Florida Law and Ethics Update: Life and Health (5-215), 11th Edition

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1.0 Introduction and Course Objectives

Insurance licensees in the State of Florida are required to complete a 5-hour update course every 2 years specific to the license held by the licensee. The rules require that the course address insurance law updates, ethics, disciplinary trends, industry trends, and suitability of insurance products. This course will address each of these pertinent topics and provide the training required to meet and/or exceed these requirements. Upon completion of this course, you should be able to discuss and analyze:

- Florida insurance law updates;
- Ethics in Florida;
- Florida disciplinary trends;
- Insurance industry trends; and
- The rules governing the suitability of insurance products.

2.0 Regulatory Awareness

As a licensed insurance professional in Florida, it is imperative that you possess a certain awareness of the regulatory framework of the Florida Department of Insurance. This section of the course will provide you with an overview of the department as well as rules and regulations surrounding your licensing as an insurance professional. Upon completion, you should have an understanding of the Florida Department of Financial Services and the insurance licensing requirements imposed by Florida regulations.

2.1 Jurisdiction of duties and responsibilities

Let’s begin with a look at the jurisdiction, duties and responsibilities of various members and departments that comprise the Florida Department of Insurance.

2.1.1 CFO

Florida's Chief Financial Officer (CFO) is responsible[1] for:

- Oversight of the state's accounting and auditing functions and unclaimed property;
- Monitoring the investment of state funds;
- Managing the deferred compensation and risk management programs for the state;
- Handling of insurance consumer service;

[1] Section 20.121(1), F.S.

- Licensing and oversight of insurance agents and agencies; and
- Insurance fraud investigation.

Knowledge Check

1. Which of the following is NOT a duty of the Chief Financial Officer (CFO)? (Refer to Section 2.1.1, page 1)

A. Writing the Florida insurance laws. **[Your answer is correct. The CFO is the head of the Department of Financial Services and is responsible for overseeing the licensing of agents, adjusters, and agencies and enforcing state insurance laws. However, the CFO does not write the state's insurance laws.]**
B. Overseeing the licensing of insurance agents and agencies. **[Your answer is incorrect. One of the CFO's duties, as head of the Department of Financial Services, is to oversee the licensing of agents and agencies in the state.]**
C. Monitoring the investment of state funds. **[Your answer is incorrect. One of the CFO's duties, as head of the Department of Financial Services, is to monitor the investment of state funds.]**
D. Overseeing the state's accounting and auditing functions and unclaimed property. **[Your answer is incorrect. One of the CFO's duties, as head of the Department of Financial Services, is to oversee the state's accounting and auditing functions and unclaimed property.]**

2.1.2 DFS

The Florida Department of Financial Services[2] was formed in January 2003 through the merger of the Department of Insurance, Treasury, State Fire Marshal and the Department of Banking and Finance. The Department consists of 13 divisions, with several specialized offices and 2,000 staffers available to assist with various insurance needs of both licensees and consumers.[3]

2.1.3 OIR

The Florida Department of Financial Services, Office of Insurance Regulation (OIR)

[2] Section 20.121(2), F.S.
[3] http://www.myfloridacfo.com/sitePages/agency/default.aspx

is tasked with ensuring that Florida licensed insurance companies[4]:

- are financially viable;
- operate within the laws and regulations governing the industry; and
- offer insurance products at fair and adequate rates that do not unfairly discriminate against the public.

The head of the OIR is the Florida Insurance Commissioner. The OIR is responsible for regulation, compliance and enforcement of all statutes related to insurance, as well as the monitoring of industry markets through the following business units:

- **Company Admissions,** which receives company applications and coordinates the review of these applications to determine whether to license companies to sell insurance in Florida.
- **Office of the Inspector General,** promotes accountability, integrity, efficiency, and cost-effectiveness in OIR operations and administration through internal audits, investigations, management and performance reviews, and other activities in accordance with professional standards and applicable laws.
- **Government Affairs**, which is responsible for Cabinet Affairs (coordinating the presentation of proposed administrative rules and performance measures before the Governor and Cabinet) and Legislative Affairs (responsible for the development, coordination, and communication of legislative and budget priorities to the Executive Office of the Governor and the Florida Legislature. This Office also works closely with the OIR Budget Director.)
- **Communications Office,** which acts as a liaison with the media and general public to address insurance matters related to the Florida Office of Insurance Regulation (OIR).
- **Legal Services,** which provides advice and counsel to the Office of Insurance Regulation. The Legal Services Office reports to the General Counsel and handles litigation in state and federal courts, informal administrative hearings, hearings at the Division of Administrative Hearings and cases in state and federal courts.
- **Budget and Personnel Office,** which is responsible for purchasing, budgetary planning, contract management, and other functions, works closely with the Department of Financial Services for personnel management.
- **Life and Health Financial Oversight,** which monitors the financial condition of all regulated Life and Health entities through the use of internal financial analysis and on-site examinations.
- **Life and Health Product Review,** which insures that all life and health

[4] Section 20.121(3)(a)1, F.S.

policy forms and rates are in compliance with Florida Statutes and regulation. Chapters 627 and 641, Florida Statutes, are the principal statutes within the Insurance Code that govern the Unit's reviews. Applicable rules within the Florida Administrative Code also serve to guide these review processes.

- **Market Research and Technology (MRTU),** which is responsible for data collections, data analysis, market research and reporting, application maintenance and support, and technology innovation and planning.
- **Market Regulation,** which monitors the conduct of insurers in the marketplace and enforces insurer compliance with the Florida Insurance Code through remediation and administrative action. Market Regulation's primary concern is to properly and timely identify and resolve consumer issues and monitor market trends which serve as early indicators that may identify large-scale problems which could affect an insurer's financial solvency.
- **Property and Casualty Financial Oversight**, which monitors the financial stability of insurers by obtaining and reviewing financial statements and conducting onsite financial examinations.
- **Property and Casualty Product Review,** which enforces the provisions of Chapters 627 and 626, Florida Statutes, and applicable rules, as they relate to the review of Property and Casualty contracts and associated rates. The principle function of the Unit is to review and act upon Property and Casualty contracts and rate filings received from insurance companies and related entities. As each filing is received, it is reviewed in order to determine compliance with applicable actuarial standards, statutory provisions, and administrative rules.
- **Specialty Product Administration,** which provides regulation and oversight to insurance administrators, continuing care retirement communities, motor vehicle service agreement companies, home warranty associations, service warranty associations, insurance premium finance companies, donor annuities, legal expense corporations, viatical settlement providers, third-party administrators, and title insurance agents and insurers. The unit licenses and monitors the quality of company assets, adequacy of stated liabilities, general operating results and market conduct of these entities to assure compliance with the Florida Insurance Code.

The OIR regulates and provides oversight for all insurance companies and insurance-related entities licensed to do business in Florida. Additionally, the office provides oversight to all residual markets and joint underwriting associations, which were created by the Legislature to provide insurance to consumers unable to obtain coverage in the private market.

The Department of Financial Services' Division of Consumer Services provides education, information and assistance to consumers for all products or services regulated by the Department of Financial Services and the Financial Services

Commission. (624.307 F.S).

2.1.4 OFR

The Florida Department of Financial Services, Office of Financial Regulation (OFR) protects the citizens of Florida by carrying out the banking, securities, and financial laws of the state efficiently and effectively, and providing regulation of businesses promoting the sound growth and development of Florida's economy[5].

The OFR is tasked with protecting consumers from illegal activities of financial institutions and financial service companies. The OFR includes a Bureau of Financial Investigations, which is a criminal justice agency that investigates securities fraud and mortgage fraud cases that affect consumers and the financial services industry in Florida. The Bureau refers cases to state and federal law enforcement agencies for administrative, civil, or criminal prosecution.

The OFR reviews consumer complaints involving illegal financial activities, business applications to conduct financial services, and individual license applications. The OFR has the authority to impose licensing restrictions, as well as denying licensure.

All insurers are required to adopt anti-fraud plans and to establish and maintain designated anti-fraud units within the companies to investigate possible fraudulent insurance acts or contract with others to investigate fraudulent insurance acts (this began in 2017). The insurers are required to make annual filings with the Department of Financial Services (DFS) describing their anti-fraud programs.

Beginning in 2019, insurers are required to make an annual statistical report to DFS including the number of anti-fraud cases reported and investigated, whether the case dealt with fraudulent claims or other matters, whether the case was referred to DFS or law enforcement, and the dollar amounts involved. The law then requires DFS to create a biennial report detailing best practices for the detection, investigation, prevention, and reporting of insurance fraud and other fraudulent insurance acts.

Knowledge Check

1. Which of the following is NOT a responsibility of the Office of Insurance Regulation (OIR)? (Refer to Section 2.1.3, pages 2-4)

[5] Section 20.121(3)(a)2, F.S.

A. Ensuring that Florida-licensed insurance companies are financially viable **[Your answer is incorrect. One of the duties of the OIR is to ensure that Florida licensed insurance companies are financially viable.]**
B. Ensuring that insurance companies operate within state laws and regulations governing the industry **[Your answer is incorrect. One of the duties of the OIR is to ensure that Florida licensed insurance companies operate within the laws and regulations governing the industry.]**
C. Provide oversight of residual markets and joint underwriting associations in the state **[Your answer is incorrect. One of the duties of the OIR is to provide oversight to all residual markets and joint underwriting associations, which were created by the legislature to provide insurance to consumers unable to obtain coverage in the private market.]**
D. Investigating and prosecuting insurance fraud **[Your answer is correct. The OIR is not responsible for investigating and prosecuting insurance fraud in Florida.]**

2.2 Licensing Requirements

Let's first look at important definitions and then examine Florida's licensing requirements and review processes for licensing of insurance professionals.

> *(1) "Agent" means a general lines agent, life agent, health agent, or title agent, or all such agents, as indicated by context. The term "agent" includes an insurance producer or producer, but does not include a customer representative, limited customer representative, or service representative.*
>
> *(2) "Appointment" means the authority given by an insurer or employer to a licensee to transact insurance or adjust claims on behalf of an insurer or employer.*
>
> *(3) "Customer representative" means an individual appointed by a general lines agent or agency to assist that agent or agency in transacting the business of insurance from the office of that agent or agency.*
>
> *(4) "General lines agent" means an agent transacting any one or more of*

the following kinds of insurance:

(a) Property insurance.

(b) Casualty insurance, including commercial liability insurance underwritten by a risk retention group, a commercial self-insurance fund, or a workers' compensation self-insurance fund.

(c) Surety insurance.

(d) Health insurance.

(e) Marine insurance.

(5) "Health agent" means an agent representing a health maintenance organization or, as to health insurance only, an insurer transacting health insurance.

(6) "Home state" means the District of Columbia and any state or territory of the United States in which an agent or adjuster maintains his or her principal place of residence or principal place of business and is licensed to act as an insurance agent or adjuster.

(7) "Insurance agency" means a business location at which an individual, firm, partnership, corporation, association, or other entity, other than an employee of the individual, firm, partnership, corporation, association, or other entity and other than an insurer, engages in any activity or employs individuals to engage in any activity which by law may be performed only by a licensed insurance agent.

(8) "License" means a document issued by the department or office authorizing a person to be appointed to transact insurance or adjust claims for the kind, line, or class of insurance identified in the document.

(9) "Line of authority" means a kind, line, or class of insurance an agent is

authorized to transact.

(10) "Personal lines agent" means a general lines agent who is limited to transacting business related to property and casualty insurance sold to individuals and families for noncommercial purposes.

(11) "Resident" means an individual whose home state is the State of Florida.

(12) "Uniform application" means the uniform application of the National Association of Insurance Commissioners for nonresident agent licensing (626.015, F.S.).

(13) "Renewal" shall mean the continuation of an existing appointment for an additional period of time (69B-211.004, F.A.C.).

(14) "Renewal notice" means an electronic notification sent by the Department to the appointing entity for its use in notifying the Department of persons to be renewed or not renewed (69B-211.004, F.A.C.).

Knowledge Check

1. Blake is a licensed general lines agent. Which type of insurance is he NOT able to transact under this license in Florida? (Refer to Section 2.2, pages 6-8)

A. Life insurance **[Your answer is correct. General lines agents are not authorized to transact life insurance in Florida unless they are also licensed as life insurance agents.]**
B. Property insurance **[Your answer is incorrect. General lines agents are authorized to transact property, casualty, surety, health, and marine insurance in Florida.]**
C. Casualty insurance **[Your answer is incorrect. General lines agents are authorized to transact property, casualty, surety, health, and marine insurance in Florida.]**
D. Marine insurance **[Your answer is incorrect. General lines agents are authorized to transact property, casualty, surety, health, and marine insurance in Florida.]**

2.2.1 Health & Life (Including Annuities & Variable Contracts) Insurance (Exam Required)

To qualify for a 2-15 Health & Life (Including Annuities & Variable Contracts) Agent License, an applicant must complete each of the items below and/or meet the associated requirements, as well as sit for their state exam (if required).

Per the Division of Insurance Agent and Agency Services, Bureau of Licensing, an applicant for a 2-15 Health & Life (Including Annuities & Variable Contracts) Agent License must:

- Be a natural person at least 18 years of age.
- Be a bona fide resident of Florida.
- Be a United States citizen or legal alien with a work authorization
- Not be an employee of the United States Department of Veterans Affairs or state service office, as referred to in Section 626.833, Florida Statutes
- Not be a funeral director or direct disposer, or an employee or representative thereof, or have an office in or in connection with a funeral establishment.
- Be fingerprinted.
- Complete application and license fees. Click here for a complete list of Payment Methods and Fees.
- Complete a 60-hour approved insurance course for life and health, including variable annuity insurance, which must be completed within 4 years of the application date.

2.2.2 Appointment

Under Florida law, an appointment is the authority given by an insurer or employer to a licensee to transact insurance or adjust claims on behalf of an insurer or employer. (Florida Insurance Laws 626.015)

No person may be, act as, or advertise or hold himself or herself out to be an insurance agent, insurance adjuster, or customer representative unless they are currently licensed by the department and appointed by an appropriate appointing entity or person. (Florida Insurance Laws 626.112)

"Unaffiliated insurance agents" are self-appointed. An unaffiliated insurance agent is a licensed insurance agent who practices as an independent consultant in the business of analyzing or abstracting insurance policies, providing insurance advice or counseling, or making specific recommendations or comparisons of insurance products for a fee established in advance by written contract signed by the

parties. An unaffiliated insurance agent may not be affiliated with an insurer, insurer-appointed insurance agent, or insurance agency contracted with or employing insurer appointed insurance agents. A licensed adjuster who is also an unaffiliated insurance agent may obtain an adjuster appointment in order to adjust claims while holding an unaffiliated appointment on the agent license. (Florida Insurance Laws 626.015(20))

2.2.2.1 Filing Deadline

An insurer must submit initial appointments to the Department on a monthly basis no later than 21 days after the date of appointment. (Florida Insurance Laws 626.371)

An appointment becomes effective on the date requested in the filing. The appointing entity will be assessed a delinquent fee if it does not file notice of the appointment within the required time period. (Florida Insurance Laws 626.371)

2.2.2.2 Filing Procedure

Electronic submission of the appointment notice using Florida's eAppoint system is required.

Failure to file an original appointment within 21 days of the effective appointment date will result in a late fee of $250 for each original appointment. This fee must be paid by the appointing entity and may not be charged to the licensee. (Florida Insurance Laws 626.371)

2.2.2.3 Other Requirements

By authorizing the effectuation of an appointment for a licensee, the appointing entity is certifying to the Department that it has made an investigation of the licensee, and that in its opinion and to the best of its knowledge and belief, the licensee is of good moral character and reputation, and is fit to engage in the insurance business. The appointing entity may be required to provide other information on the proposed appointee if reasonably required by the Department. (Florida Insurance Laws 626.451)

Each licensee must advise the department in writing within 30 days after having been found guilty of or having pleaded guilty or no contest to a felony, or any crime punishable by imprisonment of 1 year or more under the laws of the United States, any state of the United States, or any other country, without regard to whether a judgment of conviction was entered by the court with jurisdiction in the case. (Florida Insurance Laws 626.451)

An appointing entity must advise the department in writing within 15 days after it or its general agent or officer, or other official becomes aware that an appointee pleaded guilty or no contest to a felony, or has been found guilty of a felony since, since being appointed. (Florida Insurance Laws 626.451)

Failure to timely renew an appointment by an appointing entity prior to the expiration date of the appointment will result in the appointing entity being assessed late filing, continuation, and reinstatement fees as prescribed in § 624.501. Such fees must be paid by the appointing entity and cannot be charged back to the appointee. (Florida Insurance Laws 626.371)

Upon the expiration of any person's appointment, as provided in § 626.381, the person shall be without any authority conferred by the appointment and shall not engage or attempt to engage in any activity requiring an appointment. (Florida Insurance Laws 626.431)

An individual who fails to maintain an appointment with an appointing entity writing the class of business listed on their license during any 48-month period shall not be granted an appointment for that class of insurance until they qualify as a first-time applicant. (Florida Insurance Laws 626.431)

The Florida 2-14 Life and Variable Annuities Agent license allows an individual to transact contracts for life insurance, fixed-dollar annuity contracts, or some variable annuity contracts offered by the same insurer. This license has a 40-hour pre-qualification course requirement.

The Florida Department of Financial Services regulations require that all life, health, and variable annuity license candidates obtain the latest edition of the FAIFA Life, Health, and Variable Annuity Study Manual from the Florida Association of Insurance and Financial Advisors (www.FAIFA.org), 1-850-422-1701.

In Florida, any resident or non-resident life producer who solicits individual consumers in order to sell annuities must complete a 4-hour specifically designated annuity training course every two years prior to license renewal.

2.2.2.4 Agents' Additional Appointments

At any time while a licensee's license is in force, an insurer may apply to the Department on behalf of a licensee for an appointment. Once the Department receives the appointment notice and the applicable appointment taxes and fees, it may issue the additional appointment without further investigation of the applicant. (Florida Insurance Laws 626.341)

Unless the agent's contract provides otherwise, a life or health agent who has a

Florida appointment in force may solicit applications for insurance on behalf of an insurer to which they are not appointed, if the agent requests appointment at the same time that they submit the insurance application to the insurer. However, the insurer may not pay commissions to the agent until the Department receives an additional appointment from the insurer for that agent. (Florida Insurance Laws 626.341)

2.2.3 Contact Information

Florida requires all licensed insurance professionals to update and/or verify their addresses and other contact information through their MyProfile account. For those who hold an additional license (e.g., an agency license), those licenses need verification and updates where appropriate through its separate MyProfile account.

Most licensees have 30 days from the change in information to notify the Department or be subject to administrative action (626.551, F.S.).

2.2.3 Continuing Education

In Florida, the following resident and nonresident licensees must complete a certain number of hours of continuing education courses required by statute[6] and approved by the Florida DFS:

- Health only agents
- Life and health agents
- Life including variable annuity agents
- Life including variable annuity and health agents
- Life only agents
- Other license types

Failing to complete the required continuing education for your license type will result in a refusal by the Department to:

- *Renew or continue appointments,*
- *Issue new appointments to the delinquent licensee.*

This failure may also result in other forms of administrative penalty.

Continuing education hours required will depend on the license type held and number of years the license has been held. For most license types, continuing education is due every 2 years. Members of certain professional associations may

[6] Section 626.2815, F.S.

receive up to 2 hours credit for each year of active participation. To get this credit the member must attend four hours of association meetings for the year.

For most license types, continuing education is due every 2 years. Members of certain professional associations may receive up to 2 hours credit for each year of active participation. To get this credit the member must attend four hours of association meetings for the year. Agents licensed for 25 years or more, who also hold a CLU or CPCU designation, or who also have a B.S. degree in risk management or insurance with 18 or more semester hours in upper-level insurance-related courses, must complete 12 hours biennially.

Required CE courses are determined in Section 626.2815, Florida Statutes. See the chart below for a breakdown by license type.

License Type	License Type Number	Effective after January 1, 2022
Life	02-16 & 02-14	4 hours of Law and Ethics update (5-214) 20 hours of Elective credits
Health	02-40	4 hours of Law and Ethics update (5-240) 20 hours of Elective credits
Life and Health	02-15 & 02-18	4 hours of Law and Ethics update (5-215) 20 hours of Elective credits

Note: *The chart above does not reflect reductions, if applicable. Reductions are applied to the elective category.*

****The four-hour ethics requirement will be satisfied by department-approved courses in ethics, rules, or compliance with state and federal regulations relating specifically to title insurance and closing services. The course authority for title agent ethics is currently CE9908.*

The department may immediately terminate or refuse to renew the appointment of an agent or adjuster who has been notified by the department that their continuing education requirements have not been certified, unless the agent or adjuster has been granted an extension or waiver by the department. The department may not issue a new appointment of the same or similar type to a licensee who was denied a renewal appointment for failing to complete continuing education as required until the licensee completes their continuing education requirement. Failure to complete continuing education hours done by the end of a compliance period will result in assessment of a $250 fine, and the licensee will be required to complete the remaining continuing education hours. You will be notified of noncompliance by way of a Preliminary Notice of Non-Compliance and a

settlement stipulation located in the licensee's MyProfile account approximately 45 days from the end of his or her compliance period. The licensee must sign and return the settlement stipulation and return it to the department at the address listed on the form. Once the signed settlement stipulation is received, a consent order with an invoice will be added to the licensee's MyProfile account. The fine should be paid in full through MyProfile within 30 days after the invoice date.

Licensees have 60 days from the invoice date to complete their remaining continuing education hours. Failure to return the stipulation agreement or pay the assessed fine will result in the cancellation of any appointments.

To inquire as to continuing education status, you can log in to MyProfile or contact the DFS directly at 1-877-693-5236. Keep in mind that in Florida, you cannot repeat the same course within two years and receive continuing education credit for the course.

In addition to the continuing education requirements, producers who sell annuities must complete additional product training. This requirement stems from the 2010 Suitability in Annuity Transactions Model Regulation from the NAIC. The Model Act requires that carriers provide product training to those producers selling annuities. The training is made available by each carrier and is a requirement for selling for the carrier. Carriers may also require that courseware is retaken periodically as product features change. (As noted, later in this course, the NAIC is in the process of updating this model regulation to raise the standard from "suitability" to "best interest." It is expected that the updated regulation will continue this training requirement in a similar form.)

2.2.4 Insurance Agency Licensing

Subsection 626.015(8), Florida Statutes, defines an "INSURANCE AGENCY" as:

> *a business location at which an individual, firm, partnership, corporation, association, or other entity engages in any activity or employs individuals to engage in any activity which by law may be performed only by a licensed insurance agent.*

Subsection 626.112(7)(a), Florida Statutes, states that:

> *No individual, firm, partnership, corporation, association, or any other entity shall act in its own name or under a trade name directly or indirectly, as an insurance agency, unless it complies with s. 626.172, F.S., with respect to possessing an insurance agency license for each place of business at which it engages in any activity which may be performed only*

by a licensed insurance agent.

Qualifications for an agency license in Florida include that:

- *The business must be located in Florida.*
- *The sole proprietor, partner, owner, president, vice president, treasurer, secretary, directors and any other person who directs or participates in the management or control of an incorporated agency whose shares are not traded on a securities exchange are required to be fingerprinted. Individuals who are currently licensed and appointed in Florida are not required to be fingerprinted.*
- *If there are two or more lines of insurance being transacted out of the agency, an agent-in-charge must be licensed for at least two lines of business being conducted.*
- *The business must have an agent-in-charge licensed and appointed in at least one of the following lines of authority:*

    - *General Lines (2-20)*
    - *Life (2-16)*
    - *Life including Variable Annuity (2-14)*
    - *Health (2-40)*
    - *Health and Life (2-18)*
    - *Health and Life including Variable Annuity (2-15)*

In Florida, there was a distinct difference between agency registration and agency licensure. This changed in 2015, with the elimination of registration.

Beginning in 2015, all agencies must be licensed and agencies that previously would have registered are required to apply for licensure. On October 1, 2015, all registered agencies were converted to licenses. (Florida Insurance Laws 626.112)

Currently, a renewal notice is emailed by the department to all agencies 90 and 30 days before the expiration date of the agency license. Renewal can occur between the date of receipt of the renewal notice and the expiration date of the license. An application for agency licensure can be found by logging in to the agency's account in MyProfile. There is no fee associated with agency license or registration. The exception is in the case of individuals requiring fingerprinting and these applications will have a processing fee assessed.

Penalties for failure to apply for licensure include:

> *If an agency is required to be licensed but fails to file an application for licensure in accordance with this section, the department shall impose on the agency an administrative penalty in an amount of up to $10,000.* (Florida Insurance Laws 626.112)

An insurance agency that is owned and operated by a single licensed agent conducting business in their individual name and not employing or otherwise using the services of or appointing other licensees shall be exempt from the agency licensing requirements.

2.2.5 Transfer, Surrender/Termination of Licensing

Florida insurance agent and adjuster licenses are perpetual, meaning there is no formal license renewal. However, this perpetual license status will expire if more than 48 months go by without an appointment. Licensees who fail to complete their particular continuing education requirements could face cancellation of their appointment, which in turn could lead to termination of their license.

Specifically, Florida statutes provide guidance on the transfer, surrender and termination of a license. Let's start with a look at transfer.

As to **transfer** of a license, (see Section 626.292, Florida Statutes), any individual licensed in good standing in another state may apply to the department to have the license transferred to this state to obtain a Florida resident license for the same lines of authority covered by the license in the other state. To qualify for a license based on the transfer of license option, an applicant must meet the following requirements:

- Become a resident of Florida.
- Have held a valid license for one (1) year in their home state prior to applying for a license in Florida.
- Submit the application for license and appropriate fees within 90 days of becoming a resident of Florida.
- Provide an original letter of clearance.
- Submit a set of fingerprints.

Note: The transfer of license option does not apply to bail bond agents. It also does not necessarily exempt you from the examination requirement.

For those licensees wishing to surrender their license, a letter should be mailed to the Bureau of Licensing at:

Florida Department of Financial Services
Division of Agent and Agency Services
Bureau of Licensing
200 East Gaines St.
Tallahassee, FL 32399-0319

The letter should contain the following information:

- *Name*
- *Florida License ID Number*
- *Mailing address*
- *Telephone number*
- *Enclose your Florida insurance license ID or a statement indicating that you do not have the ID*
- *Signature of the licensee*

2.2.6 Grounds for Compulsory/Discretionary Refusal, Suspension, or Revocation of Insurance License/Agency License/Appointment

Florida statutes, Section 626.611[7], set forth the grounds for compulsory refusal, suspension, or revocation of a license or appointment. Specifically, the statute provides that the department will *deny an application for, suspend, revoke, or refuse to renew or continue the license or appointment of any applicant, agent, title agency, adjuster, customer representative, service representative, or managing general agent, and it shall suspend or revoke the eligibility to hold a license or appointment of any such person, if it finds that as to the applicant, licensee, or appointee any one or more of the following applicable grounds exist:*

(1) Lack of one or more of the qualifications for the license or appointment as specified in this code.

(2) Material misstatement, misrepresentation, or fraud in obtaining the license or appointment or in attempting to obtain the license or appointment.

(3) Failure to pass to the satisfaction of the department any examination required under this code.

(4) If the license or appointment is willfully used, or to be used, to circumvent any of the requirements or prohibitions of this code.

(5) Willful misrepresentation of any insurance policy or annuity contract or willful deception with regard to any such policy or contract, done either in person or by any form of dissemination of information or advertising.

(6) If, as an adjuster, or agent licensed and appointed to adjust claims under this code, they have materially misrepresented to an insured or other interested party the terms and coverage of an insurance contract with intent and for the purpose of effecting settlement of claim for loss or damage or benefit under such contract

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7 http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=0600-0699/0626/Sections/0626.611.html

on less favorable terms than those provided in and contemplated by the contract.

(7) Demonstrated lack of fitness or trustworthiness to engage in the business of insurance.

(8) Demonstrated lack of reasonably adequate knowledge and technical competence to engage in the transactions authorized by the license or appointment.

(9) Fraudulent or dishonest practices in the conduct of business under the license or appointment.

(10) Misappropriation, conversion, or unlawful withholding of moneys belonging to insurers or insureds or beneficiaries or to others and received in conduct of business under the license or appointment.

(11) Unlawfully rebating, attempting to unlawfully rebate, or unlawfully dividing or offering to divide his or her commission with another.

(12) Having obtained or attempted to obtain, or having used or using, a license or appointment as agent or customer representative for the purpose of soliciting or handling "controlled business" as defined in s. 626.730 with respect to general lines agents, s. 626.784 with respect to life agents, and s. 626.830 with respect to health agents.

(13) Willful failure to comply with, or willful violation of, any proper order or rule of the department or willful violation of any provision of this code.

(14) Having been found guilty of or having pleaded guilty or nolo contendere to a felony or a crime punishable by imprisonment of 1 year or more under the law of the United States of America or of any state thereof or under the law of any other country which involves moral turpitude, without regard to whether a judgment of conviction has been entered by the court having jurisdiction of such cases.

(15) Fraudulent or dishonest practice in submitting or aiding or abetting any person in the submission of an application for workers' compensation coverage under chapter 440 containing false or misleading information as to employee payroll or classification for the purpose of avoiding or reducing the amount of premium due for such coverage.

(16) Sale of an unregistered security that was required to be registered, pursuant to chapter 517.

(17) In transactions related to viatical settlement contracts as defined in s. 626.9911:

(a) Commission of a fraudulent or dishonest act.

(b) No longer meeting the requirements for initial licensure.

(c) Having received a fee, commission, or other valuable consideration for his or her services with respect to viatical settlements that involved unlicensed viatical settlement providers or persons who offered or attempted to negotiate on behalf of another person a viatical settlement contract as defined in s. 626.9911 and who were not licensed life agents.

(d) Dealing in bad faith with viators.

2.2.7 Duties of Licensed vs. Unlicensed Personnel

In Florida (as in most states), a license is required to transact insurance business in the state. There are, however, certain functions that may be performed by unlicensed personnel. In Florida, these tasks are outlined in Chapter 69B-222 of the Florida Administrative Code.

Specifically, the Code provides that in an agency's regular course of business, it may allow unlicensed employees to give information or explain procedures to clients. The caveat is that this information or explanation must be read from agency records or files and cannot interpret or judge the information for the client.

Additionally, if requested by a licensed agent or customer representative, an unlicensed person can, at the request of the customer, call to schedule a meeting between the customer and the agent or customer representative. Also, the unlicensed employee may, at the requested of the licensed agent or representative, convey specific information to existing clients or claimants (e.g., acknowledging the receipt of a signed application).

Unlicensed employees can also conduct certain activities that are considered incidental to their duties. Incidental work is defined in Section 69B-222.020(2) of the Florida Administrative Code as follows:

...work can be classified as incidental if the employee spends ten (10) percent or less of their time on the task, and the exact amount and timing of the work is unpredictable. An unlicensed employee can perform three activities if they are incidental:

1. *Taking an application for insurance in the agent's office, for a person who has called or come into the office. Taking an application means filling in the blanks on an application form in response to information provided by the applicant, and then giving the application to an agent or*

customer representative. It does not include application of judgment, processing, binding, policy interpretation, signing an application, procedure explanations or insurance advice and counsel, or similar activity.

2. *Giving a quote in the agent's office, to a person who has called or come into the office. Giving a quote means obtaining certain basic underwriting answers from the inquirer, then consulting written underwriting materials that state the rate. It does not include application of judgment, processing, binding, policy interpretation, signing an application, procedure explanations or insurance advice and counsel, or similar activity.*
3. *Receiving premium at the agent's office. This rule does not restrict mailroom employees, or other unlicensed personnel who handle mail, from handling premium that arrives via mail.*

The Florida Administrative Code goes on to describe the activities that unlicensed insurance agency personnel are never allowed to perform, which includes:

- *Comparing insurance products;*
- *Advising customers as to insurance needs or insurance matters;*
- *Interpreting policies or coverages;*
- *Binding new, additional or replacement coverage for new or existing customers;*
- *Binding coverage on or recording additional property under existing policies; or*
- *Soliciting the sale of insurance by telephone, in person, or by other communication.*

Finally, with regard to compensation, the Florida Administrative Code provides that *unlicensed insurance agency personnel may not receive any type of pay that is formally tied to the production of insurance or insurance applications. Such payment constitutes illegal sharing of commissions*[8]*.*

2.2.8 Branches Must Be Supervised by Licensed Agent

Every place of business established by an agent or agency must be in the active full-time charge of a licensed and appointed agent holding the required agent licenses to transact the lines of insurance being handled at the location.

One licensed agent may be in charge of more than one branch provided that insurance activities that require licensure as an agent do not occur when the licensed agent is not physically present and that these activities are not done by

[8] https://www.flrules.org/gateway/RuleNo.asp?id=69B-222.030

unlicensed employees.

(Florida Insurance Laws 626.0428)

2.3 Other Requirements

In addition to the licensing and registration requirements, Florida regulates certain activities of licensees. Let's take a look at a sampling of those regulations, beginning with advertising.

2.3.1 Advertising

In an attempt to level the playing field between the insurer and insured, Florida statutes, specifically Section 626.9541, identify certain advertising practices that will be deemed unfair methods of competition or deceptive practices. These advertising practices include:

> *(a) Misrepresentations and false advertising of insurance policies.- Knowingly making, issuing, circulating, or causing to be made, issued, or circulated, any estimate, illustration, circular, statement, sales presentation, omission, comparison, or property and casualty certificate of insurance altered after being issued, which:*
>
> > *1. Misrepresents the benefits, advantages, conditions, or terms of any insurance policy.*
> >
> > *2. Misrepresents the dividends or share of the surplus to be received on any insurance policy.*
> >
> > *3. Makes any false or misleading statements as to the dividends or share of surplus previously paid on any insurance policy.*
> >
> > *4. Is misleading, or is a misrepresentation, as to the financial condition of any person or as to the legal reserve system upon which any life insurer operates.*
> >
> > *5. Uses any name or title of any insurance policy or class of insurance policies misrepresenting the true nature thereof.*
> >
> > *6. Is a misrepresentation for the purpose of inducing, or tending to induce, the lapse, forfeiture, exchange, conversion, or surrender of any insurance policy.*
> >
> > *7. Is a misrepresentation for the purpose of effecting a pledge or*

assignment of, or effecting a loan against, any insurance policy.

8. Misrepresents any insurance policy as being shares of stock or misrepresents ownership interest in the company.

9. Uses any advertisement that would mislead or otherwise cause a reasonable person to believe mistakenly that the state or the Federal Government is responsible for the insurance sales activities of any person or stands behind any person's credit or that any person, the state, or the federal government guarantees any returns on insurance products or is a source of payment of any insurance obligation of or sold by any person.

(b) False information and advertising generally.-Knowingly making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public:

1. In a newspaper, magazine, or other publication,

2. In the form of a notice, circular, pamphlet, letter, or poster,

3. Over any radio or television station, or

4. In any other way, an advertisement, announcement, or statement containing any assertion, representation, or statement with respect to the business of insurance, which is untrue, deceptive, or misleading.[9]

Those producers selling annuities should be aware of a model act from the NAIC regarding disclosures during the sale of annuities. The NAIC Annuity Disclosure Model Regulation (245) is designed to outline the minimum information that must be provided during a sale of an annuity product, requirements for the method of disclosure and the use of illustrations during an annuity sale. States are still reviewing this model regulation and adoption has been slow. Iowa was the first state to adopt the model act. However, carriers may change their policies based on this adoption and effect changes in the disclosure language that accompanies their annuity products.

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9 http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=0600-0699/0626/Sections/0626.9541.html

2.3.2 Recordkeeping

Florida Statutes, Section 626.884[10], provide that certain records must be retained by insurance administrators. Specifically, the statutes require:

- *Every administrator shall maintain in such administrator's principal administrative office for the duration of the written agreement and for 5 years thereafter adequate books and records of all transactions among such administrator, insurers, and insured persons. Such books and records shall be maintained in accordance with prudent standards of insurance recordkeeping.*
- *The office shall have access to books and records maintained by the administrator for the purpose of examination, audit, and inspection. Information contained in such books and records is confidential and exempt from the provisions of s. 119.07(1) if the disclosure of such information would reveal a trade secret as defined in s. 688.002. However, the office may use such information in any proceeding instituted against the administrator.*
- *The insurer shall retain the right of continuing access to books and records maintained by the administrator sufficient to permit the insurer to fulfill all of its contractual obligations to insured persons, subject to any restrictions in the written agreement between the insurer and the administrator on the proprietary rights of the parties in such books and records*.

2.4 Department Communication

The Florida Department of Financial Services' Division of Agent and Agency Services has many avenues for your use in contacting them regarding various licensing and regulatory matters. These include:

- MyProfile
- Website
- Insurance Insights
- New Technology

2.4.1 MyProfile

Earlier, in discussing licensing regulations, we mentioned logging into MyProfile. Let's examine MyProfile more closely so you understand the functions of the system. MyProfile is the online portal for the Florida Department of Financial

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10 http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=0600-0699/0626/Sections/0626.884.html

Services' Bureau of Licensing.

Specifically, MyProfile allows a user to:

- View their license(s), appointment(s), continuing education information, and deficiencies on a pending application for a license.
- Make a name and address change.
- Apply for an agent or adjuster examination. This allows an applicant to take the examination prior to applying for the license. When you have passed the examination, you must submit the application for the license. The passing score will expire within one year if the license application is not submitted.
- Apply for an agent or adjuster license.
- Apply for an agency license or update agency information.
- Apply for a branch license.
- Print a duplicate license.
- Apply for a Letter of Certification and a Letter of Clearance.
- Apply to be a prelicensing or continuing education provider or instructor.

2.4.2 Website

The Division of Agent and Agency Services' redesigned public website went live on August 1, 2012. They believe this updated format will *continue to improve customer service by simplifying some of the pages containing large amounts of information.*

2.4.3 Insurance Insights

Insurance Insights is the Florida Insurance Division's online newsletter that includes valuable information for agents, adjusters and agencies about what's happening in Florida's market, as well as current market trends. In each issue, you can expect to find discussion in the following areas:

- News You Can Use
- In the Know
- Education Central
- Compliance Corner
- Case Notes
- Enforcement Actions

2.4.4 New Technology

Florida's Department of Financial Services' Division of Agent and Agency Services is constantly striving to improve services to licensees by increasing communication and enhancing how it delivers that message through technology.

It would be a good idea for you to check the site periodically to keep apprised of any new technological advances that could assist you in your practice. The site may be accessed at https://www.myfloridacfo.com/division/agents/

Knowledge Check

1. Which system does the Department of Financial Services use to accept applications for insurance agent's licenses? (Refer to Section 2.4.1, page 24)

   A. MyProfile **[Your answer is correct. Individuals must use MyProfile to apply for an insurance license. MyProfile can also be used to check a licensee's appointments and continuing education requirements, among other things.]**
   B. WebPro **[Your answer is incorrect. MyProfile is the online portal that individuals must use to apply for insurance licenses and to take the written examination.]**
   C. Insurance Insights **[Your answer is incorrect. Insurance Insights is the Florida Insurance Division's online newsletter that includes information for agents, adjusters and agencies about what's happening in Florida's market, as well as current market trends.]**
   D. MyCE. **[Your answer is incorrect. Individuals who want to apply for insurance licenses must use MyProfile, the Department's online portal for adjuster licensing.]**

2.5 Guaranty Association

Life and health insurance guaranty associations were created to protect state residents who are policyholders and beneficiaries of policies issued by a life or health insurance company that has gone out of business. All 50 states, the District of Columbia, and Puerto Rico have life and health insurance guaranty associations.

All insurance companies (with limited exceptions) licensed to write life and health insurance or annuities in a state are required to be members of the state's life and health insurance guaranty association. If a member company becomes insolvent (goes out of business), the state guaranty association obtains money to continue coverage and pay claims from member insurance companies writing the same line or lines of insurance as the insolvent company. What follows are the rules and guidelines of a typical guaranty association:

- **Residency.** Guaranty association protection will generally be provided by the association in the policyholder state of residence.
- **How it works.** Insurance companies that experience severe financial difficulties are taken over by the insurance department of the state in which

they are based. Insureds should be notified by the insurance department if this occurs. Even if the company is placed under the control of the insurance department, claims will continue to be honored as long as premiums are paid or cash value exists. The claims will be covered by state guaranty associations, which will either pay them directly or transfer the policies to a financially stable insurance company.

- **Premiums.** If a policyholder is paying premiums to the insolvent company, they must continue to do so even after the company has been taken over. Those premiums go to the guaranty association providing the policyholder with continuing coverage, and if the policyholder stops paying premiums, insurance benefits may be terminated.
- **Policy questions.** In the event of insurer insolvency, policyholders should contact their state insurance department or state guaranty association with questions about coverage. Coverage will be provided by the guaranty association in the policyholder state of residence, even if the policy was purchased in another state. Policyholders who reside in states where the insolvent insurer was not licensed are covered, in most cases, by the guaranty association of the company's domiciliary state.
- **Who is protected?** Life and health insurance guaranty associations cover individual policyholders and their beneficiaries; typically, persons protected by certificates of insurance issued under policies of group life or group health insurance are also covered. For more information about coverage, policyholders should contact their state's guaranty association or insurance department.
- **What policies are covered?** Generally, direct individual or direct group life and health insurance policies as well as individual annuity contracts issued by the guaranty association's member insurers are covered by the association. Guaranty association coverage does not extend to any non-guaranteed policy or annuity, or portion thereof, or any portion of a policy in which investment risk is borne by the individual, such as a variable annuity. The guaranty association laws of each state spell out what types of policies are protected by the associations. Most states do not provide guaranty association coverage for non-indemnity health plans, such as HMOs. Unallocated annuity contracts (e.g., contracts purchased by retirement plans as a funding vehicle for participants) are protected by guaranty associations in some states. When covered, the limit is usually $5 million for all unallocated group annuity contracts issued to the contract holder, regardless of how many employees are covered.
- **When are variable annuities covered?** Generally speaking, if there are obligations under a variable annuity contract that are guaranteed by a member insurer, the contract will be eligible for guaranty association coverage, subject to applicable limits and exclusions on coverage. However, specific questions regarding coverage will be determined by the applicable guaranty association based on the terms of the contract, other relevant facts, and the guaranty association law in effect at the time of insolvency.

- **Level of protection.** Like the FDIC, state guaranty associations have maximum benefit limits. These limits are established by state law and can vary from state to state, but most states provide at least:

  - $300,000 in life insurance death benefits
  - $100,000 in cash surrender or withdrawal values for life insurance
  - $100,000 in withdrawal and cash values for annuities
  - $100,000 in health insurance policy benefits

  The overall benefit "cap" in most states for an individual life is $300,000, although some states have maximums that are much higher. The value in excess of guaranty association benefit limits is eligible for submission as a policyholder claim against the estate of the failed insurance company, and the contract holder may receive distributions as the company's assets are liquidated by the receiver.

- **How will coverage be handled by a state guaranty association?** Protection can be provided in one of several different ways. For example, a financially sound insurer may take over the troubled company's policies and assume the responsibility for continuing coverage and paying covered claims. The guaranty association may provide coverage directly by continuing the insurer's policies or issuing replacement policies with the guaranty association; in some situations, the association may work with other state guaranty associations to develop an overall plan to provide protection for the failed insurer's policyholders. The amount of protection provided and when the policyholder receives it may depend on the particular arrangement worked out for handling the failed insurer's policyholder obligations.

In Florida, that entity is the Florida Life and Health Insurance Guaranty Association (**FLAHIGA)**[11]**.** FLAHIGA is composed of all insurers licensed to sell direct life insurance, accident and health insurance, and certain annuities in the state of Florida. In the event that a member insurer is found to be insolvent and is ordered to be liquidated by a court, FLAHIGA will provide protection (up to the limits spelled out in the FLAHIGA Act) to Florida residents who are holders of life and health insurance policies and certain annuities with the insolvent insurer.

The FLAHIGA website explains, "Specifically, when a member insurer is found to be insolvent and is ordered liquidated, a receiver takes over the insurer under court supervision and processes the assets and liabilities through liquidation. Upon liquidation, FLAHIGA automatically becomes liable for the policy obligations the liquidated insurer owed to its Florida policyholders. We service the policies, collect premiums and pay valid claims under the policies. Our rights under the policies

[11] Section 631.715, F.S.

are those that applied to the insurer prior to liquidation. Our rights may include canceling the policy if the insurer could have done so, but normally we continue the policies until we can transfer them to a new, stable insurer with approval of the State. In any event, we pay all valid claims the insurer would have been liable for. Since the founding of FLAHIGA, we have paid out hundreds of millions in dollars for claims and to provide underlying support for policies."

Section Review

1. Continuing education hours required by an insurance licensee will depend on the license type held and number of years the license has been held. For most license types, continuing education is due every: (Refer to section 2.2.3, page 9)
   A. Two years **[Your answer is correct. Continuing education hours required will depend on the license type held and number of years the license has been held. For most license types, continuing education is due every 2 years.]**
   B. Four years **[Your answer is incorrect. For most license types, continuing education is not due every 4 years.]**
   C. Five years **[Your answer is incorrect. For most license types, continuing education is not due every 5 years.]**
   D. Seven years **[Your answer is incorrect. For most license types, continuing education is not due every 7 years.]**

2. Annuities product training must be completed: (Refer to section 2.2.1.3, page 8)

   A. Every two years **[Your answer is correct. Annuities product training must be completed every two years.]**
   B. Every four years **[Your answer is incorrect. Annuities product training must be completed every two years.]**
   C. Only if you are a new producer **[Your answer is incorrect. Annuities product training must be completed every two years.]**
   D. As mandated by the insurer **[Your answer is incorrect. Annuities product training must be completed every two years.**]

3. Which of the following activities can unlicensed insurance agency personnel perform? (Refer to section 2.2.7, pages 16-17)

   A. Advising customers as to insurance needs or insurance matters **[Your**

answer is incorrect. This activity is prohibited for unlicensed personnel.]

B. Interpreting polices or coverages **[Your answer is incorrect. This activity is prohibited for unlicensed personnel.]**
C. Soliciting the sale of insurance by telephone, in person, or by other communication **[Your answer is incorrect. This activity is prohibited for unlicensed personnel.]**
D. Giving a quote from written underwriting materials that state the rate in the agent's office, to a person who has called or come into the office **[Your answer is correct. Giving a quote is allowed provided it does not include application of judgment, processing, binding, policy interpretation, signing an application, procedure explanations or insurance advice and counsel, or similar activity.]**

3.0 Insurance Law and Updates

As a general rule, it is a licensee's responsibility to be familiar with all laws and administrative regulations applicable to whatever license(s) the licensee holds. You may access the applicable rules and regulations in the State of Florida by clicking on the following links applicable to your inquiry:

- State of Florida Statutes (Insurance)
- Florida Administrative Code (Rules)
- Pre-licensing rules
- Continuing education rules

3.1 New Law Updates

What follows is an overview of recent legislative activity that may impact you as a licensed insurance professional.

HB 959 – Unaffiliated Insurance Agents

A recent law created the category of "unaffiliated insurance agent." This law prohibited affiliation between the "unaffiliated" insurance agent and an insurer. A new law modified this restriction to allow unaffiliated agents to be appointed as adjusters (just not as agents).

[Effective: July 1, 2022, amending Florida Statutes 626.015 and 626.311.]

HB 1041 – Forfeiture for Abuse, Neglect, Exploitation, or Manslaughter of Elderly or Disabled Adult

It has long been law that a murderer can't inherit from their victim. Florida has now modified this rule to prohibit beneficiaries from inheriting if they have been convicted of abuse, neglect, exploitation, or aggravated manslaughter of an elderly or disabled adult. This prohibition applies, also if, in the absence of conviction the abuse, neglect, exploitation, or aggravated manslaughter of an elderly or disabled adult is proven by clear and convincing evidence. The prohibition does not just apply to inheritance by will, but also to joint accounts, trusts, or life insurance or other contracts (including annuities), or any other interest. These instruments will be interpreted as if the beneficiary predeceased the individual who was abused, etc.

Third parties who unknowingly purchased such inherited property are not liable, but the abuser (etc.) is liable to repay the estate, trust, etc.

This provision does not apply if it can be shown that the elderly or disabled individual ratified the arrangement after the conviction.

[Effective: July 1, 2021, amending Florida Statutes 732.8031]

HB 1209 – *Continuing Education for Agents (This Course)*

HB 1209 revises the number of continuing education hours for most insurance agents. The update course needed every two years, for example, will be four hours instead of five, the law reads.

[Effective: January 1, 2022; amending Florida Statutes 626.2815]

SB 2518

This bill revises the amount of money residents of a veterans' nursing home must receive monthly before being required to contribute to their maintenance and support; revising eligibility for Medicaid coverage for children according to the resource limits under the Temporary Cash Assistance Program; deleting authorization for payment for chiropractic, hearing, optometric, podiatric, and visual services provided to Medicaid recipients; revising the years of audited disproportionate share data the agency must use for calculating an average for purposes of calculating disproportionate share payments, etc.

[Effective: July 1, 2021; amending Florida Statutes 296.36; 414.115; 409.908]

CS/SB 292 — Newborn Screenings

Requires a hospital or other state-licensed birthing facility to test a newborn for congenital cytomegalovirus (CMV) if the newborn has failed their hearing screening, before the newborn is 21 days old or before discharge, whichever occurs earlier.

For home births and births in a licensed birth center, if a newborn fails a hearing test, the bill requires that the newborn's primary health care provider must refer the newborn to be tested for CMV and changes the timeframe in which a referral for appointment for a newborn hearing screening must occur, to within seven days after delivery, rather than 30 days.

Additionally, the bill requires that the results of any newborn screening test to be reported to the Department of Health within seven days of receipt of the results.

[Effective January 1, 2023; amending Florida Statues 381.145]

3.1.1 About the Statutes

You may view all of the Florida Statutes online at www.leg.state.fl.us. A complete listing of statutes of the Florida Department of Financial Services' Division of Agent and Agency Services can be found in Title 37, Chapters 624-651

To search for a specific statute at www.leg.state.fl.us: Click on the link and open their page, then type in the statute number (e.g., 626.015) in search field located in the upper right of their page.

3.1.2 About the Rules

You may view all Florida Administrative Rules online at www.flrules.org. A complete listing of administrative rules of the Florida Department of Financial Services' Division of Agent and Agency Services can be found in Chapter 69B of the Florida Administrative Code.

To search for a specific rule at www.flrules.org: Click on the link and open their page, then type in the rule number (e.g., 1B-11.004) in search field located in the upper center of their page.

3.2 Pertinent Federal Law Review

There are many federal statutes enacted in addition to state statutes that impact you as a licensed insurance professional. Although insurance regulation is typically a state matter, interstate matters are regulated by federal insurance laws. You should ensure that you keep current on these laws.

The principal federal law affecting many insurance agents is the Patient Protection and Affordable Care Act (PPACA—or, more frequently, just ACA). Pursuant to the ACA, most individual health insurance policies and group health plans[12] cannot:

- Impose coverage exclusions based on an insured's pre-existing conditions;
- Impose annual or lifetime benefit limits; or
- Be rescinded by the insurer except in the case of fraud or the intentional misrepresentation of a material fact on the application for coverage.

In addition, the ACA requires that health plans providing coverage for dependent children permit dependent child coverage to remain in force until the child reaches age 26. It also provides for certain patient protections on health plans:

- Involving networks of healthcare providers; and
- Providing emergency services.

The ACA also requires non-exempt individuals to maintain health insurance whose coverage is at least equal to minimum essential coverage. This requirement was previously enforced through payment of a tax penalty.

2018 was the last year this penalty applied. The Tax Cuts and Jobs Act of 2017, reduced the penalty amount to zero for tax years starting in 2019.ACA, as originally enacted, provided for an extension of Medicaid coverage for low-income individuals. Since Medicaid is a federal-state partnership, according to the U.S. Supreme Court, state approval is required. Florida has not, however, approved the extension (enabling legislation failed in 2015), so extended Medicaid coverage is not approved in Florida. As of January 2023, Florida is 1 of 11 states declining to accept federal money to expand Medicaid. With the end of the COVID public health emergency, 1.7 million people in Florida will soon lose their Medicaid health coverage, despite having incomes under 138 percent of the poverty level.

The ACA requires large employers to offer minimum essential, affordable coverage to their employees. Employers with 50 or more full-time employees are covered by this rule. Most large employers already have plans for their employees, but will come under new reporting requirements.

[12] Group and individual insurance coverage in force on March 23, 2010 (the date on which the PPACA became law) is grandfathered and may be exempt from certain PPACA provisions as long as its grandfathered status is maintained.

In 2021, a health plan was considered affordable if self-only coverage costs no more than 9.83 percent of an employee's total household income. In 2023, a job-based health plan is considered "affordable" if your share of the monthly premium in the lowest-cost plan offered by the employer is less than 9.12% of your household income.

Small employers (those with fewer than 50 full-time employees) are not required to offer health insurance to their employees. However, if certain small employers (those with 25 or fewer employees) obtain coverage through a Small Business Health Options Program (SHOP) in the ACA healthcare marketplace, they may be eligible to receive a tax credit for premiums paid for employee health insurance coverage.

During the Trump Administration, insurance companies offering policies on HealthCare.gov were permitted to refuse to renew coverage for people who had fallen behind on premium payments. For 2023, that will no longer be the case. People who fell behind on premium payments in 2022 (or even lapsed coverage due to nonpayment) will still be able to enroll in a 2023 policy offered by that insurer; and the binder payment (the January 2023 monthly premium payment) required to effectuate coverage cannot be applied to past-due premiums.

In addition, once Open Enrollment ends, people will continue to be able to sign up for Marketplace coverage mid-year if they have a qualifying life event (such as loss of other coverage, marriage or divorce, or a permanent move) using a 60-day special enrollment period (SEP). In HealthCare.gov states, people had been required to first complete a pre-enrollment verification process by providing documentation of their qualifying event that made them eligible for an SEP. People who could not provide such documentation within 30 days often were denied the SEP. Starting in 2023, HealthCare.gov will only require pre-enrollment verification for SEPs due to loss of other prior coverage. For other qualifying events (marriage, divorce, permanent move, etc.) people will be able to self-attest to their eligibility and proceed to enroll in coverage during their SEP.

Annual Inflation Adjustments

Licensed insurance professionals should be aware of recent cost-of-living adjustments made to several insurance-related plans—including health savings accounts, flexible savings accounts, and long-term care insurance—that are given favorable tax treatment under the Internal Revenue Code.

Health savings accounts (HSAs) may be opened by individuals who are covered by high-deductible health plans. Individuals can take an income tax

deduction for contributions to these accounts, and funds may be withdrawn tax-free to pay for qualified medical expenses, including dental and vision care. Any amounts remaining in an HSA at the end of a year roll over and may be used to pay for future medical expenses.

The following contribution, deductible, and out-of-pocket spending limits apply to HSAs and high-deductible health plans:

deduction for contributions to these accounts, and funds may be withdrawn tax-free to pay for qualified medical expenses, including dental and vision care. Any amounts remaining in an HSA at the end of a year roll over and may be used to pay for future medical expenses.

The following contribution, deductible, and out-of-pocket spending limits apply to HSAs and high-deductible health plans:

Contribution and Out-of-Pocket Limits for Health Savings Accounts and High-Deductible Health Plans			
	2023	**2022**	**Change**
HSA contribution limit (employer + employee)	Self-only: $3,850 Family: $7,750	Self-only: $3,650 Family: $7,300	Self-only: +$200 Family: +$450
HSA catch-up contributions (age 55 or older)	$1,000	$1,000	No change
HDHP minimum deductibles	Self-only: $1,500 Family: $3.000	Self-only: $1,400 Family: $2,800	Self-only: $100 Family: $200
HDHP maximum out-of-pocket amounts (deductibles, co-payments and other amounts, but not premiums)	Self-only: $7,500 Family: $15,000	Self-only: $7,050 Family: $14,100	Self-only: +$450 Family: +$900
Source: IRS, Revenue Procedure 2020-32.			

Flexible spending accounts (FSAs) are another type of tax-favored account that workers can use to pay for various out-of-pocket health care costs, including deductibles, copayments, dental, and other medical expenses. Amounts contributed are deducted from a worker's paycheck and withdrawals can be used tax-free to pay for medical expenses. Any amounts in excess of $500 that remain in an FSA at year-end are forfeited—hence the "use it or lose it" name associated with these accounts.

For calendar year 2022, the dependent care flexible spending account (FSA) pretax contribution limit remained at $5,000 for single taxpayers and married

couples filing jointly, and to $2,500 for married individuals filing separately.

The health FSA contribution limit is $3,050 for 2023, up from the previous year's amount of $2,850.

Flexible spending accounts (FSAs) are another type of tax-favored account that workers can use to pay for various out-of-pocket health care costs, including deductibles, copayments, dental, and other medical expenses. Amounts contributed are deducted from a worker's paycheck and withdrawals can be used tax-free to pay for medical expenses. Any amounts in excess of $500 that remain in an FSA at year-end are forfeited—hence the "use it or lose it" name associated with these accounts.

For calendar year 2022, the dependent care flexible spending account (FSA) pretax contribution limit remained at $5,000 for single taxpayers and married couples filing jointly, and to $2,500 for married individuals filing separately.

The health FSA contribution limit is $3,050 for 2023, up from the previous year's amount of $2,850.

Individuals who purchase qualified long-term care insurance policies also receive favorable tax treatment: they may take an income tax deduction for premiums paid to the extent premiums and any other medical expenses as long as they exceed 7.5 percent of their adjusted gross income. Those who are self-employed can take the amount of the premium as a deduction as long as they made a net profit; their medical expenses do not have to exceed a certain percentage of their income. What is deductible as a medical expense is spelled out in Internal Revenue Service Publication 502.

However, there is a limit on how large a premium can be deducted, depending on the age of the taxpayer at the end of the year. Following are the deductibility limits for the current and past year. Any premium amounts for the year above these limits are not considered to be a medical expense. (The limits are adjusted annually with inflation.)

Age attained before the end of the taxable year	Amount allowed as a medical expense in	
	2023	2022
40 or under	$450	$450
41-50	$850	$850
51-60	$1,690	$1,690
61-70	$4,520	$4,510
71 or older	$5,640	$5,640

Medicare Inflation Adjustments

Health insurance agents should also be aware of changes to certain Medicare figures that are adjusted for inflation and subject to change annually.

Most people don't pay a Part A premium because they paid Medicare taxes while working. If they don't get premium-free Part A, the standard monthly premium for Medicare Part B enrollees may be up to $506 each month

For example, individuals who are covered by Medicare Part A are responsible for certain cost-sharing amounts that are subject to annual inflation adjustments. For 2023, these amounts are:

MEDICARE PART A COSTS 2023	
Full Part A Premium	$506
Partial Part B Premium	$164.90
Hospital Stay	
Inpatient Hospital Deductible (per benefit period)	$1,600
Daily Coinsurance for First 60 Days of Each Benefit Period	$0
Daily Coinsurance for Days 61 to 90 of Each Benefit Period	$400
Daily Coinsurance for Lifetime Reserve Days	$800
Skilled Nursing Facility Stay	
Coinsurance for First 20 Days of Each Benefit Period	$0
Coinsurance per Day for Days 21–100 of Each Benefit Period	$200
After Day 100 of the Benefit Period	All costs

Late enrollment penalty: If they don't buy it Medicare Part A when they're first eligible, the monthly premium may go up 10%. (They'll have to pay the higher premium for twice the number of years they could have had Part A, but didn't sign up.)

Individuals who are covered by Medicare Part B must pay a monthly premium for coverage. In 2023, the premium was $164.90 for most individuals. Some higher-income beneficiaries must pay an additional amount, which is based on their adjusted gross income. Once a person meets the deductible, they will then pay 20% of the Medicare-approved amount for most doctor services, outpatient therapy, and durable medical equipment.

2023 MEDICARE PART B COSTS			
If your yearly income in 2021 (for what you pay in 2023) was			You pay each month (in 2023)
File individual tax return	File joint tax return	File married & separate tax return	
Less than or equal to $97,000	Less than or equal to $194,000	$0.00	$164.90
Above $97,000 and up to $123,000	Above $194,000 up to $246,000	$65.00	$230.80
Above $123,000 up to $153,000	Above $246,000 up to $306,000	$164.80	$329.70
Above $153,000 up to $183,000	Above $306,000 up to $366,000	$263.70	$428.60
Above $183,00 and less than $500,000	Above $366,000 and less than $750,000	$336.60	$527.50
$500,000 and above	$750,000 and above	$395.90	$560.50

Late enrollment penalty: In most cases, if someone doesn't sign up for Part B when they're first eligible, they'll have to pay a late enrollment penalty for as long as they have Part B. The monthly premium for Part B may go up 10% of the standard premium for each full 12-month period that they could have had Part B,

but didn't sign up for it. Also, they may have to wait until the General Enrollment Period (from January 1 to March 31) to enroll in Part B. Coverage will start July 1 of that year.

Individuals who are enrolled in Medicare Parts A and B must purchase a stand-alone **Medicare Part D prescription plan** if they want to obtain prescription drug coverage. Some plans require you to pay a deductible, or 100% of the cost of prescription drugs, up to a certain limit before your plan starts to pay. The deductibles vary between plans and some Part D plans have no deductible. In 2023, the deductible can’t be more than $505.

If someone has a Medicare Part D plan, they move through the CMS coverage stages in this order: deductible (if applicable), initial coverage, coverage gap, and catastrophic coverage.

If your plan has a **deductible,** this stage begins when you fill your first prescription of the year. During this stage, you pay the full cost of your prescription drugs, this stage begins when you fill your first prescription of the year. During this stage, you pay the full cost of your prescription drugs.

During the **initial phase**, copayments and coinsurance come into play. The insured pays just their share of prescription costs and their plan pays the rest for covered drugs. For example, if their plan has a 25% copayment for a $200 prescription, the insured would pay $50 and their plan would cover the $150 balance.

Most Medicare drug plans have a **coverage gap** (also called the "donut hole"). This means there's a temporary limit on what the drug plan will cover for drugs. Not everyone will enter the coverage gap, and it doesn’t apply to members who get Extra Help to pay for their Part D costs. Once in the gap, the insured pays no more than 25% of the cost for brand-name and generic prescription drugs covered by their plan, although the full cost of those drugs will be used to move them closer to the catastrophic coverage phase.

The **catastrophic coverage phase** is the last phase of Part D plan coverage. The insured pays only a small coinsurance amount or copayment for covered drugs for the rest of the year. When the new plan year begins, they start over at the initial phase.

For 2023, once you've spent $7,400 in 2023 (up from $7,050 in 2022, and up considerably from 2019, when it was $5,100), you're out of the coverage gap and move into phase 4—catastrophic coverage.

The chart below shows the estimated prescription drug plan monthly premium based on income as reported on IRS tax return. If someone's income is above a certain limit, they'll pay an income-related monthly adjustment amount in addition to their plan premium.

If your filing status and yearly income in 2021 was:			
File individual tax return	**File joint tax return**	**File married & separate tax return**	**You pay each month (in 2022)**
$97,000 or less	$194,000 or less	$97,000 or less	your plan premium
Above $97,000 up to $123,000	Above $194,000 up to $246,000	not applicable	$12.20 + your plan premium
Above $123,000 up to $153,000	Above $228,000 up to $284,000	not applicable	$31.50 + your plan premium
Above 153,000 up to $183,000	Above $306,000 up to $366,000	not applicable	$50.70 + your plan premium plan premium
Above $183,000 and less than $500,000	Above $366,000 and less than $750,00	Above $97,000 and less than $403,000	$70.00 + your plan premium
$500,000 and above	$750,000 and above	$403,000 and above	$76.40 + your plan premium

The 2023 Part D National Base Beneficiary Premium was $32.74. This amount is used to estimate the Part D late enrollment penalty and the income-related monthly adjustment amounts listed in the table above. The national base beneficiary premium amount can change each year. See your *Medicare & You* handbook or visit Medicare.gov for more information.

Protections for Senior Clients

Much of the push behind the development of client protections in the annuity market came from the approaching retirement of the baby boomers. Suitability is only part of the scheme for protecting retirees. Heightened concern for the financial risks of older clients is becoming a daily part of an agent's business. This includes preparing for the possibility that the client's capacity to handle financial matters may diminish over time and being alert for scam artists who like to prey on older individuals.

The details of these protections are beyond the scope of this course, but agents

who sell annuities inevitably deal with older clients and should be aware of protections that apply. The details vary in each state, but include things such as:

- getting the client to identify a trusted individual who can receive information on the account (otherwise, general privacy laws may prevent that);
- immunity from legal liability when an agent reports suspected financial exploitation of a senior client to the authorities (this is also part of federal law under the 2018 Senior$afe Act); and
- procedures for delaying disbursement of funds when financial exploitation is suspected (FINRA Rule 2165 and a 2016 model law proposed by the North American Securities Administrators Association both cover this).

Section Review

1. The ACA requires that health plans providing coverage for dependent children permit dependent child coverage to remain in force until the child is what age? (Refer to Section 3.2, page 32)
   A. 26, but only if the child is disabled**. [Your answer is incorrect. ACA requires that health plans providing coverage for dependent children permit dependent child coverage to remain in force up to the child's age 26.]**
   B. 18, unless the child is enrolled in college and is still listed as a dependent. **[Your answer is incorrect. ACA requires that health plans providing coverage for dependent children permit dependent child coverage to remain in force up to the child's age 26.]**
   C. 21, provided that the child still lives in your primary residence. **[Your answer is incorrect. ACA requires that health plans providing coverage for dependent children permit dependent child coverage to remain in force up to the child's age 26.]**
   D. 26. **[Your answer is correct. ACA requires that health plans providing coverage for dependent children permit dependent child coverage to remain in force up to the child's age 26.]**

2. Eduardo, age 45, paid $1,000 this year in premiums for his qualified long-term care insurance policy. His adjusted gross income was $80,000, and he had $8,000 in other medical expenses for the year. Which statement about Eduardo's ability to take an income tax deduction for the premium payments is correct? (Refer to Section 3.2, page 33)
   A. Eduardo may take an income tax deduction for the entire amount of long-term care premiums paid. **[Your answer is incorrect. A person may take an income tax deduction for long-term care premiums paid to**

the extent such amounts exceed 7.5 percent of adjusted gross income. The amount that may be deducted also depends on a person's age.]

B. Eduardo may take an income tax deduction only if he is age 60 or older. [**Your answer is incorrect. A person may take an income tax deduction for long-term care premiums paid to the extent such amounts exceed 7.5 percent of adjusted gross income. The amount that may be deducted also depends on a person's age.]**

C. Eduardo's income tax deduction will be limited to a maximum amount, which depends on his age. [**Your answer is correct. The maximum amount of long-term care premiums that may be deducted depends on a policyowner's age. Expenses are also deductible only to the extent they exceed 7.5 percent of adjusted gross income.]**

D. Eduardo is not eligible to take an income tax deduction for premiums paid. **[Your answer is incorrect. A person may take an income tax deduction for long-term care premiums paid to the extent such amounts exceed 7.5 percent of adjusted gross income. The amount that may be deducted also depends on a person's age.]**

3. Assume your client was eligible for Medicare Part A coverage in 2017 but didn't sign up until five years later. How long would your client pay a late-enrollment penalty? (Refer to Section 3.2, page 34)

   A. 2 years **[Your answer is incorrect. The Medicare Part A late-enrollment penalty is a 10% higher premium for twice the number of years that someone was eligible, but didn't sign up.]**

   B. 5 years **[Your answer is incorrect. The Medicare Part A late-enrollment penalty is a 10% higher premium for twice the number of years that someone was eligible, but didn't sign up.]**

   C. 8 years **[Your answer is incorrect. The Medicare Part A late-enrollment penalty is a 10% higher premium for twice the number of years that someone was eligible, but didn't sign up.]**

   D. 10 years **[Your answer is correct. 5 x 2 =10. The Medicare Part A late-enrollment penalty is a 10% higher premium for twice the number of years that someone was eligible, but didn't sign up.]**

4. Why is it that most people do not have to pay a Part A premium? (Refer to Section 3.2, page 35)

   A. Because of their age **[Your answer is incorrect. Age is not a factor.]**

B. Because they qualify for Medicaid **[Your answer is incorrect. Qualifying for Medicaid is not a factor.]**
C. Because they paid Medicare taxes while working **[Your answer is correct. Most people do not pay a Part A premium because they paid Medicare taxes while working.]**
D. Because of marital status **[Your answer is incorrect. Marital status is not a factor.]**

Heightened Standard When Fiduciary Rules Apply

In recent years, there has been controversy over whether commissioned agents have a conflict of interest, due to the commission itself, when they recommend annuities, particularly high-commission products. This has led a variety of regulatory bodies and professional societies to require that the agent act as a fiduciary in the "best interest" of the client, to put the client's interest ahead of the agents and, in some cases to be paid on some basis other than commissions.

There are many ways an agent could be considered a fiduciary. Here is a list of possibilities (there may be more). The agent could be:

- A registered investment advisor;
- A member of a professional association or hold a designation that requires you to act as a fiduciary;
- A trustee or agent under a power of attorney for the client;
- Giving advice under an agreement with a client that states that you are a fiduciary; or
- Giving advice on a *regular basis* to a client in the context of a retirement plan covered by ERISA.

In April 2016, the U.S. Department of Labor (DOL) issued a set of rules to apply the fiduciary standard investment advice provided to employer-sponsored retirement plans, IRAs, and their participants. In the area of annuities, these rules partially overlap the NAIC annuity suitability rule-particularly in the area of advice to IRAs and their owners. In May 2018, before the rule was scheduled to be fully implemented, however, it was vacated nationally by the U.S. Court of Appeals for the 5th Circuit.

This is not the end of the story, however. The Securities and Exchange Commission has issued Regulation Best Interest (Reg BI), which will apply to insurance licensees who are also licensed with the SEC as registered representatives. Details of Reg BI appear below.

The NAIC is also considering modification of its NAIC annuity suitability rule to incorporate a best interest standard, as well, that will apply to insurance licensees when their state adopts the NAIC modification. As this course was written, the NAIC hadn't yet taken action, but action is expected in the coming year, as the drafting process is nearing completion. Various states also are considering their own requirements.[13] And, of course, the fiduciary standard already does apply in the cases noted above.

Before we get to Reg BI, it is important to understand what the **fiduciary standard** is and how it applies in a variety of situations. A short answer includes two components:

- **Duty of care.** The fiduciary duty of care is similar to the suitability analysis that we have already discussed in this course, but with a heightened level of diligence. The agent must know the client and the client's need. The agent must know the costs and benefits of the products being recommended. And the agent's analysis must support the recommendation as being in the best interest of the client.
- **Duty of loyalty.** The fiduciary duty of care requires the agent to be focused on the client's best interest and not any interest of the agent. There must be no conflict of interest (in some, but not all cases, disclosed conflicts may be waived, depending on the specific rule). A major source of conflicts comes from commissioned products where a commission differential between products might be considered an improper incentive for an agent to recommend a product. Other conflicts, of course, are possible and must be avoided.

Best practices dictate (and in many cases the law or professional rules demand) careful documentation of the reasons for any recommendation in order to show that the standard of care has been met.

SEC's Regulation BI

Now that we have reviewed the general requirements of a fiduciary standard, let's briefly look at the specific requirements of the SEC's new Regulation BI. It has been called a fiduciary standard or a quasi-fiduciary standard. Reg BI will apply to insurance licensees mostly in the area of variable products, because they are the type of products sold by dual licenses. If you sell mutual funds or other security products (for which an insurance license is not require), Reg BI will cover those activities as well. Your firm will be developing policies and procedures in this area

[13] For example, the State of New York has adopted a best interest standard for recommendations of annuities and life insurance. See 11 NYCRR 224.

and the compliance deadline for having everything in place is June 30, 2020.

What does Reg BI require? As you will see below, it tracks the duties of care and loyalty that we just discussed. These are broken down into four components:

1. **Care.** You and your firm are obligated to act in the best interest of the customer when making recommendations involving investment products (again, this refers to products subject to SEC regulation and products subject to combined SEC and state insurance regulation, but not "fixed" insurance or annuity products that are outside SEC jurisdiction), strategies, or account changes, like rollovers. Your obligation of care does not require you to be perfect or clairvoyant. You are required to understand the risks, rewards, and costs of your recommendations. And you are required to consider the customer's investment profile (see below) and have a reasonable basis to believe that your recommendation is in the customer's best interest, not excessive, and doesn't place your interest or the firm's interest ahead of the customer's interest.
2. **Conflicts of Interest (i.e., Loyalty).** Your firm is required to establish policies and procedures designed to identify, disclose, and mitigate conflicts of interest that might create an incentive for you to make recommendations that place your interest or your firm's interest ahead of the customer's interest. The reg particularly requires the firm to identify and eliminate incentives such as sales contests, sales quotas, bonuses, etc. that are based on you selling particular products or types of product, because those incentives create a conflict of interest that would tend to work against the interests of customers.
3. **Disclosure.** One check on your adherence to the two rules we just discussed is the requirement that you make full and fair disclosure to your customers when you make recommendations. Your disclosures must include the type and scope of your recommendations, including the pros and cons, and particularly including all material fees and costs. You must also disclose any material conflicts of interest associated with the recommendation.
4. **Compliance.** The second check on your adherence to the first two requirements will be the policies and procedures your firm sets up to document and achieve compliance with Reg BI. You are required to follow them.

Regulation BI only applies to retail customers.

Item 1, above, requires you to consider the customer's investment profile. A retail

customer's investment profile includes:

- age,
- other investments,
- financial situation and needs,
- tax status,
- investment objectives,
- investment experience,
- investment time horizon,
- liquidity needs,
- risk tolerance, and
- other information disclosed to the firm.

Protections for Senior Clients

Much of the push behind the development of client protections in the annuity market came from the approaching retirement of the baby boomers. Suitability is only part of the scheme for protecting retirees. Heightened concern for the financial risks of older clients is becoming a daily part of an agent's business. This includes preparing for the possibility that the client's capacity to handle financial matters may diminish over time and being alert for scam artists who like to prey on older individuals.

The details of these protections are beyond the scope of this course, but agents who sell annuities inevitably deal with older clients and should be aware of protections that apply. The details vary in each state, but include things such as:

- getting the client to identify a trusted individual who can receive information on the account (otherwise, general privacy laws may prevent that);
- immunity from legal liability when an agent reports suspected financial exploitation of a senior client to the authorities (this is also part of federal law under the 2018 Senior$afe Act); and
- procedures for delaying disbursement of funds when financial exploitation is suspected (FINRA Rule 2165 and a 2016 model law proposed by the North American Securities Administrators Association both cover this).

Health Insurance

The principal federal law affecting many insurance agents is the Patient Protection and Affordable Care Act (PPACA-or, more frequently, just ACA). Pursuant to the

ACA, most individual health insurance policies and group health plans[14] cannot:

- Impose coverage exclusions based on an insured's pre-existing conditions;
- Impose annual or lifetime benefit limits; or
- Be rescinded by the insurer except in the case of fraud or the intentional misrepresentation of a material fact on the application for coverage.

In addition, the ACA requires that health plans providing coverage for dependent children permit dependent child coverage to remain in force until the child reaches age 26. It also provides for certain patient protections on health plans:

- Involving networks of healthcare providers; and
- Providing emergency services.

The ACA also requires non-exempt individuals to maintain health insurance whose coverage is at least equal to minimum essential coverage. This requirement was previously enforced through payment of a tax penalty.

2018 was the last year this penalty applied. The Tax Cuts and Jobs Act of 2017, reduced the penalty amount to zero for tax years starting in 2019.

ACA, as originally enacted, provided for an extension of Medicaid coverage for low-income individuals. Since Medicaid is a federal-state partnership, according to the U.S. Supreme Court, state approval is required. As of June 2021, Florida is one of 12 states that have not expanded Medicaid. Those states are Wyoming, Texas, South Dakota, Wisconsin, Mississippi, Tennessee, Alabama, Georgia, North Carolina, South Carolina, Kansas and Florida. Florida legislators have refused to expand Medicaid as envisioned under the Affordable Care Act. Their decision left an estimated 850,000 Floridians without healthcare insurance in the "coverage gap." Those caught in the gap earn too much to receive Medicaid, but not enough to qualify for subsidies to buy a plan through the federal marketplace.

The ACA requires large employers to offer minimum essential coverage to their employees. Employers with 50 or more full-time employees are covered by this rule. Most large employers already have plans for their employees, but will come under new reporting requirements.

Small employers (those with fewer than 50 full-time employees) are not required to offer health insurance to their employees. However, if certain small employers (those with 25 or fewer employees) obtain coverage through a Small Business Health Options Program (SHOP) in the ACA healthcare marketplace, they may be

[14] Group and individual insurance coverage in force on March 23, 2010 (the date on which the PPACA became law) is grandfathered and may be exempt from certain PPACA provisions as long as its grandfathered status is maintained.

eligible to receive a tax credit for premiums paid for employee health insurance coverage.

Section Review

1. Under the SEC's Regulation BI, you and your firm are required to do all of the following EXCEPT: (Refer to Section 3.2, pages 34-35)

    A. Understand the risks, rewards, and costs of your recommendations. **[Your answer is incorrect. Under the SEC's Regulation BI, you and your firm are required to understand the risks, rewards, and costs of your recommendations.]**
    B. Identify and eliminate incentives such as sales contests, sales quotas, bonuses, etc. that are based on you selling particular products or types of product **[Your answer is incorrect. Under the SEC's Regulation BI, you and your firm are required to identify and eliminate incentives such as sales contests, sales quotas, bonuses, etc. that are based on you selling particular products or types of products.]**
    C. Consider the customer's investment profile, excluding their age**. [Your answer is correct. Under the SEC's Regulation BI, you and your firm are required to consider the customer's investment profile which includes their age, age, other investments, financial situation and needs, tax status, investment objectives, investment experience, investment time horizon, liquidity needs, risk tolerance, and other information disclosed to the firm.]**
    D. Make full and fair disclosure to your customers when you make recommendations. **[Your answer is incorrect. Under the SEC's Regulation BI, you and your firm are required to make full and fair disclosure to your customers when you make recommendations.]**

2. Under Florida law, an individual who has been convicted of abuse, neglect, exploitation, or aggravated manslaughter of an elderly or disabled adult may not "inherit" from them. This restriction applies to all of the following EXCEPT: (Refer to Section 3.1, page 30)

    A. The individual may not be a beneficiary of the decedent's trust **[Your answer is incorrect. Interests ratified after the conviction are an exception to the new rule and may take effect at the death of the elderly or disabled adult. An interest as a trust beneficiary is cut off, however.]**
    B. The individual may not take ownership of a joint account **[Your answer is incorrect. Interests ratified after the conviction are an exception to**

the new rule and may take effect at the death of the elderly or disabled adult. An interest as a joint account holder is cut off, however.]

C. The individual may not receipt life insurance proceeds **[Your answer is incorrect. Interests ratified after the conviction are an exception to the new rule and may take effect at the death of the elderly or disabled adult. An interest as a life insurance beneficiary is cut off, however.]**
D. The individual may not take possession of an interest created or ratified by the decedent after the conviction **[Your answer is correct. Interests ratified after the conviction are an exception to the new rule and may take effect at the death of the elderly or disabled adult.]**

4.0 Ethical Requirements

Let's begin with a look at the rights of the consumer. The DFS believes that all licensees should adhere to the same policyholders' bill of rights. As a result, they have passed legislation containing a policyholder bill of rights at Florida Statutes, Section 626.9641.[15] The Florida policyholders' bill of rights states as follows:

> *(1) The principles expressed in the following statements shall serve as standards to be followed by the department, commission, and office in exercising their powers and duties, in exercising administrative discretion, in dispensing administrative interpretations of the law, and in adopting rules:*
>
> > *(a) Policyholders shall have the right to competitive pricing practices and marketing methods that enable them to determine the best value among comparable policies.*
> >
> > *(b) Policyholders shall have the right to obtain comprehensive coverage.*
> >
> > *(c) Policyholders shall have the right to insurance advertising and other selling approaches that provide accurate and balanced information on the benefits and limitations of a policy.*
> >
> > *(d) Policyholders shall have a right to an insurance company that is*

15 http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=0600-0699/0626/Sections/0626.9641.html

financially stable.

(e) Policyholders shall have the right to be serviced by a competent, honest insurance agent or broker.

(f) Policyholders shall have the right to a readable policy.

(g) Policyholders shall have the right to an insurance company that provides an economic delivery of coverage and that tries to prevent losses.

(h) Policyholders shall have the right to a balanced and positive regulation by the department, commission, and office.

(2) This section shall not be construed as creating a civil cause of action by any individual policyholder against any individual insurer.

4.1 Agent's Code of Ethics

The NAIFA Code of Ethics, which was also adopted by the Florida Association of Insurance and Financial Advisors provides:

PREAMBLE: Helping my clients protect their assets and establish financial security, independence and economic freedom for themselves and those they care about is a noble endeavor and deserves my promise to support high standards of integrity, trust and professionalism throughout my career as an insurance and financial professional. With these principles as a foundation, I freely accept the following obligations:

- *To help maintain my clients' confidences and protect their right to privacy.*
- *To work diligently to satisfy the needs of my clients.*
- *To present, accurately and honestly, all facts essential to my clients' financial decisions.*
- *To render timely and proper service to my clients and ultimately their beneficiaries.*
- *To continually enhance professionalism by developing my skills and increasing my knowledge through education.*
- *To obey the letter and spirit of all laws and regulations which govern my profession.*
- *To conduct all business dealings in a manner which would reflect favorably on NAIFA and my profession.*
- *To cooperate with others whose services best promote the interests of my clients.*

- *To protect the financial interests of my clients, their financial products and my profession, through political advocacy*

4.2 Agent's Fiduciary Responsibility to Client

A fiduciary is defined as "a person to whom property or power is entrusted for the benefit of another." In general, the duties owed by a fiduciary to those they represent include:

- **The Duty of Utmost Care** The agent is bound to the higher standard of a professional in the field, which extends the standard of duty to investigate within the means of the profession, ensure maximum protection and provide information to the principal.
- **The Duty of Integrity** Defined as the soundness of moral principle and character, this means the agent must act with fidelity and honesty.
- **The Duty of Honesty and Full Disclosure** of all material facts, either within the knowledge of or reasonably discoverable by the agent, which could influence the principal's decisions, actions or willingness to enter into a transaction.
- **The Duty of Loyalty** An obligation to refrain from acquiring any interest adverse to that of a principal without full and complete disclosure of all material facts and obtaining the principal's informed consent, this precludes the agent from personally benefitting from secret profits, competing with the principal, or obtaining an advantage from the agency relationship for personal benefit of any kind.
- **The Duty of Good Faith** includes total truthfulness, absolute integrity and total fidelity to the principal's interest. The duty of good faith prohibits any advantage over the principal obtained by the slightest misrepresentation, concealment, threat or adverse pressure of any kind.

The State of Florida has in place some of the most stringent ethics regulations in the industry. Let's take a closer look.

4.3 Code of Ethics (DFS Rule 69B-215.210, F.A.C.)

Florida's Administrative Code at 69B-215.210 addresses ethics and the business of life insurance. Specifically, the Code provides that:

> *the business of life insurance is declared to be a public trust in which all agents of all companies have a common obligation to work together in serving the best interests of the insuring public, by understanding and*

observing the laws governing life insurance in letter and in spirit by presenting accurately and completely every fact essential to a client's decision, and by being fair in all relations with colleagues and competitors always placing the policyholder's interests first.

You should strive at all times to meet or exceed the ethical expectations of the state placed on you as an insurance professional.

4.4 Marketing

There are ethical implications associated with the way insurance products are marketed and sold. Although many people know exactly what is NOT acceptable in insurance marketing (taking advantage of certain groups of people like senior citizens, lying about a competitor, misleading customers about a product or service, commingling premium money and personal money, falsifying or encouraging the insureds to falsify information to the insurer, sharing confidential information, etc.) few are fully aware of what marketing practices comprise ethical marketing.

Ethical marketing is defined as "*practices that emphasize transparent, trustworthy, and responsible marketing practices and actions which exhibit integrity and fairness to consumers and other stakeholders*."[16] The concept of appropriate selling has evolved over the years and today employs a collaborative, trust-based approach. This collaborative method is referred to as consultative selling and requires spending a greater amount of time developing a rapport with the customer, determining the customer's true needs, and then coming up with innovative solutions best suited to the customer's needs. The consultative approach is more transparent, creates an atmosphere of trust, and the produces results that tend to favor the policyholder rather than the producer or insurance company.

On point, Florida Administrative Code at Section 69B-215.235 addresses one aspect of deceptive marketing that often involves the use (or misuse) of designations. The Code provides:

> *(1) The purpose of this rule is to set forth standards to protect consumers from dishonest, deceptive, misleading, and fraudulent trade practices with respect to the use of certifications and professional designations in the marketing, solicitation, negotiation, sale or advice made in connection with an insurance transaction by any licensee.*
>
> *(2) The department does NOT endorse any professional designation.*

[16] *Ethical Marketing and Marketing Strategy*, Gene R. Laczniak and Patrick E. Murphy

(3) For purposes of this rule:

(a) A designation is any combination of words, any acronym standing for a combination of words or any job title that indicates or implies that a licensee has special knowledge or training in advising or servicing consumers beyond the knowledge or training required for the license held.

(b) A certification is any designation that indicates, implies or recognizes that an individual or organization meets certain established criteria beyond the criteria required for the license held.

(4) A designation may not be lawfully used under the Insurance Code unless the designation is obtained from an organization that has published standards and procedures for assuring the competency of its certificants or designees on specific subject matters, which standards and procedures are continually utilized by the organization.

(5) The organization or entity conferring the designation must approve any terminology, combination of words and/or acronym to be used by the designee.

(6) The prohibited use of any designation includes, but is not limited to, the following:

(a) Use of a designation by a person who has not actually earned or is otherwise ineligible to use such designation;

(b) Use of a nonexistent or self-conferred designation;

(c) Use of a designation that indicates or implies a level of occupational qualifications obtained through education, training, or experience that the person using the designation does not have, and

(d) Use of any designation not obtained in compliance with subsection (4), above.[17]

4.5 Understanding Industry Products and Suitability of Sales

Understanding industry products and suitability of sales is best explored through the eyes of a senior customer, the segment of the population often considered the most vulnerable to deception and who may have a lesser understanding of what is being offered than say, a 30-year-old consumer. This is not a reflection on the senior's intelligence; it is an acknowledgement that as we age, our cognitive skills may decline, making it easier to be confused and in some instances, deceived. It

[17] https://www.flrules.org/gateway/RuleNo.asp?id=69B-215.235

is your duty as an insurance professional to make sure that when making a suitability determination, you follow the dictates of professional ethics and the law of the land.

Florida statutes provide that when recommending the purchase or exchange of an annuity that an agent or insurer must obtain, at a minimum, the following information from a consumer/potential customer:

- Personal information, including the age and sex of the parties to the annuity and the ages and number of any dependents;
- Tax status of the consumer;
- Investment objectives of the consumer;
- The source of the funds to be used to purchase the annuity;
- The applicant's annual income;
- Intended use of the annuity;
- The applicant's existing assets, including investment holdings;
- The applicant's liquid net worth and liquidity needs;
- The applicant's financial situation and needs;
- The applicant's risk tolerance; and
- Such other information used or considered to be relevant by the insurance agent or insurer in making recommendations to the consumer regarding the purchase or exchange of an annuity contract.

Additionally, statutes require that the information be collected on a form prescribed by the department of insurance and that the form be completed and signed by both the applicant and agent. A signed copy of the form must be provided to the insurer within 10 days after the form is signed and provided to the consumer no later than the date of delivery of the contract or contracts.

The only exceptions to the suitability requirements for a senior consumer are if the senior consumer:

- Refuses to provide relevant information requested by the insurer or insurance agent;
- Decides to enter into an insurance transaction that is not based on a recommendation of the insurer or insurance agent; or
- Fails to provide complete or accurate information.

If a consumer refuses to provide the relevant information requested by the insurance agent or insurer before an insurance transaction, a disclosure must be made to the consumer that certain protections may be lost. Thus, statutes require the insurance agent or insurer-before executing a sale-to obtain a signed verification from the senior consumer (on a form adopted by the department of insurance) stating that they refuse to provide the requested information and may be limiting protections afforded regarding suitability of the sale.

Florida statutes also provide that any person who is registered with a member of the Financial Industry Regulatory Authority (FINRA), who is required to make an annuity suitability determination, and documents this determination will have satisfied the requirements for the recommendation of annuities. This determination does not limit the ability of the department of insurance to bring an enforcement action against insurance agents, insurance agencies, and managing general agents, or to enforce provisions of the statute with respect to insurers.[18]

It's important to keep in mind that while the suitability standard has represented the standard by which all annuity products were to be recommended and sold, the DOL's fiduciary rule has changed this standard for some annuity sales. As noted earlier in the course, insurance professionals who make annuity recommendations to qualified plans, IRAs, and other tax-favored accounts will be considered fiduciaries and must provide advice that it is in their clients' best interest.

To address ongoing complaints and concerns with regard to the treatment of seniors, in 2009 the state of Florida enacted The John and Patricia Seibel Act (Seibel Act), increasing the fines and penalties for unfair and deceptive insurance practices known as "twisting" and "churning." It also prohibits the practice of willfully submitting to an insurer, on behalf of a consumer, any document bearing a false signature.

In an effort to stem these practices, the Seibel Act classifies twisting and churning as second-degree felonies if the victim is at least 65 years old or mentally disabled, and third-degree felonies if done to any other types of victims. Willfully submitting a false signature is also a third-degree felony. The Seibel Act increases the fines for these practices to:

- $5000 for each nonwillful violation, up to a maximum aggregate amount of $20,000.
- $30,000 for each willful violation, up to a maximum aggregate amount of $150,000.

In addition, the Seibel Act:

- *Prohibits agents from using designations or titles that falsely imply they have special financial knowledge or training;*
- *Requires the insurer or agent to have an objectively reasonable basis for believing a recommendation to a senior consumer is suitable given the*

[18] 69B-162.011 , *Suitability and Disclosure in Annuity Contracts – Forms Required*

senior's investments, other insurance products, and financial situation and needs.

- *With regard to surrender or replacement of an in-force insurance or investment product, requires an insurance agent to call the company of the in-force investment, in the presence of the consumer, to inquire and document whether there are any surrender charges or penalties.*
- *Requires the insurer or agent to provide the consumer with specified information concerning differences between the annuity and life insurance policy being recommended for purchase and an existing annuity or life insurance policy that would be surrendered or replaced. The information must be provided on a disclosure form the DFS adopts by rule, and a copy must be provided to the insurer and consumer.*
- *Increases the "free-look" period (which is one of the alternative requirements an insurer must meet) from 10 to 14 days after purchase of a life insurance or fixed annuity for the consumer to obtain a refund, and applies this requirement to all annuities. (The annuity free-look period increased under Florida law to 21 days for all consumers effective October 1, 2013.)*
- *Authorizes the Office of Insurance Regulation to order an insurer to rescind a life insurance policy or annuity and provide a full refund of the premiums paid or the accumulation value, whichever is greater, when a senior consumer is harmed by a violation of the suitability statute by the insurer or insurer's insurance agent.*
- *Requires insurers, managing general agents, and insurance agencies to each maintain or make available to the DFS or OIR records of information collected from senior consumers and other information used in making recommendations that resulted in insurance transactions, for five years after the insurance transaction is completed. Insurers may maintain documentation on behalf of an agent, but the agent must be able to make available such documentation.*
- *Requires applicants for agent licensure to provide home and business telephone numbers and email addresses in the application and notify the department within 60 days of changes.*
- *Requires all licensees to complete three hours of department-approved continuing education on the subject of suitability in annuity and life insurance transactions. The hours may be used to satisfy the current ethics continuing education requirement*.

In an effort to further strengthen the protection of seniors, in 2010 the Florida legislature enacted the Safeguard Our Seniors Act, implementing the following safeguards for seniors:

- *Increases the financial penalty for the willful act of "twisting" or "churning" of an annuity to a maximum of $75,000, which is intended to be a strong disincentive to this unlawful behavior.*

- *Limits the period of a surrender charge for an annuity sold to a senior consumer (age 65 or older) to 10 years and limits the surrender charge to 10 percent.*
- *Extends the "free-look" period for the purchase of an annuity by a senior consumer from 14 to 21 days. (This lengthened free-look period has been further extended to all consumers under Florida law.)*
- *Authorizes the Department of Financial Services to require an agent to make monetary restitution to a senior consumer harmed by a violation of the insurance code under certain circumstances.*
- *Includes a third-party marketer that aids and abets an insurance agent in the violation of the insurance code involving an annuity sale to a senior consumer as an affiliated party of the insurance agent, bringing that marketer under the regulatory authority of the department.*
- *Gives the department authority to take license disciplinary action against an agent who has been disciplined under their securities broker-dealer license or a related license.*
- *Prohibits the department from issuing a license to a former licensee who has had their license revoked resulting from the solicitation or sale of an insurance product to a senior consumer.*
- *Extends the prohibition on a life insurance agent being the beneficiary of an insured's life insurance policy by also prohibiting the agent's family members from being a beneficiary and by prohibiting the agent from serving as a guardian or trustee or having power of attorney over the insured.*
- *Requires an insurer, when an annuity is issued, to provide a cover sheet attached to the policy informing the purchaser about the free-look period and about how to contact the insurer and the department if they have questions about the annuity.*
- *Allows the use of video depositions in administrative hearings involving a senior consumer and requires compliance with the Federal Rules of Civil Procedure.*

4.6 Unfair Methods of Competition and Unfair or Deceptive Acts

Florida statutes[19] define the following as unfair methods of competition and unfair or deceptive acts or practices:

> ***Misrepresentations and false advertising of insurance policies*** *(Section 626.9541(a), F.S.). This involves knowingly making, issuing, circulating, or causing to be made, issued, or circulated, any estimate, illustration, circular, statement, sales presentation, omission, or comparison which:*

[19] Section 626.9541, F.S.

- *Misrepresents the benefits, advantages, conditions, or terms of any insurance policy.*
- *Misrepresents the dividends or share of the surplus to be received on any insurance policy.*
- *Makes any false or misleading statements as to the dividends or share of surplus previously paid on any insurance policy.*
- *Is misleading, or is a misrepresentation, as to the financial condition of any person or as to the legal reserve system upon which any life insurer operates.*
- *Uses any name or title of any insurance policy or class of insurance policies misrepresenting the true nature thereof.*
- *Is a misrepresentation for the purpose of inducing, or tending to induce, the lapse, forfeiture, exchange, conversion, or surrender of any insurance policy.*
- *Is a misrepresentation for the purpose of effecting a pledge or assignment of, or effecting a loan against, any insurance policy.*
- *Misrepresents any insurance policy as being shares of stock or misrepresents ownership interest in the company.*
- *Uses any advertisement that would mislead or otherwise cause a reasonable person to believe mistakenly that the state or the Federal Government is responsible for the insurance sales activities of any person or stands behind any person's credit or that any person, the state, or the Federal Government guarantees any returns on insurance products or is a source of payment of any insurance obligation of or sold by any person.*

False information and advertising *(Section 626.9541(b), F.S.)**. This involves knowingly making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public:*

- *In a newspaper, magazine, or other publication,*
- *In the form of a notice, circular, pamphlet, letter, or poster,*
- *Over any radio or television station, or*
- *In any other way, an advertisement, announcement, or statement containing any assertion, representation, or statement with respect to the business of insurance, which is untrue, deceptive, or misleading.*

Defamation *(Section 626.9541(c), F.S.). This involves knowingly making, publishing, disseminating, or circulating, directly or indirectly, or aiding, abetting, or encouraging the making, publishing, disseminating, or circulating of, any oral or written statement, or any pamphlet, circular, article, or literature, which is false or maliciously critical of, or derogatory to, any person and which is calculated to injure such person.*

Boycott, coercion, and intimidation *(Section 626.9541(d), F.S.). This involves entering into any agreement to commit, or by any concerted action committing, any act of boycott, coercion, or intimidation resulting in, or tending to result in, unreasonable restraint of, or monopoly in, the business of insurance.*

False statements and entries *(Section 626.9541(e), F.S.). The prohibition against making false statements and entries forbids knowingly:*

- *Filing with any supervisory or other public official,*
- *Making, publishing, disseminating, circulating,*
- *Delivering to any person,*
- *Placing before the public,*
- *Causing, directly or indirectly, to be made, published, disseminated, circulated, delivered to any person, or placed before the public, any false material statement.*
- *Making any false entry of a material fact in any book, report, or statement of any person, or knowingly omitting to make a true entry of any material fact pertaining to the business of such person in any book, report, or statement of such person.*

Stock operations and advisory board contracts *(Section 626.9541(f), F.S.). This involves issuing or delivering, promising to issue or deliver, or permitting agents, officers, or employees to issue or deliver, agency company stock or other capital stock, benefit certificates or shares in any common-law corporation, or securities or any special or advisory board contracts or other contracts of any kind promising returns or profits as an inducement to insurance.*

Unfair discrimination *(Section 626.9541(g), F.S.). This involves knowingly making or permitting any unfair discrimination between individuals of the same actuarially supportable class and equal expectation of life, in the rates charged for any life insurance or annuity contract, in the dividends or other benefits payable thereon, or in any other of the terms and conditions of a contract.*

Knowingly making or permitting any unfair discrimination between individuals of the same actuarially supportable class, as determined at the original time of issuance of the coverage, and essentially the same hazard, in the amount of premium, policy fees, or rates charged for any policy or contract of accident, disability, or health insurance, in the benefits payable thereunder, in any of the terms or conditions of a contract, or in any other manner whatever.

Unlawful rebates *(Section 626.9541(h), F.S.). Unless allowed elsewhere in the statutes, this involves knowingly:*

- *Permitting, or offering to make, or making, any contract or agreement other than as plainly expressed in the insurance contract issued thereon;*
- *Paying, allowing, or giving, or offering to pay, allow, or give, directly or indirectly, as inducement to such insurance contract, any unlawful rebate of premiums payable on the contract, any special favor or advantage in the dividends or other benefits thereon, or any valuable consideration or inducement whatever not specified in the contract;*
- *Giving, selling, or purchasing, or offering to give, sell, or purchase, as inducement to such insurance contract or in connection therewith, any stocks, bonds, or other securities of any insurance company or other corporation, association, or partnership, or any dividends or profits accrued thereon, or anything of value whatsoever not specified in the insurance contract.*

The definitions of discrimination or unlawful rebates do not include:

- In the case of any contract of life insurance or life annuity, paying bonuses to all policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance; provided that any such bonuses or abatement of premiums is fair and equitable to all policyholders and for the best interests of the company and its policyholders.
- In the case of life insurance policies issued on the industrial debit plan, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount which fairly represents the saving in collection expenses.
- Readjustment of the rate of premium for a group insurance policy based on the loss or expense thereunder, at the end of the first or any subsequent policy year of insurance thereunder, which may be made retroactive only for such policy year.
- Issuance of life insurance policies or annuity contracts at rates less than the usual rates of premiums for such policies or contracts, as group insurance or employee insurance as defined in this code.
- Issuing life or disability insurance policies on a salary savings, bank draft, preauthorized check, payroll deduction, or other similar plan at a reduced rate reasonably related to the savings made by the use of such plan.

Unfair claim settlement practices *(Section 626.9541(i), F.S.). This involves attempting to settle claims on the basis of an application, when serving as a binder or intended to become a part of the policy, or any other material document which was altered without notice to, or knowledge or consent of, the insured.*

Additionally, unfair claim settlement practices include a material misrepresentation made to an insured or any other person having an interest in the proceeds payable under a contract or policy, for the purpose and with the intent of effecting settlement of such claims, loss, or damage under a contract or policy on less favorable terms than those provided in, and contemplated by, a contract or policy; or

Committing or performing with such frequency as to indicate a general business practice any of the following:

- *Failing to adopt and implement standards for the proper investigation of claims;*
- *Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;*
- *Failing to acknowledge and act promptly upon communications with respect to claims;*
- *Denying claims without conducting reasonable investigations based upon available information;*
- *Failing to affirm or deny full or partial coverage of claims, and, as to partial coverage, the dollar amount or extent of coverage, or failing to provide a written statement that the claim is being investigated, upon the written request of the insured within 30 days after proof-of-loss statements have been completed;*
- *Failing to promptly provide a reasonable explanation in writing to the insured of the basis in the insurance policy, in relation to the facts or applicable law, for denial of a claim or for the offer of a compromise settlement;*
- *Failing to promptly notify the insured of any additional information necessary for the processing of a claim; or*
- *Failing to clearly explain the nature of the requested information and the reasons why such information is necessary.*
- *Failing to pay undisputed amounts of partial or full benefits owed under first-party property insurance policies within 90 days after an insurer receives notice of a residential property insurance claim, determines the amounts of partial or full benefits, and agrees to coverage, unless payment of the undisputed benefits is prevented by an act of God, prevented by the impossibility of performance, or due to actions by the insured or claimant that constitute fraud, lack of cooperation, or intentional misrepresentation regarding the claim for which benefits are owed.*
- *Failing of any person to maintain a complete record of all the complaints received since the date of the last examination. Complaint means any written communication primarily expressing a grievance. (Section 626.9541(j), F.S.)*

Misrepresentation in insurance applications *(Section 626.9541(k), F.S.). This involves knowingly making a false or fraudulent written or oral statement or representation on, or relative to, an application or negotiation for an insurance policy for obtaining a fee, commission, money, or other benefit from any insurer, agent, broker, or individual.*

Advertising gifts permitted *(Section 626.9541(m), F.S.). No provision in the statute prohibits a licensed insurer or its agent from giving to insureds, prospective insureds, and others, any article of merchandise, goods, wares, store gift cards, gift certificates, event tickets, anti-fraud or loss mitigation services, or other items having a total value of $100 or less per insured or prospective insured in any calendar year; or making charitable contributions, as defined in s. 170(c) of the Internal Revenue Code, on behalf of insureds or prospective insureds, of up to $100 per insured or prospective insured in any calendar year.*

Fraudulent signatures on an application or policy-related document *(Section 626.9541(ee), F.S.). This involves willfully submitting to an insurer on behalf of a consumer an insurance application or policy-related document bearing a false or fraudulent signature.*

Unlawful use of designations; misrepresentation of agent qualifications *(Section 626.9541(ff), F.S.). The statute provides that a licensee may not, in any sales presentation or solicitation for insurance, use a designation or title in such a way as to falsely imply that the licensee:*

- *Possesses special financial knowledge or has obtained specialized financial training; or*
- *Is certified or qualified to provide specialized financial advice to senior citizens.*

Additionally, a licensee may not:

- *use terms such as "financial advisor" in such a way as to falsely imply that the licensee is licensed or qualified to discuss, sell, or recommend financial products other than insurance products.*
- *in any sales presentation or solicitation for insurance, falsely imply that they are qualified to discuss, recommend, or sell securities or other investment products in addition to insurance products.*

A licensee who also holds a designation as a Certified Financial Planner (CFP), Chartered Life Underwriter (CLU), Chartered Financial Consultant (ChFC), Life Underwriter Training Council Fellow (LUTC), or the appropriate license to sell securities from the Financial Industry Regulatory Authority (FINRA) may inform the customer of those licenses or designations and make recommendations in

accordance with those licenses or designations, and in so doing does not violate the statute.

The statute goes on to define the two practices discussed at the beginning of this course, twisting and churning.

Churning *(Section 626.9541(aa), F.S.). Churning is the practice whereby policy values in an existing life insurance policy or annuity contract, including, but not limited to, cash, loan values, or dividend values, and in any riders to that policy or contract, are directly or indirectly used to purchase another insurance policy or annuity contract with that same insurer for the purpose of earning additional premiums, fees, commissions, or other compensation:*

- *Without an objectively reasonable basis for believing that the replacement or extraction will result in an actual and demonstrable benefit to the policyholder;*
- *In a fashion that is fraudulent, deceptive, or otherwise misleading or that involves a deceptive omission;*
- *When the applicant is not informed that the policy values including cash values, dividends, and other assets of the existing policy or contract will be reduced, forfeited, or used in the purchase of the replacing or additional policy or contract, if this is the case; or*
- *Without informing the applicant that the replacing or additional policy or contract will not be a paid-up policy or that additional premiums will be due, if this is the case.*

Churning by an insurer or an agent is considered an unfair method of competition and an unfair or deceptive act or practice.

Each insurer must comply by disclosing to the applicant at the time of the offer on a form designed and adopted by rule by the commission if, how, and the extent to which the policy or contract values (including cash value, dividends, and other assets) of a previously issued policy or contract will be used to purchase a replacing or additional policy or contract with the same insurer. The form must include disclosure of the premium, the death benefit of the proposed replacing or additional policy, and the date when the policy values of the existing policy or contract will be insufficient to pay the premiums of the replacing or additional policy or contract.

Additionally, each insurer must adopt written procedures to reasonably avoid churning of policies or contracts that it has issued, and failure to adopt written procedures sufficient to reasonably avoid churning must be an unfair method of competition and an unfair or deceptive act or practice.

Twisting (Section 626.9541(l), F.S.). The State of Florida defines twisting as "knowingly making any misleading representations or incomplete or fraudulent comparisons or fraudulent material omissions of or with respect to any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out a policy of insurance in another insurer."

CS/SB 292 — Newborn Screenings

Requires a hospital or other state-licensed birthing facility to test a newborn for congenital cytomegalovirus (CMV) if the newborn has failed their hearing screening, before the newborn is 21 days old or before discharge, whichever occurs earlier.

For home births and births in a licensed birth center, if a newborn fails a hearing test, the bill requires that the newborn's primary health care provider must refer the newborn to be tested for CMV and changes the timeframe in which a referral for appointment for a newborn hearing screening must occur, to within seven days after delivery, rather than 30 days.

Additionally, the bill requires that the results of any newborn screening test to be reported to the Department of Health within seven days of receipt of the results.

[Effective January 1, 2023; amending Florida Statues 381.145]

4.6.1 Penalties

The penalties imposed for violation of unfair methods of competition and unfair or deceptive acts or practices statutes include:

Any person who violates any provision is subject to a fine in an amount not greater than $5,000 for each nonwillful violation and not greater than $40,000 for each willful violation. Fines under this subsection imposed against an insurer may not exceed an aggregate amount of $20,000 for all nonwillful violations arising out of the same action or an aggregate amount of $200,000 for all willful violations arising out of the same action. The fines may be imposed in addition to any other applicable penalty.

If a person violates statutes with regard to the offenses known as "twisting," or "churning," the person commits a misdemeanor of the first degree, punishable by a definite term of imprisonment not exceeding 1 year as provided in 775.082. In addition, an administrative fine not greater than $5,000 must be imposed for each nonwillful violation or an administrative fine not greater than $75,000 must be imposed for each willful violation. To impose an administrative fine for a willful violation under this paragraph, the practice of "churning" or "twisting" must involve fraudulent conduct.

If a person willfully submits fraudulent signatures on an application or policy-related document, the person commits a felony of the third degree, punishable by a term of imprisonment not exceeding 5 years as provided in 775.082, and an administrative fine not greater than $5,000 must be imposed for each nonwillful violation or an administrative fine not greater than $75,000 must be imposed for each willful violation.

Administrative fines may not exceed an aggregate amount of $50,000 for all nonwillful violations arising out of the same action or an aggregate amount of $250,000 for all willful violations arising out of the same action.

In addition to the statutory provisions outlined, Florida Administrative Code 69B-231 sets forth penalty guidelines for insurance representatives as they relate to penalties imposed upon licensees. These rules apply to all licensed resident and nonresident insurance agents, customer representatives, adjusters and service representatives.

4.7 Selling Marketplace Plans to Medicare Beneficiaries Is Illegal

Medicare open enrollment and the requirements of the Patient Protection and

Affordable Care Act must be understood. Starting January 1, 2014, federal law requires most Americans to have health insurance or pay a penalty. (The Tax Cuts and Jobs Act of 2017, reduced the penalty amount to zero for tax years starting in 2019.) Those without health insurance may buy it from the Federally-facilitated Marketplace, also known as an Exchange. Also, each October 15 through December 7, the enrollment period is open for Medicare beneficiaries to buy prescription drug coverage or the Medicare Advantage medical policies that are an alternative to traditional Medicare.

Agents should be cautious not to sell Medicare beneficiaries a plan on the Federally-facilitated Exchange. Federal administration officials have warned that selling marketplace coverage to people who have Medicare is illegal. There can be serious consequences for anyone who violates the federal law, such as fines of up $25,000 or up to five years imprisonment or both.

The law prohibiting the sale of private health insurance to Medicare beneficiaries is intended as a safeguard to prevent Medicare beneficiaries from buying coverage they don't need because it duplicates what they already have.

Section Review

1. Arthur has been found guilty of a willful violation of Florida unfair or deceptive acts or practices statutes. For what maximum fine is he liable? (Refer to Section 4.6.1, page 55)

   A. $5,000 **[Your answer is incorrect. Florida law provides for a fine not exceeding $5,000 for a nonwillful violation of Florida unfair or deceptive acts or practices statutes; the violation, in this case, was considered willful.]**
   B. $20,000 **[Your answer is incorrect. Florida law provides for a fine not exceeding $20,000 for all nonwillful violations of Florida unfair or deceptive acts or practices statutes arising out of the same action; the violation, in this case, was considered willful.]**
   C. $40,000 **[Your answer is correct. Florida law provides for a fine not exceeding $40,000 for a willful violation of Florida unfair or deceptive acts or practices statutes.]**
   D. $200,000 **[Your answer is incorrect. Florida law provides for a fine not exceeding $200,000 in the aggregate for all willful violations of Florida unfair or deceptive acts or practices statutes arising out of the same action; in this case, however, Arthur was guilty of only a single willful violation.]**

2. Helen was found guilty of lying to her client and causing him to replace his life insurance policy with a policy issued by her insurer. Since her actions involve a willful violation of Florida statutes prohibiting twisting, they are punishable by up to 1 year of imprisonment and an administrative fine not exceeding _____. (Refer to 4.5, page 53)

   A. $5,000 **[Your answer is incorrect. Florida law provides for a fine not exceeding $5,000 for a nonwillful violation of Florida statutes prohibiting twisting; Helen was found to be guilty of willful violation, however.]**
   B. $20,000 **[Your answer is incorrect. Florida law provides for a fine not exceeding $20,000 for all nonwillful violations of Florida unfair or deceptive acts or practices statutes arising out of the same action; Helen's violation involved the prohibited practice of twisting.]**
   C. $40,000 **[Your answer is incorrect. Florida law provides for a fine not exceeding $40,000 for a willful violation of Florida unfair or deceptive acts or practices statutes. Helen's violation involved the prohibited practice of twisting.]**
   D. $75,000 **[Your answer is correct. Florida law provides that an administrative fine not greater than $75,000 must be imposed for each willful violation of the Florida statutes involving twisting.]**

3. Selling federally-facilitated exchange coverage to a Medicare beneficiary is a violation of federal law. (Refer to section 4.7, page 51)

   A. True **[Your answer is correct. Federal administration officials warn that selling marketplace coverage to Medicare beneficiaries is illegal and may involve fine and or imprisonment.]**
   B. False **[Your answer is incorrect. Federal administration officials warn that selling marketplace coverage to Medicare beneficiaries is illegal and may involve fine and or imprisonment.]**

5.0 Trends

The world is continually changing, and insurance companies need to be adaptable and flexible to evolving circumstances. To do so, they need to understand the latest news and respond to the newest trends in quick and efficient ways. As a result, their clients will significantly benefit by purchasing insurance plans, submitting claims, and planning for the future.

5.1 Insurance and COVID-19

The COVID-19 pandemic greatly impacted insurance companies that had to make their entire operations remote. At the same time, they were fielding calls about changing coverage, answering questions about business interruption policies, and continuing to pay claims for life, health, and disability insurance.

Previously fueled by changing demographics, customer expectations, and competitive pressures, the trend toward automation and digitization increased because of the pandemic. Because many insurers found that virtual conferences and meetings work quite well, remote work may remain the norm at many firms. In fact, virtual interactions may open up new opportunities for servicing and selling insurance and building customer relationships.

As the broader economy recovers and responds to the pandemic, insurers will face a number of challenges but also see many new opportunities in the medium to long term.

5.1.1 New Medicare Changes

In 2023, Medicare had several important changes:

- **Insulin copays capped:** Under the Inflation Reduction Act of 2022, which includes a number of provisions to lower the prices of prescription drugs for Medicare beneficiaries, beginning in 2023 copays for a 30-day supply of any insulin that a Medicare drug plan covers will be capped at $35. Enrollees won't have to pay more than $35 even if they have not yet met their annual Part D deductible. Not every plan covers every type of insulin.

  Beginning on July 1, 2023, Medicare enrollees who take their insulin through a pump as part of the Part B durable medical equipment benefit will not have to pay a deductible and they will also benefit from the $35 copay cap.

- **Price negotiation:** Under the Inflation Reduction Act of 2022, some high-priced drugs are to be subject to price negotiation with drugmakers. So although the monthly maximum copay for insulins covered by Medicare will be $35 in 2023, 2024 and 2025, beginning in 2026 — the first year negotiated prices will take effect — covered insulin copays for any drugs that have been part of the new negotiations will be $35 or 25 percent of the negotiated price, whichever is less.

- **Free vaccines:** Also under the new law, vaccines recommended for adults by the Centers for Disease Control and Prevention's Advisory Committee on

Immunization Practices (ACIP) will be available to Medicare recipients with prescription drug coverage free of charge.

Some vaccines are covered under Part B and are already free to Medicare enrollees. Others are covered by Part D prescription drug plans and require beneficiaries to pay some of the cost. For example, shots for the flu, pneumonia, COVID-19 (initial shots and boosters) and hepatitis B for some enrollees are free under Part B and that coverage will continue in 2023. Part B also covers vaccines needed to treat certain injuries or if you have direct exposure to a disease. Those include hepatitis A, rabies and tetanus.

Other vaccines, most notably the two-dose Shingrix, which guards against shingles, are covered under Part D prescription drug plans and may require cost sharing depending on the plan. Shingrix, for example, can run as much as $200 a dose. Starting in 2023, even if a beneficiary hadn't satisfied their Part D deductible, that vaccine and others recommended by ACIP will be free to beneficiaries.

- **Drugmakers face penalties for high price hikes:** Another provision of the new law that will be fully effective in 2023 requires pharmaceutical manufacturers to pay a rebate to Medicare if they raise the prices of their drugs more than the rate of general inflation.

  Beginning in 2023, companies that market both Part D prescription drugs — those bought at pharmacies — and Part B drugs, typically administered in doctor's offices, will face penalties if they increase prices more than the rate of inflation. The rebates the companies owe will be the amount they raised a drug's price above an increase to equal inflation, multiplied by what Medicare paid for all sales of that drug.

- **Some access to dental care:** Medicare does not cover routine dental care. It does pay for some dental work that is needed in conjunction with another medical procedure, such as pulling a tooth during jaw surgery.

  Beginning in 2023, the program expanded the type of "medically necessary" dental services it will cover when needed with other procedures, such as a cleaning or other dental work that will improve the outcome of an organ transplant or cancer treatment.

5.1.2 New Opportunities

In ordinary times, consumers might not think much about their insurance products. But the COVID-19 pandemic caused uncertainty and shifted consumer focus with unmatched speed and magnitude. Consumers are now seeking to understand their coverage, free up money, and address risks. Meanwhile, insurance companies have been scrambling to adapt their operations, expand digital channels, and meet the needs of their customers.

Younger generations took the biggest financial hit and show the greatest interest in new insurance products. These insurance consumers are profoundly different from their parents and grandparents. The use of technology in their everyday lives has created a new kind of customer. They expect unlimited choices, constant change, and instant gratification.

Historically, younger consumers have been a difficult market to serve profitably. But insurers and insurance producers should view the scope of the growth potential in terms of greatly expanded and intensified consumer interest in their products. The opportunity to bridge the protection gap and build lifelong customer relationships has never been greater.

The percentage of Americans with life insurance is about 52%, including individual and workplace life insurance, according to LIMRA.[20] Lack of knowledge about life insurance appears to be the greatest obstacle preventing younger parents from getting coverage. Less than 1 in 3 Gen Z and millennial parents feel very knowledgeable about life insurance. Moreover, 40% of Gen Z parents and 29% of millennial parents say they haven't purchased coverage because they don't know how much coverage they need or what type to buy.[21]

In addition to accessible and affordable products, insurers will need stronger digital capabilities to connect with these consumers. Insurers will also need to communicate more effectively, demonstrating that they understand what younger consumers need now.

While the biggest surge in insurance protection has been for term life insurance, this pattern has extended to other product lines. Demand for disability insurance

[20] https://www.limra.com/en/newsroom/news-releases/2023/new-study-shows-interest-in-life-insurance-at-all-time-high-in-2023/
[21] https://www.limra.com/en/newsroom/news-releases/2023/new-study-shows-interest-in-life-insurance-at-all-time-high-in-2023/

has increased. On the P&C side, interest in homeowners insurance has risen more than in the past few years. For the P&C products, from people looking to shop around or save money on their insurance premiums.

Significant numbers of younger consumers are interested in new types of insurance products. They are interested in policies that pay for hospitalization expenses and an add-on feature for life insurance that allows access to funds in case of emergencies. They are also interested in short-term income protection products, such as insurance that funds college education plans or pays for credit card bills in the case of a job loss.

Consumers are aware that digital communications mean that their insurer collects their personal data —anything from behavioral data to their location or any information they have submitted. In return, potential insurance customers expect insurers to use this information to improve and personalize their experience. From the moment a potential customer clicks on an insurers' website, the insurer must use the valuable data they have on each user to improve that user's experience.

A primary driver of switching insurance coverage in the digital world is the insurer's ability to deliver a personalized, timely alternative. Not only do new policy sales benefit from personalization, but there many cross-selling opportunities. Offering someone a tailored product at a competitive price point can increase the probability of a policy sale, as well as customer retention for years to come.

5.2 Social Media Trends

Agents who have been around the insurance business for a while may remember a time before communications became "content." There were brochures and ads and illustrations-and business cards. There was no talking back to that-other than by actually talking-on the phone or face to face. Traditional forms of communication and advertising were the norm.

Today, however, social media has become an important component of many insurers' business models. **Social media**, websites and applications that enable users to create and share content or to participate in social networking, has evolved rapidly from an emerging form of communication to a mainstream source of information. From posting mundane pictures of dinner to uploading scores of snapshots from seats at a sporting event, people are recording their entire life on social media sites.

Insurance agents can use social media to reach potential clients, build trust, inspire confidence in your agency, and advertise agency promotions. No insurance agent can be on every platform and still provide quality content. It's better to choose some of the most important social media channels for your industry and focus on perfecting your content on those platforms.

Insurers, as we'll see, have embraced these social medial platforms and are using them to complement their marketing, communication, and customer service strategies.

Here are the top platforms for insurance social media marketing:

- **Twitter:** Since 2006, Twitter has been the backbone of social media. Twitter had 69.3 million users in 2021. Although Twitter is less visual than other social media platforms, people can post videos and images. Limiting a

message to 280 characters is great way to hone your email headline writing skills.

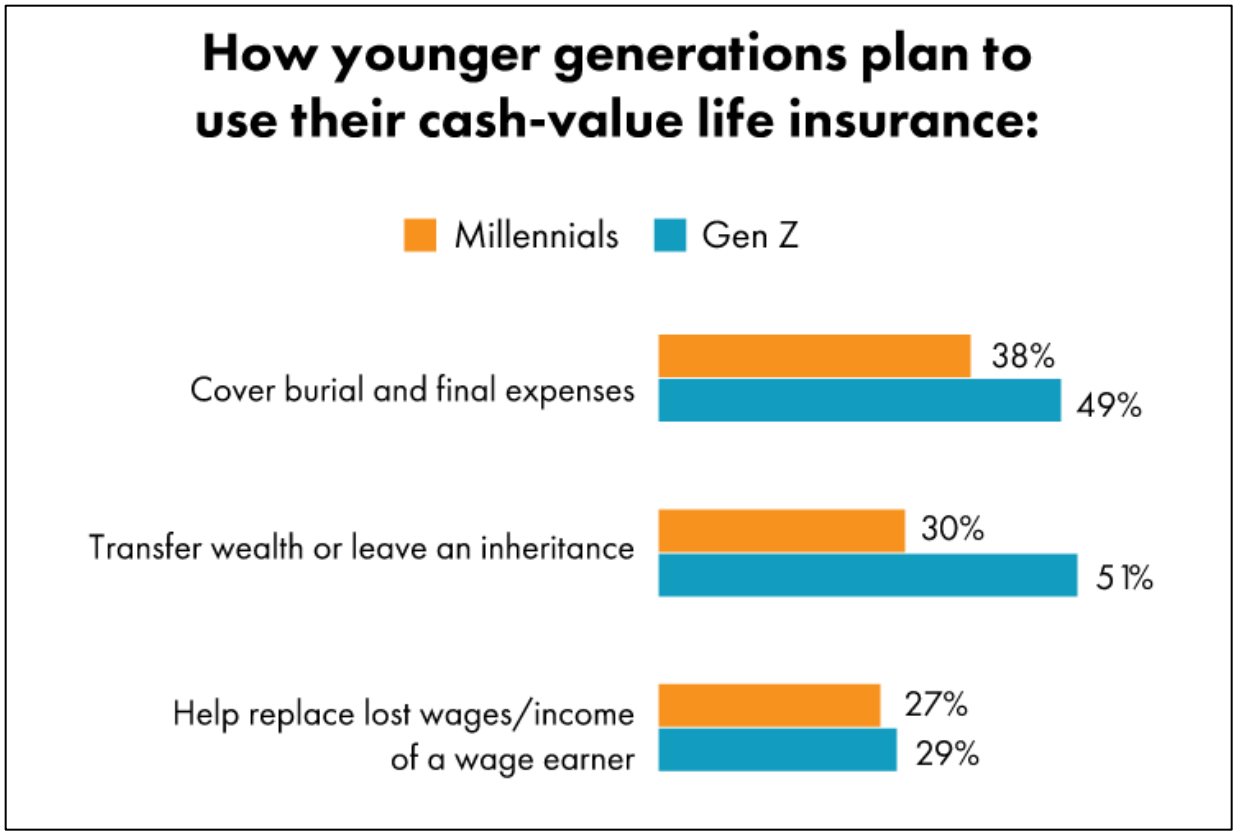
- **YouTube:** YouTube is the top social platform for influencing consumer behavior. It's also a recommended platform for watching videos, with 83 percent of consumers logging on to YouTube daily. YouTube had 1.86 billion users worldwide in 2021.
- **Facebook:** Your insurance business needs an active Facebook account. Facebook's user base amounted to 225.61 million people in 2021. By 2025, that number should grow to 235.15 million users. Unlike Twitter, Facebook allows longer-form posts, videos, and photo.

Insurers are not just using social media to increase their visibility and develop relationships with customers, however. With so much visual data chronicling people's daily activities, insurance companies have begun taking advantage of this when they investigate claims and to discover insurance fraud. Facebook, Twitter, Pinterest, Instagram and even dating sites. These social media sites offer the investigators a real-time account of people's activities, which, in many instances, includes geotagging their location as well.Other insurers are using it to monitor workers' compensation claimants' posts to determine if they are engaged in activities that might indicate fraudulent claims. Many property and casualty insurers have also turned to social media after catastrophic events such as storms or fires to communicate with insureds regarding the claims process.

More than 59% of the world's population is on social media channels. With this in mind, having a social media presence is really a no-brainer to grow your life insurance business. In fact, it's a necessity. Using the right social media tools is essential to reach potential buyers, gain valuable insights, and build your brand.

When purchasing life insurance, consumers are engaging online and through social media platforms as a way to evaluate financial products and financial professionals. In January 2023, LIMRA and Life Happens engaged an online panel to survey adult consumers who are financial decision-makers in their households. The survey generated more than 8,000 responses. The study shows that shows younger generations are less likely to have coverage and more likely to live with a life insurance coverage gap. Overall, 52% of American adults report owning life insurance, and 41% of adults — both insured and uninsured — say they don't have sufficient life insurance coverage. In comparison, just 40% of Gen Z adults and 48% of millennials say they own life insurance and nearly half say they either need to get coverage or increase their life insurance protection (49% and 47%,

respectively), representing 53 million adults.[22]



Although insurers currently use Facebook and LinkedIn most often, eexperts predict companies will expand their use of other social media platforms in the next few years. Let's briefly consider the features of largest of these. Many of the features of one service may also be shared by other services. And these features are changing all the time.

5.2.1 Facebook

Although Facebook was started to facilitate social-oriented networking among college students only a little more than a decade ago, it is now used for business as well as personal networking and is almost universally used in the insurance industry.

Facebook allows individuals to create a profile of their business that is generally regarded as static content (though it may be changed at any time). Individuals can post pictures and provide links to any other Facebook page (through Likes or

[22] Source: 2023 Insurance Barometer Study, LIMRA and Life Happens

Shares). The heart of Facebook is the timeline, which allows users to post short text, pictures, and links (including links to outside articles and video). All the posts are arranged in reverse chronological order. Individuals can allow others to post content on their timeline or they may restrict this. Friends or followers are allowed to comment on each of these posts, they may respond to comments, and commenters can respond to each other.

What are some issues implicated in this form of social media?

- **It is public.** Although Facebook allows you to limit the people who can see your page, what you post must be regarded as potentially visible by the public. Most insurance company, producer, and adjuster pages are not restricted in who can see them. They are intended to be seen by anyone who looks-the entire public.
- **It is constantly changing.** One of the things that engages people is that a Facebook page is constantly changing. You are posting content. People you allow are posting content. People are commenting or asking questions. You are answering them. It's a conversation. But if you are required to keep records of your communications with the public, what do you keep record of, if it is constantly changing?
- **You don't have full control of your content.** Facebook users can vet their own content with their firm's supervisory organization, when required, but they can't vet their customers' posts or comments-other than to possibly delete them after the fact. Facebook users may not want to delete them, however, and may want to respond to what others post.
- **Links to outside content may not be stable.** You or a customer may provide a link to an article or other Internet content today, but that article could be gone tomorrow-or it could be changed. It could be something you agree with today, but something you disagree with tomorrow. Could you find yourself vouching for someone's point of view and then find that their point of view has changed?
- **You have access to commenters' own Facebook pages.** When someone posts something, including comments, on your Facebook page, they do this under their own Facebook user name. This gives you some degree of access to the commenter's own Facebook page and, depending on their privacy settings, to the Facebook pages of their friends' pages (again, depending on the privacy settings of the friends).
- **People can "share" your content on other Facebook pages.** People who visit your page can share your posts on other Facebook pages. This, of course, spreads your message, but it potentially exposes your content to comments that you will never see-again, depending on the privacy settings.

- **Privacy options can be changed by Facebook.** From time to time Facebook changes privacy options in their service. This could expose your content in ways that you don't expect-or restrict it.

Knowledge Check

1. You posted a link on your Facebook page to an article entitled "What to Look for in a Life Insurance Policy." Rick comments on your post, mocking you and the article. Which of the following responses would be LEAST helpful? (Refer to Section 5.2.1, pages 57)
   A. Delete Rick's comment only **[Your answer is incorrect. Deleting a comment is a valid response, but might leave Rick and anyone who saw his comment wondering why. Posting a disparaging comment on Rick's Facebook page is definitely a bad idea and could expose you to liability and would certainly not win Rick as a friend.]**
   B. Post a comment responding to Rick's points **[Your answer is incorrect. Posting a response to Rick's points is a valid response and could possibly show a difference of opinion and the reasons for the difference. Posting a disparaging comment on Rick's Facebook page is definitely a bad idea and could expose you to liability and would certainly not win Rick as a friend.]**
   C. Post a disparaging comment on Rick's Facebook page **[Your answer is correct. Posting a disparaging comment on Rick's Facebook page is definitely a bad idea and could expose you to liability and would certainly not win Rick as a friend. Deleting the post and/or comments or responding to Rick's points are valid options.]**
   D. Delete your entire post, including Rick's comment **[Your answer is incorrect. Deleting a post with Rick's comment is a valid response, but might leave Rick and anyone who saw his comment wondering why. Nevertheless, if you agree with Rick's criticism, it is a possibility. Posting a disparaging comment on Rick's Facebook page is definitely a bad idea and could expose you to liability and would certainly not win Rick as a friend.]**

5.2.2 LinkedIn

LinkedIn is a more business-oriented social networking service. Many insurance agents and adjusters may have used it to find a job or to check out someone they considered for hiring or another business opportunity. It has many of the same features as Facebook, but they tend to be used in a different way.

Both services allow a person to post "profile" content, but a LinkedIn profile tends

to be more like a professional resume. And people are more likely to come to your LinkedIn profile to "research" you. Making connections is an important part of LinkedIn and you can invite people to be your connection and they can invite you to be their connection. If you would like to meet a LinkedIn member that you are not connected to, you can search for their name and learn whether you are connected to anyone who is connected to them (called 2nd-degree or 3rd-degree connections, etc.). You can then ask your connection for an introduction to the member you want to meet.

You can post content to your LinkedIn page in a manner that is similar to Facebook and people can make comments and you can respond back. When you make changes to your profile, email notices go out to your connections (if you don't turn this feature off), so they will get notices when you change jobs or on job anniversaries and they can send back congratulations.

LinkedIn supports the formation of interest groups. You can join existing groups or form groups of your own that others can join. You can post content to a group and get comments. You can act as moderator of a group so that you can control membership of the group and what gets posted before it appears. Some groups have active discussions. You may join groups to learn the latest developments in long-term care insurance, to share thoughts on implementation of the new DOL fiduciary rule for retirement accounts, to discuss trends in auto insurance, or many other topics. Alternatively, you may position yourself as an expert on some topic and have clients and potential clients join your group.

Introductions to Connections. Every now and again a client may ask you to provide a referral to a colleague to provide advice or other services that you cannot perform yourself. In real life, a referral can be subject to ethical or legal obligations. LinkedIn is part of real life, so providing LinkedIn introductions could be subject to the same obligations.

Posts and Groups. When you make posts and participate in groups, particularly groups that you lead, you are giving out information that clients may be relying on to make financial decisions. Again, your obligations on LinkedIn are the same as they would be in real life. You have all the obligations for honest communication that you would have in speaking to a group down at the public library or a hotel or on TV.

Knowledge Check

Your client Gerald is looking to insure his new home. Rather than call or email you

directly, Gerald sends you a request through LinkedIn because he sees that property and casualty agent Lucy is one of your LinkedIn contacts. Gerald asks for a LinkedIn introduction to Lucy so he can get her specialized advice.

1. What is your BEST option for responding to Gerald's request? [Refer to Sec. 5.3.2, pages 87-88]
   A. Immediately respond to the request to make the introduction. **[Your answer is incorrect. In some circumstances, referrals are subject to a fiduciary standard of care, which would require you to document your reasons for the referral. You should take your time to give proper thought to any referral.]**
   B. Refuse the LinkedIn request. **[Your answer is incorrect. In some circumstances, referrals are subject to a fiduciary standard of care, which would require you to document your reasons for the referral. This does not require you to deny the request, only that you give proper thought to the referral.]**
   C. Document the reasons for responding to the request before making the introduction. **[Your answer is correct. In some circumstances, referrals are subject to a fiduciary standard of care, which would require you to document your reasons for the referral.]**
   D. Take the referral offline so there is no record of it. **[Your answer is incorrect. In some circumstances, referrals are subject to a fiduciary standard of care, which would require you to document your reasons for the referral. Documentation will help you, if anything goes wrong, so taking the referral offline is a bad idea.]**

5.2.3 Twitter

The third social networking service is Twitter. Twitter is unique in that Twitter limits your posts, called "tweets," to 280 characters, and may include a link. As you can see, Twitter imposes a huge challenge upon someone wanting to tweet about insurance. When ethical communication requires you to give a complete picture of a financial concept, Twitter is not an ideal tool, to say the least.

This does not mean that Twitter has no use for individuals in the insurance business. You just have to be aware of the limit created by the 280-character rule. Many people use Twitter to pass on reading material in the form of links. Links are allowed in Twitter, and so are pictures. When you tweet links, your text can be used either as a sort of headline for the link or as a very brief comment about it.

5.2.4 YouTube

YouTube is a video sharing website. Anyone can use it. You can find videos of

Aunt Rhoda's cats, commercial TV shows, instructional videos, movie trailers, and your favorite music, to name just a few possibilities. Users may also post comments on the videos.

YouTube is commonly used to store videos that are used on other websites. You can provide a link to a YouTube video in Facebook or LinkedIn or Twitter or pretty much any website. Or you can create a "channel" that groups your videos together in a kind of timeline format, similar to posts in other social media services.

Investor Education. You produce the videos you post in one way or another. They may center on the process of adjusting claims, the products, general discussions of insurance concepts, or whatever you want. One consequence of the need to produce videos is that whatever you post is more like a seminar or an advertisement than some of the other social media, which may be more off-the-cuff in nature. All of the requirements your firm would impose on a seminar or a TV advertisement would apply to a YouTube video.

5.2.5 Blogs and Other Social Media

The oldest of popular social media is the **blog** (but even blogs are not so old). A blog is a website that is easily editable and usually is a sequence of posts in reverse chronological order (newest first). Users are able to leave comments.

Comments. The comments are what separate a blog from ordinary websites. Comments are common with the other social media services we have discussed, but they got their start with blogs. Comments are great for getting people engaged, but they have a downside. People without a stake in your site can post all sorts of nasty and misleading things there.

Many blogs allow anonymous comments. Anonymity breeds irresponsible commenting. The blogosphere (i.e., the world of blogging) loves the tough give-and-take, but hostile or misleading comments can be inappropriate for a blog in the insurance business. Most blogging services allow you to require commenters to identify themselves or even to register.

Another approach to controlling comments is to require commenters to submit their comments for approval before they actually appear. These are called moderated comments. You can use this feature to screen out abusive comments, but excessive moderation can make you responsible for what appears in the comments.

Risks of blogging. Blogging entails all the risks that come with any kind of

publishing. You can be sued for defamation or for violation of copyright. The additional risk in blogging is that content can be published real time. There can be only a second between when a thought comes into your mind and the moment the public can read that thought. This gives blogs an immediacy that other well-edited media don't have, but it increases the likelihood of mistakes.

The ease of blogging (all you need to know is how to type) also makes it possible for anyone to have a blog. Your employer may have a blog and you might too. Blogging inappropriately about your employer's business can get you in trouble. You could lose your job. Anything you might post on your blog that is contrary to the requirements of the firms you work with will have repercussions.

5.2.6 Regulatory Issues

Because social media is being used increasingly by insurers, producers, adjusters, and others in the insurance industry, the NAIC's Social Media Working Group issued a white paper entitled "The Use of Social Media in Insurance" to help guide state regulators as they consider the myriad issues surrounding this evolving platform. The white paper first explains the various types of social media and then outlines the difference between static and interactive content. According to the NAIC paper, static content is treated in the same way as more traditional communications by insurers and producers and, therefore, is subject to existing state marketing and advertising regulations.

Although it does not specifically identify social networking as marketing or advertising, at least three states-Massachusetts, New York and Virginia-have clarified that social media are subject to their regulations governing marketing and advertising.

The white paper states that "an insurer is responsible for its appointed producers' posts, provided such posts may be directly related to the appointing insurer or the insurer's products or services" and also states that insurers are encouraged to train appointed producers who wish to use social media before permitting its use. Given the uncertainty of regulators' attitudes and the law in this area, insurers may want to take a cautious approach to the use of social media by appointed producers and adjusters who work on their behalf.

The white paper encourages insurers and producers to adopt policies and procedures reasonably designed to ensure that insurer and "insurer-attributed" social media communications are accurate and timely. Like FINRA's guidance, the white paper states that insurers should employ risk-based principles to determine

the extent to which the review of social media communications is necessary for proper supervision of their business. Procedures for such review may require pre-approval of some or all interactive content or, where appropriate, retrospective review-for example, through sampling or lexicon-based screening.

With respect to recordkeeping, the white paper states that "when an insurer and/or producer is responsible for the content of a specific social media communication, then the insurer and/or producer is also responsible for complying with state record retention regulations relative to the subject communication.

5.3 Protection of Senior Clients

A variety of measures governing your behavior as an agent are either designed specifically to protect senior clients or are heightened when you work with senior clients. This is an issue that keeps coming up and has gotten increased attention around the country in recent years. In this section we will talk about recognizing when your senior client may have diminished capacity, what to do about that, recognizing fraud and senior financial exploitation and what to do about that.

This issue affects many facets of the insurance business. It comes up, of course, in the context of long-term care, but it affects all manner of financial decisions facing seniors.

5.3.1 Recognizing Diminished Capacity

Loss of ability is a gradual process. Your client can have a lapse on one day and be perfectly fine the next. Some clients may be sharp their entire lives and others may decline to the point where decisions become problematic. For some the decline, if it comes, is gradual. For some, it may be sudden, precipitated by a stroke or other illness.

In this section we will be sorting the signs of diminished capacity into three categories focused on the individual: cognitive signs, emotional signs, and behavioral signs. We will also consider signs of incapacity that might be inferred from your client's relationship with others. And finally, we will consider factors that might explain or mitigate apparent incapacity.

Before we go on, we want to stress that most of your clients will be completely healthy and capable of handling their affairs. But you need to be aware of the signs of change.

5.3.1.1 Signs of Cognitive Incapacity

Let's consider a variety of signs of cognitive incapacity might appear when you meet a client in your office or talk to them on the phone.

Short-term memory loss. The main signs or short-term memory loss are repeating statements and repeated questions for the same information. Your client may be able to recall events from 40 years ago, but they can't remember things that were just said, even things they said themselves.

People with short-term memory loss are able to make small talk, so they may sound fine in short conversations, like the conversations you have on the phone. Phone conversations often don't convey the problem well.

Trouble staying on topic. Some older adults have trouble staying on topic. You might see this as a short-term memory problem, but it might also exist even if memory is not impaired. Another way of seeing this is as a loss in the ability to organize your thoughts. Clients with this problem may shift unexpectedly to new topics or mover erratically among multiple topics. They might start a sentence on topic, but not finish or move to something else entirely.

Difficulty finding words. We all do this. A word is on the tip of your tongue, but you can't quite think of it. As we age, this can happen more and more. A word is in the brain somewhere, but the client can't access it. It may be a concept word or it may be the name of a person or object.

Difficulty with calculation. We live in a society that laughs at math skills. Yet we all have *some* math skills. Our level of skill naturally depends on our education and the type of work we do. Losing these skills can be a sign of growing incapacity.

Disorientation or getting lost. This cognitive incapacity can be spatial or temporal. Your client might be getting lost on the way to your office or even within your office. Or they might be unaware of the time or the day or the month or the season.

Deferring to others. Your clients may or may not tell you about the difficulties they are having. They may be embarrassed. They may not yet have an understanding of what is happening to them. If they do understand, they may take steps to hide the problem. A common way of disguising mental deficits is to defer to others. You may ask a client about a matter and your client responds, "oh, my wife handles that." While it is not unusual for married couples to divide responsibilities, if you get this answer a lot or the answer doesn't make sense, then the client is covering up for a mental deficit.

Difficulty acknowledging multiple alternatives or viewpoints. We all know people who think their way is the only way. We're not talking about stubbornness and narrowmindedness here. The mental deficit we're talking about here is the inability to even understand that alternatives or different viewpoints exist. A narrow-minded person may disagree with you but still understand your viewpoint. They can give you reasons for their disagreement. A person who lacks mental flexibility is fear-based and vague. This can also manifest itself as an inability to adjust to change.

Let's move on to emotional incapacity.

5.3.1.2 Signs of Emotional Incapacity

Emotional incapacity manifests itself as extremes and variability.

An individual may be having problems if they are having emotional distress beyond that which is normal for the situation. This can include extreme anxiety, worry, crying, depression, lethargy-the whole range of emotions can be off. This judgment can sometimes be difficult to make without knowledge of the individual's "normal" behavior. Rambling by a person who has always been reserved could be a sign of a problem. But what would you notice if this person became even more withdrawn? At the other end of the spectrum, you would notice if a normally gregarious person stopped talking. When we say to look for emotional extremes, we mean extremes that are unusual for the individual.

Just as important as extremes is changeableness. A person who goes from laughter to tears in a second without any apparent reason may be exhibiting signs of emotional incapacity. Inappropriate reactions are also signs.

Emotional incapacity can be totally separate from financial capacity. An individual may be acting strange on an emotional level and still may shrewd and appropriate financial decisions. These are all just warning signs that should be discussed with colleagues in your firm and with family members (subject to any privacy restrictions that might apply).

5.3.1.3 Signs of Behavioral Incapacity

The last category of individual signs of incapacity are behavioral. And we're going to look at this in two ways.

You may be familiar with the term "instrumental activities of daily living" or IADLs. These are things that allow an individual to function independently. IADLs

include housework, preparing meals, taking medications as prescribed, managing money, shopping for groceries or clothing, using the telephone, using transportation.

We are probably not concerned with all of these. Not all are related to an individual's ability to manage finances. Managing money is obviously of concern. Not taking medications as prescribed could indicate memory problems. Trouble using a telephone could indicate nothing more than hearing problems, but with smartphones, it could also indicate cognitive incapacity. And so on.

There is another class of behaviors you should be aware of. We first consider delusions and hallucinations. Delusions are beliefs that are unlikely to be true. A delusion may be the belief that the government or neighbors are spying on you or stealing things from you. Now, these things could be true, but if you don't believe them, they could be delusions. It can be a bit tricky. Older adults who live in assisted living facilities could actually have staff or fellow residents stealing from them.

Hallucinations are similar but involve actual sensory experiences without physical stimulation: seeing things that are not there or hearing voices. Before making a judgment about hallucinations, however, you should consider whether there is a vision or hearing problem. Also, older adults who have recently lost a spouse frequently report hearing the deceased spouse. This can be a sign of grief rather than mental incapacity.

Finally, poor grooming can be a sign of incapacity. Individuals with dementia may not shower or shave or comb their hair. They may have an unpleasant odor. They may wear multiple layers of clothing.

Again, any of these signs may be unrelated to your client's financial capacity, but they are warnings signs that you should take note of and address.

5.3.1.4 Relationships with Others

What we've considered so far are observations that you make about the individuals themselves. It is also important to be aware of relationships that make individuals potentially vulnerable to improper influence by others.

People who are fully capable may still be fearful about financial transactions and may depend on others for advice. This is their right and may serve them well. The concern is about overdependence, fear, and isolation. Is the relationship one of trust? Is it a long-term relationship? Or has you client found a new friend in a

long-lost family member, caregiver, or acquaintance?

5.3.1.5 Mitigating Factors

We've now filled your head with quite an array of warning signs for possible diminished capacity in managing finances. Many of these signs are quite explicit, but many are subject to interpretation. We are now going to muddy the waters even further by considering factors other than diminished capacity that might explain odd behavior.

Here are five conditions that could explain many of the observations we discussed in the last few sections of this course:

- **Stress.** Various life stresses can produce signs of diminished capacity that can go away when the stress is removed, eased, or treated. We've already considered the effect of grief, as when a spouse dies. Family illness, loneliness, financial losses, problems with children, etc. can also cause stress. Depression can also be a factor and may be treated with the result that diminished financial capacity goes away.
- **Fatigue.** It may be surprising, but the time of day can make a big difference. An individual may be fully capable of making financial decisions and not capable later in the afternoon or evening due to being tired. It's good to figure out the best time of day to work with these clients. For many older clients, mid-morning is best.
- **Medical.** Sometimes mental deficits can result from medical problems. Persistent pain can dim the mind. Certain medications have the same effect, or the interaction between multiple medications create problems.
- **Hearing and vision.** If you have vision problems, you may have difficulty reading. If you have hearing problems, you may have difficulty carrying on a conversation. If you can't read or carry on a conversation, you may be seen as having cognitive incapacity. Furthermore, the resulting isolation can lead to depression. Once the vision or hearing problems are detected and remedied, however, the apparent cognitive incapacity can simply disappear. So it is important to recognize when hearing and vision are impaired.
- **Personal differences.** Finally, it is important to emphasize that people have natural differences. This may be due to education, religion, upbringing, jobs, lifestyle, life experiences, personality, or eccentricity. These personal differences are not (by themselves) diminished capacity. They are just differences.

Now that you have an idea of many of the signs of diminished capacity. Let's

consider what this means for your practice.

Knowledge Check

1. Which of the following individuals is most likely to have cognitive incapacity? (Refer to Section 5.3.1.1, pages 64-65)
   A. Douglas met you briefly at a concert and doesn't recognize your name when you call to set up an appointment. **[Your answer is incorrect. Although memory loss is part of diminished cognitive ability, not remembering your name after a brief meeting at a concert is something we all do. Layla's trouble staying on topic could be a sign of diminished cognitive ability.]**
   B. Esther doesn't know what a variable annuity is. **[Your answer is incorrect. Although difficulty finding words can be part of diminished cognitive ability, not knowing what a variable annuity is, is common. You're looking for persistent difficulty with words, not just one word. Layla's trouble staying on topic could be a sign of diminished cognitive ability.]**
   C. Layla never finishes a sentence and jumps from topic to topic. **[Your answer is correct. Layla's trouble staying on topic could be a sign of diminished cognitive ability.]**
   D. Anthony responds to a question about his taxes by suggesting you call his accountant. **[Your answer is incorrect. Although deferring to others can be a sign of diminished cognitive ability, it is not uncommon for people to refer you to their accountant for information about their taxes. Layla's trouble staying on topic could be a sign of diminished cognitive ability.]**

5.3.2 Anticipating and Responding to Diminished Capacity

Before we get into the details of "handling" a client with real diminished capacity, consider this fact: There are really only three possibilities: (1) the client handles things on their own (despite the diminished capacity); (2) someone else does it on their behalf; and (3) no one does it. Each of these possibilities has risks.

5.3.2.1 Privacy Issues-Getting Family and Friends Involved

A common response to declines in client abilities is to get family or friends involved, people who the client would trust to help. Before you rush off and call the kids, however, it is important to know the requirement of privacy laws that may apply to you. This may be Regulation S-P (Privacy of Consumer Financial Information), your state's version of the NAIC Model Regulation on Privacy of Consumer Financial and Health Information (or comparable legislation), your

firm's privacy policies, or a combination of all of these.

What these rules say, basically, is "keep it to yourself." Your firm is required to have a privacy policy. This policy will say how a client's personal information may be used and disseminated. It's going to allow you to share information within the firm, but for limited purposes: namely, to get your client's business done. It's going to be pretty restrictive about sharing information outside the firm. And that probably means: no sharing with "the kids" without permission. In some states, you may actually be prohibited from disclosing even the limited fact that the senior is your client!

This can get troublesome once your client starts showing signs of diminished capacity. How can you get help, if your privacy policy prohibits disclosure to third-parties?

Many jurisdictions are considering or have adopted exceptions to cover this situation, however, so find out what rules apply where you work. The standard response, however, is to be pro-active and get consents in place when the client first comes to you rather than waiting until something happens. This may entail two things:

- Creating or modifying the firm's privacy policy to allow limited disclosure to a designated third party in such cases (usually called an "emergency contact")-this may already exist; and
- Getting the client to name the emergency contact.

This doesn't solve the entire problem, but it removes a roadblock to getting a trusted person involved when needed.

5.3.2.2 Legal Capacity

In this section, we're going to tell you what constitutes legal capacity to enter into a financial transaction. As with this entire discussion, however, theory is often clearer than actual practice.

Here's the definition of legal capacity to enter into a contract, which is usually the most relevant definition for your practice. In most states, the standard for mental capacity is whether the party understood the meaning and effect of the words comprising the contract or transaction. If a transaction ever goes to court, a judge will assess your client's ability, at the time of the transaction, to understand the nature and effect of the business being transacted. This includes:

- Understanding their personal financial needs and goals, and
- Understanding the product choices you recommend.

This means that, if a transaction is highly complicated, your client will need a level of understanding that is more than just understanding needs and goals, but rather a level of understanding that matches the complexity of the transaction. Considering that *unimpaired* people often have trouble with some financial transaction, the existence of an impairment could raise issues of legal capacity.

A client's capacity to transact business, of course, is not all-or-nothing. It depends on what they need to do. The legal capacity to make a will or designate beneficiaries is quite different from being able to understand and agree to an insurance or other financial transaction. To name a beneficiary in a will, for example, an individual need not know much more than who they want their property to go to and a general idea of what property they have. On the other hand, evaluating an investment like a variable annuity needs much more specific knowledge and ability.

Transactions by seniors can be challenged by family members. Your firm could have legal liability if:

- A transaction they requested turns out to be detrimental;
- Heirs are disappointed by a small estate and they sue you to "get the money back";
- You acted in their place as a fiduciary (maybe under a power-of-attorney) and your decisions didn't work out; or
- You participated in or allowed (wittingly or not) in financial abuse by others.

They never sue you if the action made lots of money for your client. They sue you when there is a loss of some kind. If you don't handle a loss of capacity right, you could be in the position of "guaranteeing" transactions. It's not a legal guaranty, of course, but it could feel like that if the family sues you. So you better have your errors and omissions insurance paid up.

Work with your compliance department to make sure you are doing the right things even before the first signs of lost capacity appear.

5.3.2.3 Advance Planning Tools

Some of your clients may have everything well-planned and in place so that they will have everything they need if they start to lose capacity to act on their own.

Clients like this are a rarity. More likely, actions will need to be taken after that day arrives. You may not be able to craft the perfect financial plan in advance, but you can take steps in advance that will enable you and your client's loved ones to step in when needed. Here are some possibilities:

Joint Accounts

Your clients may already have joint accounts, especially if they are married. A joint account allows two (or more) people to make decisions for the account and take withdrawals. In addition to marital joint accounts, it is common for people to set up joint accounts between them and, say, a child who stands to inherit the money anyway. It is often seen as a way to avoid probate.

Joint accounts solve part of the problem of incapacity. If one joint tenant (Robert) becomes incapacitated, the other joint tenant (his wife Ashley) can still make decisions and authorize transactions in the account. This, of course, is limited to assets within the joint account.

And, of course, no joint account should be set up unless the two parties trust one another entirely.

Durable Power-of-Attorney

A power-of-attorney (sometimes referred to as a POA) is a document that gives one person (called the "agent" or "attorney-in-fact") the power to act on behalf of another (called the "principal"). Powers-of-attorney are often limited to a specific task (and should be) and they become invalid if the principal becomes incapacitated and unable to act on their own. A durable power-of-attorney is a similar document that is durable. That is, it remains in effect even if the principal becomes incapacitated. It becomes void once the principal dies.

Just like nondurable type, durable powers-of-attorney can be limited in what the document allows the agent to do. There are two common types:

- A durable power-of-attorney for health care gives the designated person the power to make health care decisions for the principal, and
- A durable power-of-attorney for finances gives the designated person the power to make financial decisions for the principal.

It is the latter type that we are concerned with in this course. The durable power-of-attorney typically gives the designated person the power to pay bills for the principal and to take actions to arrange the financial affairs of the principal. It may contain a variety of specific limitations. It may list assets or transactions for

which the agent has power to take action or it may be general.

There are two risks with any power-of-attorney. One is that the power-of-attorney may not be accepted. If you are selling property under a power-of-attorney, for example, the buyer may not want to accept it. They have no way of knowing whether the document is legitimate or, if legitimate, that it has not been revoked or modified. Durable powers-of-attorney are . . . well, durable. That is, they are more likely to be accepted. Having one is better than not having one. POAs that have been written recently are more likely to be accepted than old ones, so it is good practice to update these documents periodically. But there is no guarantee that any power-of-attorney will be accepted.

The second risk is that the agent may not be trustworthy. It is very important for your client to have a high degree of trust in the person they designate under a durable power-of-attorney.

Another consideration in executing a durable power-of-attorney is whether it should become effective immediately or only after it is determined that the individual lacks the capacity to act on their own. This is a difficult decision for many clients. They don't like losing their independence and may balk at signing a durable power-of-attorney for that reason.

Despite the name "power-of-attorney," the person named to act on behalf of your client does not need to be an attorney. They are an "attorney-in-fact" (just another way of saying "agent") not an "attorney-at-law." However, it would not be a bad idea to get an attorney involved in drafting the documents. Don't be practicing law yourself.

Trusts

A trust is a third device that allows one person to manage property for another. It is generally the most complicated of the three tools we are discussing here.

A trust is an arrangement in which one person (or entity) called the "trustee" is named to manage property for a second person, called the "beneficiary." The person who creates the trust, called the "grantor" or "settlor," gets things off and running by transferring property to the trustee who is given managing powers under a trust document that names the beneficiary, among other things.

The type of trust we are talking about here is commonly called a "living trust" because the grantor is living when they set up the trust and because the grantor names him or herself to be the first beneficiary of the trust, so that the trust

assets can be used by the grantor while alive. Once the grantor dies, the assets go to secondary beneficiaries.

Trusts can be very complicated, but the main feature of a trust that concerns us here is that the trustee is authorized to make financial decisions for the trust and, by extension, for the grantor, who is your client.

As with the power-of-attorney, this is something that a lawyer should set up. Don't practice law yourself. It is important, however, that you know that these things exist and how they operate.

The Shadow of a Guardianship

A fourth tool for handling the financial assets of an incapacitated client is a guardianship. This section has been about advance planning tools. A guardianship is *not* an advance planning tool. A **guardianship** means obtaining the legal authority to make decisions for another person and is what might happen if a client fails to do advance planning. It is not a good thing.

None of the advance planning tools is ideal. The ideal thing would be to live forever and always be healthy. But this doesn't happen. Your clients would be well advised to make use of these advance planning tools to avoid a guardianship when and if the day comes. But you can't do this for them. You can only suggest and send them off to their lawyer.

Fiduciary Responsibility

One final note. In Section 4.2, we talked about fiduciary responsibility. Whether you have it depends on many factors. One of those factors is being named as a representative for your client under one of the advance planning tools we just discussed.

Recall that, while you always have the responsibility to make recommendations that are suitable for your client, being a fiduciary means that your responsibility is heightened. You have a duty of care and a duty of loyalty beyond that required under suitability rules.

The fiduciary rules would apply to you if your client gives you a durable power of attorney to act in their behalf or names you as trustee of their trust. Consult your compliance department before you sign on to act in either of these capacities. It may be better to have these roles filled by family members. (And it should go without saying that you should not open a joint account with your client unless

your client is your spouse or you have some other familial or business reason to do so.)

5.3.2.4 Working with the Client

Working with an individual who is losing the capacity to manage their financial affairs can be difficult and can carry risks. One might be tempted to avoid the problem altogether, but that could mean abandoning a client at their moment of need.

The best advice is not to go it alone. Often this means getting a client's family or a trusted friend involved. Often this means consulting with other members of your firm. How this goes depends on the type of firm you are with and the types of procedures and guidance they have for this type of situation. If you are with a large firm, you may be directed to work with your compliance department. If you work on your own, you may have established relationships with colleagues, attorneys, or other professionals you can look to for support. There also may be social service agencies in your area that you can work with.

Who Do You Call?

It is a common practice to ask clients to bring a trusted person to client meetings once you begin to see signs of diminished capacity we discussed earlier in this chapter. In addition to, or as an alternative to this, you may wish to bring in any individual identified as an emergency contact in the client's file, the agent on a power-of-attorney, a trustee on a trust, or other fiduciary you are aware of.

Again, we want to stress that you follow your firm's procedures, if they exist. Some firms may require you to escalate the issue to a supervisor or compliance department. By getting other people involved, you get the benefit of a second (or third) pair of eyes to review any transactions that occur. You also get a witness to the fact that you are handling the account properly. Some firms require you to stop all transactions until the issue is resolved and a plan is in place to go forward.

As we have mentioned a number of times, the loss of capacity is often gradual. Measures you take have to be appropriate to the degree of loss in order to both protect the client's finances and maintain their dignity.

5.3.2.5 When the Client Can No Longer Handle Matters Themselves

Earlier in this section, we discussed the advisability of avoiding a guardianship or,

at least, putting it off as long as possible. Here's why.

It is expensive. A guardianship is initiated by going to court. Courts may appoint guardians who are entirely unrelated to your client and who may be unwilling or legally unable to make the best decisions for your client. Proceedings are public record. Guardians are paid. Reports are required that are reviewed by the court. And guardianship is all or nothing. It takes over everything, depriving the client of their rights in areas that they may still be capable of handling. A guardianship is a last resort.

In most cases, you see this coming. In the early stages of decline, a client still may have the capacity to sign a power-of-attorney (POA) or to set up a trust. Work with your firm, an attorney, or both to make these things happen.

But if these advance planning tools are not in place, or they are not broad enough to cover the need, a guardianship is always a possibility, as the last resort.

Knowledge Check

1. All of the following are advance planning tools EXCEPT: (Refer to Section 5.3.2.3, page 71)
   A. Joint accounts **[Your answer is incorrect. A joint account can be used in advance to give another person authority to manage assets in the account. A guardianship is not an advance planning tool. A guardianship is what might happen if a client fails to do advance planning.]**
   B. Trusts **[Your answer is incorrect. A trust can be set up in advance to give another person the authority to manage specified assets for the benefit of your client. A guardianship is not an advance planning tool. A guardianship is what might happen if a client fails to do advance planning.]**
   C. Powers-of-attorney **[Your answer is incorrect. A power-of-attorney can be used in advance to give another person authority to take specified actions on behalf of your client. A guardianship is not an advance planning tool. A guardianship is what might happen if a client fails to do advance planning.]**
   D. Guardianships **[Your answer is correct. A guardianship is not an advance planning tool. A guardianship is what might happen if a client fails to do advance planning.]**

5.3.3 Recognizing Fraud and Elder Financial Abuse

The problem with all this is that individuals your client names as trusted

individuals (family, friend, agent, emergency contact, trustee) may not be so trustworthy. Fraud and elder financial abuse, sadly, is not uncommon. It is, therefore, important of you to understand and recognize this type of fraud. Fraud can come from trusted individuals, but it often comes from outsiders as well.

5.3.3.1 Who Is Vulnerable to Elder Financial Abuse

Who is vulnerable to elder financial abuse?

Women are nearly twice as likely to be victims as men.[23] This is largely due to the fact that women tend to live longer than men and often survive their husbands. This means that they were there to help their husbands at the end, but they, themselves, will be living alone as widows and may require some level of outside help. The typical victim of elder financial abuse is in her 80s.

Older adults are likely targets of scammers for another reason that is entirely separate from any incapacity or vulnerability. They are targets because that's where the money is. This does not mean that targets are well-to-do, however. It simply means that individuals who have saved money toward retirement all their lives are likely to have more than when they were young and first starting out.

Loss of a nest egg can be devastating, especially for those whose nest eggs are modest to begin with. Losses at an advanced age cannot be made up through employment. And these individuals are rarely able to recover lost assets through legal action. They often don't have money for lawyers and any recovery they could get might come too late.

5.3.3.2 Who Are the Abusers?

Not all abusers are cynical criminals.

We are not forgiving anybody here. We just want to make you aware that abusers may appear as sympathetic characters. Abusers are not just strangers. More frequently, they are family members. Let's consider some of the possibilities:

Family Members

Consider the following cases:

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[23] The MetLife Study of Elder Financial Abuse: Crimes of Occasion, Desperation, and Predation against America's Elders. New York: Metropolitan Life Insurance Company, 2011.

- Your client's son Douglas recently **lost his job** and has been spending a lot of time helping your client out. Your client wants to help Douglas' family in return, but Douglas' needs seem to be growing. He seems to expect more from your client than she can provide without compromising her ability to take care of herself.
- Your client's daughter Bianca's **home is in foreclosure**. She has asked your client to take out a mortgage and use the proceeds to help her pay her own mortgage and end the foreclosure case.
- Your client's children Jeff, Gale, and Harper are concerned that a prolonged illness could **deplete your client's estate** and deprive them of an inheritance. They agree with your client to transfer substantial assets to a trust in their names.

Do these situations seem to be abusive or are they normal responses to difficulties that families face from time to time? Each situation has to be evaluated on its own in light of your client's wishes. Other family situations that could create problems include:

- Divorces,
- Substance abuse,
- Gambling,
- Financial loses,
- Negative feelings toward coinheritors and a desire to prevent them from inheriting, and
- A sense of entitlement.

Abusers can be close family or estranged family who have recently reconciled with your client. Really, it can be anyone.

Nonfamily Financial Abuse

Other suspicious characters are strangers. (Family and strangers, everyone is suspicious!) These can be true strangers who are scammers who make a living cheating people out of their hard-earned money. In the next section, we'll talk about some of the different kinds of scams. But often, nonfamily financial abuse of elders comes from people known and trusted by the elder. Here are some examples:

- Caretakers and personal care attendants,
- Neighbors and friends,
- Attorneys and financial services professionals,
- Pastors, or
- Doctors and nurses.

Take a second look at this list. This is also a list of the people we expect to be the best help and support in our retirement years. These are the people we trust. Unfortunately, these are also people who can prey on your clients.

We're not asking you to be suspicious of everyone, just to be aware. In the next section, we will talk about common scams.

5.3.3.3 Common Schemes

In this section, we will talk about common schemes that result in financial loss by elders. We'll start with scams by strangers, then talk about scams by financial services professionals, and end with a discussion of devices families used to get their hands on your clients' money.

Scams by Strangers

Scams by strangers may or may not be focused on the elder. They can be in-person cons, telemarketing cons, or email and internet cons. They can include any of the following:

- Lottery and sweepstakes scams ("you've already won . . . send us $X to cover . . . and we'll send you your winnings"),
- Home-repair cons,
- Your grandson is in jail and needs bail, and
- Phishing (getting the elder to reveal account passwords or other similar information).

You could become involved when your client complains that they were taken or if they consult you to get money needed to respond to the con.

Financial Services Abuse

Naturally, this course is mostly concerned about financial abuse by financial services professionals. Common scams include:

- **Fraud.** Some financial services professionals use their position of trust to execute transactions in client accounts by forgery, false documentation, and similar activity.
- **High fees.** Some financial services professionals generate high fees by recommending unnecessary and unsuitable transaction, including replacements and churning.

- **Unsuitable sale.** Annuities may be sold to people too old to ever expect to live to collect from the annuity. In some cases, these may be financed through reverse mortgages, depleting equity from people's homes.
- **Pyramid schemes.** These are common with elderly clients. Unrealistic returns may be promised.
- **Identity theft.** A position of trust may be exploited to gain access to identifying information that enables the scammer to access funds of the client for their personal use.

Abuse by Family and Friends

Things can get more complicated when it's your client's family or friends who are the abusers. As noted earlier in this chapter, abusive financial transactions involving family are often difficult to distinguish from completely legitimate transactions.

Here are some ways that family and friends accomplish their money-grabs. Some of these could come across your desk.

- **Powers-of-attorney.** These may be POAs that you already have on file. Your client may have willingly authorized a family member to act on their behalf. Or your client may execute a new POA. Powers-of-attorney are very useful, as we have seen, but they carry risks.
- **Joint accounts.** Anyone on a joint account with your client has the potential of stealing money from your client. As with a power-of-attorney, this planning device can be used for good or ill.
- **Using debit or credit card or stealing checks.** Anyone with physical access to ATM (debit) cards, credit cards, or checks has the potential of using them to steal-or may use them for the benefit of your client.
- **Threats of harm or abandonment.** Family, friends, and caregivers may attempt to manipulate and "persuade" your clients to give them money on threat of harm or abandonment.
- **Refusal of care.** Another possibility is for heirs or potential heirs to refuse to spend your client's money for legitimate care in order to preserve the estate for themselves.

Knowledge Check

1. All of the following are common reasons that younger family members might legitimately look to your senior client for funds EXCEPT: (Refer to Section 5.3.3.2, pages 117-118)
   A. Your client's son Ira lost his job and needs money to support his family until he gets a new job. **[Your answer is incorrect. All these situations**

could cause problems for your client, but you should be suspicious of Hal's get-rich-quick scheme. Helping out a childlike Ira who lost his job is common.]

B. Your client's son Hal has a get-rich-quick scheme and wants your client to invest. **[Your answer is correct. All these situations could cause problems for your client, but you should be suspicious of Hal's get-rich-quick scheme.]**
C. Your client's son Steve had a medical emergency and now his home is in foreclosure and needs help. **[Your answer is incorrect. All these situations could cause problems for your client, but you should be suspicious of Hal's get-rich-quick scheme. Helping out a child like Steve who had a medical emergency is common.]**
D. Your client's daughters Bianca and Gale want to set up a trust that would provide money for your client to live but protect the assets in case of a prolonged illness. **[Your answer is incorrect. All these situations could cause problems for your client, but you should be suspicious of Hal's get-rich-quick scheme. Working with children to protect an estate for inheritance is common.]**

5.3.3.4 Red Flags of Elder Financial Abuse

Let's now consider some warning signs ("red flags") of elder financial abuse. A red flag is an alert. It is possible that you will see a red flag, but discover that no harm is being done when you investigate. But these are areas where experience has shown that abuse is common. There are a lot of red flags, so we will consider them in groups, starting with the elder's living arrangements.

Living Arrangements

The following are a number of red flags relating to the elder client's living arrangements. There may be cause for concern if the elder client:

- Has unpaid bills despite adequate income, eviction notices, or disconnected utilities;
- Has been subjected to property liens or has received foreclosure notices;
- Reports belongings or property that is missing;
- Is receiving care that is inappropriate to the size of the estate (could be too little or too much);
- Is giving away money or spending wildly; or
- Is making purchases that the elder would not have made, such as high-end electronics by a person who could never operate them.

Relationships

Now let's consider the warnings that may come from considering the elder client's relationships. The following factors may be cause for concern:

- The elder has a new "best friend";
- Assets are transferred to the new friend;
- The elder's caregiver expresses excessive interest in the amount of money being spent on the elder;
- The caregiver seems to be "living off" the elder;
- Oversight of finances is surrendered to others without explanation or consent;
- The elder's spouse, partner, or friend runs up bills and finagles the elder into buying things;
- A family member or friend makes the elder feel guilty about their own job loss, foreclosure, or divorce; or
- Previously uninvolved relatives suddenly appear claiming rights.

Accounts

The red flags we've talked about up till now may come to your attention from discussions with your clients and their families. Here we are going to talk about some red flags that may come to your attention directly because of accounts you manage or are aware of. Here they are:

- Inclusion of new name on signature cards;
- Unexplained change of address;
- Bank or other account statements no longer go to elder's home;
- Unexplained withdrawals or transfers;
- Unusual activity, including large, unexplained withdrawals, frequent transfers between accounts, or frequent ATM withdrawals;
- Checks written to "Cash";
- Large credit card transactions or sudden increase in credit card debt; or
- Financial activity that would have been impossible for the elder (too complex or physically impossible, such as ATM transactions by someone who is bedridden).

Documents

Sometimes problems may be flagged in documents. Here are some that you should be aware of:

- Legal documents, including powers-of-attorney (POAs), that the elder did not understand when signed;
- Suspicious signatures on checks or other documents;
- Lack of documentation about financial arrangements; or

- Unexplained or unauthorized changes to wills or other estate documents.

5.3.3.5 What You Should Do

As we discussed in cases of diminished capacity, it is important for you to find out your firm's policies for responding to cases of elder financial abuse. If your firm doesn't have a policy, consider talking to them about developing a policy. If you are in business on your own, you should consider developing your own policy. Talking to legal counsel would be a good first step.

These two issues—diminished capacity and elder financial abuse-are often (but not always) intertwined. A person who has been financially exploited may be seen, after the fact, to have been already suffering diminished capacity. And a person who is suffering diminished capacity is vulnerable to financial exploitation.

Of course, while these things can go together, they don't necessarily. Fully competent people can be scammed. People with diminished financial capacity may be fully protected by their families and advisers. It can go either way. So you need to know the signs of both types of problem if you are working with older clients.

If Financial Abuse Has Occurred

If financial abuse has occurred or is in process, there are steps that can be taken to stop it. Five important steps that can be taken are:

- Close joint accounts, if the threat comes from the joint holder of the account.
- Revoke powers-of-attorney, if the threat comes from the person authorized by the POA to act for the elder client.
- Get a responsible and trustworthy person involved to manage the funds.
- Get a lawyer involved.
- Call police or relevant regulators to report the abuse.

Increased Transparency

Regardless of whether a problem has arisen yet or you are planning for the future, it is important to consider getting multiple people involved. As we discussed in the section on diminished capacity, there are privacy issues to consider in doing this. You should know your firm's privacy policy. But generally, consents can be put into place in advance to allow people other than your client to be informed about the account. This could include:

- Family and/or trusted friends;
- Professional advisers, accountants, or lawyers; and
- Representatives from social service agencies that exist for this purpose (if your client doesn't want family or friends to be informed).

In addition, your supervisor and compliance department should be in the loop.

5.3.4 Federal Legal Protections When You Take Steps to Protect Client
Your relationship with your client is confidential. It is important to get advance authorizations from your clients to get help when things go wrong, either from trusted family members or from law enforcement. Your firm may have policies about when and how to get these.

But there are times when authorizations are either not in place or may not cover a specific situation.

In recent years, the federal government has adopted laws designed to help you help your clients in these situations.

5.3.4.1 Immunity from Suit for Disclosure of Senior Financial Exploitation

The federal Senior$afe Act enacted in 2018[24] provides immunity from lawsuit if you report suspected exploitation of a senior citizen under the following conditions:

- You made the report in good faith and with reasonable care; and
- You received training on exploitation of seniors from your firm (this course may be part of that training, but you may also receive firm-specific training).

Who you can report to. This law covers reports to a wide variety of agencies, including:

- State financial regulatory agencies (including securities or law enforcement authorities and an insurance regulators of any state, the District of Columbia, or any U.S. territory or possession);
- A variety of federal financial institution regulators (Comptroller of the Currency, FDIC, Federal Reserve System, Consumer Financial Protection Bureau, National Credit Union Administration, and State Liaison Committee);

[24] Sec. 303 of the Economic Growth, Regulatory Relief, and Consumer Protection Act of 2018.

- Financial Industry Regulatory Authority (FINRA)[25];
- Securities and Exchange Commission (SEC);
- A law enforcement agency; and
- A state or local agency responsible for administering adult protective service laws.

While this list is broad, it is restricted to governmental agencies. Private and nonprofit organizations are not covered.

To which proceedings immunity applies. If you are in compliance with the requirements of this law, immunity applies to any civil or administrative proceeding against you both at the federal and state levels. This is a minimum level of protection: if your state gives you additional protections, those will apply as well.

Immunity does not prevent any legal action for any act, omission, or fraud that you may be guilty of. It just protects you from liability for making a report. You can't immunize your bad actions by reporting yourself!

Who gets the immunity. The immunity granted by this federal statute applies to:

- Insurance producers, registered representatives, and investment adviser representatives who are affiliated with a covered financial or associated with a covered financial institution;
- Individuals who serve as supervisors or in a compliance or legal function (including Bank Secrecy Act officers) for a covered financial institution; and
- The financial institution (credit union, depository institution, investment adviser, broker-dealer, insurance company, insurance agency, or transfer agent)

In the case of the individuals listed, immunity applies if the individual took the required training. In the case of the financial institutions, immunity applies if they gave the training (or otherwise made sure their people got the training).

Required training. If you are taking this course, chances are good that you are getting the required training, but talk to your compliance department for sure. Here is what the law requires:

[25] The law speaks of a securities association registered under section 15A of the Securities Exchange Act of 1934, but currently only FINRA qualifies.

- ***Content*.** The training must discuss how you identify and report suspected exploitation of a senior citizen both internally and, as appropriate, to government officials; discuss the need to protect the privacy and respect the integrity of each individual customer; and be appropriate for your job responsibilities.
- ***Timing*.** You must receive the training as soon as reasonably practicable and, if you are a new hire, within one year of your date of employment, affiliation, or association.
- ***Records*.** Your firm must maintain records of this training for each individual (including training completed before employment, affiliation, or association or before the enactment of this federal legislation). These records, together with the content of the training, must be made available to the relevant regulatory agencies.

5.3.4.2 Placing Holds on Suspicious Disbursements

Blowing the whistle on scam artists without repercussions is only one of the changes to the legal landscape adopted in recent years. It's not enough to cry foul after the fact. Sometimes you want to stop the scam in progress. FINRA Rule 2165 gives you tools to do just that.

If you reasonably believe that your client is being financially exploited, you may act to prevent that by placing a temporary hold on any disbursement of funds or securities from their account. This will give you and your firm a chance to investigate the situation and either release the funds or securities or take further steps to protect the client. This is a powerful tool, but you must be aware of the details:

Which clients are protected? This rule applies to any client who is 65 or older and to any client who is 18 or older if you reasonably believe they have a mental or physical impairment that makes them unable to protect their own interest. This does not require a diagnosis by a professional. You may base this "reasonable belief" on your own observations.

What constitutes financial exploitation? The rule defines "financial exploitation" pretty much in the same way we have done in this course, but it's worth looking at how FINRA puts it. For the purposes of this rule, financial exploitation means:

- Wrongful or unauthorized taking, withholding, appropriation, or use of your client's funds or securities;

- Use of a power of attorney, guardianship, or other authority (such as a trusteeship) to gain control or steal (FINRA says "convert") your clients money, assets, or property. This may involve overt acts by the scammer or omissions to act and may or may not involve deception, intimidation, or undue influence.

How long is the hold? The hold is temporary. It's to give you a chance to do an investigation and take other steps, if necessary. You have 15 business days-unless the hold is terminated or extended by a regulator, agency, or court. You and your firm also have a procedure to extend the hold for up to 10 business days. We'll talk about that in a bit. But we have other matters to discuss first.

Who needs to know about the hold? You have 2 business days to give notice to:

- Everyone authorized to transact business on the account (this would include the client, joint accountholders, and others with power to transact business in the account); and
- Anyone designated as a Trusted Contact Person (see next section for more details on this).

Notice is NOT required to anyone who is suspected of being the exploiter, even if they are one of the people who would ordinarily be required to receive notice. You don't have to tip off the bad guy to what you are doing.

What kind of investigation is required? You were suspicious, you placed a hold on your client's disbursement, you notified everyone. Finally, you have to act on your suspicion. The rule requires you and your firm to conduct an internal review of the facts and circumstances that set this chain of events in motion. You are required to follow through. Is your client being financial exploited or was it a false alarm? The situation must be investigated to find an answer to that question.

If you need more time for the investigation and your internal review is supporting your suspicion that financial exploitation of your client has occurred, is occurring, or will occur, you and your firm can extend the temporary hold by another 10 business days. A temporary hold may also be extended by a state regulator, agency, or court. This does not require a formal order, but the firm would need to maintain a record of an agency's request.

A Firm's Written Supervisory Procedures

There is more to this process than we have covered here. The rule requires your firm to maintain written supervisory procedures that cover the identification, escalation, and reporting of matters relating to the financial exploitation of the clients covered by the rule. You should become familiar with these procedures. They will also tell you who in the firm is authorized to place, terminate, or extend the temporary hold for the firm. This person (or persons) is required to be a supervisor or a compliance or legal officer for the firm.

Recordkeeping

As with so much in this business, recordkeeping is important and required by the rule. This includes records of:

- The request for disbursement that resulted in the temporary hold;
- A statement of your reasonable belief that financial exploitation of your client had occurred, is occurring, has been attempted, or will be attempted in the future;
- The name and title of the person who authorized the temporary hold;
- The notifications that went out; and
- The internal review of the facts and circumstances that was conducted as a result of the placement of the temporary hold.

Temporary Hold Applies Only to Disbursements

FINRA rule 2165 applies only to disbursements from the account. Securities transactions that don't result in disbursements are not covered. If you have concerns about transactions that do not involve disbursements, subject to your firm's procedures, you may have to report the problem to the authorities (previous section of this course) or to your client's trusted contact (next section of this course).

5.3.4.3 Trusted Contact Information

We've talked in this course about the value of getting your client's family or friends involved when things start going wrong. This applies not just to financial exploitation. A trusted person can be a big help in cases of diminished capacity. We've also talked about obstacles to getting this type of assistance that come out of privacy laws. We've talked about how getting the client to authorize a trusted contact in advance is a good way around this problem.

FINRA Rule 4512 formalizes this advice for member firms.[26] As with other FINRA rules, this does not apply to insurance-only agents, but state laws may allow similar activity. We will discuss state laws in the next section. Here are the details of the FINRA rule:

How is trusted contact information collected? Firms are required to make reasonable efforts to obtain the name and contact information for a trusted individual who may be contacted in connection with the account. This occurs at the time an account is opened and periodically when account information is updated. At these times, the client receives a written notice describing the types of information that may be disclosed to the trusted contact. A client is not required to provide a trusted contact. The firm is just required to ask. If a customer declines or simply fails to respond, the firm cans still open and maintain the account.

Who may serve as the trusted contact? Anyone the client designates may be a trusted contact, provided they are at least 18 years old.[27] The trusted contact must be a person, however, and not a business entity. The rule does not prevent joint accountholders, trustees, individuals with powers of attorney, etc. from being designated as trusted contact. The only requirement is that they are individuals who are at least 18 years of age.

What may be disclosed to the trusted contact? FINRA Rule 4512 allows the following to be disclosed to the trusted contact:

- Information about a customer's account to address possible financial exploitation;
- Contact information for the client (has there been a change?);
- Health status (is the client's capacity to manage their account impaired?);
- Identity of any legal guardian, executor, trustee or holder of a power of attorney; and
- Any notice of temporary holds placed on disbursements under Rule 2165 discussed above (again, not if the trusted contact is suspected of financial exploitation).

Keep in mind that these disclosures pertain to people designated as "trusted contacts" under the rule. Individuals may have other relationships to your client that may entitle them to broader access to information, such as joint

[26] FINRA Rule 4512(a)(1)(F) and Supplementary Material .06 on the identification of a trusted contact as part of the Customer Account Information rule.
[27] FINRA does not require you or your firm to verify the age.

accountholders, people with powers of attorney, trustees, guardians, etc.

Next we turn our attention to state laws.

Knowledge Check

1. All of the following clients are exhibiting red flags of elder financial abuse EXCEPT: (Refer to Section 5.3.3.4, pages 81-82)
   A. Harper has a new "best friend." **[Your answer is incorrect. Suddenly discovering a new "best friend" is a red flag. Giving a limited power-of-attorney to a child while recovering from surgery is not a red flag.]**
   B. Jack's account has unusual, large, unexplained withdrawals. **[Your answer is incorrect. Making unusual, large, unexplained withdrawals is a red flag. Giving a limited power-of-attorney to a child while recovering from surgery is not a red flag.]**
   C. Francisco recently changes his will to include an individual not known to the family. **[Your answer is incorrect. Making unexplained changes to wills or other estate documents is a red flag. Giving a limited power-of-attorney to a child while recovering from surgery is not a red flag.]**
   D. Selena recently signed a power-of-attorney naming her daughter Lindsey until she recovers from surgery. **[Your answer is correct. Giving a limited power-of-attorney to a child while recovering from surgery is not a red flag.]**

5.4 Unauthorized Products and Entities

Activities that constitute "transacting insurance" are those that are routinely accomplished by an insurance agent or broker. As a result, the agent or broker that engages in any of the following activities may be guilty of transacting insurance through an unauthorized insurer.

- Soliciting applications for insurance through an unauthorized insurer;
- Engaging in any negotiations that may be construed as intending to result in an insurance purchase through an unauthorized insurer;
- Actually selling an insurance policy offered by an unauthorized insurer; or
- Providing any service with respect to a policy issued by an unauthorized insurer.

5.4.1 Regulatory Oversight of Authorized Insurance Entities

Generally, an authorized insurer is "one duly authorized by a subsisting certificate of authority issued by the Department of Insurance to transact insurance in the state." Insurers are required to obtain a certificate of authority in each state in which they do business. However, once a certificate of authority is granted, the involvement of the regulators has just begun.

The process begins with the review of the financial status and operations of any insurer seeking admission to a state. The Uniform Certificate of Authority Application (UCAA), an application for authorization to transact insurance generally required by all states, requires an insurer to provide a substantial amount of information. At a minimum, insurance regulators in all states review:

- The insurance company's financial status, including its assets, capital, surplus and reserves; and
- The identity and background of the insurance company's principal officers.

Insurance regulators continue to monitor the following after granting a certificate of authority to an insurance company:

- The insurance company's ongoing operations;
- Policy forms offered for sale by the insurer;
- Supervision of the insurer's claims and sales representatives; and
- Certain premium rates charged, claims ratios incurred and actuarial adequacy.

5.4.2 Reasons for Concern Regarding Unauthorized Insurance Entities

The problem of unauthorized insurance entities is not an isolated or limited one. Hundreds of insurance companies in various states have been ordered to stop transacting unlicensed insurance business.

The insurance industry may be an attractive target for organized criminal activity because the commodity in which it deals is money. To the extent that entities involved in the handling of substantial premiums and their principals and licensees are not authorized to transact business, there is a substantial risk that the organizations and their employees may be dishonest.

Furthermore, unauthorized insurance entities and their operations are not supervised as they would be if they were authorized. This lack of regulatory oversight is a potential breeding ground for criminal elements and illicit activity.

5.4.3 Unauthorized Entities Typically Claim ERISA Exemption

Unauthorized insurance entities may claim that they are multiple employer welfare arrangements (MEWAs) that do not require state licensure or authorization since they are regulated by the federal government under ERISA.

We will now take a look at these claims that are usually not true.

The principal factual and legal issue in the problem of unauthorized insurers centers around the claim that particular transactions and the unauthorized entity that is sponsoring it are not subject to state insurance regulation. This arises, in part, out of Section 514(a) of ERISA, which states that ERISA:

> "supersedes any and all state laws insofar as they...relate to any employee benefit plan ..."

This concept that the federal law overrides the state law is generally referred to as preemption.

It is this preemption language on which unauthorized insurers make the claim that their plans are not subject to state regulation. In reality, ERISA contains another provision that specifically excludes certain industries from its preemption. ERISA bars states from regulating private-sector employer benefit plans and union-sponsored benefit plans. However, it permits the states to regulate insurers who serve these employer-sponsored and union-sponsored plans.

Therefore, an ERISA plan must be **self-insured** to avoid state regulation entirely.

Significantly, this ERISA provision permitting employer-sponsored plans to be self-insured applies only to single employer plans. A MEWA is generally defined as an employee welfare benefit plan or other arrangement that is established or maintained to provide one or more insurance benefits to the employees of two or more employers.

Since a MEWA is generally defined in applicable state laws as providing benefits for the employees of two or more employers, it is not exempt from regulation by the individual states under ERISA. MEWAs, therefore, are subject to concurrent state and federal regulatory authority.

5.4.4 Consequences for Transacting Business on Behalf of Unauthorized Insurers

In view of the harm that unauthorized insurance entities can inflict on an unsuspecting public, it is not surprising that the consequences of acting as an

unauthorized insurer or as licensee or agent for such an entity are severe.

For agents who transact insurance for an unauthorized insurance entity, the penalties may include:

- Disciplinary action that may involve criminal prosecution;
- The imposition of monetary fines; and
- Suspension or revocation of insurance licenses.

In assessing the possible liability for transacting insurance for an unauthorized insurance entity, be mindful of those activities which may constitute such a transaction, including:

- Soliciting or proposing to make an insurance contract;
- Taking an application for insurance;
- Receiving or collecting premiums;
- Issuing or delivering contracts of insurance; or
- Adjusting claims

Virtually any of these actions taken by a licensee on behalf of a prospect or client, by mail or otherwise, will most likely be considered to be transacting insurance.

The penalties for acting as an insurer without a proper license (i.e., as an unauthorized insurance entity) or acting as a principal for such an entity are also severe. They include:

- Criminal prosecution;
- Suspension or revocation of all insurance licenses; and
- Liability for customers' unpaid claims.

In 1968, well before the proliferation of unauthorized insurance entities became an epidemic, the NAIC adopted a model act to combat the problem. Known as the "Unauthorized Insurers Model Act," it subjects unauthorized insurance entities to the jurisdiction of the insurance commissioner and the courts of the enacting state.

The vast majority of states have enacted the model act or related legislation to control unauthorized insurance entities.

A recent Florida case involved the disciplining of an agent in connection with an unauthorized insurer. In that case, an investigation of a life, health and variable annuity agent alleged that he aided or represented an unauthorized insurer. Accordingly, the agent's license was suspended for six months. If the agent applies for reinstatement after the suspension period, he will be placed on

probation for 12 months. In addition, the agent was fined $5,500 and required to make restitution of $660.50.

Another Florida case involved the apparent sale of health insurance from insurers unauthorized to do business in Florida. The case involved a life and health agent who was alleged to have sold consumers health insurance plans from certain unauthorized insurers. When the consumers had medical claims they were informed there was no coverage, thereby causing the consumers to suffer significant financial harm. The agent was fined $1,000 and investigative costs of $1,000. In addition, the agent was ordered to:

- Disgorge all commissions received from any and all of the contract plans or policies he sold; and
- Satisfy all unpaid claims or losses for all persons entitled to coverage for the policies he sold.

Knowledge Check

1. All of the following are reasons for concern regarding unauthorized insurance entities EXCEPT: (Refer to Section 5.4.2, page 91)
   A. The insurance industry is an attractive target for criminal activity because it deals in money. **[Your answer is incorrect. The potential for criminal activities is one of the reasons for concern. The Florida Life and Health Insurance Guaranty Association does not provide protection for entities that are not members.]**
   B. Customers of unauthorized entities receive guarantees under the Florida Life and Health Insurance Guaranty Association **[Your answer is correct. The Florida Life and Health Insurance Guaranty Association does not provide protection for entities that are not members.]**
   C. Unauthorized entities are not supervised and at substantial risk that they might be unable to pay claims **[Your answer is incorrect. The risk that claims may not be paid is one of the reasons for concern. The Florida Life and Health Insurance Guaranty Association does not provide protection for entities that are not members.]**
   D. Without supervision there is substantial risk that employees of these entities might be dishonest. **[Your answer is incorrect. The potential for employment of dishonest individuals is one of the reasons for concern. The Florida Life and Health Insurance Guaranty Association does not provide protection for entities that are not members.]**

5.4.5 Due Diligence Required

Licensees and brokers must determine a course of action if contacted by an insurer offering extremely low rates and claiming an exemption from state regulation. The appropriate response is one of due diligence. The place to begin the investigation is the insurance department in the state where the licensee does business.

A telephone call to the insurance department produces two potential benefits:

- It should enable the licensee to obtain the answer; and
- It will notify the insurance department.

Some insurers wish to limit their licensees' individual contact with state regulators; in this case, the licensee should contact their company's general counsel or compliance department and explain the situation before agreeing to further discussions with a possibly unauthorized insurance entity.

5.4.6 Florida and Unauthorized Insurers

The State of Florida has taken a very strong position on the issue of unauthorized entities. An unauthorized entity is an insurance company that is not licensed by the Florida Department of Financial Services. Agents and brokers have responsibility for conducting reasonable research to ensure that they are not writing policies or placing business with unauthorized entities. Lack of careful screening can result in significant financial loss to Florida residents due to unpaid claims and/or theft of premiums. Agents may be held liable when representing these unauthorized entities. It is the responsibility of agents and brokers to give fair and accurate information regarding the companies they represent. Any question about the authorized status of a company can be checked by calling the Florida Department of Financial Services at 1.877.693.5236 (inside Florida) or 850.413.3089 (outside of Florida).We urge all agents and brokers to adhere to this admonition.

State regulators have an obligation to protect the investors from loss in their insurance transactions. By granting a certificate of authority to an insurer and maintaining supervision over the insurer's activities, the regulators provide a measure of protection. An unauthorized carrier can cause significant financial injury to reputable insurance agents, their clients and service providers.

The specific *Unauthorized Entities Verbiage* from the State of Florida states:

> *An entity that is required to be licensed or registered with the Florida Office*

*of Insurance Regulation but is operating without the proper authorization is identified as an **unauthorized insurer**. All persons have the responsibility of conducting reasonable research to ensure they are not writing policies or placing business with an unauthorized insurer. Any person who, directly or indirectly, aids or represents an unauthorized insurer can lose their licenses or face other disciplinary sanctions. Please see section 626.901, Florida Statutes, to read the law. Lack of careful screening can result in significant financial loss to Florida consumers due to unpaid claims and/or theft of premiums. Under Florida law, a person can be charged with a third-degree felony and also held liable for any unpaid claims and refund of premiums when representing an unauthorized insurer. It is the person's responsibility to give fair and accurate information regarding the companies they represent*

Specifically, Florida Statutes Sections 626.901 through 626.911 regulate unauthorized insurers and those representing or aiding unauthorized insurers. You may view these regulations HERE.

5.5 Recent Violations and Enforcement Actions

The following are instances in which licensees or other persons violated the Florida Insurance Code and the administrative action the department has taken against them. Note: All administrative investigations are subject to referral to the Division of Insurance Fraud for criminal investigation.

Case—Agent Enrolled a Client in Health Policy Without the Client's Knowledge. A consumer filed a complaint with the Division of Consumer Services stating that a health insurance agent enrolled her into a health insurance policy without her knowledge or consent and renewed the fraudulent policy a year later.

After investigators spoke to the agent and sent several written requests for copies of the agent's records, the agent failed to produce the records then and stopped responding to the Department. As specified under s. 624.318(2), F.S., the Department took action against the agent for failing to provide records to the Department during the course of an investigation.

Disposition: License suspended 90 days. The former agent will be required to reapply for a license. However, the license may not be reinstated if the circumstances that caused the suspension still exist or are likely to recur. (Case Notes. Fall 2022. *Insurance Insights*.)

Case—An Agent Deleted the Wrong Vehicle From Policy. The Department's Division of Consumer Services opened a case on an insurance agency related to a

denied auto insurance claim.

When an insured requested removal of a vehicle from the auto policy, the agency removed a different vehicle. An investigation confirmed that the incorrect vehicle was removed from the policy by the agency without the insured's knowledge or consent. When the vehicle was involved in an accident, the insurance company denied the claim. The agency then covered the cost of the vehicle damage to make the consumer whole.

Disposition: The agency's agent in charge was fined $3,500 and placed on probation for one year. (Case Notes. Fall 2022. *Insurance Insights*.)

Case—Agent Made Herself the Enrolling Agent. The Bureau of Investigation opened an investigation on a health and general lines agent for a complaint alleging the agent named herself as the enrolling agent of record for approximately 500 health insurance policies issued through the Federally Facilitated Marketplace (FFM). The agent, who did not have lawful authority to make changes, made changes without the knowledge and consent of the insureds.

Investigators interviews the agent and acquired wide-ranging insurer documentation, and consumer-insured affidavits related to the case. The agent deceived the insureds and the legitimate agents of record for the policies, which meant a major disruption in the lives of the insureds and a loss of income to the agents who were replaced.

Disposition: License revoked. (Case Notes. Fall 2022. *Insurance Insights*.)

Case—Two Agents Were Engaged in Identity Theft. The Bureau of Investigation investigated two agents based on a complaint from an agent who worked briefly at the same agency as the agents. That agent alleged the two agents stole her identity to write more than 750 Accidental Death & Dismemberment (AD&D) policies using her name and license number without her knowledge and consent.

The two agents used the victim’s identification to open a bank account in her name to deposit commissions that were disbursed to the agents after the payments had cleared.

Investigators obtained insurer documentation, bank records, and affidavits from consumers and insurance company personnel. During the course of the investigation, many insureds reported they were not aware AD&D policies were issued for them.

The charging agent received a 1099 tax form indicating she had earned $153,000 in commissions which she never received, making her liable for taxes on the commissions. She then reported the identity theft.

Disposition: Both agents were suspended for 24 months and ordered to pay $100,000 in shared restitution to the victimized agent. (Case Notes. Fall 2022. *Insurance Insights*.)

Case—Agent made Self-beneficiary of Life Policy. A married couple who were both life, annuity, and health agents were writing a life insurance policy. The client told the agent to make the client's son beneficiary of the policy, but the agent made her husband (the other agent) beneficiary instead.

Disposition: Both agents' licenses revoked. (Case Notes. November 2021. *Insurance Insights.*)

Case—Agent Bought Life Policy on Ex-spouse by Forging her Signature. A life and variable annuity agent, while divorce proceedings were pending, purchased an accidental death policy on his soon-to-be ex-wife. The ex-wife did not sign the application; rather, the agent forged her signature.

Disposition: License suspended for 12 months. (Case Notes. November 2021. *Insurance Insights.*)

Case—Life agent Submitted Fraudulent Applications to get Commissions. A licensed insurance agent filed almost 100 fraudulent life insurance policy applications written without the permission or knowledge of the purported policyholders. Although he used different names, he used his own address, phone, and bank information in the applications. He paid the initial premium for each policy by electronic funds transfer from his own account and he would receive back a commission for the policy.

Disposition: Licensed revoked and charged with insurance fraud and organized fraud by a licensed agent. If convicted, he faces up to 10 years in prison. (News You Can Use. Fall 2021. *Insurance Insights.*)

Case—Agency Operated Without a License. A purported agency was operating without a license. Investigators obtained evidence from the insurer that had appointed the principal of the purported agency that multiple policies had been sold.

Disposition: Fined $1,000 and required to get an agency license. (Case Notes. Fall 2021. *Insurance Insights.*)

Case—Health Agent Submitted Fraudulent Applications to get Commissions. A licensed health agent submitted health benefit applications for

two businesses and a total of 35 employees and received advance commissions. The insurer terminated the agent who owes the commissions back due to nonpayment of premiums.

Disposition: Agent suspended for 18 months. (Case Notes. Fall 2021. *Insurance Insights.*)

Case—Agent used Customer Credit Card Without Authorization. A life, health, and variable annuity agent used a client's credit card to pay for personal expenses of almost $2,000. The client said he had given the credit card information to the agent to pay his insurance premium and did not authorize any other charges. The insurer terminated the agent and reported the situation to the department.

Disposition: License suspended for 6 months. (Case Notes. Fall 2021. *Insurance Insights.*)

Case—Agency Operated Without a License. A life, health, variable annuity, and customer representative sold insurance products in the name of an unlicensed entity and she was not licensed or appointed to do so. She used email to solicit referrals and offered a chance at winning a $500 gift card to those who filled out a survey. Once caught, the individual agreed to stop the emails and take down the unlicensed entity's Facebook page and correct its website within 10 days. She failed to do so.

Disposition: Fined $2,500 and put on probation for 1 year. (Case Notes. Fall 2021. *Insurance Insights.*)

Case—Agent used Fraudulent Applications to Qualify for Contest. A life, variable annuity, and health agent submitted multiple applications using client bank account information in order to qualify for a production-based contest sponsored by his insurance company. The agent's clients swore that they did not authorize any applications other than their own. They also said that the fraudulent applications were made to a different insurance company than what they had authorized.

Disposition: License revoked. In addition, the agent was arrested and charged with organized scheme to defraud, false and fraudulent insurance applications, criminal use of personal identifying information, and grand theft, and faces up to 40 years in prison if convicted. (Case Notes. Fall 2021. *Insurance Insights.*)

Case—Agent Signed up Consumers for Insurance Without Their Knowledge or Consent. A life, variable annuity, and health agent signed up two consumers for insurance policies without their knowledge or consent, submitted a fraudulent signature on an insurance policy application, changed the payment

information on three policy-holders' accounts without their knowledge or consent, failed to reimburse his employer for commission chargebacks and bonuses resulting from fraudulent sales, and lacked the qualifications to hold any resident licenses after moving out of the state.

Disposition: All licenses revoked and agent my not apply for any license for 2 years. (Enforcement Actions. Fall 2021. *Insurance Insights.*)

Case—Agent Convicted of a Felony. A health agent was convicted of possession of a controlled substance with intent to sell or deliver after a plea of nolo contendere.

Disposition: License revoked. (Enforcement Actions. Fall 2021. *Insurance Insights.*)

Case—Agent Charged with Felonies. A life and variable annuity agent was charged with wire fraud and aggravated identity theft.

Disposition: License suspended (with instructions to revoke depending on the outcome of the criminal proceeding. (Enforcement Actions. Fall 2021. *Insurance Insights.*)

Case—Agent Charged with Aiding Excessive Trading. A life, variable annuity, and health agent was charged with violating FINRA Rule 2010 by aiding and abetting excessive trading and churning of accounts resulting in an order barring her from association with any FINRA member firm. She also failed to report this order to the Department of Financial Services, as required, within 30 days.

Disposition: Licenses revoked. (Enforcement Actions. Fall 2021. *Insurance Insights.*)

Case—Agent Charged with Child Abuse. A life, variable annuity, and health agent was charged with child abuse. She entered a plea of nolo contender.

Disposition: All licenses revoked and agent may not apply for any license for 2 years. (Enforcement Actions. Fall 2021. *Insurance Insights.*)

5.5.1 Enforcement Actions

Some disciplinary actions are resolved through a settlement process resulting in an order for discipline. The State of Florida believes that notification of disciplinary actions is in the public interest. It is in that spirit that they provide access to a listing of all disciplinary actions in their *Insurance Insights* newsletter HERE. Bear in mind that while every effort is made to provide correct information, they caution readers to check with the department before making a decision based

upon information contained in the listing.

Additionally, the State warns that no part of the listing may be used by a licensee to gain an unfair competitive advantage over any person named in the listing and any licensee who does do so will violate Section 626.9541(1)(c), Florida Statutes.[28]

You can access enforcement actions from the *Insurance Insights* newsletter.

5.6 New and Other Important Terminology

As a licensed insurance professional, you have an obligation to keep informed of new and important terminology. Suggested sources of this information include Insurance Insights and the National Association of Insurance Commissioners.

5.6.1 Premium Discounts

It is a general principle of insurance law that premium levels must reflect actuarial risk. So in both life and certain types of health insurance, for example, premiums are higher for older individuals than younger individuals. Discounts are also available for factors relating to the health of an insured individual (or prospective insured). The factors that may be taken into account in providing premium discounts are broader than what is permissible in health insurance due to restrictions of the federal Patient Protection and Affordable Care Act (PPACA or ACA).

For a health plan, premium discounts are permitted in two health-related circumstances:

- Tobacco non-use, and
- Participation in a wellness program.

The amount of the discount is limited by the ACA for health insurance plans. Life insurance and long-term care insurance may give similar discounts, without restriction as to amount other than the need to reflect actuarial risk, as noted above. Life and long-term care insurance may charge higher premiums for individuals who are determined to be substandard risks, based on factors such as pre-existing conditions (not allowed for health insurance), but the standard premium for a healthy individual is considered a standard premium and not a

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28 http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=0600-0699/0626/Sections/0626.9541.html

discount.

6.0 Conclusion

You have now completed your 5-hour law and ethics training and you should be able to discuss, and analyze:

- Florida insurance law updates;
- Ethics in Florida;
- Florida disciplinary trends;
- Insurance industry trends; and
- Suitability of insurance products.

It is important for you as a licensee to keep up-to-date on the rules that govern our profession in Florida. Every year, we see changes both in the laws that govern us and in the industry itself. That is why the state required you to complete this course.

Over the years we have seen changes in the state concerning the operation of agencies, including the creation of a new category of agent (unaffiliated insurance agent), elimination of the distinction between licensed and registered agencies, and the type of licensees that must be in charge of an agency and its branches.

We have seen changes in health and life insurance (particularly changes resulting from federal legislation), in employee health care plans, in Medicare reimbursements, in inflation adjusted factors pertinent to employer and other plans, and in long-term care insurance. Other changes have included changes relating to insurer solvency and records and business information. Many of these changes are technical, so, if your practice is affected, it is important for you to be aware and study how the changes will affect the way you do business.

Both annuities and life insurance should be considered in your clients' long-term financial plan. While both include death benefits, your clients buy life insurance in the event they die too soon and an annuity in case they live too long. In other words, life insurance provides economic protection to their loved ones if the client dies before their financial obligations to them are met, while annuities guard against outliving their assets.

This course covered technological advances that are changing the way products are sold, the challenge of cybersecurity to the industry, the impact of the Affordable Care Act on the number of uninsureds and health care costs, the

growth of wellness plans, and many more issues. Your work has consequences. You work in a complicated field that is constantly changing. It is important for you to be up-to-date in order to best serve your clients and to keep out of trouble. Mistakes are made, whether through oversight or intention. As you learned in this course, those who violate the rules can suffer severe penalties. We hope that, by expanding your awareness, we are contributing both to your avoidance of penalties and to your constant improvement of your service to your clients.

Thank you for studying with RegEd!