet qualify for the payment of commissions. This is why agents are so anxious to have their policies issued and paid-for.

In addition, some companies "annualize" first-year commissions, paying the full first-year commission before all of the actual first-year premiums are received.

For Example:

Semi-Annual Premium x 2 = 1st-year premium
 Quarterly Premium x 4 = 1st-year premium
 Monthly Premium x 12 = 1st-year premium

2. **Renewal Commissions:** A percentage of each premium paid after the first year's premium, for a specified number of years. Renewal commissions are commonly payable for nine years and generally range from 3 percent to 10 percent, depending on the product, the policy year, and the company.

For Example:

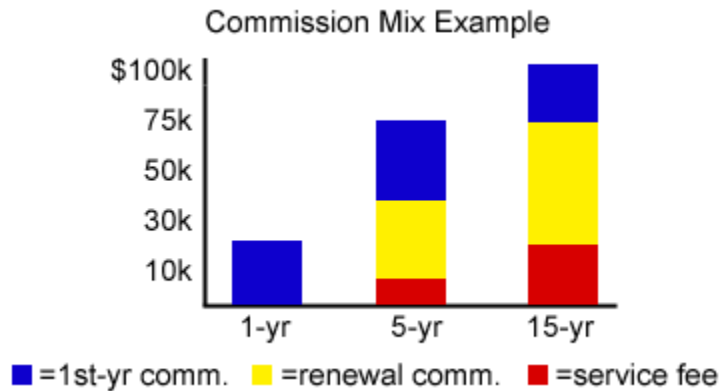
<u>Policy Years</u>	<u>Renewal Commission Rate</u>
2-4	10 percent
5-10	3 percent
\$1,500	3rd-year premium
<u>x 10 percent</u>	renewal commission rate
\$150	renewal commission

3. **Service Fees:** After all renewal commissions have been paid, or when renewal commissions are payable, some companies pay a service fee on certain products. This is a small percentage, 1 percent or 2 percent, of each premium as it is paid in order to compensate the agent for continuing to provide service to the policyowner.

For Example:

<u>Policy Years</u>	<u>Service Fee Rate</u>
11+	2 percent
\$1,800	15th-year premium
<u>x 2 percent</u>	service fee rate

At first glance, renewal commissions and service fees might not appear to be much, but as an agent builds a career and a book of business, they can earn a steady and increasingly valuable source of income. Renewal commissions and service fees form an income foundation to which agents can add first-year commission earnings.



In addition to commissions, agents can earn bonuses. These bonuses are generally paid in a lump sum and are structured to encourage agents to write good quality, profitable business that stays in force. The two most common types of bonuses are:

1. **Persistency Bonus:** The higher the agent's persistency rate (the percentage of policies remaining in force for a specified period of time), the higher the bonus paid.
2. **Loss Ratio Bonus:** On property and casualty policies, the lower the losses paid by the company on an agent's book of business, the higher the bonus.

In addition to monetary incentives, many companies provide their agents with a package of fringe benefits, either on an employer-pay-all basis or on a contributory basis. These fringe benefits are generally provided only to a company's agents, not to its brokers. Brokers, in turn, may be paid a higher commission rate.

Once an agent becomes established, the commission concept works very nicely. However, beginning a career can be frightening. As a result, some companies with career agencies provide a plan of subsidy and support payments during the initial phase of an agent's career. The variations in these new agent financing plans are almost infinite and depend on the philosophy of each company toward the development of new agents.

In general, these financing plans will pay the new agent a stipulated weekly or monthly amount, based on the new agent's income needs and potential, for a specified period of time. This amount may be considered an advance against future commissions the agent will earn, or it may be an outright subsidy. Over time, this training subsidy is generally scaled down, with the subsidy gradually being replaced by commission income.

An agent can remain under the new agent finance plan for a specified period of time, such as two or three years, at which time the agent "graduates" to a straight commission contract. In return for the subsidies provided during the training period, companies generally require that the new agent meet minimum performance standards in order to remain under the plan. These

standards can be based on first-year commissions earned, on the number of applications written, or both. Minimum performance standards are frequently referred to as validation requirements.

Companies with new agent finance plans are willing to make an investment in the development of successful new career agents. These companies know that, if a new agent is to be successful, they must be capable of generating business at a certain level. Validation requirements are generally the minimum levels of production a new agent needs to achieve in order to demonstrate the potential for future success. If a new agent cannot achieve these minimum performance standards, it is probable a career in insurance sales is not for that person.

Many companies also provide a catalyst for new agents in the form of incentives or bonuses. While these vary widely, they generally have a common purpose—to encourage the agent to get off to a fast start by rewarding performance in excess of the validation requirements.

Since experience has shown that new agents who get off to a fast start are more likely to succeed, companies are willing to encourage and reward this type of performance through monetary incentives.

7.12 Agency Law

Up to this point, you have learned how an agent can be liable either through contracts or through the commission of a tort. Liability for both of these can reach an agent even though the agent was not directly involved in the act by virtue of the agent's relationship to the parties of the contract or to the person committing the tort. This part of the course explores the law of agency and the responsibilities or duties of parties to an agency agreement.

7.12.1 Creation of an Agency

An agency is created anytime one party agrees to act for the benefit of another. As a rule, the agent is put in place of the person being represented (the principal) and acts of the agent are considered to be acts of the principal. As with contracts, the parties to an agency agreement must generally have the capacity to enter into it. An exception is when a principal is incapable of acting for themselves and a legal guardian is appointed to act on their behalf. Incapacity of the agent, on the other hand, always renders the agency agreement void. For the most part, anything principals can do for themselves can be delegated to an agent. Exceptions are making statements under oath, signing a will, voting, and some types of personal service (lawyers, doctors, artists, etc.).

7.12.2 Agency Authority

An agent has two types of authority: actual and apparent. Actual authority must be communicated to the agent either expressly or by implication. An express communication is anything written or verbally given to the agent that details their duties. Implied authority would include anything that is reasonably necessary for an agent to do in order to carry out the duties in their express authority.

For Example:

Vern's agency agreement with Zeta Casualty states that Vern can bind the insurer to any line of insurance for which the agency agreement shows a commission. Implied in that express grant of authority is the implied authority to issue certificates of coverage to third parties.

Apparent authority comes about when acts of the principal have led a third party to reasonably believe that the agent has authority.

For Example:

Assume that Zeta Casualty decided to terminate its relationship with Vern but neglected to pick up blank policies and signs from Vern's office that bore Zeta's logo and name. Upon entering Vern's office, a third party might reasonably believe that Vern still represented Zeta. A coverage binder issued by Vern could be effective against Zeta in those circumstances.

Scenario:

Edwin Eagle gave his credit card to his assistant during a business trip. He told her only to use the card for a car rental and for hotel lodging. After Edwin returned from the trip, he found that his assistant had made 15 unauthorized uses of his card. For 13 of these purchases, his assistant signed Edwin's name to the charge slip; for the other two, she signed her own name. Edwin eventually obtained a \$3,200 judgment against his assistant but was only able to collect \$750 on that judgment. After the credit card issuer refused to cancel his assistant's unauthorized charges, Edwin sued for a declaration that he should not be liable for those charges. The trial court ruled in the credit card issuer's favor on all 15 charges, and an appellate court ruled in the bank's favor on the 13 charges his assistant signed in Edwin's name. Edwin appealed this ruling. Edwin argued that he had the right to expect his assistant to use the card only for the charges he authorized, and that he cannot be liable for her acting beyond the scope of her authority. He further argued that his assistant could not reasonably present herself as Edwin Eagle and that a merchant should be required to give greater scrutiny to the person using the card.

Question: Does Edwin's argument have merit?

Answer: No. By voluntarily giving his assistant the card, Edwin placed her in position to mislead third parties into believing that she had the authority to use the card. Note: The \$50 limit on unauthorized use of credit cards under the Truth in Lending Act does not apply when third party charges are made with actual, implied, or apparent authority.

7.12.3 Types of Agency

Agents may be general, special, or sub-agents. A general agent is one appointed to conduct a series of transactions on behalf of a principal. Most insurance agents are general agents. A special agent is one appointed to perform a specific duty on behalf of a principal. An insurance agent who deals with a non-admitted insurer for the single purpose of obtaining surplus lines coverage for a client is acting as a special agent for that insurer. Sub-agents occupy a dual role.

They are agents of the originating agent's principal and also represent the agent themselves.

7.12.4 Duties of Agent to Principal

When an agency is formed by contract, the agent is obligated to perform the duties called for in the contract. Regardless, the law recognizes several other duties owed by an agent whether or not they are spelled out in the contract.

7.12.4.1 Duty of Loyalty

An agent's interest must be subordinated to the interest of his principal. This means that the agent must avoid situations where there is a conflict of interest between the two. Thus, an agent cannot, for example, sell the principal's property to themselves unless the principal is aware of it and consents. Similarly, an agent may not compete with the principal unless, again, the principal is aware of the situation. Independent insurance agents often represent multiple insurers who compete with each other, but the insurers are aware of the situation. A captive agent, on the other hand, usually represents only one insurer and would not be allowed to place business with another absent the insurer's consent.

Because an agency is founded on trust, an agent must also avoid disclosing confidential information about the principal even after the agency relationship has ended.

Scenario:

Derrick Dial is an agent handling all lines of insurance. In October 2023, Dial hired Fletcher Fall as a claims representative. Fall's responsibilities included the investigating and settling of all claims within the agency's authority, according to the agency agreements Dial had with insurers. Fall had no sales responsibilities, though he had an insurance license prior to his employment with Dial, which he personally maintained. The employment lasted until July 2024, when Fall either quit or was fired.

Prior to leaving Dial's employ and without his knowledge, Fall took various steps to form and operate a risk management business that competed with Dial's business. Most importantly, he obtained three clients and performed work for them during that period. He also solicited a fourth account but did no work for that firm until after ceasing to work for Dial. None of these businesses was an existing customer of Dial. In addition, Fall's soliciting activities did not take place during his regular working hours, which he devoted to Dial's business. Dial sued Fall for breach of his agent's duty of loyalty.

Question: Did Fall breach his duty of loyalty to Dial?

Answer: Yes. An employee owes a duty of loyalty to the employer and must not, while employed, act contrary to the employer's interest. Unless otherwise agreed, an agent is subject to a duty not to compete with the principal concerning the subject matter of his agency. By engaging in a competitive enterprise, Fall crossed the line between permissible preparation to change jobs and actionable conduct. Dial was entitled to expect that a person on his payroll would not undertake to pursue competitive commercial opportunities. The protection accorded is

not limited to the diversion of an employer's customers. It extends to pursuing and transacting business within the larger pool of potential customers who might have been solicited by the employer.

7.12.4.2 Duty of Obedience

As a rule, agents must follow the lawful instructions of their principal, unless the instructions conflict with the ethical rules of their profession.

Scenario:

Jarred Joy arranged for a Florida vacation package for himself and his sister with Sunny Destination Travel, a travel agency. The travel agent selected a *Fly Me Away Air* package that included *Fly Me Away Air* vouchers for a rental car, hotel, and theme park tickets. Aware of the labor and other problems *Fly Me Away Air* was experiencing at that time, Joy's sister contacted the agent several times requesting that all the arrangements be made with another airline. The agent assured her that the flights could be changed and that the vouchers would be honored. After *Fly Me Away Air* went into bankruptcy, the agent arranged for Mr. Joy and his sister to be transported to Florida on a different airline. After they arrived, however, the providers of the voucher bookings refused to honor *Fly Me Away Air's* vouchers.

Question: Did the agent breach a duty to Mr. Joy (and his sister)? If so, which one? You can assume that the travel agent was acting for both Mr. Joy and his sister, and that the communications to the agent by Mr. Joy's sister were communications to an agent by his principal.

Answer: Yes, the agent did breach a duty to Mr. Joy and his sister. The agent breached the duty "to obey all reasonable instructions and directions in regard to the manner of performing a service that they have contracted to perform and to adhere faithfully to them in all cases where they ought properly to be applied and in which they can be obeyed by the exercise of reasonable and diligent care." The agent breached this duty by failing to arrange for suitable substitute vouchers. It appears that the duty to act with care and skill may have been breached here as well.

7.12.4.3 Duty to Act with Care and Skill

A paid agent must exercise the level of skill that is normally expected of one in that occupation. An unpaid, or gratuitous, agent needs to only exercise the level of skill possessed by a reasonable person not in the occupation of a paid agent. Paid agents are usually held to a higher standard of care than non-paid agents. As with any contractual arrangement, the agent and principal may change the level of care required by mutual agreement.

7.12.4.4 Duty to Notify the Principal

Related to the duty to act with care and skill, an agent is expected to advise his principal of any matters that are related to the agency agreement and which he knows or reasonably should know would be of interest to his principal. This duty ends, however, if the information is privileged and was obtained from another confidential source. An agent, for example, is not obligated to tell one insurer of the pricing policies of another insurer the agency represents

regarding an account both insurers desire.

Scenario:

Blanche Dubois bought her daughter a round-trip plane ticket from New York City to Rome from Around the World Travel, Inc. Upon arriving in Rome, Mrs. Dubois' daughter was denied entry and was placed on the next return flight to the United States because she did not have a visa. The apparent reason for the visa requirement was the Italian government's effort to deal with terrorist activities directed at Americans abroad. Neither Mrs. Dubois nor her daughter was aware of the requirement; indeed, a few years earlier, Mrs. Dubois had traveled to Italy without being required to present a visa. Dubois sued Around the World for failing to notify her about the visa requirement. Around the World moved to dismiss her complaint.

Question: Did Around the World breach an agent's duty of notification to its principal?

Answer: Yes. It was reasonable to expect Around the World to alert its principal to important changes in the visa requirements of foreign nations. It was also reasonable for Mrs. Dubois to rely on Around the World to supply this information. The travel agency was clearly in a position to assemble and disseminate this basic and significant type of travel information.

7.12.4.5 Duty to Account for Money and Property

An agent must account for all money and property received or distributed in the principal's interest. Agents may not mix their personal property with property held for the principal without the principal's approval. This means that agents may not mix (commingle) their personal or business funds with insurance premiums collected by them unless the insurer gives its permission. Some state insurance laws may not allow this even if the insurer is willing.

Scenario:

Equipment Merchants, Inc. was an agent for Frank Holman. Hollis Bryce was Equipment Merchants' president and sole employee. Holman instructed Bryce to accept payment for the sale of some equipment owned by Holman, to deduct his commission from the payment, and to wire the remainder to Holman. Instead, Bryce diverted the funds to his own purposes and refused to pay Holman the amount due. When sued individually for breach of the agent's duty to obey, Bryce argued that Holman had employed Equipment Merchants as its agent, that he was merely an employee of Equipment Merchants, and that he thus owed no duty to Holman.

Question: Is Bryce correct?

Answer: No. Bryce was a subagent of his corporation. Where the agent is authorized to appoint a subagent, the relation of principal and agent exists between the principal and the subagent. Since the agent has a duty to obey the principal's instructions, the subagent (Bryce) likewise has such a duty. A subagent who is aware of the principal's existence owes the principal all the duties an agent owes his principal, except those created only by the contract between the original principal and the agent.

7.12.5 Duties of Principal to Agent

The law implies that certain duties are owed by the principal to an agent even if the duties are not included in the written agency agreement.

7.12.5.1 Duty to Compensate

An agent's compensation is the consideration a principal offers when the agency contract is formed, and the amount is typically covered in the agency contract or an addendum to it. Without compensation, there would be no contract. But, a principal is not required to compensate an agent who has materially breached the agreement. There is, of course, no duty to compensate a gratuitous agent.

7.12.5.2 Duty to Reimburse and Indemnify

An agent is entitled to reimbursement for any expenses or losses incurred while acting on the principal's behalf, but a principal is not required to indemnify an agent because of losses resulting from unauthorized acts or from the agent's own negligence.

7.12.6 Agency Termination

An agency agreement can be terminated in several ways, loosely grouped under **termination by act of the parties involved** and **termination by law**.

7.12.6.1.1 Termination by Act of the Parties

- When the agency agreement specifies that it will end at a certain date or upon a certain event such as the achievement of a specific result (like the sale of a house).
- When the agent and principal mutually agree to end the relationship or when either party unilaterally decides to end it. However, in the latter case, the terminating party may be liable for damages to the other.

7.12.6.1.2 Termination by Law

- When either the principal or agent dies.
- When there has been a change in business conditions dealing with the subject matter of the agreement (as when the value of property to be sold drops significantly, the supply of property to be purchased declines, or the property has been destroyed).
- When changes in the law make the agency business illegal (as when the Volstead Act made the sale of alcoholic beverages illegal).
- When either the principal or the agent is bankrupt (if the agent's bankruptcy affects his ability to represent the principal).

7.12.6.1.3 How Termination Affects an Agent's Authority

An agent's authority ends when an agency is terminated. That includes the express authority as well as any implied authority that went with it. However, an agent may retain apparent authority as previously discussed. Apparent authority ends whenever there ceases to be a reasonable basis for a third party to believe the agent still represents the principal. It also ends if the

principal dies or loses mental capacity.

7.13 Relationship of Principal and Agent to Third Parties

Much of the discussion on the nature of agency to this point has focused on the relationship between an agent and the principal and the responsibilities of one to the other. However, both the agent and the principal usually have responsibilities to third parties as well because the purpose of most agencies is to create contracts with third parties for the principal.

7.13.1 Ratification

If an agent or someone claiming to be an agent acts without authorization, a principal may yet bind himself to an agreement by ratification. Ratification can be express or implied. An express ratification would be words by the principal indicating his intention to be bound by the agreement. Implied ratification comes about when the principal's behavior indicates an intent to be bound to the agreement. An example would be a principal's partial performance of a contract made by an agent even though the agent did not have the authority to make the contract.

7.13.2 Contractual Liability of an Agent to Third Parties

An agent's liability to third parties depends upon whether or not the third party is aware that the agent is acting on behalf of another. If the principal is disclosed to the third party, the agent is not liable on contracts made for the principal. If the third party knows that the agent is acting for another but does not know who the principal is (a partially disclosed principal), then the agent is liable on those contracts. The same is true if the principal is not disclosed and the third party has no reason to believe the agent is acting for another (undisclosed principal). The agent's liability for contracts they make is further conditioned by the extent to which the contracts are made within the agent's authority, as the following table shows. (Mallor et al. 2000)

Principal	Agent's Authority		
	Actual (express and implied)	Apparent	No authority
Disclosed	Principal liable Agent not liable	Principal liable Agent not liable	Principal not liable Agent usually liable
Partially Disclosed	Principal liable Agent liable	Principal liable Agent liable	Principal liable Agent liable
Undisclosed	Principal liable Agent liable	Impossible – there can be no apparent authority if the principal is undisclosed	Principal liable Agent liable

Scenario:

Tanya Malloy was the sole shareholder, director, and president of RM Agency, Inc., an Illinois Corporation. On various occasions, Mercer, Inc. sold Malloy and/or RM Agency office equipment and supplies. To all appearances, Mercer gave little thought to the party with whom it

was dealing. Initially, its records listed Tanya Malloy as the customer; later, this was changed to RM Agency, but without any indication that RM Agency was a corporation. The checks with which Malloy paid for her orders and her firm's stationery bore the name RM Agency but likewise did not indicate that the firm was a corporation. Eventually, Malloy did not pay for a shipment from Mercer, and Mercer sued her personally for damages in an Illinois trial court. Malloy's defense was that only the corporation was liable. After the trial court awarded Mercer \$1,530 in damages, Malloy appealed.

Question: Is Mercer or Malloy correct?

Answer: Mercer. Unless the parties agree otherwise, an agent who enters into a contract for an undisclosed or a partially disclosed principal is personally liable on the contract; an agent who contracts on behalf of a disclosed principal is not personally liable on the contract. The trial court found as a fact, with adequate support in the record, that Mercer was not informed and did not know that RM Agency was a corporation. The record gives no indication that Mercer was informed of other facts from which it had reason to know that RM Agency was a corporation. If Malloy was acting as an agent for her corporation, she was an agent for an undisclosed or partially disclosed principal and she was therefore personally liable on its purchase contracts.

7.13.3 Tort Liability of a Principal to Third Parties

7.13.3.1 Respondeat Superior

When an agent is an employee of the principal, the doctrine of respondeat superior (literally "let the master answer") makes the employer/principal liable for intentional and unintentional torts of the agent, provided four conditions are met.

- The employee's injurious conduct was of the type that the employee was hired to perform.
- The injury occurred substantially within the employee's work period.
- The injury occurred substantially within the location of employment.
- The injury was motivated at least in part by the purpose of the employment.

Scenario:

Martin, the president of Martin Insurance, was talking with Behm, a new sub-agent, about Behm's first week with Martin. Behm told Martin that he had hit one of Martin's customers in the customer's store. The blow came after Behm and the customer got into an argument, during which the customer ordered Behm out of his store. In striking the customer, Behm was motivated at least in part by a feeling that no Martin employee should have to endure such disrespect. Then, Behm also told Martin that he had gotten into an accident while driving a company van. The accident occurred after Behm negligently ran a stop sign while thinking about the fight. The driver of the other car was seriously injured in the accident.

Question: Assuming that Behm is an employee, is Martin liable to the customer for any battery Behm committed, and/or to the driver of the car for Behm's negligence?

Answer: Battery – no; car accident - yes. There is nothing in the question to suggest Martin's

direct liability with respect to Behm, so the only way Martin can be liable is through the doctrine of respondeat superior. These are two separate cases. It was stipulated that Behm is an employee. Behm's negligent auto accident was pretty clearly within the scope of his employment. He was performing an act of the kind he was employed to perform at the time of the accident (driving to see a customer), he was within the time and space limits of the employment, and he apparently was motivated by a desire to serve his employer. However, Although the answer is less clear, Martin probably is not liable for any battery Behm may have committed. This is true even though respondeat superior includes intentional torts, and even though Behm was within the time and space limits of the employment. Behm's blow probably was not an act of the kind he was employed to perform. If an employee intentionally uses force on another, the presumption is that this must not have been expected by the employer to be within the scope of employment, but this should be investigated further.

7.13.3.2 Direct Liability

As you have seen, a principal can be liable due to the negligence of an employee under the doctrine of respondeat superior, but a principal is directly liable for the conduct of an agent whether or not an employee when the principal actually directed the conduct and intended the results. Most often, this is a case of the principal's negligence rather than that of the agent's. Examples include:

- When the principal has given incorrect or vague instructions.
- When the principal has failed to set and enforce reasonable regulations to control the agent's conduct.
- When the principal was negligent in selecting the agent or removing an unsatisfactory agent.
- When the principal furnished the agent with improper tools and equipment.
- When the principal failed to properly supervise the agent.

Scenario:

Lillian was injured on October 14, 2022, when a vehicle owned by Walter Woods was accidentally driven over her foot. The vehicle was insured by Kappa. Its claim adjuster, Mr. Wheeler, investigated the accident, and on September 21, 2023, offered Lillian \$5,000 in settlement for Lillian's injuries, noting that he had been "following closely with the attending physicians . . . Lillian's progression with respect to her injury." Lillian rejected the offer. On December 28, 2023, Kappa offered to settle the claim for the policy liability limit of \$25,000. Wheeler's letter to Lillian accompanying that offer confirmed that the no-fault Personal Injury Protection provisions under Woods's policy would continue to cover Lillian's medical expenses to a limit of \$30,000. Lillian accepted this offer in April 2024 and settled her claim with Kappa. Thereafter, Lillian retained counsel and sued Kappa for damages, alleging that the initial \$5,000 offer was unreasonable and made in bad faith. Lillian alleged in her complaint that Kappa's initial low offer constituted "a breach of contract, actual fraud, constructive fraud, deceit, negligence, a breach of the implied covenant of good faith, arbitrary, unreasonable, and vexatious conduct, and bad faith." Lillian sought compensatory damages of \$25,000, exemplary damages of \$50,000, attorney fees, and costs.

Question: Will Lillian be successful in this suit?

Answer: No. An insurer has a duty to act in good faith in its relationships with its policyholders. Lillian had no contractual right under the insurance policy to directly sue Kappa; she had only a potential tort claim against Woods, Kappa's insured. Absent a clause in the insurance contract bestowing the right to bring a direct action against the insurer, an injured party's claim must be asserted against the tortfeasor, not the tortfeasor's insurer. An insurer's duty of good faith and fair dealing is owed to the insured, but not to third party claimants.

7.13.3.3 Liability for Acts of General Contractors

The general rule is that a principal is not liable for the acts of a general contractor, but there are exceptions.

1. A principal may be liable if the principal was negligent in hiring the contractor (i.e., hiring a contractor who was clearly unqualified to do the work).
2. A principal may be liable if the contractor was performing a duty that the principal could not legally delegate to the contractor.

For Example:

A landlord has a duty to keep the premises reasonably safe for occupants. The landlord cannot escape the duty by hiring an independent contractor to make repairs. If the repairs are faulty, the landlord retains liability. The landlord may (emphasis on "may") be able to recover a loss from the contractor, but that in no way eliminates the landlord's responsibility.

3. A principal may be liable for damage caused by an independent contractor hired to perform extremely dangerous activities. Assume that a building owner hires a contractor to demolish a building in an area exposed to the public. If the contractor fails to warn people and take reasonable steps to keep them at a safe distance, the building owner is liable.

7.13.3.4 Liability for Agent's Misrepresentation

A principal is directly liable for misrepresentations an agent makes if the principal intended for the agent to make the misrepresentation. Even if the principal did not so intend, they may still be liable if the agent had actual (express or implied) or apparent authority to make true statements about the subject. An insurance agent who makes false statements about the coverage provided by an insurer the agent represents has exposed that insurer to liability.

Principals may attempt to avoid liability by requiring that any contract an agent makes with a third party includes an exculpatory clause, but an exculpatory clause will not protect a principal who nevertheless intends or expects that the agent will make false statements.

7.13.3.5 Tort Liability of the Agent

As a rule, any agents are liable for any torts they commit unless:

1. The agent is exercising a privilege of the principal. Assume that Thomas grants Moller the right to enter his land for the purpose of prospecting for oil and Moller engages Harris to do the survey work. Harris would not be liable for trespass on Thomas's land as long as he is operating within the scope of authority given by Moller.

2. The agent is defending the life or property of the principal. An agent who uses deadly force to protect the principal would not be liable for injuries because the principal would have that same right. However, an agent who sets a booby-trap to protect the property of a principal would be liable (just as the principal would if he had set the trap) because deadly force is not permitted to protect property – only to protect life.
3. The agent who makes innocent misrepresentations in the conduct of the principal's affairs is not liable. Note the emphasis on "innocent." An agent who is aware of the falsity of the statements or who should reasonably have been aware will not escape liability.
4. The principal provided the agent with defective tools and the agent was unaware and did not have reason to be aware of the defect.

7.13.3.6 Suits Against the Principal and Agent

On occasion, both the agent and the principal are jointly and severally liable. Joint and severable liability means that the plaintiff can sue either party or both parties for the full amount of the claim. This can happen where both the agent and the principal were independently negligent in causing the loss.

Section Review:

1. An insurer that issues a certificate of insurance for an insurance binder even though the agent was not authorized to issue that binder has the binder: Refer to Section 7.8, page 145

- A. Denied **[Your answer is incorrect. The insurer has not denied the binder.]**
- B. Mitigated **[Your answer is incorrect. The insurer has not mitigated the binder.]**
- C. Ratified **[Your answer is correct. The insurer has ratified the binder and is liable to provide the coverage it represents.]**
- D. Exorcised **[Your answer is incorrect. The insurer has not exorcised the binder.]**

2. A disclosed principal is one who is _____ .

Refer to Section 7.13.2, page 156

- A. known to the agent. **[Your answer is incorrect. A disclosed principal is not one who is known to the agent.]**
- B. Publicly listed on the stock exchange. **[Your answer is incorrect. A disclosed principal is not one who is publicly listed on the stock exchange.]**
- C. Has brand name recognition. **[Your answer is incorrect. A disclosed principal is not one who has brand name recognition.]**

D. known to the third party. **[Your answer is correct. A disclosed principal is one who is known to the third party.]**

3. All of the following are considered agents EXCEPT: Refer to Section 7.2, page 143

A. Ordinary Agents **[Your answer is incorrect. An ordinary agent is considered an agent.]**

B. PPGAs **[Your answer is incorrect. PPGAs are considered agents.]**

C. Combination Agents **[Your answer is incorrect. Combination agents are considered agents.]**

D. Solicitors **[Your answer is correct. Solicitors are not considered agents.]**

4. All of the following are prohibited sales practices EXCEPT: Refer to Section 7.10, page 146

A. Twisting **[Your answer is incorrect. Twisting is a prohibited sales practice.]**

B. Rebating **[Your answer is incorrect. Rebating is a prohibited sales practice.]**

C. Misrepresentation **[Your answer is incorrect. Misrepresentation is a prohibited sales practice.]**

D. Replacement **[Your answer is correct. Replacement is not a prohibited sales practice.]**

5. Which of the following acts may NOT be delegated to an agent? Refer to Section 7.12.1, pages 150-151

A. Buying the necessities of life (food, shelter, and clothing). **[Your answer is incorrect. The purchase of necessities may be delegated to an agent.]**

B. Making a contract for purchase of goods over \$500. **[Your answer is incorrect. The authority to make contracts for goods valued at more than \$500 may be delegated and many are.]**

C. Signing a will. **[Your answer is correct. Of the four choices available, signing a will is the one task that cannot be delegated.]**

D. Purchasing a home. **[Your answer is incorrect. Purchasing a home may be delegated to an agent.]**

6. Apparent authority is created by_____.

Refer to Section 7.12.2, page 151

A. Acts of the principal. **[Your answer is correct. Apparent authority results from those actions of the principal that would lead a reasonable third party to believe that an agent has authority to act.]**

B. Acts of the agent. **[Your answer is incorrect. Apparent authority is not created by acts of the agent.]**

C. Acts of a third party. **[Your answer is incorrect. Apparent authority is not created by acts of a third party.]**

D. Acts of law. **[Your answer is incorrect. Apparent authority is not created by acts of law.]**

7. Which of the following acts violates a duty owed by an agent to a principal? Refer to Section 7.12.4.5, page 154

A. Failure to disclose information about other clients the agent represents. **[Your answer is incorrect. An agent is under no obligation to reveal facts about other principals the agent represents.]**

B. Commingling of funds without the principal's permission. **[Your answer is correct. An agent must have permission to mix personal funds with funds belonging to the principal, though this is an illegal practice in some states even with permission.]**

C. Failure to act on the principal's behalf with the highest possible standard of care. **[Your answer is incorrect. An agent is not required to act according to the highest possible standard of care but to the standard of care that is reasonable.]**

D. Failure to obey instructions of the principal even if the instructions violate the law. **[Your answer is incorrect. An agent is under no obligation to obey instructions that violate the law.]**

8.0 The Current State of the Property and Casualty Industry

Technology is rapidly changing many facets of the insurance industry. The newest generation of insurance consumers—the Millennials and Gen Zers—are tech-savvy and expect simpler and faster buying experiences. Recognizing that technology has to be a big piece of their sales pitch to appeal to these groups, many insurers are investing in new technologies to make the buying experience easier, more efficient, and automated.

One of the primary changes that insurance companies are taking to modernize their

operations is the growth of online portals, which is changing the way many consumers shop for insurance. Because many consumers today prefer to research and purchase insurance online and expect to be able to access information about their policies electronically, many insurers have developed mobile apps that customers can use to accomplish a variety of tasks: locating agents, calculating retirement income, requesting policy quotes, and checking on claims status, among other things. According to J.D. Power's 2024 U.S. Insurance Digital Experience Study, over half (53%) of first-time insurance consumers begin their relationships with auto insurers digitally via their websites and/or mobile apps. Digital tools also appeal to 42% of those looking to switch insurers and to 46% of existing policyholders. Furthermore, J.D. Power found in its 2024 U.S. Insurance Shopping Study that Gen Zers have the highest switch rates, making it more important for insurers to evolve their online offerings to help appeal to and retain these policyholders.

Many insurers' agents, adjusters, field underwriters, and loss-control specialists are also using tablet devices to streamline the policy application and claims settlement processes and take advantage of available technology. Insurance professionals can instantly view and illustrate various insurance products on these devices and access information from an insurer's website to answer questions or provide examples. Advisors can now conduct an entire sales cycle in one meeting through their tablets: They can provide details about a product, collect client information, obtain e-signatures, and submit applications. Cloud-based software has also enabled insurance professionals to seamlessly move data from their desktop computers to tablets and back again, making the insurance sales and claims process easier for all parties.

Several insurers have launched voice ID technology so that customers no longer have to enter passwords when they call an insurer's customer service lines. Instead, once a customer enrolls in the voice ID service, they must simply repeat a simple passphrase to access their accounts. According to insurers, voice ID is more secure than having to enter a password or PIN, since it would be difficult to fake a voice in a manner that would fool a computer.

As these examples show, technology is significantly impacting the insurance industry. According to a recent study, Accenture's "Technology Vision 2025 – AI: A Declaration of Autonomy," artificial intelligence (AI) will continue to transform the business world, including the insurance industry. More than 4,000 executives were surveyed around the world, with over 500 based in the U.S. According to the report, 76% of surveyed executives believe that conversational interactions using artificial intelligence will help gather relevant customer context. Many organizations are also planning to incorporate AI agents into their daily operations, such as accessing internal data, building workflow automations, and connecting to third-party systems. Depending on the specific function, 29% to 48% have implementation goals of three years and 52% to 71% have goals of four or more years.

The report notes the importance of understanding AI on a deep level. Why? "Because the rate of AI's technology diffusion is unprecedented and the pace is only increasing—

creating new opportunities for reinvention across the enterprise—including new ways of achieving efficiencies, operating the core of businesses, new business models and new ways of engaging with customers.”

Stakeholders on all sides of the insurance industry – businesses (insurers), workers (agents, underwriters, adjusters, etc.), governments (regulatory bodies), and customers (policyholders) – can use AI to alter operations, enhance customer experience, and ultimately transform the way the industry works. This may manifest, according to the report, in the following ways:

- **For individuals:** AI can tailor itself to an individual’s preferences based on their interactions, helping them understand their jobs and/or achieve the level of service and customization they require.
- **For businesses:** AI can capture a business’s knowledge, unique differentiators, culture, and persona to orchestrate key operations.
- **For industries:** AI can shape industries by creating common frameworks and communication standards and addressing major challenges.
- **For governments:** AI can combine factors such as knowledge, language, culture, laws, and security so industries, businesses, and individuals can engage at all levels.

While executives appear to be pushing AI development and adoption into the future, workers are already incorporating automated tools into their daily workflows. In fact, the 2024 Work Trend Index Annual Report from Microsoft and LinkedIn found that three out of four people (75%) are already using AI at work. Survey respondents, which includes 31,000 workers across 31 countries, report that AI helps them save time (90%), focus on the most important tasks (85%), be more creative (84%), and better enjoy their work (83%).

Adopting AI has its challenges, though, including high upfront costs, quality of data, and the need for new talent and skills. According to Accenture’s report, the largest challenge businesses are facing is trust, with 77% of executives believing they won’t see the full benefits of AI until there is a foundation of trust. The report states, “Leaders must build trust in digital systems and the AI models, with customers and the workforce by ensuring accuracy, predictability, consistency and traceability over and above the responsible use of AI. People’s trust in AI that it will perform as expected and justly—beyond any technical aspect— is an essential component that we must get right.”

This level of trust starts with internal operations. Although a vast majority of employees are relying on AI to complete their day-to-day tasks, over half are reluctant to share this information for fear that it makes them look replaceable, according to Microsoft and LinkedIn’s Work Trend report. Accenture points out that this isn’t a question of trust in the technology but rather trust between employer and employee.

By encouraging a new understanding of AI and the world around it, Accenture wants more autonomy for workers and access to on-demand purchases and innovated levels of customization for customers. But, it stresses that this all needs to be facilitated by trust: “How much customers trust the enterprise, or enterprise leaders trust their systems, or workers trust their employers, how much people trust AI, or dozens of other permutations across the ecosystem of relationships an enterprise has.”

Several major property and casualty insurers are also using drones to collect important data for claims adjusting, notably to conduct on-site assessments of roof damage after storms. Insurers hope that, by using drones, the risk and danger to adjusters will be minimized because they will no longer have to scale ladders to complete roof inspections.

Using drones is also expected to reduce the time needed to complete a roof inspection. A roof inspection that would have taken an hour is now estimated to take only 20 minutes if conducted by a drone. Insurers also expect to save costs because they will no longer have to pay adjusters to drive to claim sites. And, the speed of claims processing is expected to improve. Previously, adjusters might typically conduct two or three estimates per day, while the same adjuster will now be able complete eight or more desk reviews per day once they receive images from drones.

To establish a drone program, insurers are typically pursuing one of two routes: building their own drone technology and training staff to use it or partnering with third-party companies who are drone experts.

However, policyholders across the U.S. are struggling to trust insurers' use of drones in this capacity, with several reports and complaints of policy cancellations and non-renewals due to drone findings. This connects back to Accenture's report emphasizing the importance of trust. Without trust, the insurance industry may find itself at a standstill. Even if technological developments help improve efficiency and cut down on operational costs, distrustful and unhappy policyholders can lead to high turnover rates and subsequent increases in premiums, undercutting any progress achieved by the former and creating a never-ending cycle.

Section Review:

1. Insurers are implementing all of the following types of technology into their business operations EXCEPT:
 - A. Voice ID technology [**Your answer is incorrect. Some insurers have launched voice ID technology so that customers no longer have to enter passwords when they call an insurer's customer service lines. Instead, once a customer enrolls in the voice ID service, they must simply repeat a simple passphrase to access their accounts.**]
 - B. Tablet devices [**Your answer is incorrect. Many agents, adjusters, field underwriters, and loss-control specialists are using tablet devices to streamline the policy application and claims settlement processes.**]
 - C. Gaming devices [**Your answer is correct. Insurers are not using gaming devices as part of their business models.**]
 - D. Drones [**Your answer is incorrect. Several property and casualty insurers are using drones to assess roof damage and help expedite the claims process.**]

9.0 Conclusion

You have learned about property and casualty risks, contracts, and the roles of an agent. You should walk away from this course with at least a basic understanding of the property and casualty industry and some valuable tools to assist you in your own role as an agent.