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CHAPTER 1: RELATIONSHIPS WITH CONSUMERS

Introduction

Insurance can be tremendously helpful during some of life's worst times. But for most people, risk management through insurance policies is something that can only be competently done with the assistance of a good insurance representative. Before going into specifics about how insurance can be used, let's examine some of the basic consumer-focused responsibilities for agents and brokers.

Although the public sometimes views the insurance industry as an impersonal entity, dedicated insurance professionals will likely denounce that image as a major misconception and proclaim that the insurance business involves much more than making cold calls to prospects, working with claim forms and actuarial data. Veterans in their field have probably learned that much of an insurance producer's job pertains to the development of relationships with the public, and that countless professionals nurture such relationships every day by assisting individuals, families, and businesses in the procurement of coverage for personal, commercial and industrial needs. Most of those professionals should agree that without those solid relationships, consumers have little incentive to trust an insurer to protect them, their loved ones or their businesses from financial risks and that one of the most reliable ways for an insurance producer to earn trust is to behave in an ethical manner toward every customer.

Insurance Agent vs. Broker

Perhaps the most visible members from the insurance world and the ones most capable of shaping the average person's perception of the insurance industry are insurance producers, who may act as agents or brokers. The terms "agent" and "broker" are common in various parts of the professional world. One can hear those titles in conversations related to real estate and investments, to name only two examples. It must be noted, however, that the definitions of these terms can vary from one field to the next and that, contrary to popular belief, agents and brokers do not have identical job duties. In fact, agents and brokers perform importantly distinct functions with differing ultimate goals.

In terms of insurance, both agents and brokers examine a consumer's requests and serve as intermediaries who set up prospective insureds with coverage from an insurance company.

The important difference between agents and brokers involves the people who they ultimately represent in an insurance transaction. Whereas a broker has traditionally been considered a representative of the insured, an agent's ultimate has generally been to a specific insurer. Simply put, a broker is usually paid to act in the consumer's best interest, while the agent is usually paid to act in the insurer's best interest. Companies purchasing businesses for themselves are more likely to do it with the assistance of a broker. Individuals who are purchasing insurance for personal use will usually do it with the assistance of an agent.

Despite those important differences, ethical insurance producers don't simply devote themselves to the people who pay them and ignore potential responsibilities to the other parties in an insurance transaction. The majority of brokers don't deceive insurers so that policyholders can reap benefits, and most agents do not take predatory stances toward consumers in the hopes of selling deficient or unnecessary policies.

Agents and brokers generally have different bottom-line responsibilities, but it can be argued that both types of professional insurance producers have ethical obligations to current and prospective policyholders.

Analyzing Needs and Choosing a Policy

At some point in every transaction with the public, insurance producers must at least try to pursue what clients and customers want. If someone decides that he or she must have a particular policy that costs a particular amount, the broker should search for a provider who can accommodate the client, and agents should return to their company and do what they can to obtain the requested policy for the customer. The insurance producer should not allow personal feelings to override a consumer's decisions.

That doesn't mean that insurance producers must never use their experience and personal instincts to influence a consumer's thought process. In fact, doing so is sometimes ethically encouraged, as long as the producer has the person's welfare in mind. The responsible insurance producer listens to the consumer and tries to decipher what the person needs, which may or may not be exactly the same as what the consumer requests.

It is the producer's ethical (and, in some jurisdictions, legal) responsibility to make clients and customers understand their insurance needs. If the insurance producer recognizes risks that would not be covered based on the consumer's stated requests, the agent or broker should disclose the insurance gap. Specifically for agents, this might even mean making the consumer aware of insurance gaps that can't be filled by their own carrier.

Explaining Coverage

When discussing insurance policies, producers should make no assumptions about the consumer's knowledge of what a policy will cover and what it will exclude. Even though exclusions are documented within the policies themselves, agents and brokers should discuss these exclusions in a detailed manner with the public so that potential policyholders understand the following:

- What they are buying.
- What risks they are managing through insurance.
- What risks they are still financially exposed to.

Answering Questions

Insurance agents should be well-schooled about the products they sell. Brokers should also make themselves as informed as possible of the various policies that they can provide from various companies.

Of course, no insurance producer knows the answer to every question. Competent, ethical insurance professionals admit when they do not have an answer for a consumer and then attempt to follow up on the query by diligently consulting a more knowledgeable source. However, it is not enough for the producer to merely repeat a reliable source's answer. Assuming the agent or broker finds the answer to the question, he or she must also clearly understand it and anticipate any further questions. It's also worth noting that, as in many situations in life, it is sometimes best to admit that you do not know the answer to a question and to advise the person to ask a more specialized individual. It should go without saying that a consumer will appreciate honesty more than factually shaky and potentially harmful advice.

Conclusion

Despite ethical duties owed to consumers, insurance producers need not handle every aspect of a transaction. As stated previously, the insurance producer is an adviser, not a decision maker. In the end, it is the insured, rather than the producer, who must complete the following tasks:

- Choose whether or not to purchase a particular policy.
- Pay premiums.
- Provide producers with any needed documents for coverage.
- Read and acknowledge an understanding of a policy's terms.

Of course, no professional is immune to accusations of illegality. But insurance producers can reasonably protect themselves from liability by disclosing, at an early stage of a transaction, what they will do for a consumer and what they will not do. Smart, ethical agents and brokers do not allow the public to guess as to whether or not they represent the insurer or the insured. They document this disclosure, as well as every other act and discussion they have with a consumer, be it about a person's wants or needs, policy exclusions, the financial stability of an insurer or any other matter.

Adherence to ethics improves public relations, which will likely increase business. Such adherence should also lessen a producer's legal concerns in a time when few agents and brokers are absolutely certain of their court-imposed duties. The more people feel as if they have been treated fairly, the less likely they are to take legal action against someone. And even in those situations in which litigation becomes unavoidable, demonstrations of documented ethical conduct can be an insurance producer's best defense.

CHAPTER 2: COPING WITH NATURAL DISASTERS

Introduction

Just in case you need a reminder of how important a good, ethical insurance producer can be for someone, consider talking to the victim of a natural disaster. With a knowledgeable insurance professional at their side, disaster victims are likely to stand a better chance of putting their lives back together.

Scientists and insurers often agree that it is only a matter of time before people from across the nation experience a natural disaster in their own area. The Federal Emergency Management Agency (FEMA) has estimated that three-fourths of the United States is susceptible to flooding, hailstorms, hurricanes, and earthquakes, and that figure, of course, makes no mention of the wildfires, tornadoes, landslides and droughts that can also strike in a community.

At its worst, nature plays no favorites when deciding where to unleash its wrath. In recent memory, a merciless hurricane season wrecked low-income communities in Louisiana and Mississippi, and nearly untamable blazes transformed luxurious homes in California into ugly ash. Some homeowners who tried to safeguard properties from fire by building with bricks or stone have realized that their favored materials don't stand up to earthquakes. Meanwhile, people who once sang the praises of wood-framed dwellings have discovered that their sturdy foundations still don't stand much of a chance against raging flames.

For the insurance industry, the business solution to the natural catastrophe problem is not as simple as merely selling various policies in presumably safe communities and ignoring the rest of the public. If an area isn't prone to earthquakes, it may still be prone to tornadoes. If an area isn't prone to tornadoes, it may still be prone to hurricanes. So a fearful insurer can decide that it is incapable of doing business in a particular part of the country, but an insurer who refuses to take on any kind of disaster risk will end up with a very limited base of clients.

From Washington state to Maine and from California to Florida, insurers must accept the possibility of a looming "catastrophe," which the Insurance Services Office (ISO) has defined as any event resulting in $25 million or more in insured losses. Those insured losses can involve not only structural damage but also business interruption claims, auto claims, theft claims and, unfortunately, life insurance claims.

Yet compared to some developing countries, the United States is lucky in regard to natural disasters, in the sense that the catastrophes that hit its soil tend to cause widespread economic hardships rather than extremely long lists of casualties. U.S. catastrophe victims may lose precious belongings or even experience temporary homelessness, but they are at least likely to survive the ordeal. Although this generalization should not be interpreted by readers as a naïve statement that disrespects the memory of the countless men and women who have died from the effects of a natural disaster, it does explain why, in the rest of this chapter, we will ignore the life and health consequences of catastrophes and emphasize those insurance products that cover dwellings, businesses and personal property.

A handful of disaster victims have sour stories to tell about their experiences with their insurance companies, either because they did not properly educate themselves when purchasing and evaluating coverage or because their trusted insurance professional did not clearly go over policy limitations and exclusions with them. Many of these people can now be found in town halls and other community centers near disaster areas, counseling victims on how to put their lives back together and how to get the insurance benefits they deserve. The following course material empowers insurance producers by giving them information to help reduce customer dissatisfaction. In addition to mentioning the typical policies that help consumers manage the financial consequences of natural disasters, the text explains why and where these disasters occur and, perhaps most importantly, describes what insurance shoppers can do to keep their property safe and their premiums manageable.

Wildfires

The risk of suffering wildfire damage is small compared to the risks presented by earthquakes and hurricanes, and many insurers are more fearful of major hailstorms than of flames burning out of control. According to FEMA, homeowners have 25 percent chance of experiencing a flood over the course of a 30-year mortgage and only a 9 percent chance of having to cope with a fire.

But if you try spouting those facts at the people who have been displaced by wildfires, you're bound to get an impassioned, disagreeable reaction. After more than 15 years, residents of the Oakland area are still likely to have clear memories of the East Bay fires of 1991 that scorched their hilly community. The fires, which forever changed the way insurers viewed replacement-cost homeowners policies, were responsible for $1.7 billion in insured damages. Residents of Los Alamos, New Mexico, almost certainly can recall the time in 2000 when a botched burning by the federal government damaged 1,000 automobiles and forced 18,000 people out of their homes. With enough power to turn entire states into disaster areas, it is clear the risks associated with wildfires deserve a homeowner's respectful attention.

Why and Where Wildfires Occur

Though it's true that major fires have sometimes been set by arsonists, most wildfires don't require any ill will on the part of a human. They are often linked to innocent campfires that get out of hand and can also be caused by bolts of dry lightning.

In the United States, climate conditions create an annual fire season that begins in summer and stretches through the end of fall. Within this seasonal timeframe, wildfires are at their most destructive when long-term forecasts call for hot, dry and windy weather. Lack of humidity not only helps an unattended fire spread more easily but also makes it harder for firefighters to extinguish a blaze. When fueled by a strong wind, a raging fire can move uphill, endangering people in mountain and valley communities.

As anyone who watches television news knows all too well, no one can accurately predict the next day's weather 100 percent of the time. However, insurance professionals who worry about wildfire risks can keep an eye on the moisture content of a chosen area thanks to scientific measuring systems. Two popular measuring sticks are the Keetch-Bryam Drought Index and the Palmer Drought Severity Index. The Keetch-Bryam Drought Index reflects the amount of moisture in soil on a scale of 0 to 800. The index drops after rainfall and rises after a dry day. The Palmer Drought Severity Index is used to evaluate long-term climate conditions, as opposed to daily changes in moisture content, and has a base of zero. Negative numbers indicate a drought, and positive numbers indicate moisture.

Considering the standard climatic recipe for wildfires, it's no wonder California residents suffer more frequent and intense wildfires than citizens in any other state. The area is prone to hot and arid summers, and by the autumn months, desert winds often blow strongly toward the Pacific Ocean, helping fires overcome some of the state's hillier topography.

The state's sometimes sky-high home values add to insurers' wildfire worries. Even flames covering a very small radius in California can amount to millions of dollars in insured losses if they happen to make contact with some of the prized canyon properties belonging to the rich and famous.

But no matter how much attention the Golden State receives in regard to this peril, California clearly has no monopoly on wildfires in the United States. Florida, another coastal location with valuable real estate, has had its own problems with these disasters. Meanwhile, Montana, Oregon, Washington, Arkansas and even Wisconsin, which surrendered 3,800 acres to wildfires in a single incident in 2005, have sustained significant damage in recent years.

Controlled Burns

In spite of public service announcements that encourage Americans to prevent forest fires (not to mention humans' natural fear of flames), experts argue suppressing fires as quickly as possible is a nearly ineffectual, temporary fix to a serious problem, not unlike putting a finger-sized bandage on a wound that would be best served by several stitches. In fact, they say the occasional fire, when kept under careful watch, can do positive wonders for the environment and can actually prevent costly wildfires in the long run.

Fires set intentionally for these beneficial purposes are known as "controlled burns." A controlled burn acts as a housecleaning of the ecosystem. From a risk prevention standpoint, the idea is to burn away all the old, dead vegetation that might fuel a fire and to replace the vegetation with a barrier of spotless land or fresh, less-flammable plant life. Of course, performing a controlled burn in an area every 15 to 30 years does not make insurance companies entirely immune to wildfire losses, but it might mean the difference between an inconvenient number of property insurance claims and an indisputably catastrophic level of loss.

According to the San Francisco Chronicle, the state of California was engaged in controlled burns until the 1960s, when nervousness among the public and insurance companies helped put a temporary end to the practice, which resurfaced a few decades later. The misgivings surrounding controlled burns are still expressed by some of today's homeowners and insurers and relate mainly to the possibility that federal and state forest officials will not be able to keep these intentional fires within safe boundaries. Though many controlled burns are executed on government land, there is always at least the small chance a fire will find its way onto private grounds, leaving insurers exposed to property losses and liability claims. In 2000, a controlled burn in Los Alamos, New Mexico, damaged 48,000 acres in four counties, destroyed approximately 200 homes and prompted the forced evacuation of 18,000 residents. Ironically enough, however, a string of wildfires in San Diego County in 2003 made local observers wonder why authorities hadn't been lighting controlled burns in the area prior to those fires.

As an alternative to the sometimes risky controlled burns, some communities have unleashed their livestock in fire-prone areas and waited patiently for goats and other animals to graze their way through all of the flammable, old plants. This approach has its upsides, not the least of which is its non-reliance on man-made flames that could damage property and harm wildlife. The technique is also less reliant upon favorable weather conditions since, unlike in a controlled burn situation, it can be done safely and effectively in hot, dry or wet conditions. One obvious drawback, though, is that grazing is a slower procedure than controlled burns, even with a sizeable amount of hungry animals on hand.

The Urban Wildland Interface

Challenges in modern wildfire prevention have been compounded by homeowners' increased movement into the "urban wildland interface," a term used to describe the buffer zone between developed land and relatively untouched forestry. Whereas wildfires from previous generations often had nothing in their paths to damage other than timber and maybe the occasional warehouse, today's fires can burn through an increasing number of high-priced residential properties and foster more insured losses than previously imagined. Researchers at Colorado State University claimed the population of the urban wildland interface grew by 52 percent between 1970 and 2000. In 2007, the New York Times cited a report from the University of Wisconsin that said more than 8.6 million new homes had been built in the West within 30 miles of natural forestry since 1982.

Unfortunately, people's desire to live away from crowded cities and closer to nature has not always coincided with an enhanced understanding of wildfire risks. After spending most of their lifetimes in densely populated cities and suburbs where fire hydrants stood on every corner and where sidewalks and streets covered far more ground than vegetation, many new residents of the urban wildland interface enter into the community without having been schooled in fire prevention techniques. In love with the change of scenery sitting outside their window, they often keep or even augment the brush and forestry on their property for decorative purposes, rather than realizing that such plants are extremely likely to add fuel to a fire. In some cases wildfire risk mitigation has only arrived in the wildland urban interface at the insistence of property insurance companies.

Wildfires Fueled by Global Warming

Another challenge to fire prevention could materialize if scientists' predictions about climate change are accurate. As the planet grows hotter, evaporation occurs at an increasingly rapid rate, which increases the likelihood and severity of droughts in fire-prone areas. Global warming also influences the level of carbon-dioxide in the earth's atmosphere and, therefore, could dictate the amount of brush and other plants that help small fires grow into uncontrollable disasters. Time will tell if the science behind global warning has a significant impact on the way property insurance is underwritten.

Hurricanes and Tornadoes

It's not surprising that many insurance consumers are misinformed about their carrier's approach to wind damage. Based on policy language and tradition, coverage of this peril is broad in some respects and very limited in others. The typical homeowners insurance policy's references to wind are general enough for coverage to apply to many types of catastrophes, including major hurricanes, tropical storms and tornadoes. Yet various exclusions in the insurance contract allow companies to deny portions of catastrophic claims when destructive winds are paired with flooding.

Until the 1950s, wind-related disasters weren't overly problematic for insurance companies. A smaller U.S. population in those days meant there weren't as many densely inhabited areas filled with valuable real estate, and a lack of residential air conditioning kept many people from settling in hot and high-risk coastal states such as Texas and Florida.

In more recent years, however, shifts in population density and climate conditions have combined to make wind catastrophes a relatively common subject on the evening news. Today, roughly 50 percent of Americans live within 50 miles of a coast, and according to an assortment of trade groups quoted in National Underwriter, the property owned in coastal areas from Maine to Texas is worth upwards of $7 trillion. Meanwhile, higher sea-level temperatures may explain why the windstorms of today are frequently among the most intense weather events in our nation's history. All told, according to an A.M. Best study, tornadoes, hurricanes and related weather conditions have been responsible for the majority of U.S. catastrophic losses, on average, since 1953.

Hurricanes have been particularly damaging and have made coverage tighter and more expensive in many coastal areas. In 1992, Hurricane Andrew swept through Florida, left 11 insurers in a state of insolvency and became the costliest U.S. catastrophe the industry had ever seen. Insurers introduced predictive catastrophe models and windstorm deductibles in response to the storm, but those measures have clearly not spared carriers from hurricane losses in subsequent years. Of the 10 costliest hurricanes in American history through 2017, nine have occurred in the 21st century. Chief among them, of course, was Hurricane Katrina, which cost insurers $41 billion and necessitated more than $100 billion in government aid to residents of New Orleans and other affected places.

As for residents of inland states, statistics show they shouldn't feel entirely protected from wind. Midwesterners, for example, still have to cope with the fact that the United States is more prone to tornadoes than any other country. In just the first half of 2008, for example, there were more than 1,000 twisters, including the first two funnel clouds to touch down in northern Illinois in January since 1950. When viewed all at once, these various statistics suggest wind-related risk mitigation ought to be important to producers and policyholders in any region.

Why and Where Hurricanes and Tornadoes Occur

Hurricanes form at certain oceanic depths when sea temperatures are at least 80 degrees. As they move along the waterways, storm clouds absorb warm air from the lower portion of the atmosphere and release cooler air into the upper portion of the atmosphere. These storms continue to grow in strength until they hit land or are impacted by different weather conditions.

Hurricanes are created in the same general manner as other tropical storms, but they involve stronger winds and tend to push taller amounts of water onto the surface. At minimum, a hurricane is carried by a wind traveling at 74 mph and is accompanied by waves that are initially four feet high.

Many of the hurricanes impacting the United States come from the Atlantic Ocean and the Gulf of Mexico in a season running from June through November. Communities below or barely above sea level are particularly vulnerable to major storm damage.

According to FEMA, tornadoes are basically spinning thunderstorm clouds that make contact with the ground. These clouds usually touch down at the tail end of a storm and are categorized by meteorologists based on factors such as wind speed. Mild tornadoes earn a zero on the commonly used Enhanced Fujita Scale and have winds that are slower than 86 mph. The most intense tornadoes earn a 5 on the scale and blow at speeds above 200 mph.

Although a tornado can blow across a strip of land at any time of year, twister season generally runs from late winter until the middle of summer. The season begins a little earlier in southern states than in northern states.

Not surprisingly, the region that is most at risk during tornado season is the one known as "Tornado Alley." The geographical boundaries of Tornado Alley vary depending on who you ask, but it is safe to say this area generally includes much of the South, the Midwest and the Great Plains. While Iowa, Alabama, Kansas and

other states have all experienced the most intense kinds of tornadoes on multiple occasions, tornadoes are more likely to occur in Texas than in any other state.

Covering Collapse

Because hurricanes and tornadoes are sometimes strong enough to make even a sturdy house structurally unsound, we will review how the typical homeowners insurance policy treats instances of collapse.

In most cases, policy language defines “collapse” to mean an instance in which all or part of a building falls down or caves in and becomes uninhabitable. The term generally does not apply when visible bulging, shrinking or cracking has merely made collapse a possibility. It also is not used to mean a situation in which a building has been broken into separate pieces but is still standing.

Homeowners insurance covers losses caused by collapse if the collapse is due to a peril listed in the personal property section of the policy. Such losses are also covered when they are brought on by hidden decay, hidden damage caused by insects or vermin, the weight of animals, people or property or the weight of rain on a roof. Collapse caused by improper construction may be covered if the collapse occurs during the construction stage.

For the victim of a hurricane or tornado, these various provisions and exclusions mean a dwelling’s collapse will often be covered if it is caused by the force of wind or by the weight of debris that has been blown onto the building by a storm. However, it is important to note that collapse after a hurricane is not covered when it has been aided by the force of flood waters. To insure against this kind of loss, a homeowner will need to purchase adequate flood insurance.

Removal of Debris and Trees

Even if a hurricane or tornado doesn’t make direct contact with a dwelling, the home can still be damaged by debris and trees that get flung about by super-strong winds. The cost of removing debris and fallen trees from the residence premises can sometimes amount to thousands of dollars. Luckily for the homeowner, this expense may be covered by insurance.

The most common type of homeowners insurance policy covers removal of debris after a windstorm. In general, this coverage does not increase the insurer’s limit of liability. However, when the cost of removing the debris and repairing or replacing damaged property is greater than the insurer’s limit of liability, the homeowner may receive an additional 5 percent of coverage that can be applied specifically to debris removal.

When a tree falls on the residence premises because of wind, a homeowner may be reimbursed for its removal. This free additional insurance typically has a cumulative limit of $1,000 per occurrence, and no more than $500 may be applied to the removal of a single tree. For removal to be covered, the tree needs to have either done damage to the homeowner’s property or blocked access to a driveway or a ramp for disabled persons.

Following a windstorm, policyholders often wonder who is responsible for removing a neighbor’s tree from their property. Regardless of where a fallen tree once stood, the party who suffers the property damage should file a claim with his or her own insurance company. The neighbor might be liable for the loss only if the tree was obviously dying or was not being maintained properly by its owner.

Windstorm Deductibles

In order to reduce their exposure to risk after Hurricane Andrew, many insurers in coastal states added windstorm deductibles to their homeowners insurance policies. According to the Insurance Information Institute (III), these deductibles are used in roughly 20 states.

The amounts and triggers of these deductibles may vary significantly from one policy to the next. Whereas one insurer’s wind deductible might apply to any kind of windstorm, another carrier might only enforce the deductible after a hurricane. A report on the subject by National Underwriter showed some deductibles were triggered when winds reached a specific speed, when a windstorm lasted for a particular length of time, or when winds of a particular speed were detected within a specific distance from an insured’s property.

Windstorm deductibles are typically listed as a set percentage of a dwelling's insured value. If a homeowner has insured a home for $100,000 and has a windstorm deductible of 5 percent, he or she will end up paying out of pocket for any portion of wind-related losses below $5,000. The Insurance Information Institute has said insurance consumers may be eligible for flat, dollar-based wind deductibles if they pay an additional premium. Some companies might even agree to drop the windstorm deductible altogether if an insured retrofits a home in a manner that satisfies various structural requirements.

Windstorm Coverage From the States

With windstorm disasters being so costly over the past 15 years, it's no wonder many private carriers have been hesitant to cover homes in high-risk areas. At one time or another, homeowners in many states have found that insurance companies will either refuse to sell property insurance to them or only provide policies that do not list wind as a covered peril. For residents of these communities, these shortages have created some obvious problems. Affected property owners aren't just unprotected against significant losses; they also may be in violation of their mortgage lending agreement, since lenders often require borrowers to maintain all-risk insurance on their homes.

In response to such predicaments, many states have established insurers of last resort for high-risk homeowners. These state-initiated entities may provide comprehensive homeowners insurance coverage to area residents, or they might simply cover the windstorm risks that have been refused by private insurance carriers. Regardless of what specific perils they cover, these insurers of last resort usually charge consumers higher premiums than private insurers. The higher premiums reflect not only the insured property's high risk potential but also these entities' general desire to avoid competing with private carriers. Wind-prone states with a government-initiated insurer of last resort include Florida, Texas and Mississippi.

Disaster Coverage for Homeowners

Various types of wildfire and wind damage might be covered under a homeowners insurance policy, which borrowers must purchase in accordance with mortgage lending agreements. Of course, mortgage lenders do not enforce this requirement out of concern for the homeowner. Rather, they require homeowners insurance as a way to protect their own investment. The home essentially serves as the collateral in a lending agreement between the lender and the borrower. If the borrower defaults on the mortgage loan, the lender can get its money back by having the property sold to satisfy the debt. However, if the property were ever damaged beyond repair by fire or some other peril without any insurance money to compensate for the loss, the lender would not necessarily be able to secure a full return of the borrowed funds.

Since the minimal homeowners coverage required in lending agreements is meant to protect the lender and not the borrower, the basic insurance policy might provide insufficient benefits to disaster victims in times of crisis. For instance, the policy might cover the entirety of the lender's investment but only a small fraction of the homeowner's personal belongings. Displaced victims may also sadly discover that their basic policy doesn't adequately pay for "additional living expenses," such as the cost of staying temporarily in a hotel. The good news for cautious homeowners is that they are free to go above and beyond the terms of their lending agreement and purchase additional insurance as a way of filling in those possible gaps.

What is Homeowners Insurance?

Consumers can protect themselves financially from disasters by purchasing a homeowners insurance policy. This kind of insurance provides benefits to the policyholder when damage is done to an insured dwelling, a detached structure or personal property. It also compensates people for loss of use of a dwelling and provides some liability insurance for the homeowner.

For generations, insurers have sold multiple kinds of homeowners policies, including such basic products as HO-1 policies and such deluxe products as HO-3 policies. Even the plainest policies in today's market are likely to cover damage to insured property in the event of fire, severe wind, hail, theft, explosion or riots.

HO-1 and HO-2 policies, rarely sold these days, are known as "named-peril" policies because they only provide financial protection against those dangers that are specifically mentioned in the insurance contract. The HO-3 policy is the standard product for modern homeowners and is known as an "open-peril" or "all-risk" policy because it provides financial protection against every danger that might affect a dwelling, other

than those that are specifically listed as exclusions within the insurance contract. Some of the excluded perils within HO-3 contracts are listed below:

- Flood.
- Earth movement, including earthquakes and volcanic eruptions.
- Wear and tear.
- Mold.
- Rust.
- Rot.
- Acts of war.
- Nuclear reactions.

What About the Deductible?

Both before and after they purchase a homeowners policy, insurance consumers can influence the size of their premiums through their choice of a "deductible." From the standpoint of homeowners insurance, the policy's deductible is the amount of otherwise insurable losses, expressed in dollars, that will not be covered under the insurance contract. Ideally, insurance deductibles benefit policyholders by keeping premiums down. At the same time, they benefit insurance companies by making carriers less responsible for small claims.

Higher deductibles correspond with lower premiums, while lower deductibles correspond with higher premiums. Deductibles for most homeowners policies start as low as $250 and are commonly increased by policyholders to $500 or $1,000. In areas that are prone to specific kinds of disasters, the insurance company might insist on a separate deductible for those specific perils. Though not commonly applicable to fire coverage, separate deductibles may exist for hail or wind damage. Unlike a policy's main deductible, the separate deductible is usually expressed as a percentage of the policy's value, often in the range of 3 percent to 5 percent.

Levels of Replacement Coverage

Homeowners have at least a few levels of coverage to choose from when deciding how to insure their dwelling and personal property. The cheapest and lowest brand of coverage, known as "actual cash value coverage," is an extremely rare breed, at least within the context of insuring a dwelling. It covers the value of a home up to the policy limit but subtracts for depreciation. Perhaps the most common level of coverage is "replacement-cost coverage," which, as its name suggests, covers the cost of replacing the home in a similar form with similar building materials, up to the policy's dollar limit. Most insurers will not pay an entire claim for partial damage to a home unless the policyholder has insured the property for at least 80 percent of its replacement cost.

"Guaranteed replacement-cost coverage" is the most expensive variety of homeowners insurance but gives the policyholder more potential benefits than all the other levels of insurance that are available in the market. Like regular replacement-cost coverage, guaranteed replacement-cost coverage covers the cost of rebuilding a home in a similar form with similar materials. But unlike regular replacement-cost coverage, guaranteed replacement-cost coverage has no dollar limit for replacement of the dwelling. In other words, if a person's house burns down, a guaranteed replacement-cost policy forces the insurance company to pay for a brand-new, similarly configured home regardless of cost. This coverage ensures that a policy will fund the construction of a new home even if the property had been improperly appraised when the insurance was purchased and even if the cost of construction and building materials soars during the course of home ownership.

Despite the comparatively high premiums that homeowners pay for guaranteed replacement-cost coverage, many industry professionals believe that current prices might not be enough to compensate insurers in the event of a catastrophe. The East Bay fires near Oakland in 1991 taught property insurers a lesson and convinced many of them to stop selling limitless guaranteed replacement-cost policies and to switch to a newer, stricter product known as an "extended replacement-cost policy." This kind of insurance entails more

benefits than a regular replacement-cost policy. Like a guaranteed replacement-cost policy, it protects the policyholder if the cost of rebuilding a dwelling exceeds the policy's benefit limit. However, the excess coverage is capped, usually at no more than an additional 20 percent of the policy value.

As an example, let's pretend an owner insured his home for $250,000 through an extended replacement-cost policy 10 years ago. Due to a catastrophe, the house is destroyed, and contractors estimate that it will now cost $320,000 to rebuild the property. Thanks to the extended replacement cost policy, the owner should receive roughly $300,000 from his insurance company ($250,000 plus 20 percent). Yet because of a 20 percent cap on excess coverage, the owner will be responsible for paying the remaining $20,000.

The limits of extended replacement-cost coverage, as well as those of actual-cash-value and regular replacement-cost policies, ought to give homeowners an incentive to review their policies on a regular basis and update them as needed.

Covering People's Stuff

Sometimes homeowners are fortunate enough to still have a roof over their heads after a force of nature but are rocked emotionally and financially by the damage done to their dwelling's contents. "Contents coverage" can solve part of that problem because it reimburses policyholders for the loss of various belongings.

The typical homeowners policy includes contents coverage that is equal to a certain percentage of the dwelling's insured value, often within the range of 50 percent to 75 percent. So, if a homeowner insures a dwelling for $100,000 with contents coverage that is equal to 50 percent of the dwelling's insured value, the homeowner may receive up to $50,000 from the insurance company as compensation for damaged or lost belongings.

Although basing the limits of contents coverage on a dwelling's insured value helps to keep coverage understandable for homeowners, such a simple formula is not guaranteed to favor the insurance customer. Suppose, for example, a policyholder owns an old, poorly maintained house but has a soft spot for cutting-edge gadgets and other expensive items. In that case, the default amount of contents coverage, based on the home's insured value, might prove insufficient.

Regardless of a dwelling's insured value, standard contents coverage limits the amount of money homeowners may receive for the loss of special collections and extravagant items. Valuables such as stamps, works of art, coins and boats aren't excluded entirely in homeowners insurance policies, but coverage of these items tends to be minimal in both size and circumstance. Full coverage for these belongings is almost always only available at an additional cost through an add-on product called a "personal property floater."

Suppose, though, that a policyholder is a typical homeowner with standard contents coverage and no special collections to speak of. A fire breaks out in the owner's home, sparing the structure from serious damage but destroying a lot of electronic equipment, including a home theater system that the person bought for $5,000 several years ago. Leaving deductibles and policy limits out of the equation, will the policyholder receive $5,000 from the insurance company? We have no way of knowing the answer to that question unless we know whether the person has actual-cash-value coverage or replacement-cost coverage for the lost equipment.

Actual-cash-value coverage reimburses the homeowner for replacement of property minus depreciation. Replacement-cost coverage, on the other hand, pays for brand-new property, paying no attention to depreciation. Despite rarely being used to insure a dwelling, actual-cash- value coverage is standard for the contents portion of a homeowners policy. Disaster victims can still use the proceeds from cash value insurance to purchase brand-new items, but they are responsible for the difference in cost between a new item and an old one.

Replacement-cost coverage is available to consumers if they are willing to pay a bit more for the insurance. When armed with replacement-cost coverage, fire victims usually receive a monetary advance from their insurance company that is equal to the actual cash value of damaged property. They then use their own money and the advance to purchase new items and can send receipts to their insurer for reimbursement beyond the advance.

Dealing With Additional Living Expenses

For homeowners whose dwellings are destroyed by a fire or windstorm, the cost of the disaster amounts to much more than just the cost of replacing the home's structure and its contents. Unless they can depend on the kindness and long-term hospitality of friends and family, the people who are made homeless by a disaster have to bank on spending a lot of time sleeping in hotel rooms or rented apartments and eating a lot of meals in restaurants. For a family that has nowhere else to go and has to wait indefinitely for their home to be rebuilt, the bills for these unavoidable expenses can be enormous.

Luckily, a lot of these sudden costs are covered by homeowners insurance. Homeowners insurance reimburses policyholders for "additional living expenses," which may be defined as costs that the homeowner incurs as a direct result of not being able to live in his or her dwelling. Under this definition, reimbursable expenses may include money spent on meals and room and board, but would not include any expenses the homeowner would have incurred regardless of a disaster.

An insurance policy may contain a dollar limit on additional living expenses, a chronological limit or both. Dollar limits are usually no less than 20 percent or so of the damaged dwelling's insured value. Chronological limits are usually no shorter than one year. Most policyholders don't come close to reaching these limits, but delays during the rebuilding process sometimes make more coverage a wise buy.

The probability of maxing out on a policy's additional living expenses is greater when an event, such as a hurricane, has done tremendous damage to a wide stretch of land in a densely populated area. During such a time, builders are likely to be in high demand and short supply, meaning that a homeowner who hopes to have a dwelling rebuilt in a matter of months may instead have to wait a year or more before being able to move into a freshly constructed dwelling.

Coverage During Evacuations

Catastrophes can sometimes behave like unpredictable monsters, capable of taking one house as a casualty and leaving a neighboring house alone. People whose homes are left relatively unscathed amid a disaster should consider themselves very lucky, but such good fortune doesn't necessarily mean a person's insurance policy will not come into play.

As safety personnel try to gain control of a crisis, local authorities may call on all residents in the area to evacuate. If homeowners are forced to leave their homes but do not suffer any damage to their dwelling or contents, their homeowners insurance will often still cover the cost of hotel rooms and meals, though a thorough review of some policies may reveal otherwise. If these items are covered, the evacuated policyholder should still expect to be responsible for the policy's deductible.

Limits on Detached Structures and Business Property

In addition to the limits and exclusions mentioned on previous pages, a standard homeowners insurance policy will not reimburse a disaster victim in full for damage to detached structures. Common detached structures include garages, sheds and barns. Coverage of damage to these structures is generally limited to 10 percent of the dwelling's insured value, though full replacement coverage can be obtained for an additional premium. Keep in mind, however, that an insurance company can deny an entire claim for damage to a detached structure if the homeowner uses any part of the garage, shed or barn to conduct business or to store property (other than vehicles) that is used by a business. Furthermore, a homeowners policy provides minimal coverage of business property that is damaged or destroyed within a dwelling, and it usually includes no coverage of business data that may be lost in a fire.

Coverage for Renters

When weather damages an apartment building or a rented home, structural damage should be covered by the landlord's insurance policy. But what about damages to tenants' belongings and the additional living expenses a renter would incur in that situation? In nearly every case, neither landlords nor their insurers are required to indemnify a tenant for these damages and expenses.

If they want protection, most renters can be approved for "renters insurance," a close relative to homeowners insurance that applies to tenants' personal property. The perils covered by renters insurance are not as

exhaustive as those covered by the typical homeowner's policy. But a basic renters policy still deserves a mention in this text because it insures the policyholder against many weather-related disasters.

Like homeowners insurance, renters insurance can cover a dwelling's contents on either a replacement-cost basis or an actual-cash-value basis, with the latter option usually available at a lower price. If a fire or windstorm makes an apartment or rented home temporarily or permanently unusable, the tenant is covered for additional living expenses until those expenses exceed a certain percentage of the policy's value or until a particular time frame, such as one year, has passed. For landlords, the temporary loss of rental income after a disaster might be covered under their homeowners policy if they live in one of the building's units.

Fire Safety Tips for High-Risk Homes

People from all economic backgrounds can take safety measures to reduce their exposure to disaster risks. In addition to potentially saving people's lives and giving added protection to property, the following tips, when observed, could have a positive impact on a homeowner's search for affordable insurance coverage. Let's address these suggestions in order, beginning with those that are relatively easy (or cheaper) to accomplish and concluding with those that are probably only practical for people who have the opportunity to build their home from the ground up.

At the very least, a homeowner in a fire-prone area should monitor the exterior of a house and remove any hazardous plant materials within close proximity to the dwelling. Roofs should remain free of leaves and pine needles, and debris should be cleared regularly from gutters.

A homeowner's landscaping plans should include the creation of sufficient "defensible space," which acts as a safe zone that separates a home from the weeds, bushes and trees that could give fuel to a fire. Fire safety experts recommend creating a defensible space in the neighborhood of 30 feet to 100 feet, depending on a dwelling's specific location. Because fire has an easy time spreading uphill, homes situated on steep slopes may need more defensible space than other dwellings.

Other life-saving and money-saving suggestions call for some major home improvement projects. For the purpose of fire protection, roofs comprised of wood shingles can be replaced with roofing made out of tile or some other noncombustible material. If the homeowner opts for a roof made of metal, a buffer should be placed between the metal and a dwelling's wood frame. Otherwise, the metal might simply act as a conductor during a fire and help the frame burn. Adding a pond to the property is also a potentially smart option, especially when a home is in a secluded area, far away from a natural body of water.

Perhaps the best way for a person to manage wildfire risks is to consider various hazards before purchasing or building a home. People in fire-prone areas would be wise to avoid building or buying a log cabin and should resist any attraction they might have to wooden decks or wood-burning fireplaces.

When considering possible neighborhoods for their next home, people should be concerned if a property's location might complicate matters for professional firefighters. A property's proximity to firehouses and fire hydrants is an important underwriting factor, and few insurers are likely to jump at the chance to insure a property that cannot be accessed by fire trucks via clearly marked and easily travelable roads. In fact, members of the Laguna Beach community in California may have helped keep their homeowners premiums under control, following major fires in 1993, by reconstructing roads in a manner that improved access for emergency vehicles.

People with the desire and the financial resources to go the extra mile in the name of risk management can promote safety and reduce premiums from the ground up by building a "fortified home." This kind of dwelling is built to withstand the impact of various disasters, including fire, earthquakes and windstorms. Among other characteristics, a fortified home is likely to feature an inflammable roof, reinforced doors, impact-resistant windows and an extra-secure foundation.

Though these homes' appearance and cost may have kept them from capturing the public's attention, their proponents say the homes are getting prettier and cheaper over time. Builders have been experimenting with a brand of asphalt for roofs that mirrors the look of wooden shingles while minimizing fire risks. Meanwhile, the addition of fortified features to a building is said to increase regular building costs by roughly

5 to 10 percent. At this point in time, fortified dwellings certainly aren't cheap, but they are reportedly only a few thousand dollars more expensive than newly constructed energy-efficient homes.

Wind Safety Tips for High-Risk Homes

Like most other catastrophic acts of nature, major windstorms may pack a weaker punch than expected if a homeowner has taken special precautions with his or her property. In many cases, taking the precautions may also qualify a homeowner for affordable and high-quality insurance.

When it comes to maintaining a home in a manner that is resistant to major wind damage, special attention should probably be paid to the dwelling's roof. Insurers usually prefer to only cover shingled roofs that are younger than 25 years old and other roofs that are younger than 50 years old. Hip roofs, which are slanted on all sides, tend to withstand wind better than flat roofs.

Roofs, though, are hardly the only part of a dwelling that should be reinforced when windstorms are in the forecast. Doors and windows should both be strong enough, by means of shutters or other materials, to withstand the impact of debris at a high speed. This recommendation also applies to the outer door of an attached garage. Very often in a windstorm, personal property stored in a home remains safe from harm until a damaged garage door creates an entry point for the tornado or hurricane.

When thinking about landscaping around a dwelling, remember that windstorm damage is frequently caused or worsened by projectiles from people's yards. To reduce the probability of a flying object damaging a dwelling, homeowners may want to trim their trees on a periodic basis and replace mounds of decorative rocks with a softer sort of material.

A Few Words on Floods

Homeowners insurance covers a policyholder against many potentially disastrous perils. But as anyone who has made a claim for losses after a hurricane knows full well, this insurance doesn't cover flood damage. To guard against the financial consequences of a flood loss, a homeowner is likely to need a flood insurance policy from the National Flood Insurance Program (NFIP).

The premiums, terms and conditions for flood insurance policies are often determined by the Federal Emergency Management Agency (FEMA), but the policies themselves are usually sold and serviced by private insurers. These insurers are known as "Write Your Own" companies.

By being involved in the flood insurance program, the federal government hopes to achieve at least two goals. The first is to make flood coverage available to homeowners and other individuals who would not be able to obtain it in the traditional market. The second, sometimes overlooked goal is to promote the purchasing of flood insurance so that the federal government will not be overwhelmed with requests for aid after a catastrophe.

In order to make that second goal a reality, any person who purchases a home in a "special flood hazard area" with the help of a federally regulated lender is required to cover the home with flood insurance. A special flood hazard area is a place where there is at least a 1 percent chance of flooding each year.

More than 20,000 U.S. communities participate in the NFIP. Participation in the program is not mandatory, but a community that chooses not to join makes its residents ineligible for federal flood insurance and might be jeopardizing its right to certain kinds of federal disaster relief. Members of the NFIP must practice flood insurance risk mitigation by enforcing certain building codes. Through its "Community Rating System," the NFIP can give insurance discounts to communities that go above and beyond required risk mitigation by facilitating accurate insurance rating and promoting flood insurance awareness.

Although most buildings that are compliant with modern building codes are eligible for federal flood insurance, a building cannot be covered if it is principally below ground level.

More information about flood insurance is available to professionals through FEMA.

Earthquakes

Fictional, action-packed adventure stories tend to leave people with the impression that every earthquake is a major disaster that visibly splits the ground and rudely shakes people off their feet. However, the vast

majority of earthquakes do no damage to property and go unnoticed by anyone who isn't obsessed with geology. A case in point is California, where little quakes occur just about every day but where millions of residents go about their lives with no noticeable bouts of motion sickness. The fact that the likelihood of a devastating earthquake is small might make homeowners feel somewhat safe, but history also shows that major, deadly quakes have occurred periodically since the dawn of civilization and that guarding against these rare events with the help of insurance may turn out to be a smart move.

Earthquakes Throughout History

References to earthquakes can be found in the literature of ancient Greece, and it is thought that the mythical story of the underwater city known as Atlantis grew out of a real quake that wiped out an entire flourishing civilization on the island of Crete in 1400 B.C. A 16th century quake in China's Shaanxi province failed to become the stuff of legend, but, in claiming some 830,000 lives, it did set the record for the deadliest earthquake known to man.

With a few exceptions, the United States has had a much luckier relationship with earth movement than the former populations of Crete and China. But scientists and insurance companies aren't betting on that luck lasting forever. They know that the San Andreas fault, a 600-mile fissure running from the Gulf of California and along the coast, behaved like a crazed demon in the early 1900s and have been waiting nervously for history to repeat itself.

San Francisco had suffered a major quake in 1868, but, with few enforceable building codes in place at the time and with city officials clamoring to get the city back on its feet as quickly as possible, the management of earthquake risks was not a major priority in the rebuilding process. As a result, few people and fewer buildings were prepared for the minute-long shake that occurred near five o'clock on the morning of April 18, 1906.

Countless fires reigned over the city once the ground decided to hold still. With water lines out of order, buildings were being blown up in order to create breaks in the land and to possibly suppress the flames. Elsewhere, frantic homeowners were enlarging the problem by committing arson against their own homes. Realizing that no insurance company had ever dared to cover earthquake damage, they had grimaced at their suddenly crumbled dwellings and reasoned that their fire policy was their only hope for financial help. After the ashes had been swept, it was estimated that half of San Francisco, what was then the seventh largest city in the nation, was homeless. The official death toll was in the hundreds, but historians later uncovered an apparently successful plot by city officials to reduce that number in an effort to aid tourism and population growth. Revelations made public in the 1980s suggested that the actual list of casualties contained 3,000 names.

Maybe the only silver lining to emerge from the 1906 San Francisco quake was the way in which it enhanced the image of insurance companies in the eyes of the American public. According to a report completed by insurance giant Swiss Re, the day's fire policies often specifically excluded coverage for damage when a fire was caused by an earthquake. This exclusion, according to another report by National Underwriter, initially saw insurers employing a chimney test. Essentially, if an insurer couldn't otherwise tell if damage to a dwelling had been caused by an earthquake or a fire, it would check to see if the chimney was still standing. If so, the damage would be ruled a fire loss, and the claim would be covered. If the chimney had been destroyed, the damage would be ruled an earthquake loss, and the claim would be denied. But the magnitude of the San Francisco disaster made the chimney test either impractical or unreasonable for many carriers. Lloyd's of London, for one, eventually decided to pay all San Francisco claims on fire policies, regardless of any exclusionary language in its insurance contracts. Coincidentally or not, Lloyd's went on to become the top reinsurance provider for U.S. carriers.

Nearly 100 years after the 1906 quake, scientists, builders, homeowners and insurance companies had still not learned enough about earthquakes or implemented enough risk mitigation measures to avoid additional catastrophic losses on the West Coast. The death toll from a January 17, 1994, quake in the Northridge section of Los Angeles amounted to a comparatively low 57 people. But a century of population growth in the Golden State had meant that there was a lot more insurable property to be destroyed by a disaster than there had been in the Bay area of 1906. Even when the old San Francisco numbers are adjusted for inflation,

the 1994 Northridge quakes still qualify as the costliest example of earth movement in U.S. history, having caused $40 billion in total losses and more than $12 billion in insured losses.

Why and Where Earthquakes Occur

Despite centuries of study, it has only been within the past several decades that scientists have begun to gain a firm understanding of how and why earthquakes occur. In ancient times, people believed a sudden shake of the earth was a way for a god or goddess to demonstrate his or her anger. Later, people picked up on a theory by Aristotle and assumed the shaking was caused by winds trapped in caverns.

Today, most earthquakes are believed to be the byproduct of “plate tectonics,” a scientific theory relating to the constant movement of the earth’s crust. At a basic level, modern seismologists believe various portions of the crust sometimes get in each other’s way as they slide along their paths. This puts tremendous stress on the earth until, finally, the stress passes along a weak, cracked portion of crust, known as a “fault,” and is released in the form of seismic waves. The release of these waves is sometimes felt by humans in the form of shaking. The underground source of the shaking is known as the earthquake’s “focus,” and the place on the surface just above the focus is known as the “epicenter.”

Most seismologists believe we lack the tools and knowledge to predict the strength, time and location of an earthquake, though this hasn’t kept hopeful prognosticators in the United States, China and other countries from trying. Over the years, some scientifically trained soothsayers have claimed we can determine the likelihood of an earthquake by tracking elevation, water temperature, conductivity and the speed of sound in a given area. At one point, scientists in China even claimed peculiar behavior by animals was an indicator of a coming quake.

Instead of putting their faith in sound waves, critters and other variables to pinpoint the exact time and place of a future incident, many seismologists trust the historical record and use old data and maps to make somewhat broad pronouncements about earthquake risks. For example, the scientific world is unlikely to state that a moderately sized earthquake will rattle a particular town in spring 2025, but experts may be willing to state that there is a 75 percent chance of a moderately sized quake rattling that town within the next 20 years. Most of these experts are likely to freely admit that their broad predictions, while based on historical facts, should be interpreted as estimates. They would not be entirely surprised if that moderate quake in that town didn’t happen for another 50 years or if two moderate quakes occurred in consecutive years.

Based on what history and science tell them, insurance professionals who underwrite earthquake risks have come to put a tremendous amount of emphasis on a building’s proximity to fault lines. Attention to fault line proximity has made earthquake risk management extremely challenging in California, where hundreds of cracks in the earth’s crust (many of them visible to the human eye) are spread throughout the state and where, according to the California Earthquake Authority, more than two-thirds of residents live within 30 miles of a fault. In the eyes of some risk managers, places like San Francisco are additionally risky because they were built largely on landfills and because many of their buildings were constructed prior to the implementation of modern building codes.

Indeed, annual earthquake losses in California greatly exceed earthquake losses in other states. However, many Americans who live outside of California believe they are at least slightly at risk for a major earthquake and have purchased the appropriate insurance coverage to better manage that disastrous possibility.

In addition to being a hot topic in California, earthquake insurance is most popular in Washington, Missouri and Oregon. This makes sense since Washington and Oregon are in the West, where a large majority of all U.S. quakes occur, and because Missouri sits in a fault area known as the New Madrid Seismic Zone, along with parts of Illinois, Arkansas, Tennessee, Indiana and Kentucky. According to FEMA, earthquakes are considered to be a moderate, high or very high risk in 37 states.

Measuring Earthquakes

Over the past 70-plus years, seismologists have been developing ways to mathematically represent the intensity and effects of earthquakes. The most popularly known method of measuring a quake utilizes the Richter Scale, formulated by Dr. Charles F. Richter in 1935. This scale measures the severity of an earthquake by focusing on the amount of energy released at the quake’s source. An increase of one whole

number on the Richter scale represents an earthquake that is 10 times as strong. It also means that a quake involves roughly 32 times as much energy.

Another popular measuring stick, the Modified Mercalli Intensity Scale, pays attention to the damage actually caused by a quake and represents the extent of that damage in the form of a Roman numeral. A quake ranging from I to IV is only felt by a portion of people in an area, depending on how close they are to the ground. At V, fragile items and windows might break. At VI, furniture might move and plaster might sustain some damage, and so on. According to the United States Geological Survey, the scale tops out at XII, a number associated with a totally damaged community.

For reasons that are not essential to the purpose of this text, non-scientific media outlets tend to avoid these two specific scales. Instead, they just use a generally accepted measurement to represent an earthquake's magnitude. Under this basic method, magnitudes below 2.5 are not usually felt. Some damage can be seen when magnitude reaches 4. At the top end of the basic scale, a magnitude of 8 would cause what the Associated Press has termed "tremendous damage." The 1906 quake in San Francisco, for example, is believed to have had a magnitude of 7.9 on the media's basic scale.

The Non-Popularity of Earthquake Insurance

Special insurance policies that reimburse people for earthquake-related damages have been sold in the United States at least since the 1920s, but the coverage has struggled consistently to gain acceptance from most of the general population.

Nowhere is the public's relationship with earthquake insurance stranger than in California, where noticeable earth movement is far from out of the ordinary. In 1985, the state passed a law requiring all property insurers to make earthquake insurance available to all of their homeowners insurance customers. Yet the percentage of insured Californians remained surprisingly low over the next 10 years. The Northridge quakes of 1994 shot the take-up rate all the way up to roughly 30 percent for a short period of time, but that number dipped as the disaster escaped from people's short-term memory. Despite continued earth movement in the state, not to mention state-instituted assistance for high-risk homeowners, only roughly 10 percent of Californians are insured against earthquakes.

People's reluctance to purchase earthquake insurance in high-risk areas cannot be boiled down to any single reason. Rather, insurance professionals who sell earthquake coverage need to recognize many psychological, historical and financial factors that have joined together to form a firm barrier against greater market penetration.

The take-up statistics related to the Northridge quakes are a perfect example of how psychology affects people's perception of risk. Regardless of proximity to a fault line and warnings from scientists that a quake is likely to occur in the near future, homeowners in high-risk communities fall deeper and deeper into denial the longer they go without experiencing a disaster. Conversely, a violent confrontation with Mother Nature in the recent past will often give people the extra push they need to purchase more insurance. Experts have noticed that this latter kind of behavior among insurance customers has a lifespan of approximately two years. After two years have gone by with no significant threats to properties, policyholders reexamine their risk tolerance and usually start to let their coverage lapse.

Still, a person's choice to spend money on something other than an earthquake insurance policy is not always linked to a poor understanding of the geological risks residing below their properties. Many people are well aware that their house sits near a fault line, but they look at the cost of earthquake coverage and decide that, thanks to state and federal disaster relief programs, buying quake coverage is an act reserved for fools. They might be old enough to remember how, after a 1971 California quake, victims became eligible for low-interest government loans and did not need to pay back the first $2,500 they received in governmental assistance. Or they might look at an event like Hurricane Katrina and conclude that federal and state lawmakers would be committing political suicide if they did not adequately assist the uninsured after a catastrophic event. However, the reader should note that the government is not legally required to bail out citizens after a natural disaster and usually sets limits on the amount of financial relief it will give to victims.

There are also several U.S. homeowners who worry about their exposure to earthquakes but believe their location has effectively priced them out of the market. Although California has experimented with limited price controls that benefit some high-risk customers, coverage in the state has consistently been criticized for being overly basic and allegedly not worth its high cost. These criticisms help explain why only 10 to 15 percent of people in the state have purchased the insurance. Yet in Missouri, where coverage costs less, the take-up rate has neared 50 percent in some years.

Though citizens of such countries as Australia and New Zealand are extremely likely to have earthquake insurance, low take-up rates in other nations suggest the people of California and other high-risk states are not just a stubborn bunch of holdouts. Japan, for one, sits on four tectonic plates and represents the biggest earthquake risk on the globe. Every September 1, the country holds a national earthquake drill that commemorates a deadly quake from 1923, and visiting journalists report that some Japanese still keep their bathtubs filled regardless of use, in case a quake disrupts water service. But in spite of all this, Japanese insurers have had little success selling earthquake insurance to their own people. At the time of a 7.2 magnitude quake in Kobe, Japan, in 1995, less than 5 percent of residents were covered.

Earthquakes and Homeowners Insurance

Earthquakes are obviously capable of doing tremendous damage to people's homes. Along with the risk of structural collapse, homeowners in quake-prone communities must face the possibility that earth movement might cause floods by breaking water mains or cause fires by rupturing gas lines. Though basic logic might suggest that these perils ought to be covered under a homeowners insurance policy, the reality is that homeowners insurance generally excludes coverage of quake-related damage.

Policy exclusions of "earth movement," which collectively refers to quakes, landslides, sinking and volcanic eruptions, have been enforced in an increasingly strict manner over the past few decades. Several years ago, some courts awarded insurance payouts to policyholders if earthquake-related damage to a home could also be linked in some way to a cause besides earth movement. The basis for these court-mandated payouts was known as "concurrent causation" and had been practiced as early as the 1906 San Francisco quakes, when some insurers decided to pay all property claims despite exclusions for earth movement. But by the 1980s, insurance companies were getting the legal go-ahead to add "anti-concurrent causation clauses" to their contracts, effectively making it less likely that quake damage of any kind would be covered under a homeowners policy.

Today's homeowners policies might in fact cover some claims when an earthquake is responsible for a fire or a broken pipe, but such coverage is limited to damage that could have only been caused by the fire or burst pipe. Suppose, for example, that an earthquake occurs in a consumer's neighborhood, causing some buildings to partially burn and then collapse from the earth movement and other buildings to simply burn to the ground. If the person's home is one of the buildings that suffered no earthquake damage but burned down because of an ensuing fire, he or she might be able to have the home replaced in full through a homeowners insurance policy. On the other hand, if the person owns one of the buildings that suffered some fire damage and then collapsed, he or she cannot expect homeowners insurance to cover the full replacement of the dwelling.

Working Around Earthquake Exclusions

As a way of expanding business and compensating for the loopholes in homeowners insurance, many carriers sell special earthquake coverage that can either be added as an endorsement to a homeowners policy or be sold as an independent policy. Earthquake insurance can be purchased for commercial buildings, residential buildings and even for mobile homes if people are willing to pay a little extra to insure these relatively unstable dwellings. Like a homeowners policy, though, earthquake insurance contracts might still exclude some forms of earth movement, such as landslides and sinking.

Earthquakes and Mortgage Loans

Consumers have a real choice as to whether or not to insure their dwelling and belongings with an earthquake policy. This choice contrasts greatly with the lack of options people face in regard to homeowners insurance. Though a prospective homeowner is technically not required to buy homeowners insurance in conjunction with a real estate purchase, anyone who wants a mortgage loan must do so. Since

few Americans can pay out of pocket for a dwelling, insurance requirements in the mortgage industry have effectively left most homeowners with at least some financial protection against fire, vandalism, hailstorms and other perils.

Yet lenders generally don't require borrowers to insure mortgaged properties against earthquake damage. Supposedly, this difference in insurance requirements exists because banks and other lenders consider fire risks and earthquake risks to be very different from each other. Whereas fires occur in all kinds of places, significant earthquakes are common only in a small portion of the United States. It is therefore generally believed that, as long as a bank provides mortgage loans to a geographically diverse group of borrowers, it will be able to diversify its portfolio enough to keep earthquake exposure at a manageable level.

Be Aware of Moratoriums

In spite of the insurance industry's desire to sell more earthquake policies, the coverage is not easy to obtain when it is probably most appealing to the public. For obvious reasons, the uninsured and the underinsured are more likely to inquire about earthquake insurance in the days immediately following major earth movement. Yet a property insurance company is likely to turn these potential customers away for the time being, for fear of taking on an undesirable amount of risk.

Once a major quake ends, smaller quakes, called "aftershocks," can rock the same affected area for a while. Before issuing more policies in a victimized community, carriers want to feel assured that these aftershocks have passed and that, at least in the immediate future, earth movement will not produce more damage in the same spot.

In general, the uncertainty surrounding aftershocks is strong enough for an insurer to engage in a one-month or two-month moratorium, which temporarily prevents people from buying new quake policies and from updating old ones. The specifics of these potential moratoriums may differ among insurance companies and are sometimes articulated in a company's "magnitude policy." For instance, a company's magnitude policy might call for a moratorium on earthquake policies within 100 miles of a quake's epicenter if a quake has a magnitude of 4.0 or above. Sometimes, though, moratoriums can be broader and arguably severe. In 1985, two quakes in Mexico were enough to stop some companies from writing new policies as far north as San Francisco and Los Angeles.

How Much Will Coverage Cost?

The average cost of earthquake insurance varies by state and is dependent on the area's susceptibility to major earth movement. Reportedly, coverage is still inexpensive enough in high-risk states like Missouri for some agents to suggest that all homeowners add an earthquake endorsement to their dwelling policies. But further west, where many states are considered very high risks by FEMA, it is fair to say that the insurance, no matter its positive attributes, is not cheap. From an insurer's point of view, high premiums are often necessary because earthquake policies are most likely to be bought by people in high-risk parts of the country.

Premiums for earthquake insurance may also need to be higher than those for homeowners insurance and flood insurance because, compared to the extensive history of floods and hurricanes around the globe, there have been few major earthquakes. A resulting lack of data makes it more difficult for risk managers to estimate the frequency and potential damage that may be caused by a quake and makes it harder for insurers to offer coverage at a low price.

What About the Deductible?

Like premiums, earthquake insurance deductibles vary depending on where an insured person lives and the amount of risk associated with the area. Low-risk dwellings may be insurable with a 2 percent to 5 percent deductible. Moderate-risk and high-risk dwellings may require a 10 percent deductible. Properties representing a very high risk might need to be insured with a deductible of 15 percent or 20 percent.

The dwelling's deductible, which represents the amount of insured losses for which the insurer is not responsible, is applied to the dwelling's insured value rather than to the value of an insurance claim. In other words, policyholders who insure their homes for $100,000 with a 10 percent deductible would need to suffer

$10,000 in damage before their policy benefits could kick in. If a dwelling's insured value is particularly low, the insurer might impose a minimum deductible that is expressed in dollars.

In general, earthquake insurance involves one deductible per occurrence, not one deductible per policy period. So if the policyholders in our previous example had the unfortunate opportunity to live through two major earthquakes in the same year, they would have been looking at a combined deductible of $20,000 instead of $10,000. However, insurance companies usually apply a single deductible to policy benefits when multiple quakes closely follow one another. All earthquakes that occur within a three-day period are usually thought of as a single event for the purpose of deductibles. Some policies have enhanced that provision to include all quakes that occur within a seven-day period.

Earthquake insurance may require a separate deductible for damaged contents. If so, the deductible may be applied to the insured value of the contents. So with $50,000 of contents coverage and a 10 percent deductible, the insured would be looking at a minimum of $5,000 in non-reimbursable losses. Other policies might list a flat dollar amount as the contents deductible. Some policies have no deductible for contents coverage if the dwelling deductible has been met.

Dealing With Additional Living Expenses

Like homeowners insurance, most earthquake insurance policies include some coverage of additional living expenses (ALE), which might arise if a quake makes a home temporarily or permanently uninhabitable. Covered costs usually include those for temporary housing, clothing, meals and laundry services. Additional living expenses do not include those expenses that a person would have incurred regardless of a disaster.

Limits and Exclusions

Most earthquake insurance policies exclude damage caused by earthquake-related fires. (This kind of damage should be insurable through a standard homeowners policy.) Also, detached structures, including pools, garages, spas and greenhouses, often aren't covered by a basic quake policy. The same might hold true for sidewalks, patios, fences and lawns.

Insurers have sometimes enforced limits and exclusions pertaining to certain kinds of building materials. On occasion, people have had to pay out of pocket for damage to plaster or concrete walls. Sometimes coverage of exterior masonry has been optional, with the additional coverage increasing consumers' premiums and affecting their deductible.

Coverage for Renters and Condo Owners

Earthquake insurance is not just for people who own houses. It can also be customized to suit the needs of renters and condo dwellers. Quake insurance for renters covers personal property within an apartment or other rented home and also helps disaster victims pay for additional living expenses. Because a renters policy entails practically no coverage for a dwelling's structure, it tends to be cheaper than a typical earthquake policy and might involve a lower deductible.

Since condo ownership incorporates elements of renting and owning a house, an earthquake policy for a condo owner will be more extensive than a policy for a renter. Unlike a renters policy, insurance for condo owners can help a policyholder pay for interior repairs to the tune of several thousand dollars. However, damage to the exterior, as well as damage to such communal areas as hallways and laundry rooms, is not covered under a condo owner's policy. It's only covered if the condo association has purchased earthquake insurance for itself.

If the condo association lacks insurance or is faced with a large deductible, unit owners might find themselves looking at some steep assessment fees. Luckily, many policies for condo owners will cover these costs. In some cases, this assessment coverage may be available on its own, meaning that condo owners can purchase it without also needing to insure their home's interior or their personal property. Separate, higher deductibles for assessment coverage may apply.

Earthquake Insurance for Businesses

Earthquake insurance can relieve financial burdens from businesses by covering commercial properties and reimbursing companies for losses that are linked to business interruption. When insurers consider issuing earthquake coverage to a business, they may put special emphasis on a building's contents. Whereas some

offices and storefronts are likely to contain little more than standard business equipment and furniture and not seem like a major earthquake risk, an antique store located on a fault presents a problem because one good shake could mean the loss of countless fragile items.

Deductibles for commercial policies might merit special attention, particularly when a policyholder wants to insure multiple structures through a single insurance contract. Suppose, for example, that a restaurant owner operates out of two locations and insures both properties with one $300,000 policy. Assuming a 10 percent deductible, that would leave the owner with at least $30,000 in out-of-pocket expenses if a quake were to destroy both properties. But what would happen if a quake were to damage one location and spare the other? Would the owner still be responsible for a $30,000 deductible, or would the insurer cut the deductible in half? The answers to those questions will depend on the policy language.

Earthquake Safety Tips for Homeowners

For homeowners, guarding against earthquake risks is arguably more challenging than guarding against wildfire risks. Whereas wildfires can be thwarted when people remove weeds and brush from their property, earthquake risk management generally entails a major construction project or a move to a less risky part of the country.

Effective management of earthquake risks should probably begin when prospective homeowners are shopping for a dwelling. If they want to worry less about earthquakes or at least qualify for lower insurance premiums, home buyers might want to settle on land that is at least 50 feet away from a fault, according to the Insurance Information Institute.

If moving far away from a fault isn't an option, the next best thing a person can do is pay attention to a home's construction features. Poorly braced houses are difficult to insure in some areas because they are sensitive to lateral pressure. Their lack of horizontal stability prevents them from moving in one piece during a fierce quake and makes it easier for heavy shaking to pull pieces of the dwelling apart.

In general, single-story buildings have a better chance of withstanding an earthquake. "Soft-story structures," which incorporate a parking lot or some other form of open space on the building's first story, are especially risky due to the absence of adequate support. According to the Association of Bay Area Governments, soft-story structures accounted for two-thirds of all buildings that were made uninhabitable by the 1994 Northridge quakes.

For homeowners with the money and the drive to complete a major construction project, retrofitting is an option. In a general sense, "retrofitting" just means upgrading an old structure. From the perspective of earthquake risk management, it often involves tying a tighter knot around a dwelling and its foundation so the building can bend a bit more under pressure without crumbling.

Other kinds of retrofitting don't do much for a building's foundation but can help prevent the fires and floods that often follow major earth movement. Water heaters can be clamped down against walls so that they remain stationary after a good shake, and automatic shutoff valves for gas lines can prevent a bad situation from getting worse.

General Disaster Information

Despite our focus on fires, windstorms and earthquakes, there are obviously many insurance issues that pertain to seemingly all kinds of disasters. The remainder of this chapter highlights several of these topics and concerns.

Keeping Coverage Current

Buying an insurance policy to protect a home and its contents is a major step in the risk management process, but it is not the final one. No matter what kind of disaster they fear the most, policyholders put themselves in a good position when they periodically review their coverage to determine whether their insurance still meets their needs.

Homeowners are usually well-insured right after they purchase their dwelling. If their own risk tolerance doesn't successfully entice them to become adequately covered against various acts of nature, their mortgage lender is nearly certain to step in and mandate proper coverage. Yet as time goes by, a well-

covered home can turn into a poorly covered home, and there may be no one but the owner around to take control of the situation.

Admittedly, many property insurance policies feature inflation guards that increase coverage by a few percentage points each year, but this protection isn't always enough to minimize an owner's out-of-pocket expenses. Building costs can easily outpace inflation and are especially likely to rise when a disaster hits a large area. Additional coverage may also be necessary when a policyholder makes major home improvements.

As a way of reducing the amount of underinsured homeowners in the United States, insurance professionals often recommend that clients review their policies at least once a year. A policy's annual renewal period presents the opportune moment for this evaluation, since the insurer might make noteworthy changes to a policy at this time.

If consumers follow this routine and discover that they need more insurance, they are not necessarily stuck with paying more for the additional coverage. They might be entitled to greater benefits if they agree to a higher deductible.

Minding Local Building Codes

When someone buys a home, the building's age hints at more than just the probable progression of wear and tear. It might help the owner decide how much property insurance to buy and could have an influence on the premiums for that protection.

The building's age is important to insurance carriers because it suggests how fully a home complies with the most recent local building codes. When these safety and energy requirements are updated, they apply to new buildings but often don't require property owners to make changes to older dwellings. However, if an older home is destroyed, an owner who wants to rebuild is required to abide by the current standards.

The insured replacement value of a damaged dwelling is likely to be enough to cover most rebuilding costs if the damaged dwelling was built only a few years ago. On the other hand, people who want to rebuild older homes would have to comply with several years' worth of changes to the rules. Depending on where they live, these owners might need to construct a new home that boasts a fire-resistant roof, an intricate sprinkler system and several other features they had not considered when they first bought their homeowners policy.

If disaster victims are at all surprised by the cost of rebuilding in compliance with local codes, they are also likely to be shocked when they learn that the typical homeowners policy does not cover all of these mandatory upgrades. Concerned insurance customers might want to look into purchasing "building ordinance coverage," which can be added to another property insurance policy to help people manage these costs.

From an insurer's perspective, building codes are important because they give underwriters a basic idea of how buildings in a particular area are likely to respond to a disaster. The disaster-prone states California and Florida are known to have two of the strictest building codes in the nation, which might help explain why insurance companies continue to cover properties there. Yet detailed codes, in and of themselves, will not always be enough to secure affordable coverage for local residents. After paying many disaster claims for houses that were built by people who cut regulatory corners and got away with it, insurers started paying closer attention to how strongly communities enforce their codes.

Avoiding Problems at Claim Time

Insurance should be a source of relief for disaster victims, not something that amplifies someone's stress level in an already unfortunate situation. Yet as helpful as insurance companies can be during times of crisis, it appears as though every disaster in recent memory has had its share of disgruntled policyholders.

Documentation can be one of the keys to a pain-free insurance settlement. People who have kept track of their purchases will be able to pinpoint exactly what they have lost in a disaster and will be more likely than others to receive fair compensation quickly. Homeowners should either list or take pictures of everything they own before a disaster hits and ought to be as specific as possible. Lists or photos of major appliances and other electronics, for example, should include model numbers. Whether in written or photographic form, any inventory of a person's personal belongings should be kept outside of the home. There is little point in

keeping an inventory of your belongings if that inventory is likely to burn up in a fire with the rest of your stuff.

Old receipts for major items can be helpful, too. A set of house plans might prove to be invaluable if the homeowner wants to rebuild, and copies of all applicable insurance policies might turn out to be great references at a crucial moment. Like one's property inventory, these receipts, home plans and policies belong in a secure offsite location, perhaps in a safe deposit box at a bank.

Evaluating the Damage

After a disaster, it will be time for the policyholder to prepare a claim and for a claims adjuster to evaluate the damage. If a disaster has only done partial damage to a dwelling and safety officials allow owners to access the property, policyholders can do themselves a favor by scouring over the building several times before filing a claim. People accumulate a lot of personal items over the course of home ownership. It will therefore be very easy for disaster victims to overlook many losses at first glance. Also, if on-the-spot repairs must be done, the homeowner ought to document them in some way so the damage can be reported accurately to the insurance company.

Today's excellent communication systems have made it possible for claims adjusters to get on the ground and spring into action as quickly as safety allows. Often after a disaster, an insurance company will call on its top adjusters to head to the heart of the destruction as part of a "catastrophe squad." These adjusters are paid by insurance companies to assess insured losses but are also expected to provide honest service to companies' customers.

In many cases, claims adjusters, including those who work on catastrophe squads, must be registered or licensed in the state where they perform their work. On rare occasions though, the severity of a disaster is so high that insurers are permitted to call on out-of-state adjusters to help expedite quality service to victims. Licensing requirements differ across the country.

Regardless of who is assigned to an area, people who have lived through catastrophes report that victims prefer to work with one adjuster throughout the claims process. If an insurer pulls its adjusters off of cases and reassigns them to other ones, a claim might get bogged down amid the transfer of responsibility, and the claimant might have to wait longer than expected for a fair settlement.

Disaster victims who believe an insurer's claims adjuster is not playing fairly may want to turn to a "public adjuster." Public adjusters know how to evaluate damage, but they work for policyholders rather than for insurance companies. In return for serving as the middlemen between the consumer and the insurance company, they receive a percentage of the consumer's insurance settlement.

Reacting to a Proposed Settlement

Once a claims adjuster has evaluated the destruction that a disaster has caused, an insurance company might offer a quick settlement. The claimant can accept the settlement and start replacing items and rebuilding property, but acceptance of a settlement may limit the person's ability to file related claims at a later date. As an alternative, the person can decline the offer and instigate an appeals process.

Dealing With Contractors

Unfortunately, disasters have the power to bring out the worst in some opportunistic people. This sad reality has led to occasional law-breaking scams in which unskilled builders have presented themselves to victims as reputable contractors. Concerned policyholders may be able to avoid these frauds if they use contractors who have been recommended by their insurance companies.

Still, claimants are allowed to do business with contractors who have not been chosen or recommended by a carrier. When claimants go outside of their insurance company to find a contractor, industry professionals and consumer advocates recommend that they take a few preventive steps. These steps include confirming that the contractor has adequate liability coverage and checking to see if anyone has filed a complaint against the contractor through the Better Business Bureau.

Tax Breaks for Disaster Victims

The insured and the uninsured receive federal tax breaks when a disaster damages or destroys their home. Property insurance benefits that are meant to replace or repair a dwelling or personal items are tax-free. Benefits meant to cover living expenses are also non-taxable if they are only covering the difference between a person's pre-disaster and post-disaster expenses. For instance, if a disaster forces a man to move from his $800 per-month apartment into a $900 per-month apartment, the $100 difference would be non-taxable if it were paid by the insurance company. However, the other $800 would be considered a pre-disaster expense and would be taxable under federal rules.

A portion of a person's uninsured losses may be deducted on income tax returns. After subtracting an IRS-specified dollar amount from their total uninsured losses, disaster victims can deduct the portion of uninsured losses that exceeds 10 percent of their adjusted gross income.

Additional tax benefits might be made available under special circumstances. In some cases, for example, the IRS may decide that people in a disaster area are entitled to a filing extension for their income taxes. In another possible scenario, the government might decide that victims deserve a quicker refund than usual and will let people work off of a previous year's tax return instead of making them wait for the latest forms to arrive. Insurance professionals and their customers should turn to the IRS if they need specific tax information.

How Disasters Affect Affordability and Availability

As if having to live through a disaster isn't bad enough on its own, many homeowners in disaster-prone areas worry about the effect a wildfire, hurricane, earthquake or other destructive event may have on their insurance costs. With insurers often using past claims to predict the likelihood of future claims, policyholders are left to wonder if a single catastrophe will be enough to spoil a long, spotless claims history with their carriers. Will one big fire, for example, be responsible for a rate hike, or will an insurer agree to take the bad times with the good ones, accept the fire as a rare, freakish development and resist increasing people's premiums?

For homeowners who are covered by experienced insurers, one disaster shouldn't have a great impact on premiums. The cost of a potential catastrophe will have already been factored into the price of coverage, ensuring that the insurance provider will have enough reserves to handle a significant loss. Rate increases are more likely when long-term patterns suggest an increase in risk among a particular demographic of consumers. So, while one wildfire might not create a lasting insurance problem for the public, multiple fires occurring within a few years of one another might have a negative impact on pricing.

Sometimes disaster victims worry that filing a major claim will make them uninsurable when their policy comes up for renewal. Despite declarations by the industry that only about 0.5 percent of policies are not renewed each year, insiders have asserted that filing as many as three homeowners claims within a five-year span may be enough to result in a non-renewal by the insurer.

Catastrophe Models

Risk managers at insurance companies must evaluate, to the best of their ability, the probable maximum loss that a carrier could face at any given time. However, these managers often need more than an insurer's claims history in order to perform a proper, helpful evaluation. This has led risk management professionals to develop and utilize multi-faceted estimation tools called "catastrophe models," which help insurers predict the likelihood of a catastrophe and its resulting damages.

Catastrophe models don't ignore past insurance data, but they deemphasize that data in favor of computer simulation and widespread expert analysis. When evaluating earthquake risks, for example, an insurer utilizes information from geologists and software from a modeling organization in order to simulate a particular kind of quake and assess how a similar catastrophe might affect a particular area.

In order to produce as accurate an estimate of potential losses as possible, underwriters provide modelers with various pieces of information. If insurers want to determine potential losses from a particular event, they will often do the following:

- Note how many of their policies are held in a particular ZIP code.

- Examine that area's history of catastrophes.
- Study data concerning the structure of the buildings they insure in the area, reporting whether a piece of property is weather-resistant or not.
- Use documented losses from any similar disasters as guides.
- Consider the specifics of their policies, paying attention to deductibles and to what sorts of damages are actually covered through their contracts.

Catastrophe models had been around since the 1980s, but it took years for insurers to gain enough confidence in the tools to use them in estimating losses. In the summer of 1992, Hurricane Andrew hit Florida and caused $26 billion worth of damage. This catastrophe, the most financially disruptive one in American history prior to September 11, 2001, left 11 insurers insolvent and forced underwriters to admit that modeling was perhaps more reliable than traditional methods of risk assessment.

Still, confidence in the models varies from one insurer to the next. Different modelers can come up with different estimates of potential losses, prompting insurers to not always trust the findings of just one modeling service. Even when the various modeling firms are in general agreement regarding probable catastrophic losses, they can still be collectively streaky in terms of their predictions. Model estimates for the 1994 earthquake in Northridge were nearly 10 times less than the actual damage. Models related to Hurricanes George, Earl and Bonnie generally got the numbers right, but low estimates for Hurricane Katrina caused some insurers to once again question the reliability of modeling techniques. Others within the industry stress that incomplete data from insurers contributed to the poor estimates.

With all of this information in mind, it's perhaps best for an insurer to keep catastrophe models within their proper context and view them for what they truly are: helpful tools but not infallible prognosticators.

Covering Your Car

While a home is almost always a person's biggest financial asset, personal automobiles are usually very valuable, too. Drivers who want to be covered against disaster-related damage to their car, truck or van can insure their vehicle with a comprehensive auto insurance policy. They should bear in mind, however, that this kind of insurance, unlike auto liability coverage, is not required by law. Some financing agreements require drivers to purchase comprehensive insurance, but most other situations allow owners to skip the coverage at their own risk. Depending on the policy, there may be exclusions that apply to electronic accessories, such as stereo equipment, and to personal belongings stored inside the vehicle.

Liability for Disasters

On occasion, disaster victims decide that the stress and financial losses brought on by a catastrophic episode have been made needlessly worse by negligent people and irresponsible businesses. A homeowner might determine that a dwelling reacted feebly to a force of nature thanks in part to the sloppy contractor who built it. Or a community might find itself surrounded by pollution after a destructive event and place part of the blame on poor planning by a local waste management company. Professional liability insurance, directors and officers insurance and environmental insurance are all topics that will be avoided here, but risk managers should at least realize that products like these are available to help potentially liable parties cope with defense costs, court fees, settlements and monetary judgments.

Conclusion

Disasters, whether they are linked to wind, water, shakes or flames, are a threat to families and individuals in every region of our land. They possess the merciless power to not only threaten our safety but also demolish every material thing that serves as proof of our successes, hard work and good fortune. They incorporate nightmarish risks that cannot be managed sufficiently through luck and the average American's often slender emergency fund.

Quick recovery from these events may only be possible if victims have planned ahead by securing their dwellings. Though a property insurance policy cannot perform miracles or control the earth's elements like a supreme deity, it might be able to influence a disaster's psychological aftermath for the better. With adequate benefits coming their way, affected policyholders can focus on rebuilding their lives instead of thinking about what they have lost.

CHAPTER 3: PLANNING FOR BUSINESS INTERRUPTIONS

Introduction

Pretend for a moment that you are a business owner who receives a phone call earlier than usual one morning. The frantic voice on the other end of the line belongs to your office manager, who hurriedly informs you there is a fire ripping through your premises. As you arrive on site, you're relieved to learn no one was hurt. Your building, though, wasn't nearly as lucky. A bustling fire crew blocks you from inspecting the damage up close, but you could tell all the way from the road this wasn't just a small fire that relegated itself to your company's small kitchen. Based on what you see, getting your business back to where it was will require several months of rebuilding.

Fortunately, you've had a property insurance policy ever since your local bank agreed to give you a startup business loan all those years ago, and you've been careful to update your coverage as the value of your property has increased. So the bills for all the physical repairs probably won't break your business's back.

But as you dial your insurance agent's phone number, you think about the possible consequences of an extended business interruption, and you start feeling sick. You wonder how you will pay your own bills if your office is closed for an extended period of time. You question whether you'll be able to make your payroll and fear that even your most loyal employees will resign and take a steadier job with a competitor. You reason that, even if you manage to reopen in three months or so, it could take several more months for you to regain your customers and bring post-fire earnings back up to pre-fire levels.

Upon discussing matters with your accountant, you determine that the multi-faceted loss of business income will be even greater than the value of your building and its contents. To put it mildly, you've had better days.

As you return to thoughts of your real life as an insurance producer, you might think our brief introductory exercise was overdramatic in its details. However, statistics support the notion that there is nothing imaginary about the threats posed by possible business interruptions. According to a survey from the impact assessment firm Urban Environmental Research, most businesses believe a two-week interruption would amount to a "devastating" situation. A study from the Florida-based Institute for Business and Home Safety reveals at least 25 percent of all businesses that experience an interruption are never able to open their doors again.

While business owners can't control the forces of nature or prevent all serious accidents from happening, they can cushion the financial blow of a possible shutdown by purchasing adequate "business interruption insurance." This kind of insurance typically reimburses policyholders for lost income and any expenses they incur during a break in normal business operations.

For a long time, business interruption coverage was bought mainly by manufacturers, but its appeal has gradually attracted a more diverse group of buyers. Major League Baseball team owners used a form of it to insure against a players strike in the early '80s, California eventually bought a policy to protect itself against lost toll income stemming from San Francisco's Bay Bridge, and claims filed after the attacks of 9/11 showed that the insurance had found many takers among small service-oriented businesses.

Still, the coverage is probably still a foreign concept to many businessowners. Based on at least some of the extensive research that went into the creation of this material, part of what seems to keep the coverage from gaining attention is the lack of policy-oriented education among both buyers and sellers. Though most agents are likely to already understand the purpose of business interruption coverage, some of them might be too intimidated by complex policy provisions to attempt selling it themselves. At other times, business owners purchase the coverage without understanding it and are therefore incapable of promoting its positive features effectively to their peers.

Our study of business interruption insurance strives to clarify the major elements of the coverage for a general audience of industry professionals. At the same time, the information is presented in a way that also keeps the average business owner in mind. Rather than simply summarizing business interruption insurance clauses, we will apply those clauses to real-life examples and document how a few simple words in an insurance policy have sometimes made all the difference for real people in times of great need.

Availability and Affordability

Business interruption insurance is offered in one form or another by nearly every major property and casualty insurer in this country. In the past, some insurance companies were known to automatically include it as part of a standard business owners policy, which also typically includes property coverage for a business's belongings and liability insurance in case of accidents. But these days, interested businesses might need to request interruption coverage and pay an additional premium for it.

The coverage usually comes in one of three varieties. Most small and midsized businesses have insurance with terms and conditions that have been defined by the Insurance Services Office (ISO). Of the three kinds of coverage, standardized coverage using the ISO's language is generally the narrowest. A little broader are those business interruption contracts that that have been created by a carrier and offered to most of its approved applicants. Broader still are those coverage forms that an insurance carrier has rewritten for a particular applicant who has special interruption concerns.

Those latter two kinds of coverage are the result of competition in the insurance market and are sometimes particularly generous in their treatment of interruptions that are caused by perils other than physical damage. For example, although perils such as labor strikes and cyber-attacks are generally not covered under ISO language, those dangers have occasionally been covered by international insurers that use their own policy forms. Please keep these and other potential differences in mind when reading general statements about business interruption insurance and when making general statements about coverage to prospective clients.

The cost of business interruption insurance will be different for each business and will be dependent upon many variables. The perceived ability of a business to bounce back quickly from an interruption will be a major factor in determining a fair premium. Premiums can also be influenced by location and are often higher in disaster-prone regions. Residents of Florida, for example, may discover that affordable business interruption insurance is just as scarce as cheap property coverage in their area.

Basic Benefits

Having established the fact that terms and conditions can differ among carriers, we can step back and focus on some of the general contractual elements that are relevant to nearly all business interruption forms. These elements are explained in the next several sections.

Kinds of Insurable Properties

Although business interruption insurance reimburses policyholders for lost income and not for property damage, coverage is still usually linked to an insured's physical place of business. In order for an interruption at a particular business property to be covered, the property often must be named in the insurance contract.

A wide variety of properties can be named in a business interruption contract. A policy might name one building, an entire industrial complex, a rental property or a single office within a bigger building. A single policy form can be made to cover interruptions at one location, or it can be made to cover multiple properties regardless of their proximity to one another.

Coverage is available to businesses renting their commercial space, as well as to those who own and operate their own buildings. Business tenants can insure themselves against interruptions that are caused by damage to their section of a building or to any public area that is used to access that part of a building.

Coverage also extends to interruptions caused by damage to personal property, such as important equipment or machinery. In these situations, the damaged personal property usually needs to have been within 100 feet of the named premises.

ISO forms permit owners of commercial properties to choose among three kinds of business interruption coverage. Those who operate a business out of their property but do not rent out space to tenants will probably opt for "non-rental value only" coverage. Owners who rent out space to tenants but do not operate their own business out of their property will probably opt for "rental value only" coverage. Owners who operate a business out of their property and rent out space to tenants will probably opt for "business income with rental value" coverage.

In the context of the three preceding terms, “rental value” means the amount of money commercial tenants pay to building owners, plus any operating expenses that are normally paid by tenants but would be incurred by owners during an interruption.

Tenants should keep in mind that they are probably not covered by their landlord’s business interruption insurance, assuming such coverage has even been purchased by the property owner.

Regardless of the location, business interruption insurance is a combination of “business income insurance” and coverage of assorted business expenses. Let’s look at the kinds of benefits that are commonly available.

Business Income Insurance

Business income insurance generally pays business owners the amount of money they would have earned if a covered peril had not forced them to suspend normal operations. It can compensate a business for expected profits that are impacted by an interruption and can cover expenses that still need to be paid during a shutdown. (In business income terms, the phrase “net income” is sometimes used to mean the business’s expected profit before taxes.)

Continuing Normal Operating Expenses

If a business owner plans on ever reopening after an interruption, there will be several bills and other financial obligations to take care of in the meantime. Luckily for that business owner, business income insurance includes coverage of continuing normal operating expenses. Continuing normal operating expenses are those expenses that the insured would face regardless of damage to named property. Examples of these expenses include rent, commercial mortgage payments, commercial insurance premiums, utility bills and some taxes.

A normal continuing operating expense is not covered if the interruption has eliminated it. The cost of electricity, for example, is usually considered a normal continuing operating expense, but it would not be covered if business is interrupted by a blackout.

Business income payouts are determined by the actual loss a business has suffered during an interruption. In accordance with the principle of indemnity, business income insurance only pays for actual losses. Benefits will be calculated carefully to prevent the policyholder from profiting from an interruption. If a business is capable of remaining partially open and still receives some income during a partial shutdown, the insurance payouts will be adjusted accordingly.

if a business had already planned on shutting its doors for a few days, it cannot receive business income benefits for those days. So, if a business is normally closed on Sundays and is closed for seven straight days by a covered peril, it will only be reimbursed for six of those days.

A business is not covered for any extra income it might have earned as a direct result of a covered peril’s effect on the local community. As an example, consider the potential income available to a builder. If a natural disaster interrupts his business and destroys several houses, a builder cannot make a claim for all the money that could have been made if he or she had been able to stay open and rebuild those houses.

Payroll Coverage

Choosing to pay employees during a business interruption does more than create good will between labor and management. It helps the business owner by making it less likely that valuable workers will leave the company out of financial necessity.

By keeping their experienced employees on the payroll during a suspension of operations, businesses set themselves up for quicker recovery. Their reopening will not be delayed by a shortage of staff, and their productivity will not be hampered by newly hired personnel with inadequate training.

Insurers understand how employee continuity can reduce business interruption losses, and they make it a point to list payroll as a covered continuing normal operating expense. Along with wages and salaries, business interruption insurance can pay for union dues, workers compensation premiums, some employee benefits and the business’s required contributions to Social Security and Medicare under the Federal Insurance Contribution Act (FICA). Insurance benefits will be reduced appropriately if an employee is laid off during an interruption.

Businesses concerned about the size of their premiums can drop some of their payroll coverage via an "ordinary payroll limitation or exclusion endorsement." This contractual addition usually provides only a month or two of payroll coverage for nonessential employees or leaves these people with no coverage at all. It does not limit or exclude payroll costs pertaining to officers, executives, department managers or contracted workers.

Extra Expenses

Most but not all forms of business interruption insurance reimburse businesses for the extra expenses they incur during a suspension of normal operations. In order to be covered by an insurer, these costs must, in some way, either reduce the duration or scope of the interruption or help eliminate the interruption altogether. Businesses that offer essential services to the public and cannot shut down for even a brief period of time will have a heightened need for extra expense coverage as part of their insurance portfolio.

Although each insurer may have its own idea of what constitutes a legitimate extra expense, the insured could probably make a strong case for coverage of the following items:

- The cost of renting a temporary place of business.
- The cost of equipping a temporary place of business with necessary machinery and supplies.
- The cost of making a temporary place of business physically presentable to the public and serviceable for business operations.
- Expedited shipping costs for necessary machinery and supplies.
- Moving costs.
- Overtime pay for employees who assist in the relocation process.

Unlike business income insurance, which usually requires that businesses be shut down for at least three consecutive days before coverage can begin, coverage of extra expenses starts at the very beginning of an interruption. Benefits can continue throughout the "period of restoration," which will be the subject of the next section.

Despite the difference in waiting periods, insurance for extra expenses and coverage of business income are linked to each other in several ways. They are often both subjected to the same limit of liability, which means any claim made for an extra expense is likely to reduce the amount of money available for a business income claim.

There is typically no difference between the perils covered by the business income side of a policy and the perils covered by the extra-expense side of a policy. Both parts of the contract require that all claims relate to physical damage at a named property. Therefore, a business will not be covered for the extra expenses it incurs when it loses its lease and must relocate, and it will rarely be covered for the expenses it incurs during a strike.

Expenses caused by damage at another premises, such as a supplier's factory, will not be covered unless the business owns "contingent business interruption insurance."

Similar to traditional forms of business interruption insurance, contingent business interruption insurance compensates a policyholder for a suspension in operations at a particular location due to physical damage. However, benefits are triggered by an interruption at an offsite "dependent property" rather than at the business's own location.

Contingent business interruption insurance can relate to shutdowns at four kinds of dependent properties:

- A "leader property" is a property that draws customers to the insured's business. The insured and the proprietor of the leader property might do similar kinds of business and refer customers to each other. But it's also possible for their relationship to be based purely on proximity, like the link between a concert venue and a neighboring restaurant. The leader property is sometimes referred to as an "anchor store."
- A "manufacturing property" is basically the business that makes the products that are sold by the insured.

- A “recipient property” is the party that uses or utilizes the insured’s goods and services. It may be helpful for businesses to think of a recipient property as the property of an important client.
- A “contributing property” is property belonging to a third party who delivers essential materials and services to the insured.

Period of Restoration

Coverage of business income and expenses lasts until insured losses exceed the policy’s dollar limit or until the end of the “period of restoration,” whichever occurs sooner. In the case of business income, the period of restoration usually begins a few days after the start of an interruption. In the case of extra expenses, it starts at the same time as the interruption. In both cases, the period of restoration ends on the earlier of the following dates:

- The day when the damaged premises should have reasonably been repaired, rebuilt or restored.
- The day when the business has reopened at a different, permanent location.

A business interruption coverage form may also feature a chronological limit of liability that caps the period of restoration at a year. But since interrupted businesses rarely take longer than one year to resume normal operations, the cap is often not a factor at claim time and was often absent from insurance contracts prior to 9/11.

You may have noticed that none of these three possible end dates for the period of restoration relate directly to the policy’s issue date or to a yearly anniversary date. In fact, a business owner can continue to receive benefits after insurance has expired, as long as the interruption began prior to the expiration date. So if a policy’s term lasts for one year beginning in January, and an interruption begins at the end of December, the business will still be eligible for lost income and extra expenses that continue into the new year.

Limits to the Period of Restoration

While a business technically has the right to suspend operations and take all the time in the world to reopen, the insurance company will only pay benefits during what it believes to be a reasonable timeframe for repairs and rebuilding projects. This reasonable timeframe lasts only as long as it would take to make the property as serviceable as it was before the interruption. If business owners decide they want to expand their property as part of their rebuilding plans, lost business income and extra expenses will not be covered during the expansion.

The same principle applies even to projects that could reduce the risk of future interruptions. So if a business is interrupted by an earthquake, the insurer will not cover the extra time it takes to make the named property more quake-resistant.

The ISO coverage form states that the insurance company will not cover some delays that are attributable to laws or ordinances. Specifically, under this form, the business isn’t covered for the time it takes to complete a mandatory demolition of the named premises, and it isn’t covered for any extra time that is spent complying with local or federal pollution requirements.

A company that can or wants to continue operations during the period of restoration will have additional coverage issues to consider. For one, businesses need to understand that their failure to reasonably conduct limited operations from an alternative location (or from the damaged premises) may jeopardize their right to insurance money.

After the Restoration Period

Once the period of restoration has concluded, coverage of lost business income and extra expenses generally ends, too. Losses that follow the restoration period are only covered if the insurance contract contains an “extended period of indemnity” provision.

Treatment of New or Failing Businesses

Lost income can be determined within reason when the policyholder is a long-established business that has produced reliable amounts of revenue. But calculating fair compensation is considerably more challenging when the business is a young entity with no track record, or when it has been operating at a loss. Yet even for the company that is failing or newly established, business interruption insurance has value.

A new business with no firm history of profits might be able to secure business income benefits for itself by pointing to the profits that have been generated at other local companies that offer a similar product or service. If the young company is unable to secure business income benefits, it can still look for a policy that covers continuing expenses and extra expenses.

If a business was scheduled to operate at a loss at the time of an interruption, some claims for continuing expenses and extra expenses will usually still be honored. However, benefits may be reduced by the size of the probable operating loss. This practice is yet another example of how insurers prevent businesses from profiting from disasters.

Covered Perils and Benefit Triggers

For a loss to be covered, operations usually need to have been interrupted at a covered premises by a covered peril. We already know a “covered premises” can be seemingly any building, complex or office named in the insurance policy. But we haven’t yet specifically explained the perils that can lead to a valid claim.

The perils covered by business interruption insurance are usually identical to the perils in the business’s commercial property insurance policy. This link between property insurance and business interruption insurance usually ensures that interruptions are covered when they’re caused by fire, wind, lightning, burst pipes, vandalism and explosions, among other perils. In most cases, it also ensures that interruptions are not automatically covered when they’re caused by a flood or an earthquake. An insurer might agree to cover those commonly excluded perils for an additional premium.

With a few possible exceptions, an interruption will only be covered if a peril has done physical damage to a business’s premises. In practical terms, this means a restaurant would not be covered if it shuts down temporarily because of a food-poisoning scare. It also means a business would not be covered if it voluntarily closed its doors in anticipation of a covered peril (such as a windstorm) without sustaining any actual damage to its property.

Waiting Periods

Even if a covered peril has clearly caused an interruption, the insured will still have to endure a waiting period before coverage of business income and continuing expenses can apply. Typically, this waiting period ends when a business has been interrupted for 48 or 72 hours. Though not mentioned in all policies, it’s assumed that these hours must occur consecutively. So if a business closes, briefly reopens and then shuts down again, it will probably be subjected to a new waiting period. Waiting periods tend not to apply to coverage of extra expenses.

Regardless of the length of the interruption, businesses are not reimbursed for the losses they suffer during the waiting period. If a business doesn’t feel comfortable absorbing even a two-day or three-day loss on its own, the waiting period can often be reduced to a single day or a matter of hours at an additional cost. Dollar-based deductibles—while less popular than waiting periods—are also available.

Excluded Perils

Perils commonly excluded from business interruption coverage include earthquakes, floods, radiation and acts of war. However, exceptions are possible. Insurers did not invoke the war exclusion after the events of 9/11, and the subsequent Terrorism Risk Insurance Act ensured that any business owner who was willing to pay a premium could be covered for similar kinds of attacks.

Concurrent Causation

“Concurrent causation” technically occurs whenever damage is created by more than one peril, but it is almost always used to describe a situation in which one of those perils is covered by an insurance policy and another is not.

After Hurricane Katrina, for example, many interrupted businesses realized they were covered for wind damage but not for flood losses. Among the many policyholders whose professional lives were thrown off balance by both wind and water, the validity of business interruption claims seemed uncertain. In cases involving both of those perils, would the insurance company cover the entire loss, none of the loss or only a fraction of the loss?

The questions brought on by concurrent causation are probably just as plentiful as the ways insurers and courts have responded to them. While some disputes will end in the insured's favor (with the covered peril basically canceling out the excluded peril) others may come down to the judgment of an adjuster, who will itemize all the damage and try to determine how each individual peril contributed to each individual loss. In other cases, a court might focus on the "efficient cause" of the business interruption and rule ultimately on which peril made the damage possible.

Loss-of-Market Exclusion

Claims may also be denied on the basis of a "loss-of-market exclusion." In general terms, this exclusion prohibits coverage when demand for a business's goods or services is reduced or becomes non-existent. For the purpose of an example, consider a business impacted by Hurricane Katrina. Suppose the business avoided significant damage during the hurricane but had to close when most its customers in New Orleans evacuated. Depending on the language of the business's insurance policy, claims for this kind of interruption may be denied.

It's worth noting, however, that the loss-of-market exclusion can be one of the most ambiguous elements in a business interruption contract. To a court or even to an insurance company, the exclusion might not apply when the loss of market is caused by a covered peril.

Excess Clauses

Conversely, an insurance contract's "excess clause," when present, is easy to understand and explain. It states that a loss will not be covered by the business interruption contract if it can also be covered in its entirety by a different policy in the insured's name. Similarly, it may say benefits that are available under the business interruption form will only be available when all other avenues of coverage have been tried.

Excess clauses, as well as similar sorts of exclusions, are put into insurance contracts to prevent an insured from double-dipping into benefits and receiving more money than was actually lost.

Computer Interruptions

The basic business interruption form authored by the Insurance Services Office specifically excludes coverage of computer interruptions. In this context, a computer interruption means a break in operations that is caused by "destruction or corruption of electronic data, or any loss or damage to electronic data."

Additional coverage is available that reimburses policyholders for income and expenses when a virus or some other pest is introduced into a network or computer system. The additional coverage excludes cases in which the damage has been inflicted by an employee or by any third party who has been entrusted with the computer system.

These additional benefits may be capped at a few thousand dollars each year. If a company experiences a computer interruption and does not reach its benefit limit, any unused benefits may be applied to a second computer interruption during the same year. Unused benefits for computer interruptions cannot be carried over from one year to the next.

Power Outages and Service Interruptions

Power outages and service interruptions used to be commonly covered under commercial insurance policies, but that has changed as businesses have become more and more dependent upon their phones, fax machines, email accounts and Web sites. A basic business interruption contract offers no benefits when businesses are shut down by a failure at a utility company, a breakdown of an offsite transformer or deterioration of power lines.

This exclusion doesn't prevent the policyholder from collecting some insurance money when an interruption is prompted by an outage and made worse by a covered peril. According to Newsday (which cited information from the Property Loss Research Bureau), a business owner may still be covered if a company closes during an outage and has its premises vandalized during that time. In another example, a fire that is caused or made worse by an outage is still likely to be a covered event.

Admittedly, the effect of the outage exclusion is minimal for many clients. With business income coverage usually requiring a two-day or three-day waiting period, the majority of outages and service interruptions are

probably not lengthy enough to trigger benefits in the first place. But some companies, (particularly those that deal with perishable items) might want to eliminate the exclusion by buying a Utility Service—Time Element endorsement.

The Utility Service—Time Element endorsement usually gives the business several coverage options. Benefits can be made to apply to problems with power companies, telecommunication providers or water services. Coverage may also be extended to include physical damage to power lines. For coverage to be triggered, utility-related damage might need to have occurred within a specific distance from the business's premises.

Conclusion

Business interruptions can create major problems for owners and their employees. Along with other forms of risk management, business interruption insurance may minimize some of those problems. While not as popular or as widely understood as coverage for tangible property, it's a product that can be useful to all kinds of companies, regardless of their size or specialty.

CHAPTER 4: DEALING WITH DEATH

Introduction

Historically, people have bought life insurance in order to ensure that a dependent or other loved one won't suffer financial hardship after a death of an income earner. Sometimes, the death benefit—the amount paid to a beneficiary—is helpful because it allows an otherwise independent person (such as a working spouse) to adapt to life without a shared income. More importantly, life insurance can create adequate income for those dependents who either need even longer periods to adjust to a devastating financial reality or might never be able to adapt to such a major change.

Examples of possibly needy beneficiaries might include a stay-at-home spouse who would suddenly need to find a job with competitive pay in order to make ends meet, a child who would need such essentials as food, clothing and a decent education, an elderly parent who would need to hire someone to help with various household tasks or any loved one with special needs.

Life insurance can also help beneficiaries pay specific expenses in either a short-term or long-term capacity. A policy boasting significant benefits could help satisfy a mortgage loan on a family home or free a spouse from other debt obligations. A small policy might be enough to ensure that a low-income family won't need to lose thousands of hard-earned dollars in order to cover the cost of a respectable funeral.

No matter if their child is a few days old or has already spent years in the school system, middle-class parents might want to eventually borrow money from a life insurance policy and create a substantial college fund for a son or daughter, thereby making the policy not just a risk management tool but also a source of investment gains.

That last example can help us bridge the gap between traditional views on life insurance, which center on death benefits, and current views on the policies, which treat life insurance as yet another wise addition to a diversified financial plan. Following the annuity's lead, some life insurance policies have been marketed as smart investments for eventual retirement. Customers have been told about the various tax incentives that some life policies might provide. Even businesses have noted the financial flexibility of the product by taking out policies on valued employees and using life insurance as a prominent feature in buyout agreements.

Needs Analysis

Insurance producers can help reduce the millions of underinsured and over-insured people in this country by performing a "needs analysis." A needs analysis tries to determine how much insurance a person ought to possess. This analysis should be influenced by each individual applicant's concerns and risk potential.

A proper needs analysis analyzes a customer's death-related risks and insurance objectives. When calculating a dollar amount for a proper death benefit, the producer and the applicant might find it helpful to ask and answer the following questions:

- How much money will dependents need in order to maintain their current standard of living and keep up with inflation?
- How much money will dependent children need for school tuition and basic necessities?
- How long is a person likely to remain a dependent and rely on income from a policy?
- How much money should beneficiaries receive—regardless of need—as a gift from the deceased?
- If the insured is in training for a potentially lucrative career, how much money should dependents receive in order to offset the loss of expected high earnings?
- How much money should beneficiaries receive in order to offset debts (such as a mortgage loan) that the insured person would normally pay for?
- How much should beneficiaries receive in order to pay estate taxes?
- How much money should beneficiaries receive in order to pay funeral costs, burial costs and other expenses related to the insured person's death?
- How much money should be reserved for a favorite charity or some other non-traditional beneficiary?

A needs analysis can lead buyers and sellers to the best kind of life insurance policy for a given situation. For instance, a high-income applicant might prefer a policy that could maximize the amount of death benefits without causing major estate tax problems. Middle and low-income applicants, on the other hand, are less likely to need this same kind of policy because their estates don't commonly face significantly negative tax consequences upon death. Instead, their financial situations might call for a traditional policy that guarantees necessary death benefits to children, spouses and other dependents in as simple a manner as possible.

Kinds of Life Insurance

Life insurance products can be categorized broadly as either term life insurance or permanent life insurance. Let's review the purposes of those products.

Term Life Insurance

Term life insurance is sometimes called "pure insurance" because, unlike other policies, it lacks investment options and has no cash value. Instead, term life customers pay premiums only so that beneficiaries can potentially receive the policy's "face value."

The face value is clear to the insurer and the policyholder when the policy is issued, and it generally does not change as long as premiums are paid. The face value is generally not dependent on the economy or the performance of investments. If a person who is insured through a $100,000 term life policy dies, the insurance company pays $100,000 to beneficiaries, barring any unusual circumstances.

As their name suggests, term life policies remain in effect for a contractually agreed-upon time and then expire. People who opt for a term life policy instead of a permanent life policy tend to have short-term needs and view beneficiaries' welfare as their top life insurance concern. A father, for example, might purchase a term life policy in order to ensure that his young children will have some financial support if he were to die before they reach adulthood.

When a policy's term concludes, the insured individual often can reapply for another term insurance policy. However, premiums for the new term are likely to be higher than premiums under the previous term. This is because the person's susceptibility to mortality risks will have increased with age.

If policyholders have no interest in renewing a term life policy they can sometimes exchange it for a permanent life insurance policy.

Permanent Life Insurance

Permanent life insurance is very different from term life insurance. Whereas term life insurance is either renewed frequently or allowed to expire after a specified number of years, permanent life insurance should cover the insured individual no matter how long a person lives. Also, whereas the cost of some term life policies can increase dramatically as the insured person ages, many permanent life policies feature locked-in premiums that remain the same for several years.

Two of the many kinds of permanent life insurance are universal life insurance and variable life insurance.

Universal Life Insurance

"Universal life insurance" tends to get tagged with the adjective "flexible" quite often. This product attracts people because it allows them to make changes to their insurance in a far simpler manner than under a basic whole life insurance agreement.

Rather than needing to pay an agreed-upon premium for permanent coverage, a universal life insurance policyholder has some control over the size and even the frequency of premiums. A person looking to grow a universal policy's cash value can increase premiums when interest rates are high and decrease premiums when those interest rates drop. Of course, the policyholder might also have personal reasons for raising or decreasing premiums at any given time.

Universal life insurance premiums are often disclosed in a divided manner, showing how much of each payment ultimately goes toward the death benefit and how much goes toward the policy's cash-value component. The portion of premiums that goes toward the death benefit is known as the "mortality cost." In order for the policy's death benefit to remain fully guaranteed, premiums paid by the policyholder must be at least as much as the mortality cost.

Due to its flexibility and its emphasis on mortality cost, universal life insurance policies are less likely than whole life policies to fully guarantee large death benefits. Some insurers have offered policy riders that can fatten the guaranteed payouts, but these riders can make a universal insurance contract cost just as much as (or even more than) a basic whole life policy. Fully guaranteed death benefits from a universal life insurance policy tend to only apply when the policyholder has paid at least a specified minimum amount of premiums to the insurance company. The amount of premiums paid to the insurer must have been enough to fully offset the policy's mortality cost.

Variable Life Insurance

Variable life insurance is a form of permanent life insurance that exposes a policy's cash value to market risks in exchange for potentially higher returns. The owner still pays premiums for mortality costs and administrative expenses, and the beneficiary is still guaranteed to receive a death benefit when the insured dies. However, the policyholder (and not the insurance company) has control over how the premiums applied to cash value are invested. This is in contrast to the other forms of insurance we've covered in this chapter, which generally require that the insurer invest premiums in safe places and guarantee that the cash value won't drop due to economic downturns.

Variable life insurance premiums for mortality cost and administrative expenses become part of the insurance company's general account. Premiums applied to cash value, on the other hand, go into a "separate account" for the policyholder. The separation of this money is meant to ensure that bad investment choices by policyholders don't jeopardize the insurance company's solvency.

Money in the policyholder's separate account will be invested in a manner similar to mutual fund contributions. Most insurers offer a variety of investment options, including the chance to put money into bonds, government securities and domestic or foreign stocks. The owner of a variable life insurance policy can invest in several of these options at the same time and move money from one option to another within certain insurer-imposed limits. Any growth or decline in the cash value as a result of the owner's investments won't be taxable until the money is actually withdrawn and paid to the owner.

Variable life insurance can work well for people who want to pay for a death benefit and are comfortable with the uncertainty of long-term investing. People who are generally not comfortable investing in mutual funds and tend to worry about the short-term performance of their portfolios should probably avoid this product. Although variable life insurance has a guaranteed minimum death benefit that won't decline in a bad economy, the insurer will make no guarantees regarding the cash value unless the owner is willing to amend the policy with a potentially expensive rider.

Cash Value

In addition to paying premiums for possible death benefits, people who purchase permanent life insurance are engaging in a financial investment. Permanent coverage allows buyers to turn the money they spend on

their policy into accessible cash that will hopefully increase in value over time. Part of the premiums paid to the insurer is set aside and allowed to grow in tax-deferred accounts until the policyholder decides to use the money. The sum of paid premiums and accumulated interest is known as the policy's "cash value."

Cash value makes permanent life insurance a very versatile asset. In many cases, it can be utilized to keep premiums at a level amount even as the insured person grows older. It also allows policyholders to either obtain a low-interest loan from their insurer or use their policy as collateral for a loan from another lender. It also gives people who no longer want their policies the chance to recover a portion of the money that was spent on the insurance. This amount of money is known as the "cash surrender value." The cash surrender value is equal to the policy's cash value minus any unpaid policy loans and unpaid premiums.

Permanent life insurance ideally benefits the person buying coverage as well as the company selling it. The buyer not only remains covered as long as premiums are paid. He or she also has a financial incentive to maintain the coverage for various investment purposes. At the same time, the insurer benefits from offering this incentive because customers who maintain their coverage give the company a steady supply of capital to invest.

Despite this give and take, some critics say cash-value accumulation takes too long to materialize. This waiting period for growth exists, in part, because much of the premiums paid during the early years of coverage go toward sales commissions and administrative fees rather than toward the policy's cash value.

Beneficiary Designations

Correctly designating a beneficiary on a life insurance policy might seem like a simple act. But because an invalid or incorrect beneficiary designation could defeat the purpose of buying the insurance in the first place, buyers and carriers must have a mutual understanding of how a policy bestows death benefits upon selected individuals. When a person's life insurance policy doesn't clearly list a valid, identifiable beneficiary, death benefits will become part of the deceased's estate. Contrary to popular belief, a dead person's last will and testament will often not suffice when survivors try to overrule designations made on insurance beneficiary forms.

There are two general ways in which beneficiaries can be categorized. The first way categorizes beneficiaries by their permanence. Some beneficiaries are "irrevocable beneficiaries." No matter the policyholder's changing wishes and no matter any assignment of ownership, these beneficiaries will remain listed on the policy unless the policyholder cancels the coverage. Other beneficiaries are "revocable beneficiaries." No matter their own desires, these individuals can be removed from a policy at the owner's command.

Beneficiaries are further categorized as either "primary beneficiaries" or "contingent beneficiaries." Primary beneficiaries are first in line to receive any death benefits. If a policy lists more than one primary beneficiary, the listed individuals will share death benefits based on the percentage that the owner has designated for each party. Multiple contingent beneficiaries may also share benefits, but they can only receive compensation if no primary beneficiaries are alive at claim time.

Settlement Options

The manner in which a beneficiary receives policy benefits is called a "settlement option." Many companies have a default way of paying benefits, but this does not mean beneficiaries must always accept the insurer's preferred method.

Historically, most life insurance beneficiaries have received their money in a lump sum. This settlement option is perhaps the least complex and can be attractive to beneficiaries who have a pressing need for money. It also tends to suit people whose shares of death benefits are relatively small.

People who receive large death benefits might opt to have their money rationed and given out periodically so that they can count on a steady income that continues for several years. This option basically transforms the life insurance policy into an annuity.

Several insurance companies allow beneficiaries to park their death benefits in money market accounts. This option gives people more time to consider what they should do with large sums of money and gives the death benefit a chance to grow in an interest-bearing environment. When a beneficiary decides that the

death benefit can be put to good use, he or she can withdraw some or all of the parked funds via check-writing privileges. Be aware, however, that interest earned by the beneficiary on death benefits might be taxed as income.

Conclusion

By now, you should be able to comprehend the versatility of life insurance products. While marketing a particular policy to a consumer, you'll want to stress the ways in which the death benefit might fit into the person's financial goals and family-related concerns. By knowing what's available and analyzing the given situation, you should be able to help people find attractive coverage at an affordable cost.

CHAPTER 5: DISABLITY INSURANCE AND SERIOUS ACCIDENTS

Introduction

Though long-term studies have shown an increase in life expectancies and a decrease in deaths from such serious medical problems as cancer and heart trouble, improvements in mortality have magnified some serious risks for the working public. Many injuries and illnesses that would have quickly killed people three decades ago are now more likely to leave people incapacitated for several months or years. Meanwhile, the demands of a fast-paced business environment are affecting mental health and could be factoring into innumerable debilitating accidents.

No matter its true cause, disability can strike anyone at any time and is probably much more common than we would like to admit. According to the National Safety Council, a disabling incident occurs every second, and the Social Security Administration believes at least 30 percent of today's 20-year-olds will suffer a disability at some point in their life. At nearly every age, the likelihood of disability is greater than the likelihood of death.

Taking precautions to combat the financial consequences of disability is rarely thought of as a priority for the average adult. Because their idea of disability is based mainly on stereotypes involving wheelchairs and around-the-clock nursing care, people tend to disregard the aforementioned statistics and develop a misguided sense of invincibility. Since they don't know many people who fit into those stereotypes, they often doubt that a disabling incident will happen to them,

A few people might realize that a disability can mean anything from a bout with a respiratory disease to a nagging back injury, but they, too, will avoid the topic because it can be so scary. Whereas death has the potential to be quick and painless, a disability is nearly guaranteed to produce significant discomfort and make us dependent on others for an extended period of time. Putting off this form of risk management might not be the smart thing to do, but it certainly seems to be in tune with our human tendency to ignore what frightens us.

Even if they are brave enough to consider the physical side of life with a disability, people often misjudge the impact that an illness or injury can have on their finances. When a disability occurs, the harmed individual is often robbed of his or her biggest asset: the ability to earn a living. If a 40-year-old making $50,000 a year were to become disabled and permanently unable to work, lost income through age 65 could total $1.25 million, not counting adjustments for inflation. In all likelihood, that number would be considerably higher than the combined value of the person's home and savings.

Admittedly, most disabilities are not permanent and will not create a million-dollar loss of take-home pay. But that hardly guarantees they can be overcome by the typical family without some careful planning. Disabilities lasting several months or longer are one of the leading causes of foreclosure in the United States, causing even more homelessness than the death of a family member. If a parent's disability continues for too long, important goals (such as funding a child's education) might need to be postponed or abandoned, and a family's hard-earned standard of living might never be the same again.

Disability insurance replaces a portion of people's income when they are too sick or too hurt to do their job. It isn't exactly health insurance, yet it can ensure that there is enough money for life's essentials during a health crisis. It isn't exactly life insurance, yet it can serve a similar purpose by providing financial assistance to dependents when the head of a household becomes incapable of paying bills.

Injury or Illness

For insurance purposes, having a disability usually means a person is suffering from an accidental injury or illness. The injury or illness can involve many sorts of circumstances and does not need to have occurred in conjunction with performing one's job duties. The injury must have occurred during the policy period, and an illness must have started during that same period.

If symptoms of an illness were noticed prior to the policy period and were strong enough to cause a reasonable person to seek medical attention, the illness will be viewed as a pre-existing condition. Disabilities linked to pre-existing conditions might not be covered at all or might only be covered after a long waiting period.

A few disability products are accident-only policies and do not cover losses brought on by sickness. This coverage is often impractical because the majority of disability claims are linked to cancer and other diseases. Like life insurance policies that only cover people who die of a specific illness or from a specific kind of accident, an accident-only policy is probably only suitable for workers who cannot qualify for or afford other coverage.

Loss of Ability

To trigger disability insurance benefits, an injury or illness must be severe enough to have had a negative impact on the insured's professional life. More specifically, a policy will probably state that the injury or illness must be preventing the person from performing essential job duties. Depending on the insurance contract, the worker might need to be unable to perform one essential task, all essential tasks or a certain portion of tasks, such as 20 percent.

These requirements can be modified to emphasize a time element rather than a task element. As an example, consider someone who can still perform all individual job duties but must work fewer hours because of pain or fatigue. In this case, the worker might be eligible for benefits if lost time is equal to a certain percentage of a regular workweek. Like a situation involving someone who can perform some duties but not others, this is an example of a partial or "residual" disability. More information about partial and residual disabilities (which are not covered under some disability insurance contracts) appears elsewhere in this course material.

When coverage is contingent on the inability to perform job-related tasks, those tasks are usually related, for a limited time, to a person's specific occupation. Suppose Jim, a writer, and Jane, a mover, are both injured to the extent that they are unable to engage in heavy lifting. Since heavy lifting is not considered a normal aspect of a writer's job, Jim will probably not qualify for disability benefits. Jane, on the other hand, has a job that requires heavy lifting. Therefore, she might receive some insurance payments.

Coverage based on the person's own job duties is known as "own-occupation" coverage and is usually only available for a few months or a few years. Eventually, a person might only be eligible for continued benefits if the individual is incapable of having any job that is in line with his or her education level and experience. You'll read more about own-occupation insurance shortly.

Loss of Income

Some disability policies base coverage strictly on a person's inability to perform tasks, but many contracts in today's market also require a loss of income at some point. A number of insurers will not provide money to a person with a partial disability unless an injury or illness has reduced the insured's income by at least 20 percent.

Loss of income must have been caused clearly by a disability rather than by other factors. For example, a burn victim who could still do some work if her office hadn't been destroyed by fire will probably not be eligible for benefits during the rebuilding process.

Under a Doctor's Care

The insured cannot just call the insurer, claim to be disabled and expect to receive compensation. In order for the disability to be considered valid, the person usually must be under a doctor's care.

At the very least, the doctor caring for the insured typically must have enough experience to properly treat and evaluate the disability. Being under a dermatologist's care, for instance, would not suffice for someone who is supposedly disabled by a back injury. Being under a chiropractor's care would not be enough for someone who is disabled by skin cancer.

Sometimes a person claiming a disability will be required to see a physician who has been selected by the insurance company. Despite this limited control over the person's care, the insurer usually cannot force a disabled person to undergo specific kinds of treatment or surgeries. Some policies require that the insured be hospitalized before disability benefits can begin, but these contracts are very rare or might be prohibited in some states.

After a person has been diagnosed with a long-term disability, the insured and the qualified physician will need to file forms with the insurance company on a periodic basis. These filings are used as a way of verifying the disability's continued existence. The reporting requirements might be relaxed if the disability is serious, obvious and permanent.

Own Occupation vs. Any Occupation

The best (and often most expensive) kinds of disability insurance base their definition of "disability" on the insured's own occupation. People with own-occupation coverage will receive compensation when they cannot perform their basic job duties. Their ability to do a different job is irrelevant.

To demonstrate the positives of own-occupation coverage, let's use the classic example of a disabled doctor. Suppose a hand injury prevents the doctor from treating patients. If the doctor lacks own-occupation coverage, the insurer might deny his claim and argue that he could earn a living as a lecturer at a medical school. But if he has own-occupation coverage, the insurer cannot make that case, and the doctor might be eligible for full disability benefits until he can practice medicine again.

Own-occupation coverage is particularly popular among high-income professionals, such as doctors and lawyers. This is because they are the ones who would probably experience the steepest drop in income if they were to change careers. The many years of schooling and all the student loans that were required to achieve their professional goals also tend to make own-occupation insurance attractive to these people.

In the past, high-income professionals could even receive own-occupation coverage that catered to their exact specialty. If a heart surgeon could no longer perform heart surgery but remained capable of working as another kind of physician, she would still receive full benefits. Today, this form of insurance is either unavailable or only offered at a very high price.

Other varieties of own-occupation insurance that have been available over the years are explained below:

- If people are unable to perform the duties of their own occupation, they can get a job in another field and still receive their full benefits.
- If people are unable to perform the duties of their own occupation, they can receive their full benefits until they choose to do some other kind of work. After that, their benefits will end.
- If people are unable to perform the duties of their own occupation, they can receive their full benefits until they choose to do some other kind of work. After that, they will receive a portion of the difference between their pre-disability income and their new income.
- If people are unable to perform the duties of their own occupation, they can receive their full benefits until they choose to do some other kind of work. After that, they will receive limited payments until their new income equals a particular portion of their pre-disability income.
- If people are unable to perform the duties of their own occupation, they can receive full disability benefits for a limited period of time, such as two years or five years. After that, they can only continue to receive benefits if they meet stricter requirements. (This is the most common kind of own-occupation coverage.)

If a disability policy does not include own-occupation coverage (or if own-occupation coverage has expired while the person is still disabled), the insured probably has what can be called "any-occupation" coverage. In general, this kind of disability insurance pays full benefits when people cannot perform the duties required

by their own occupation and also cannot handle any job that would be suitable for them, based on their education, experience and training. An injured doctor, for example, would not receive disability payments if he was still capable of working at a medical school.

As far as own-occupation coverage is concerned, the insurer will base benefit eligibility on the person's occupation at the time of disability. Obviously, this occupation might be different from the one the person was in when the policy was issued.

The essential duties of the person's occupation probably should be determined before the applicant purchases a disability policy. If both sides are not clear about these duties, the policyholder and the insurance company could find themselves arguing over some odd questions at claim time. For example, if a teacher loses her voice but is still capable of grading papers, is she disabled? If an injured doctor cannot treat patients but can perform clerical tasks at his office, will he receive disability payments? As strange as these kinds of questions might seem, it's not uncommon for them to be the central issue in a lawsuit.

Long-Term Disability vs. Short-Term Disability

A working person can be covered by "short-term disability insurance" or by "long-term disability insurance." Short-term policies allow disabled people to collect benefits for a brief period of time, usually no longer than six months in most parts of the country. Long-term policies let people receive money for a few years, until they retire or, in rarer cases, until they die.

Workers in a few states are entitled to a portion of their regular income when they suffer a short-term, non-occupational disability. Benefit periods range from six months in some areas to one year in states such as California. Sources of funding differ too, with some states (including California) requiring employee contributions from workers, and others mandating self-insurance by employers.

Most people who work (but not necessarily reside) in the following states or territories are covered for short-term disabilities by law:

- California.
- New York.
- New Jersey.
- Rhode Island.
- Hawaii.
- Puerto Rico.

Someone with a short-term disability policy will probably receive benefits sooner than someone with a long-term policy. Short-term disability benefits from private companies usually go into effect immediately after an injury and no more than a week after the beginning of an illness. (The current waiting period under California's state plan is seven days for all disabilities.)

Long-term disability insurance often provides no benefits to the insured unless an injury or illness has lasted for several months. This waiting period is known as the policy's "elimination period" and will be explained in greater detail in the next section.

In most states, short-term disability insurance is purchased by employers as part of a group plan and is rarely marketed to individuals. Long-term disability insurance can be either provided through an employer-sponsored group plan or purchased outside of the workplace by one person. Though some businesses have established "integrated disability plans" that feature both kinds of coverage, many insurers only sell one or the other.

Please note that this course material will not focus specifically on California's short-term disability insurance plan (SDI). Requirements and other assorted details about the plan can be obtained from the state's Employment Development Department.

Elimination Periods

The benefits made possible by disability insurance are usually not approved immediately after an injury or illness. Most likely, the insured will receive no financial assistance from the insurer until after the passage of a time-based deductible known as the "elimination period." Any losses that occur during this period are not the insurer's responsibility.

The elimination period begins on the first day the insured is unable to work. It can last anywhere from a few days to a few years. Short-term policies in many states often have no elimination period for injuries and a week-long elimination period for illnesses. Long-term policies tend to have 30-day, 60-day or 90-day elimination periods and do not have separate waiting periods for injuries and illnesses.

A person's preference for a longer or shorter elimination period might be based on finances and health. All else being equal, a longer elimination period will reduce the insurance premium. A longer elimination period might also make it easier for an unhealthy applicant to qualify for a policy.

Before choosing an elimination period, applicants should determine how long they would be able to support their financial needs without any income. If a three-month stretch without any income would plunge a family into bankruptcy, there would be little point in purchasing a policy with a long elimination period.

Recurrent Disabilities and Exceptions to the Elimination Period

Most policies have a "recurrent disability clause," which explains how the elimination period is applied when disabilities go away for a while and then reoccur.

Suppose, for example, that someone with a 90-day elimination period was disabled for a year, came back to work for a week and has realized that more recovery time is needed. Does the person have to wait another 90 days before benefits can begin again?

The insured is usually not subjected to a new elimination period if the same disability reoccurs within six months of the person's initial recovery. Some policies in some states extend this timeframe to a full year if the person is covered for a disability for life or through age 65.

If a recurrent disability does not trigger a new elimination period, any benefits that have already been paid to the insured for the disability will still apply to the policy's benefit limit. In other words, if a policy calls for up to a year's worth of benefits, a person who was disabled for nine months, went back to work for a week and became unable to work for the same reason for another six months would only be covered for 12 of those combined 15 months of disability. However, if the second case of disability were to trigger a new elimination period, the benefit limit would be reset, and the person might be covered for those additional months.

As long as the period of disability is not interrupted by a return to work, multiple disabilities can satisfy a single elimination period. For example, consider someone with a 60-day elimination period. If a broken ankle keeps the person out of work for 30 days and a bout with pneumonia keeps the person out of work for more than another 30 days, the two disabilities can be combined to satisfy the 60-day waiting period.

There are also some cases in which even a long-term disability policy will not require an elimination period. The elimination period is often waived when a person suffers a loss of both eyes, both ears or multiple limbs.

Benefit Periods

When a disability insurance policy's elimination period ends, the policy's "benefit period" begins. The benefit period is the maximum amount of time the insurer will pay benefits to the policyholder for a disability. The insured will receive payments from the insurer until he or she is no longer disabled or until the end of the benefit period, whichever comes first.

Like the elimination period, the benefit period can have a major impact on a policy's price and its availability. Usually, the longer the benefit period, the higher the premiums will be. Unhealthy individuals who would otherwise not qualify for disability insurance might be able to purchase a policy with a short benefit period.

Not surprisingly, there are different benefit periods for short-term and long-term disability insurance. Short-term policies typically have benefit periods no longer than three or six months. A benefit period for long-term disability insurance might last two years, five years, until normal retirement age or until death.

A lifelong benefit period is rare these days, but an insurance professional might encounter one while working with a consumer who purchased a policy a long time ago. Though contracts with this benefit period can pay full benefits for life when a disability is caused by an injury, they often call for a reduction in benefits over time when a disability is caused by an illness that occurred late in life. The size of the reduction usually depends on when the disability began.

Suppose a man becomes disabled by multiple sclerosis at age 55 and will remain disabled for the rest of his life. In this case, a lifelong benefit period might entitle him to full benefits until he turns 65 and 80 percent of his regular benefits during additional years. If the same man were to become disabled by disease at 64, he would receive an even smaller portion of his regular benefits after turning 65. However, if he were to become disabled by disease at a relatively young age (maybe in his 40s or earlier), he might not have his benefits reduced at all.

Don't let all this talk about lifetime benefits trick you into thinking that a disability can occur at any age and still be covered. Even if a policy makes it possible to receive benefits for life, the disability that triggers those benefits must begin prior to the policy's expiration date. Most people have the option of renewing their insurance beyond the expiration date, but renewal is rarely allowed after age 65. If an elderly person is collecting disability insurance benefits, it is probably because they became disabled at a young age and had comprehensive coverage.

Benefit Amounts

By now, you should understand how disability benefits are triggered and how long they can last. But just knowing that insurance money is available will not be enough to ease a person's fears. Developing a financial contingency plan that responds to a disability will be very difficult unless you know what the exact benefit amount will be.

Since disability insurance is meant to replace income, it should not be at all surprising to learn that the benefit amount will be based on a worker's salary or wages. The income used to calculate the benefit amount will be the insured's taxable income during the 12 months prior to the disability, or perhaps the average income earned over the previous few years.

Like workers compensation, disability insurance will not replace the insured's entire paycheck. For most people, the benefit amount will be 60 to 70 percent of their pre-disability income. Insurers and state regulators enforce this percentage-based limit in order to encourage people to return to work and discourage them from committing fraud.

High-income workers might receive benefits below 60 to 70 percent of their pre-disability income. This is possible because the benefit period often has a dollar limit in addition to a percentage limit. For example, an insurer might agree to pay 60 percent of a person's salary but cap monthly benefits at $5,000 per month. Based on those figures, workers making $50,000 would have 60 percent of their income replaced by insurance, but workers making $150,000 would have their monthly benefits capped at $5,000 and would therefore receive only 40 percent of their regular income. Dollar limits are especially common in group disability plans, which might explain why many doctors, lawyers and business executives prefer individual coverage.

Most disabled people will not have to deal with different benefit amounts for injuries and illnesses. However, as was explained in the previous section, someone who is disabled by an illness and receives benefits after age 65 might have their benefits reduced. The drop in compensation will depend on when the disability began.

Believe it or not, there are some situations in which a person might be interested in lowering the benefit amount. Like reductions in the benefit period, smaller benefit amounts can help high-risk applicants receive coverage. For people who are considered lower risks, a lower benefit amount can mean lower insurance costs.

Excluded or Subtracted Income

Workers in sales should realize that disability insurance often does not compensate people for lost bonuses or commissions. Unearned income, such as money derived from investments, is also excluded from the benefit amount, and too much of it can even reduce the amount of money the insurer will provide. This might be done in cases where the level of unearned income would significantly reduce the person's desire to return to work.

Other compensation that a disabled person receives, such as workers compensation, Social Security benefits and payments from other disability insurers, can also lessen the benefit amount. Details about workers compensation and Social Security appear elsewhere in this course material.

Issues to Consider

Once a person grasps the basics of disability insurance, there is an assortment of relatively specific secondary concerns that ought to be addressed. These issues can be very important to people who want the most comprehensive policy available or who have special insurance needs. Many of these topics are summarized in the next several sections.

Residual/Partial Disabilities

Because recovery can be a gradual process, people who are interested in disability insurance deserve to know how a policy treats partial or "residual" disabilities. A residual disability is a disability that either prevents people from doing some but not all of their job duties or forces them to work fewer hours.

Some kinds of disability insurance only protect the insured from "total disability," an illness or injury that prevents a person from doing any work. However, coverage of residual disabilities is often included as a policy rider.

To receive compensation for a residual disability, there usually must be at least a 20 to 25 percent negative difference between the insured's pre-disability income and post-disability income. That percentage is multiplied by the benefit amount for a total disability, and the result is provided to the harmed individual.

As an example, let's assume a woman normally makes $50,000 per year and has a disability policy that would pay her 65 percent of her income in the event of a total disability. Therefore, her monthly benefit amount for a total disability would be roughly $2,708. But if the woman becomes partially disabled and suffers a 50 percent loss of income, she would be entitled to approximately $1,354 (or 50 percent of $2,708).

For older policies that cover partial disability, or if a person is in a highly hazardous profession, the insurance company might only be required to provide no more than 50 percent of the regular benefit amount for no more than six months and nothing beyond that timeframe . In today's market, residual benefits will typically end either when the person's new income is no longer satisfactorily lower than the person's pre-disability income (often at least 20 percent or 25 percent less) or when the policy's benefit period expires, whichever comes first.

Sometimes the insured can do part-time work and still qualify for full disability benefits. If the difference between pre-disability income and post-disability income is very large, such as 75 to 80 percent, the insurer will treat the residual disability like a total disability. Certain injuries, such as loss of both eyes, both ears or multiple limbs, are considered total disabilities no matter what the person can actually do or how much money the person is actually making.

Some insurance policies provide no residual benefits unless the residual disability occurs immediately after a total disability. Conversely, "zero-day residual coverage" offers benefits regardless of a total disability as soon as the policy's elimination period has passed.

Non-Cancelable vs. Guaranteed Renewable

Individual disability insurance policies can be either "guaranteed renewable" or "non-cancelable." These two terms explain how long a policy can remain in force and how long premiums will remain the same.

A guaranteed renewable policy can be renewed by the policyholder until the insured reaches age 65. The insurance company is not allowed to cancel the policy because of the insured's personal health status or raise premiums for that same reason. If the insurer wants to increase the cost of a guaranteed renewable

policy, it must do so for all covered people in a particular class, such as all policyholders in a certain group of professions or age group. When the insured turns 65, the policy might be renewable if the person pays premiums and works a full-time job.

These days, there are more guaranteed renewable policies than non-cancelable policies. A non-cancelable policy can be renewed by the policyholder until the insured reaches age 65. The insurance company is not allowed to cancel the policy unless the purchaser either made a grave misstatement when applying for it or stops paying premiums. The insurer is not allowed to increase the price of the policy even if a proposed increase would apply to all people in a particular class.

Pre-Existing Conditions

For obvious reasons, disability insurance companies have little interest in selling coverage to people who are already ill or hurt. This explains why many insurers refuse to honor disability claims that are linked to "pre-existing conditions."

In general, a pre-existing condition is any health problem that caused a person to seek out medical advice or treatment within three to six months prior to the policy's issue date. It can also mean any condition from that period that would have made a reasonable person seek advice or treatment. In some states, a pre-existing condition might be any medical problem that the insured experienced within the past two years.

Mental Health Benefits

Disabilities involving emotional problems make insurers uncomfortable because they often cannot be detected through medical testing and are not always responsive to medication or cognitive therapy. The potential for large and drawn-out losses remains high enough for many insurers to deny disability coverage to applicants who are taking prescribed psychiatric drugs.

People who make it through the underwriting process and are approved for insurance are likely to have their benefit period shortened to two years when they become disabled by mental illness. This cutoff in compensation will probably be waived if the mental illness puts the insured in a hospital or is clearly caused by an organic disease, such as Alzheimer's disease.

Similar two-year limits are commonly enforced for other kinds of self-reported disabilities that are not easily confirmable. Claims related to chronic fatigue syndrome, an increasingly common issue for insurers, are usually impacted by these restrictions.

It is worth noting, however, that special limitations for mental illness and other self-reported disabilities have angered consumers to the point of legal action. Critics argue that the two-year limits are unfairly discriminatory toward classes of disabled people, and the caps on benefits might not be allowed in a particular state.

Pregnancy

Disabilities stemming from pregnancy can be covered by disability insurance, but it depends on when a woman purchases her policy. If the woman is already pregnant when she applies for insurance, her application can be denied outright or her pregnancy can be treated as a pre-existing condition. If she purchases her insurance before becoming pregnant, she might be eligible for benefits if there are complications. Pregnancy exclusions that are enforced when the policy is purchased can often be eliminated in time to cover the women during subsequent pregnancies.

Though certainly an issue for many women, pregnancy coverage is not utilized after most births. To receive compensation, a woman must experience complications that are enough to disable her beyond the elimination period. Depending on the policy, the elimination period for pregnancy coverage might be longer than the elimination period for other injuries and illnesses.

Rehabilitation Benefits

Some disability policies provide rehabilitation benefits, which can assist people financially as they attempt to re-enter the workforce. Benefits can go toward a vocational training program that has been pre-approved by the insurance company. Participants in occupational rehab programs can still receive their regular disability benefits as long as they remain disabled.

Tax Concerns

The taxation of disability benefits is often an important factor when workers can't decide between enrolling in a group plan and purchasing an individual policy. Although group plans are usually less expensive than individual policies, they can produce negative tax consequences during some inconvenient times.

When disability insurance premiums are either paid by an employer or paid by a group member with pre-tax dollars, benefits received by the insured will be taxed as income. From the government's perspective, treating benefits as income makes up for the premiums that the employer deducted for itself as business expenses and for regular compensation that was not reported as income on a healthy employee's tax returns.

Having to pay taxes on disability benefits can be burdensome for people who are unable to work, especially since disability insurance never makes up for 100 percent of someone's income. After taxes, a benefit amount that is supposed to replace 65 percent of one's income might be closer to 40 percent of that income.. The 40 percent is certainly better than nothing, but it might not be enough to uphold a family's standard of living for long.

Disability benefits are tax-free when premiums were paid with after-tax dollars. In practical terms, this means that benefits from most individual policies do not need to be shared with the Internal Revenue Service. Group plans funded entirely with participants' after-tax dollars are also treated this way.

When premiums come from the employer as well as from an employee's after-tax dollars, only a fraction of disability benefits will be taxed as income. In general, the fraction of benefits that is tax-free will be equal to the fraction of premiums that was paid with after-tax dollars.

Please note that the information in this section applies to federal tax laws. Each state might have its own way of dealing with disability benefits.

Policy Cancellations

Even a policy that is advertised as "guaranteed renewable" or "non-cancelable" can be rescinded by the insurance company in limited circumstances. If an applicant misstates a major fact or tells a lie that influences an underwriting decision, the insurer often has two years from the policy's issue date to investigate the matter and cancel coverage. (Some lies or misstatements might not result in cancellation but will reduce a person's benefits.) This two-year window is known as the policy's "contestability period."

Grace Periods and Policy Reinstatements

Some disability insurers allow for a grace period, which lets the policyholder miss payment of a premium without immediately losing coverage. Similarly, if a person misses payments and loses the insurance, it may be possible to have the policy reinstated when those late payments are made. When this is allowed, the insurer is not responsible for covering any disability that began while the person was temporarily uninsured.

Common Exclusions

There are some kinds of disabilities that will not be covered, no matter how severe they might be or how long they might last. These exclusions are important to know, but they aren't difficult to understand. In fact, you might find that many of them are rooted in common sense.

Intentional Injuries

Since insurance premiums are based on risk rather than a person's intentions, disability insurance will not cover someone who purposely becomes ill or injured. The insured will receive no compensation for the aftereffects of a failed suicide and is not supposed to get any benefits when an injury was staged in order to obtain disability checks.

Some older policies have even stricter exclusions and provide no benefits when a person becomes unintentionally injured while intentionally doing something dangerous. Contracts with this language might not cover people who have an accident while engaged in a particularly risky hobby, such as skydiving or bungee jumping.

A few disabilities arguably come close to being intentional but are still covered by most disability insurers. Injuries that result from organ donation or plastic surgery, for instance, can sometimes be covered if they extend beyond the elimination period.

Disabilities caused by alcoholism or drug abuse are often self-inflicted yet not exactly intentional. Some insurance companies treat substance abuse problems in a manner similar to mental illness, limiting the benefit period to a year or two.

Illegal Activity

Insurance companies expect their policyholders to abide by the law and will not compensate someone who becomes disabled while committing a crime. Some policies also specifically state that the insured will receive no benefits while in prison.

Of course, fraudulent disability claims are illegal and will be denied. To shield itself from fraud, an insurance company might ask applicants to disclose any criminal history.

War Disabilities

Disability insurance policies do not compensate people who are hurt while fighting a war or while engaged in other military activities. Instead, benefits are typically provided by the federal government.

Important Riders and Policy Features

Having spent a lot of time going over restrictions and exclusions, let's move in the opposite direction and examine some of the consumer-friendly portions of a disability insurance policy. A few of these attractive features can be found in basic disability contracts. However, most of them are popularly added as riders, often at an additional cost.

Cost of Living Adjustment

A benefit amount that seems large enough today might be insufficient in 10 years when the cost of goods and services has increased. Disability policyholders can work around this risk by purchasing a "cost-of-living adjustment" rider.

A cost-of-living adjustment can increase disability payments when the insured has been unable to work for at least one year. On an annual basis, the benefit amount will be recalculated to reflect the 12-month change in a specified economic index.

Though deflation can cause the benefit amount to drop at some point, money owed to the insured will not be lower than the benefit amount that was in effect before the first cost-of-living adjustment. The insurer may impose caps on the cost-of-living adjustment to protect itself from overly expensive claims.

Future Purchase Option

Major changes in people's lives can cause them to reevaluate their insurance situation. When a person gets married, buys a home or becomes a parent, buying more disability insurance often seems like a good idea. At times like these, a "future purchase option" can come in handy.

A future purchase option gives the insured the chance to buy more insurance later in life without having to medically qualify for it. For example, if a healthy man buys disability insurance at 25, becomes a diabetic by age 40 and decides to buy more coverage, the insurance company would not be allowed to deny his request for additional coverage or make him pay a higher price because of his diabetes.

A future purchase option can be very helpful, but it cannot be exercised at any time and in any amount. Policyholders may only take advantage of the future purchase option during certain windows of opportunity, often near renewal periods every few years. Some insurers provide additional purchase opportunities when the insured experiences a major life event like the ones mentioned in the first paragraph of this section.

No matter when or how often a future purchase option is used, the additional insurance cannot push the benefit amount above 100 percent of the insured's income. As usual, the insurer will not want the future purchase option to be used as an incentive for people to avoid employment.

People who are interested in a future purchase option should recognize that it can help them when they become unhealthy but not when they are merely getting older. Though health cannot be considered when additional insurance is bought through a future purchase option, insurers are allowed to base the cost of the additional insurance on the insured's age at the time of sale. Also, the amount of coverage that can be bought via the future purchase option can decline as the insured grows older.

Waiver of Premium

Someone who becomes disabled will have plenty of financial worries besides how to keep paying for insurance. If applicants want to keep their coverage intact while they are disabled without having to concern themselves with premiums, they can purchase a "waiver of premium" rider. A waiver of premium excuses the policyholder from paying premiums after the insured has been disabled for 90 days or after the elimination period has passed, whichever comes first.

Return of Premium

One of the barriers to any insurance sale is a person's belief that money will go toward a policy that will never actually be used. A reluctant insurance applicant can minimize this concern by purchasing a "return of premium" rider.

A return of premium provision lets the policyholder receive a refund of premiums that have not been paid back to the insured in the form of benefits. The insurer might add up the amount of premiums that the person has paid, subtract the amount of benefits that the insured has received and multiply that result by a particular percentage. The return of premium might occur at age 65 or at scheduled intervals after several years.

Retirement Protection Riders

When insurance companies cut back on selling disability policies with lifetime benefits, the outlook for retired claimants became awfully bleak. With benefits now commonly ending at age 65, people who remain ill or injured beyond that point must rely on government assistance and their own savings to pay their living expenses. But because they have been disabled and unable to earn an income for so long, these people have missed out on the chance to make adequate contributions to retirement accounts and make extra money through employer matches.

To help their customers deal with this problem, disability insurers offer retirement protection riders. When the insured becomes disabled, the insurer provides an amount equal to the employee's and employer's regular retirement contribution and puts it in an insurer-managed trust. Contributions are made until the insured recovers or turns 65, whichever happens first.

Catastrophic Disability Rider

As if being unable to work wasn't bad enough, many disabled people are too hurt or too ill to perform basic personal tasks like bathing or eating. In order to ensure that their needs are met, they might have to rely on around-the-clock assistance from family members or professional caregivers.

Such extreme cases of disability can greatly increase a person's expenses, but the cost might be manageable with the help of a "catastrophic disability rider." A catastrophic disability rider increases a disability policy's benefit amount when the insured is cognitively impaired or is unable to perform two or more "activities of daily living" (ADLs).

Insurance professionals who specialize in long-term care policies are already familiar with ADLs. The most common ADLs are as follows:

- Bathing (including the ability to move in and out of a shower or tub, clean oneself and dry oneself).
- Dressing (including the ability to put on clothing and any medical accessories, such as leg braces).
- Eating (including the ability to chew and swallow food and use utensils).
- Transferring (including the ability to move in and out of beds, cars and chairs).
- Toileting (including the ability to get to a restroom and perform related personal hygiene).

- Continence (including the ability to control the bladder and bowel muscles and perform related personal hygiene).

Principal Sum Benefit

The principal sum benefit (also known as the "capital sum benefit") is basically extra dismemberment insurance. It provides an additional amount of money (often equal to a year's worth of total disability payments) when the insured loses an eye or limb. Even if the insured suffers dismemberment on several occasions, the benefit will be available no more than twice during the person's lifetime.

Hospital Confinement Benefits

Hospital confinement benefits can help the insured receive insurance money without having to go through an elimination period. This policy feature makes the insurer responsible for paying full disability benefits for each day that a sick or injured person is hospitalized. Days spent out of the hospital will not be covered until the end of the elimination period.

Unconventional Kinds of Disability Insurance

There's more to find in the disability insurance market than just individual policies and group plans for workers. High-quality coverage also exists for business owners and can even be included as a rider to more popular insurance products like life insurance policies. These kinds of disability insurance aren't as popular as those we've already mentioned, but no study of the disability market would be complete without them.

Business Overhead Expense Policies

Few small businesses would be capable of surviving without the labor, expertise and networking skills of their owners. Even if a company is resilient enough to continue during an owner's absence, managers and staff would probably have to work extra hours and tighten the business's budget to remain profitable.

Companies can manage the risk of an owner's disability by purchasing "business overhead expense insurance." If an owner becomes too ill or injured to work, this insurance covers continuing business costs like employee salaries, rent and utilities. With the appropriate rider attached to it, it can also pay the price of hiring an owner's replacement.

Like disability insurance for individuals, business overhead expense policies have an elimination period and a benefit period. Still, they differ from traditional kinds of disability insurance in a few important ways.

One major difference is the length of the benefit period. Whereas disability policies for individuals can be made to last until age 65 or later, policies that cover business expenses often provide money for no more than two years. It is assumed that if the owner has not returned to work by then, he or she will have at least sold the business or transferred authority in an appropriate manner.

Another difference between business overhead expense insurance and regular disability insurance relates to how the benefit amount is calculated. Regular disability policies provide only a fraction of a person's income, but business overhead policies can cover all of a company's ongoing expenses. The appropriate benefit amount will be determined during the application stage when the applicant shows the insurer proof of regular business expenses. Based on those figures, the insurer will pay for all incurred expenses during a disability up to a specific monthly limit. If a business goes a month without reaching that limit, unused benefits can be carried over and applied to expenses in another month.

A business overhead expense policy does not cover a disabled owner's lost income. In order to receive help with personal expenses, the owner must purchase an individual disability insurance policy or enroll in a group plan.

Disability Buyouts

Businesses with multiple shareholders often draft buy-and-sell agreements, which explain what should happen to a shareholder's stake in a company when the person leaves the organization. When companies purchase insurance to help them comply with these agreements, they are usually trying to make it easier for living owners to eventually purchase a deceased owner's shares. However, insurance can also be used in situations where a shareholder is dealing with a long-term disability.

"Disability buyout insurance" provides money to healthy shareholders so that they can purchase a disabled shareholder's portion of the business. Each policy will probably be designed to help the healthy owners meet the requirements of the company's buy-and-sell agreement. For example, depending on what is stated in the buy-sell agreement, the policy might allow beneficiaries to receive a large lump sum, or it might compensate people through regular installments.

Because there will probably be no need to buy out a shareholder who only has a short-term disability, these policies typically do not pay any benefits until the disability has lasted for a year, two years or more.

Key-Person Disability Insurance

Some employees are so valuable to a business that a company would lose a significant amount of money if any of those workers were to become disabled. A replacement might eventually be hired, but the new employee is unlikely to be as proficient as the disabled employee right away.

Businesses can purchase "key-person disability insurance" to protect themselves from losses when an important employee is too ill or injured to work. Coverage is similar to the kind found in individual policies and group plans, but the benefits are meant to compensate the employer, not the employee. Many sports teams, for example, purchase key-person insurance to reimburse themselves in case a star player with a guaranteed contract becomes seriously injured and can no longer compete.

Disability Riders

If workers would rather not purchase a full-blown disability policy, they might still have the option of getting some coverage as a rider to their life insurance policy. In fact, that's how disability insurance was originally offered to the public.

Disability riders are very similar to regular disability policies, but they offer fewer benefits for a shorter length of time. Instead of receiving benefits that are based mainly on income, the insured might get a few dollars of disability coverage for every $1,000 of life insurance. These benefits usually do not continue for more than a few years.

Other methods that disabled people can use to get money from their insurer include taking advantage of loan provisions in a life insurance policy and making an early withdrawal from an annuity. However, these options are not always preferable or even possible. Policy loans can only be done if the person has permanent life insurance (rather than term insurance), and withdrawals from annuities can create disadvantageous tax situations.

Credit Disability and Dread Disease Insurance

When someone wants insurance but cannot obtain a disability policy or a disability rider, they might try shopping for "credit disability insurance" or "dread disease insurance." These kinds of insurance can be easy to purchase and tend to have small premiums. However, they spark debate in the industry because they only provide benefits under very limited circumstances.

Credit disability insurance makes the insurer responsible for the insured's debt while the person cannot work. Living expenses are not covered by this insurance.

Dread disease insurance gives people money when they contract a specific illness. For example, a policy might pay benefits to the insured only in the event of a cancer diagnosis. Money received through this insurance is designed to go toward medical expenses, but policyholders are often allowed to use it as they please.

Alternatives to Disability Insurance

When people suffer a serious injury or illness, financial assistance can come from sources besides disability insurance. The last several sections of this chapter address those additional sources in order to help you increase your insurance knowledge and give fully informed service to your prospects.

You'll discover that some of these possibilities, such as Social Security, can directly impact the size of an insured's benefit amount under a disability insurance policy. You'll also be alerted to coverage gaps in these programs and products, all of which might help explain why disability insurance can be so valuable.

Social Security Benefits

The Social Security Administration gives financial assistance to retirees, disabled people and some dependent family members.

In general, eligibility for Social Security disability benefits depends on a person's work history and the severity of an illness or injury. Because disability benefits are funded through payroll taxes, applicants must have worked a minimum number of years to qualify for federal assistance. A certain fraction of those years must have been in the recent past. Exact requirements pertaining to work history are different for every age.

An inability to perform one's current job duties is not enough to qualify someone for Social Security. In order to make compensation possible, an illness or injury must prevent the person from having any kind of gainful employment. Furthermore, the disability must be expected to last at least a year or until death.

The government allows for a few exceptions in regard to a disability's severity. For example, it is acceptable for a person to do some work while collecting benefits if monthly work-related income does not exceed a certain dollar amount (roughly $1,000). There are also "compassionate allowances," which waive some eligibility requirements and waiting periods for people with certain diseases, such as Lou Gehrig's disease and advanced cancers.

If an applicant satisfies the eligibility requirements, disability benefits from Social Security will begin after a five-month elimination period and will continue until the person is no longer disabled or reaches retirement age, whichever comes first. After two years, beneficiaries can enroll in Medicare, the government health program most commonly used by senior citizens.

The amount provided by Social Security will be based on the amount of payroll taxes the person has paid over his or her lifetime. Benefits calculated on that basis may be taxed as income if the person is earning money from other sources.

When a beneficiary reaches retirement age, disability benefits from Social Security will end, and retirement benefits will begin. Monthly retirement benefits are likely to be equal to monthly disability benefits, assuming there is a direct transition from disability to retirement.

Problems With Social Security Disability Benefits

Pundits and politicians spend a lot of time debating the problems that Social Security might encounter in the future, but there are still plenty of reasons why the system is inadequate for many disabled workers in the present. Most notably, benefits take a long time to arrive, and when they finally do, they are often too small to maintain a person's regular standard of living.

An application for disability benefits will usually be evaluated by a Social Security employee within 90 days of receipt, and approved applicants must satisfy a five-month elimination period. Approximately two-thirds of all applicants will be denied assistance on their first try and will either give up or file an appeal. Most appellants are eventually approved, but a final judgment often won't arrive for more than a year.

Some consumers, and even some lawmakers, have blamed disability insurers for the large backlog of Social Security appeals. Many carriers require that claimants apply for government assistance before they can receive insurance benefits. When the Social Security Administration denies these people, insurance companies sometimes make them apply a second time.

One reason why insurers do this is because disability insurance benefits can be reduced if the insured is also receiving Social Security. This dollar-for-dollar offset is especially common in group disability plans and is meant to keep premiums down and encourage people to work. Conversely, a few disability insurers offer a rider that gives the insured more money if the person is ineligible for Social Security.

Workers who expect to qualify for Social Security can use online tools at the Social Security Administration's website to estimate their probable monthly benefit. Unlike compensation available through disability insurance, this amount is likely to be much less than 60 to 65 percent of current income.

Supplemental Security Income

Money from the government's general tax funds can be used to pay monthly benefits to sick or injured people who are poor. There are no work-history requirements attached to this assistance, but like in the Medicaid system, a person can be declared ineligible because of income or personal assets. In 2020, for example, a person could not qualify for this "supplemental security income" if personal assets, other than a personal residence and a few other items, were collectively worth more than $2,000.

Workers Compensation

Workers compensation is a no-fault system that allows employees to receive money from their employer (or an employer's insurer) when they are hurt while doing their job. In all states other than Texas, most employers are required to purchase workers compensation insurance for employees.

In order for a disabled person to receive workers compensation for an injury, the following three statements must be true:

- The person was a company's employee at the time of the injury.
- The injury was accidental.
- The person suffered the injury in connection with his or her job duties.

Occupational Diseases

A broad assortment of diseases can lead to workers compensation claims. In general, a person who contracts a disease is covered for workers compensation if either of the following statements is true:

- The person's assigned tasks or work environment are responsible for causing the illness.
- The person's assigned tasks or work environment are responsible for worsening a pre-existing medical condition.

Medical Coverage

Employees who become injured or ill while performing their job duties will have their medical expenses covered by workers compensation. There is no waiting period for this coverage to begin, and there is no dollar limit. Covered employees are also exempt from having to pay deductibles or copayments.

Claims for workers compensation that only involve medical coverage are "medical-only claims." Since they do not involve lost wages, medical-only claims can be relatively inexpensive for employers and their insurance company. The majority of workers compensation claims are medical-only claims.

Wage Replacement

If an injury or illness causes an employee to miss work for more than a few days, workers compensation might allow the person to recover a portion of lost wages. This is known as a "lost-time claim." Lost-time claims are not as common as medical-only claims, but they tend to be much more expensive for insurance companies.

Not unlike the elimination period in a disability insurance policy, most workers compensation systems will not cover lost wages unless an employee has missed a certain number of workdays. Though some states have required at least a week-long absence, employees are usually eligible for lost-income benefits if an accident has kept them out of work for three days.

The amount received for lost wages will depend on the worker's financial situation, as well as on the provisions in state laws. For most claimants in the United States, the amount will be based on roughly 66 percent of their regular income over the past year.

Like disability insurers, states set maximum limits on wage replacement in order to benefit the public and discourage wrongdoing. As a result, Injured workers who are reasonably wealthy might find that their compensation for lost wages is based on less than two-thirds of their salary. Maximum weekly benefits are likely to be equal to some percentage of the average wages for workers in the area.

Death Benefits

When a workplace injury results in death, surviving family members are likely to receive a death benefit. The death benefit is typically based on roughly 66 percent of the worker's wages. Like compensation for lost wages, it may be capped at a certain percentage of the state's average income.

Workers Comp Exemptions

Employers are generally required to purchase workers compensation insurance that protects all of their employees. However, exceptions to this rule exist in every part of the country and are listed in workers compensation statutes. If a certain kind of worker is specifically not protected under state statute, an employer generally does not need to obtain insurance to cover the worker's injuries.

Depending on state law, the following classes of people might not be automatically covered for workers compensation:

- Employees at very small businesses.
- Employees of family members.
- Self-employed individuals.
- Executive officers.
- Volunteers.
- Interns.
- Domestic employees.
- Independent contractors.
- Marine workers.
- Coal miners.
- Real estate licensees.
- Farm workers.
- Employees of religious organizations.

Even for those employees who are not exempt from workers compensation coverage, it is worth mentioning that most disabilities do not occur while people are working. Compensation for non-occupational disabilities will only come from disability insurance or Social Security.

Long-Term Care Insurance

Long-term care insurance helps pay for the skilled, intermediate or custodial care that a chronically ill or recovering person needs beyond 90 days. It can be used to cover everything from physical therapy to assistance at mealtimes.

When people first started buying it a few decades ago, long-term care insurance was viewed strictly as something for patients in nursing homes. Today's policies still address the needs of people in advanced-care settings, but they also can be used by residents at assisted-living facilities, continuing-care communities and private homes. The cost of respite services, such as adult day care, is typically covered, too.

Benefits from long-term care policies are triggered when the insured becomes cognitively impaired or is unable to perform two or more activities of daily living. These activities are typically the same as those found in catastrophic disability riders and are listed below. More detailed descriptions of these activities appear elsewhere in this chapter:

- Eating.
- Bathing.
- Dressing.
- Transferring.

- Toileting.
- Continence.

Long-term care insurance can be an important asset, particularly for older consumers who are concerned about coverage gaps in the Medicare system. But becoming eligible for benefits requires incapacitation in the insured's personal life, rather than the mere inability to perform job duties. Plus, the insurer usually only pays for expenses that are specifically related to a person's disability. By contrast, disability insurers do not require that beneficiaries be incapacitated outside of work, and money from disability policies can be used in whatever way a person sees fit.

The Family and Medical Leave Act of 1993

Cultural shifts away from one-income families with two parents have increased the number of cases in which people's personal lives keep them away from work. A middle-aged worker, for example, might have no other choice than to take time off to ensure that sick children or elderly parents receive appropriate care.

Congress passed the Family and Medical Leave Act in 1993 as a way of ensuring that workers would not need to choose between keeping their job and looking after a loved one. The law also gives protection to disabled employees. More specifically, the protections provided by the law can apply under any of the following circumstances:

- The employee is having or caring for a newborn.
- The employee is welcoming a foster child or adopted child.
- The employee is caring for a spouse, child or parent with a serious medical condition.
- The employee is personally suffering from a serious medical condition.

In any of those situations, federal law allows the employee to take up to 12 weeks of unpaid leave each year without running the risk of losing a job. Additional leave is allowed if the person is caring for a family member who was seriously injured while serving in the military. While on leave, the employee will not lose employer-sponsored insurance, and the employee's financial contribution for that insurance cannot change.

Though several states have enacted similar legislation that makes medical leave available to a broader population, not all employees are covered by the federal law. The Family and Medical Leave Act only applies to people who meet all of the following criteria:

- They work for an employer who has at least 50 employees.
- They have worked for the employer (continuously or otherwise) for at least one year.
- During the 52 weeks prior to taking medical leave, they worked for the employer for at least 1,250 hours (roughly 24 hours per week).

The Family and Medical Leave Act is an important law that gives people the chance to preserve their position with their current employer. However, it does not force the employer to keep paying the employee during an extended absence. To avoid going without a paycheck, a person would need to use available sick days or (in some cases) purchase insurance.

Conclusion

Disability policies aren't always easy to understand, but gaining an understanding of them and passing this knowledge along to the public can be worth the effort. People who are unaware of disability insurance might end up relying on workers compensation or Social Security and discover all too late that those sources of protection are sometimes unavailable or inadequate.

Of course, no insurance can prevent all bad things from happening. But comprehensive disability insurance can allow people to focus on recovering from physical problems without having to worry too much about financial ones.

CHAPTER 6: INSURING YOUR HOBBY

Introduction

Since we've spent so much time studying scary, worst-case scenarios, it's probably a good idea to take a relatively light-hearted break and turn our attention to subjects that can be a bit more fun. Let's go over how to insure art, musical instruments, stamp collections and other hobby-related items.

Over the past dozen years or so, flea-market fanatics and consumers of all things collectible have had reason to smile. Thanks to online auction sites, such as eBay, accumulating interesting and rare valuables has never been simpler. If you've already run out of antique stores to scour in your town or simply don't have the time to shop for new finds in person, you're no longer out of luck. Nearly anything a buyer might want, be it an antique copy of a great book or an original oil painting from the 16th century, can be purchased from the comforts of home with a few mouse clicks, a little luck and enough money.

Meanwhile, millions of Americans have lounged in their living rooms each week and watched "The Antiques Roadshow," the highest-rated program on public television. The show and others like it can lead viewers to believe that the people who spend their weekends going from garage sale to garage sale might be onto something. The program, which blends history lessons with the big-money thrills of a game show, teaches us that sometimes what looks like junk is not junk at all.

An elderly woman's wallet-sized painting of a baby? Turns out it's worth roughly $15,000, one hundred times what she paid for it in 1950. That 1920s Art Deco jewelry that came from a Hawaiian man's great-aunt? It could fetch nearly $200,000 on the market, according to an expert appraiser.

Recent history has also seen an increase in the number of millionaires around the globe. That translates to a jump in the number of people who can splurge on Picassos, diamonds and the best bottles of wine money can buy.

Many new members of the wealthy class have purchased art, antiques, gems and other valuables as a way of satisfying a long-held affection for these supposedly finer things. Others admit they can't tell a Manet from Monet or a real diamond from a fake, but they have gotten into the art and jewelry markets anyway for investment purposes. In fact, the appeal of fine arts has been monetarily enticing enough for some financial service organizations to employ art investment consultants and people who can assist jewelry owners with tax issues.

When examined together, all the aforementioned developments in modern society point to the same conclusion: Consumers have never been more conscious of the fact that a piece of personal property can appreciate in value and either be passed lovingly onto heirs or be sold at a significant profit.

The Insurer's Role in Protecting Valuables

As was hoped by the Chubb Insurance Group when it first agreed to sponsor the "Roadshow" program, the public's attention to art, antiques and other appreciating valuables has created opportunities for dedicated insurance producers. If clients believe an item is worth a small fortune, they are likely to be interested in the ways to properly insure that item against damage, loss or theft. Would a standard homeowners insurance policy be enough to cover an expensive stamp collection that gets destroyed in a fire? Would special insurance be needed to cover a lost engagement ring? And what about jewelers and gallery owners who handle valuables on a daily basis? How can insurance companies help them protect their inventory?

Believe it or not, there are many insurance professionals who become genuinely excited when given the chance to answer those questions. A lot of the people who help clients insure art were artists themselves at one point or got wrapped up in art history while attending college. For them, an art insurance endorsement or stand-alone fine arts policy is a link between their private passions and their professional callings.

Other producers lack a personal history with the kinds of property that they insure, but they still find great pleasure in helping consumers protect some very intriguing items. Countless insurers can claim to have helped people insure modest homes and typical household belongings. But how many can say they've helped cover a mummy, a copy of "The Gettysburg Address" or a ridiculously large collection of Coca-Cola memorabilia?

Readers should rest assured that they do not need to become experts in art, antiques, jewelry or wine in order to help insure those things. Being able to tell the difference between an abstract Jackson Pollack painting and a child's wild scribbles is the responsibility of an appraiser and the person who wants to insure the art. It is not the job of the insurance producer.

Still, when given the probable value of a piece of property, the professional producer ought to understand how to cover the item sufficiently. He or she should also be able to tell a client what to expect from the insurer if the item or one like it is ever damaged, lost or stolen. As an added bonus, the insurance professional can explain the risks that are associated with certain kinds of property, so that consumers can better protect their valuables and manage their insurance costs.

This chapter contains special sections on insurance for art, antiques, jewelry, musical instruments and more. Upon reading it, students will have a general understanding of how insurance companies treat each of these items. They are also likely to note commonalities among each section and determine that, no matter the item and no matter its value, there is almost always a way to insure someone's treasure.

Personal Property and Homeowners Insurance

The most basic way to cover art, antiques, jewelry and the like is to rely on the benefits that are made available through either a homeowners insurance policy or a renters insurance policy. Both of those products feature "contents coverage," which is essentially insurance for all the personal property stored in people's homes and elsewhere.

In a homeowners insurance contract, maximum contents benefits are equal to a specified fraction of the corresponding building's insured value. Often, that fraction is equal to one-half or three-fourths of the dwelling coverage. So, if a home is insured for $100,000 with 50 percent contents coverage and is subjected to fire or some other covered peril, the owner will receive no more than $50,000 in contents benefits. Renters insurance involves practically no dwelling coverage, so the consumer is allowed to choose the amount of contents coverage.

Many people believe that their homeowners insurance is good enough to cover their valuables and collectibles. And contrary to what some aggressive salespersons might say, these customers are not necessarily wrong. Basic benefits may be enough to indemnify a homeowner who loses one or two paintings in a fire. Larger amounts of collectibles may be adequately covered, too, assuming that the contents of the collection are worth a few thousand dollars or less. But people who own pricier pieces deserve to know that there are several limits to what homeowners insurance will cover.

Cumulative Limit

Basic contents coverage under an unaltered homeowners insurance policy applies to unscheduled items. This means that a customer does not declare ownership of any specific items when applying for the policy. In practical terms, it also means the policy's benefit limit is intended to cover all items in a home, other than those that have been excluded specifically from the policy.

The unscheduled approach to coverage can produce positive or negative consequences for a claimant. On the one hand, it frees the person from having to phone the insurer whenever he or she buys something new and wants the item covered. It also allows the insured to get the benefit of the doubt at claim time, helping him or her receive benefits despite a lack of receipts.

On the negative side, the total replacement cost of a person's belongings can be greater than the cumulative benefit limit for unscheduled items. This undesirable situation is particularly possible when damage is done to something of significant value, such as an old painting or a priceless piece of jewelry.

Imagine that a fire has totally destroyed a person's home and that she has a $50,000 limit on contents coverage. Keep in mind that she will need to replace everything she owns with that money. She'll need new clothes, new appliances, new furniture, new kitchenware, and those are just the basics. The $50,000 might turn out to be enough to handle most of her replacement purchases if her extravagances were few. But what happens if she had started an art collection prior to the fire and had lost a $40,000 painting in the blaze?

As an unscheduled item under her policy, the painting would be lumped in with all her other belongings, and she would still receive no more than $50,000 to replace the totality of her property.

Covered Perils

Homeowners insurance contracts can be “named-peril” policies or “all-risk” policies.

Named-peril policies only provide financial protection against those dangers that are specifically mentioned in the insurance contract. Perils that are commonly covered by this insurance include the following:

- Fire or lightning.
- Windstorm or hail.
- Explosion.
- Riot or civil commotion.
- Aircraft.
- Vehicles.
- Vandalism or malicious mischief.
- Theft.
- Falling objects.
- Freezing.

An all-risk policy provides financial protection against every peril, other than those that are specifically listed as exclusions. Some of the commonly excluded perils within all-risk policies are listed below:

- Flood.
- Earth movement, including earthquakes.
- Wear and tear.
- Mold.
- Rot.
- Acts of war.
- Nuclear reactions.

The most popular form of homeowners insurance is the HO-3 form, which many insurance people market as an all-risk policy. Yet the “all-risk” tag is often only partially appropriate in that case.

While H0-3 policies are all-risk in regard to dwelling coverage, their contents coverage may be offered by default on a named-peril basis. This still entitles policyholders to benefits when common perils like fire and theft leave them without a valuable work of art or piece of jewelry. But it keeps the door open for countless kinds of uninsured losses. Hypothetical claims that would almost certainly be denied under this kind of policy include the following:

- A claim for a ring that fell down a drain.
- A claim for an antique vase that was knocked over by a housecat.
- A claim for a stamp collection that was ruined by a spilled drink.
- A claim for a painting that was damaged when a careless party guest leaned his elbow into it.

Sub-Limits

Not even all-risk contents coverage can ensure that a homeowner will be reimbursed for the true value of a lost, stolen or destroyed item. In addition to the cumulative benefit limit that applies to all unscheduled items, insurance companies put sub-limits on the amount of money that people can receive in connection with certain kinds of property. Among other possibilities, a homeowners insurance policy typically sets a low ceiling on coverage for jewelry, stamp collections, coin collections, furs and firearms.

Depending on the policy and the item, the insured is likely to receive no more than a few hundred dollars or a few thousand dollars when he or she files a claim for these belongings. The sub-limits are in effect no matter how much an item or collection is worth, and they will often be enforced even if the policyholder has purchased replacement-cost coverage for personal property.

Sub-limits for the aforementioned items exist because these valuables present special levels of risk to insurance companies. Jewelry, for example, is expensive to replace, easy to lose and often the target of thieves. That's a triple whammy that many careful underwriters are likely to shun.

At the same time, though, the sub-limits can be viewed as being beneficial to many insurance customers. The limited protection for jewelry, stamps, furs and firearms helps keep premiums down for people who do not own these items and encourages those who do own them to take greater care of their collections.

If there is a problem with the sub-limits in homeowners insurance, it is that most policyholders do not know they exist. When appropriate, these underemphasized sub-limits can be turned into non-issues through the purchase of either a special stand-alone policy or an add-on to a homeowners insurance policy.

Covering Valuables Through Add-Ons and Separate Policies

Insurance customers who want special coverage for valuables and collectibles have several options to choose from. They can purchase a rider or endorsement that is attached to their homeowners insurance contract, or they can leave their homeowners policy as it is and buy a separate policy that has been crafted specifically for jewelry, fine arts, musical instruments and other specific types of personal property. Separate policies sometimes give property owners the broadest coverage, but add-ons to homeowners policies can work just fine for many buyers.

Insured Values

One major reason to buy an add-on or a separate policy for valuables is that these products give owners greater control over their items' insured values. An item that would otherwise be subjected to a sub-limit under a homeowners insurance policy can be insured for an amount that at least approaches its true worth.

The special items that are mentioned in this chapter are typically insured for either their "replacement cost" or their "fair market value." An item's replacement cost is whatever amount it would take to purchase a substitute item of like kind and quality. An item's fair market value is basically the amount of money that owners would receive if they were to sell the item in its current condition.

To arrive at either of these figures, insurance companies often require applicants to have a formal appraisal done on their valuables. Pictures, receipts and general descriptions may suffice if an item is being insured for a few thousand dollars or less.

Broader Coverage

Other differences between these special insurance products and homeowners policies relate to the completeness of coverage. In general, these add-ons and separate policies provide all-risk insurance. As a result, the dropped ring, the knocked-over antique, the soggy stamps and the elbowed painting are all likely to be covered if their owner has bought the proper add-on or separate policy. Assorted accidents will only be considered uncovered perils if they are specifically listed as exclusions within the insurance contract.

What About the Deductible?

Add-ons and special policies for valuables often do not have a deductible. This further differentiates these products from homeowners insurance, which typically makes the owner responsible for $250 or more of otherwise insurable losses.

What's Excluded?

Though covered perils under either an add-on or a special policy for valuables tend to be greater in number than covered perils under a homeowners policy, some exclusions will still be enforced. A few of them may be removed for an additional premium. Others may be non-factors if a consumer chooses a separate policy over an add-on.

Commonly excluded perils are as follows:

- Flood.
- Earth movement.
- Accidental breakage (often an optional covered peril).
- Acts of war.
- Wear and tear.
- Damage caused by insects or vermin.
- Damage that occurs during retouching or restoration.
- Loss of property when it is seized by police or other authorities.

Where to Find Coverage

To obtain special coverage for items like jewelry, paintings and collectibles, property owners can turn first to the insurer that issued their homeowners policy. However, many property insurance companies lack experience insuring certain valuables and will not be willing to insure something if they do not adequately understand the relevant risks. Also, even if a property insurance company is willing to insure a few valuables for a customer, it may draw the line when the person's collection is worth a large sum of money.

If the property insurance company isn't comfortable enough adding coverage to its own homeowners contract, the person will have to peruse the market for a separate policy.

When shopping for a separate policy for valuables, a person is likely to work with a specialty broker and come into contact with a specialty insurer. The market for this coverage will be much smaller than the homeowners insurance market, but consumers are likely to find at least one or two companies or agencies that are not scared off by the items in question.

There are insurers that specialize in fine arts, jewelry, musical instruments and oddball collectibles. Some even extend their services to gallery owners, professional jewelers and other businesspeople who handle valuables on a daily basis.

Scheduling and Blanket Coverage

People can specially insure their valuables by "scheduling" them. Scheduling involves itemizing a person's valuables and insuring each item for a specific amount. A person with two paintings, for example, might schedule one of them for $50,000 and the other for $100,000.

Scheduling may minimize disputes at claim time because it often forces the owner to prove ownership of an item before insurance can be issued. It's also a relatively simple solution if a person wants to insure only a few items of special value.

Scheduling is less beneficial for people who want to insure large collections, since each item must be appraised and added to the policy individually.

"Blanket coverage" is an alternative to scheduling. Rather than covering different items at different amounts, it provides uniform benefits that apply to every piece in a collection.

Blanket insurance for valuables is likely to feature a cumulative benefit limit as well as a per-item benefit limit. Suppose, for example, that a book collector has insured her manuscripts with blanket coverage that has a $100,000 cumulative limit and a $1,000 per-item limit. If a fire breaks out and destroys all of the collector's books, she may be in line for a full $100,000 settlement. But if the fire only damages two books, the insurer might simply multiply the two books by $1,000 and pay the collector a $2,000 settlement.

Because each item covered by a blanket policy does not require its own appraisal, the per-item limit could work in the collector's favor or against her. If the two books were the gems of her collection and were worth more than $2,000, she won't be fully covered for her loss. Yet if the two books were relatively insignificant and were actually worth less than $2,000, she'll have more than enough insurance to cover the items.

Property Insurance Appraisals

An “appraisal” is a formal, expert opinion that pertains to an item’s authenticity, condition and value. It may entail taking pictures of an item, measuring it and conducting historical and market research.

There are many different kinds of appraisals and many reasons for property owners to have one done. For our purposes though, appraisals are mainly important because they help owners decide how much property insurance to buy. They also help underwriters realize how much risk they may be absorbing when they issue a policy.

Appraisals for valuables are usually not required when the items are being insured through a typical homeowners insurance policy. However, appraisals are often mandatory when a person wants to schedule an item for a large sum of money or obtain significant blanket coverage for a collection.

When performed properly and regularly, appraisals can assist owners in understanding the value of their property and can give them a good reason to modify their insurance portfolios. Besides having an initial appraisal completed in order to set coverage in motion, businesses and individuals can pay for additional appraisals that will determine whether an item’s value has gone up or down since coverage began.

By and large, things like paintings tend to appreciate in value over time, whereas items like computers and other electronics depreciate in value with each passing year. To avoid being underinsured or over-insured, it is sometimes recommended that policyholders have their valuables appraised every three to five years.

Each appraiser might have his or her own way of assessing fees to consumers. Some might charge a flat amount, while others will charge an hourly rate or a daily rate for their services. Consumer advocates and insurance professionals generally agree that people should avoid doing business with appraisers who ask for a percentage of an item’s appraised value. This sort of fee structure is even forbidden by many appraisal organizations because it creates the appearance of ethical misconduct, leaving people to wonder if an appraiser has inflated an item’s value for the purpose of personal gain. Some insurance professionals also caution that an appraisal that is given to a buyer by a seller might be inaccurate, since sellers want their customers to feel as though they have gotten a good deal on an item.

Insurance consumers will want to feel as though an appraiser has the necessary expertise to come up with a well-reasoned assessment of their property’s value. An appraiser who specializes in real estate valuations, for example, is probably not the best person to appraise someone’s jewelry. Likewise, someone who specializes in appraising business assets is probably not the perfect candidate to evaluate a personal coin collection. A generalist in the field, called an “estate appraiser,” might be the easiest choice for property owners if they have a variety of different items to insure and are looking for a one-stop shop. Otherwise, they will probably be served best by someone whose expertise is focused almost entirely on a specific market.

Due in part to a general lack of licensing requirements for personal-property appraisers, there are no guarantees that a person has proper expertise. The absence of regulation in this area contrasts significantly with the state-level licensing requirements that apply to real estate appraisers. Still, many personal property appraisers belong to trade organizations, such as the American Society of Appraisers. These organizations routinely require members to pass exams and adhere to codes of ethics.

Covering Art and Antiques

A homeowners insurance policy does not exclude art or antiques from coverage. Nor does it subject these items of beauty and craftsmanship to any sub-limits. Yet there are several reasons why a person might opt to insure art and antiques through a fine arts add-on or a separate fine arts policy.

With nothing covering it other than homeowners insurance, a painting, sculpture or even a centuries-old piece of furniture is treated like just another piece of personal property. In the event of a covered loss, insurance benefits for these items will come out of a person’s general contents coverage and will eat away at the policy’s benefit limit. Since contents coverage is often equal to just 50 percent of a dwelling’s insured value, this insurance, by itself, might not be enough to cover an expensive collection.

Another problem with basic art and antique benefits in homeowners insurance policies relates to the named-peril nature of regular contents coverage. Something as valuable and fragile as an antique vase can lose a significant portion of its value if it becomes scratched or chipped. However, significant perils like accidental breakage are typically excluded from a homeowners policy. Other excluded perils that an art lover or antique collector might care about include overexposure to sunlight and damage to pieces while they are in transit.

Fine Arts Policies and Add-Ons

Many of these significant risks, among many others, can be managed appropriately when people insure their art and antiques through a fine arts endorsement or a separate fine arts policy. Overall, these special products are very similar to all the other property-specific endorsements and policies that are mentioned in this chapter, but they also address some of the risk management concerns that are especially important in the art world. For instance, a fine arts policy or endorsement is more likely than just about any other policy or rider to be a "valued contract," with an item insured for its market value.

Someone who has a valued contract generally knows how big an insurance cash settlement will be after a loss. If a painting is scheduled for $500,000 and is damaged beyond repair, the owner can expect to receive $500,000 from the insurance company.

Insurers use valued contracts to insure arts and antiques because of the uniqueness of these belongings. If the Louvre were to ever lose Leonardo da Vinci's "Mona Lisa" in a fire, it isn't as if the museum's insurer could get in touch with a wholesaler or even a private dealer and purchase a replacement at a reduced cost. Even if the insurer could get its hands on another work by da Vinci (hardly an easy task to begin with), the replacement would not be a real replacement at all. Rather, the alternate painting would have its own past and its own special status in the art world, all of which would make it worth something different than nearly every other painting in existence.

As long as an owner can prove ownership of the artwork or antique and as long as the item is stolen or damaged beyond repair, an insurance company is not likely to get involved in a heated debate over art history and replacement paintings. Instead, the company is likely to rely on insurance appraisals that were done on the item and cover the item for its insured value.

The relative predictability of a fine arts settlement does not mean, however, that policyholders can avoid taking responsibility for properly covering their art and antiques. A fine arts policy does not increase in value the minute an insured item becomes more valuable on the market. The owner must evaluate coverage periodically and perhaps make changes to it in order to remain adequately insured.

Suppose a collector of modern art bought a painting 20 years ago and has insured it ever since for $10,000. If the artist has died since that time, resulting in a current market value of $50,000 for the painting, the collector would not be entitled to a $50,000 settlement after a loss. Instead, the claimant would receive no more than $10,000, the original and unchanged value of the insurance policy.

Insuring Fine Art From Place to Place

Insurers who specialize in fine art also understand that valuables such as paintings and antiques are not just things that individuals hang on their living room walls or put atop their mantles. These items travel frequently, with the owner lending them to museums and galleries.

Owners may agree to these temporary loans for a multitude of reasons. For instance, putting a piece on display at a venerable museum might increase its value and do wonders for an owner's investment. Risk management is often a deciding factor, too. If a work of art or an antique is on loan to a gallery, that means it is out of the owner's home and that protecting it from theft or damage is the borrower's short-term responsibility.

In spite of these benefits for their owners, paintings and similar items can make an insurer nervous while they travel the globe. Valuables can be crushed on their way to a destination, dropped by movers or stolen from trucks. In fact, according to an item in the trade publication American Artist, most fine arts claims for damage and theft are filed while an insured item is being transported from place to place.

In an effort to manage these unwelcome risks, owners, borrowers and insurers often take several important precautions. When an item is to be transferred temporarily from one party to another, a formal loan agreement is often drawn up. Among other information, the agreement is likely to list the current condition of the item, the party that will be responsible for insuring the item and the party that will be responsible for handling shipments. In most cases, the party that borrows the item (usually a gallery or museum) is the one who insures it.

After arrangements have been made with each party's insurance company, the item will be ready to become covered by the borrower's policy from the time it leaves the owner's hands until it comes back to that person. Coverage has typically been exclusive to transit within the United States and Canada, though worldwide benefits have long been available for an additional premium. Global coverage may also be available through the federal government's Arts and Artifacts Indemnity Program, which will be explained at a later point in this text.

Before an insurer agrees to cover art and antiques in transit, it may insist that shipping guidelines be followed by experienced personnel. An owner cannot just stuff a fragile item in a cardboard box, take it to the post office and expect it to be covered for damage while en route to a borrower's address.

Most paintings should be shipped in wooden, temperature-controlled crates. Antiques require just the right amount of foam so that they are properly cushioned without being crushed by too much packing material. If an owner is not sure who to hire to handle packing and shipping, the insurance company might be able to recommend a reliable specialist.

New Purchase Protection

When people pay big money for art or an antique, there is always a chance that their new prized possession could get damaged or stolen before insurance coverage can be formally obtained. Luckily for avid collectors, many fine arts policies feature "new purchase protection." Thanks to this feature, a person can buy something valuable and have it covered immediately for a limited time, even if there isn't an insurance agent in sight to schedule it.

Though new purchase protection varies among providers, it usually covers new purchases for 30 or 90 days and is equal to either a set dollar amount or a set percentage of all similar items that have already been insured through the add-on or fine arts policy. As an example, a freshly bought painting might be covered for $10,000 or 25 percent of the cumulative insured value of all paintings that have already been scheduled by the owner.

New purchase protection is not applicable when the owner makes a purchase and has not insured similar items with an add-on or separate policy. In other words, people who have only scheduled their paintings would probably not receive new purchase protection for their first rare stamp.

Pair and Set Coverage

Let us assume that a person has found a full set of antique figurines and wants to insure all the pieces with an add-on or a separate fine arts policy. Though each individual figurine is worth something on the open market, the fact that the set is complete gives it a value that is higher than the sum of its parts.

Insurers that offer fine arts policies often take this into account and make "pair and set coverage" available to their customers. This coverage is also sold by many companies that insure sets of jewelry, including earrings.

Pair and set coverage in a fine arts policy gives an owner the option of receiving the full insured value of a set when a lost or damaged piece causes the rest of the set to depreciate in value. However, in order to receive the full value of a set, the owner must surrender the remaining pieces to the insurer. As an alternative, the insurance contract may permit the owner to keep the rest of the set and receive a cash settlement that covers the depreciation.

Restorations

If a painting or antique is damaged in some way, the insurer might not automatically consider it a total loss. Instead, the insurer may retain the services of an expert who will examine the item and determine if it is possible to restore the item to its full value.

If restoration is possible, the insurer will gladly pay for repairs as an alternative to replacing the item or settling for its insured value. Types of damage that are sometimes reversible through careful restoration include those caused by oxidation, soot or smoke.

Considering a Fine Arts Appraisal?

Whether an owner had an item appraised years ago or is considering having a valuation done on a newly acquired possession, there are a few art-specific concerns that owners should keep in mind. Above all else, art owners should understand that paintings, sculptures and similar items are, in some ways, similar to stocks. Some depreciate over time. Others go up in value over a relatively brief period. Everything depends on attitudes and behaviors within the art market. If owners do not have the desire or the finances to do a regularly scheduled appraisal of their art, they should at least keep tabs on this market and consider contacting an appraiser when supply and demand for their valuables shifts significantly in one direction or the other.

As a way of diving deeper into this point, let's compare the value of a Michelangelo to that of modern art. Even an inexperienced art collector knows that paintings by Michelangelo have been worth a lot of money for a long time, will probably continue to be worth a lot of money for many years and almost certainly should merit some special insurance coverage. On the other hand, many forms of modern art were worth a relatively small amount up until the last few years. But, thanks to a flood of new millionaires who flooded the art market toward the end of the last century, modern art increasingly became a tasteful addition to people's collections. People who had long ago insured their modern art for a small figure saw the value of their property rise to significant heights. As a consequence, insurance companies that underwrote fine arts risks encouraged collectors to have frequent appraisals done on their modern art as a way of maintaining sufficient coverage.

Some fine arts policies anticipate the financial appreciation of paintings and other items by offering a kind of inflation protection. For instance, an insurance contract might call for the policyholder to receive as much as 150 percent of a painting's insured value, depending on how much appreciation has occurred between the policy's starting date and the date of a claim. This kind of policy does not penalize the owner when a claim has been made on a depreciated item. If the item is worth less than its insured value and a loss occurs, the owner is still likely to receive a settlement equal to 100 percent of the insured value.

Preventing Damage to Art and Antiques

Since a claim on a fine arts policy can amount to thousands of dollars or more, it is no wonder that insurers stress the importance of risk mitigation to their customers. This stress is communicated not only through marketing campaigns but also through the premiums different people pay to cover their valuables. In general, applicants who have a passion for fine arts and demonstrate knowledge of how to keep their valuables safe will be rewarded with good coverage at an affordable price. Conversely, applicants who demonstrate carelessness with their belongings may face higher premiums.

Contrary to what many fictional capers depicted in books and movies tend to suggest, theft is not the biggest risk to a work of art. Instead, art collectors and their insurers should mostly be concerned about various kinds of damage that can be sustained by an expensive item. Since we have already touched on damage that can be done to art and antiques in transit, we ought to set those risks aside and focus chiefly on damage that can occur in private homes.

Picking the right room in which to store art and antiques could help minimize the need for future restorations and insurance claims. In this way, expensive art is not comparable to personal keepsakes that can be stashed in a typical basement or attic. It sometimes requires just the right climate in order to remain in good condition.

Since moisture can be destructive, paintings should not be placed in a spot where a leak is possible. For fear of water seepage, some people even claim it is a bad idea to hang a painting on a wall if the wall's other

side is on the home's exterior. Still, a total lack of moisture in the air can cause wood to warp. As a precaution, the art collector may want to put a humidifier wherever paintings are stored.

Minimized exposure to light and controlled fires is essential to preserving artwork. Too much sunlight will cause colors to fade, and placement above a fireplace might put an item in unwelcome contact with smoke.

Art Theft

Now and then, details of an art heist will add some excitement to the evening news. Of note, there was the $200 million theft of 12 paintings, including a Degas, a Rembrandt and a Manet, from a Boston museum in 1990. There were the criminals who went into an Oslo museum in 2004 and came out in broad daylight with Edvard Munch's "The Scream". There were even cases involving the Irish Republican Army in which people's stolen art was being ransomed back to them in a proposed exchange of paintings for prisoners. On the whole though, theft of the world's most priceless paintings probably occurs more often in crime novels than in the real world.

Theft of well-known paintings from museums is rare, and when these cases do occur, there is still a decent chance that the art will eventually be recovered. The reasons why are simple. If a painting like da Vinci's "Mona Lisa" were to disappear, the news would reach most corners of the world and be heard by art experts and non-experts alike. Since practically everyone would know about the theft, the painting would become extremely difficult to sell. Probably the only realistic option available to the thief or reseller would be to find a buyer in a foreign country where laws regarding stolen property are not as strict.

The Art Loss Register

In 1991, the art and insurance communities banded together to fight art theft and created the Art Loss Register (ALR). Through offices around the world, the ALR maintains a database of roughly 170,000 paintings, antiques, collectibles and other items and uses that database to help rightful owners recover stolen property. Individuals can register a lost or stolen item, or they can register a new purchase in order to prove that it does not belong to someone else.

On a broader level, the ALR's database is available to national and international law enforcement entities, including the FBI and Interpol, and assists those entities in finding and redistributing works of art. Among other endeavors, the ALR attempted to hasten the return of items that were looted from museums in Baghdad during the recent Iraq war and has provided free recovery assistance to families who lost valuables during the Holocaust.

The ALR's database is not just for art and is not just for well-known pieces. Though the database generally lists items that are worth at least $2,000, registration is open to virtually any item, as long as the owner pays a fee and can properly identify the item for recovery purposes.

Along with contributions from individuals, the ALR receives money from insurance companies that subscribe to its services. When a lost or stolen item is recovered thanks to the ALR, the organization receives a commission that is based on the item's value.

Buyback Rights

After a claim for a lost or stolen work of art has been paid, the item becomes the insurance company's property. This means that if the item is ever found, it will not automatically go back to the owner. However, some insurers provide "buyback rights" to policyholders.

In general, buyback rights give a person the ability to purchase a recovered item from an insurance company for the lesser of the claim amount or the insured item's market value. If the insurance company has spent any money in an attempt to recover the item, relevant expenses may be added to the buyback amount. For example, the person who repurchases an antique might have to reimburse the insurer for any reward that was given to an informant.

Title Insurance for Art

As German soldiers stomped their way through various countries during World War II, looting stripped many overrun Europeans of their art. Hitler and those who were in charge of raids were on the lookout for examples

of modern art, impressionism, surrealism or any picture that was at all thought to be “un-German” in its color or style.

Some of the captured pieces were either destroyed or sold to other countries. Other pieces were kept intact by the Nazis and marked for inclusion in a nationalistic art museum that Hitler (himself a failed artist) planned to establish. In total, it is estimated that this long and thorough pillage involved at least one-fifth of all the art in Europe at the time.

During the 70-plus years that have followed the war, successive generations have attempted to return plundered paintings and other works of art to their rightful owners. Of course, this has been good news to victimized survivors and their families, but it has put some modern collectors in a tight spot. If a person has spent thousands of dollars on a painting that turns out to have been stolen in a Nazi raid, what happens to the person’s investment when a court gives ownership rights back to the original owner? That question has prompted a recent interest in title insurance for art.

The companies that offer this insurance reimburse collectors when a court orders that ownership of art be transferred to another party. They also cover the defense costs that are related to the case. Premiums can be paid in a lump sum, or they may be payable in yearly installments. Coverage may remain in place as long as the owner does not sell the art or gift it to another party. When the policyholder dies, coverage for the art can extend to the person’s heirs.

Before issuing title insurance for art, the insurance company is likely to conduct its own investigation into the item’s “provenance” or ownership history. If this investigation gives the insurer reason to believe that the item was stolen, the company will refuse to do business with the applicant. According to the ARIS Corporation, which offers title insurance to U.S. art collectors, the results of this underwriting investigation are considered confidential.

Insurance for Museums

An individual’s art collection is often small enough in size and value for the owner to insure each piece fully and separately. Museums, on the other hand, usually lack the resources to follow this risk management strategy. The contents of their collections are often too numerous for scheduling to seem like a practical option, and their collections’ value, sometimes in the billions of dollars, often makes full coverage unaffordable.

Rather than insure each work of art for its independent value, many museums prefer to purchase blanket coverage that can apply to every piece in their possession. Under this kind of policy, there is a cumulative benefit limit and usually a per-item benefit limit. For example, a policy might insure an entire collection for a cumulative total of $1 million and limit coverage of each individual item to $100,000.

Museums and galleries have ways of cutting their insurance costs besides adjusting benefit limits. Out of all the paintings and other works that are likely to be in its care, a museum may opt to only insure those pieces that are on display. Or the museum might decide not to insure its most famous pieces against theft, figuring that a criminal would have too difficult a time reselling those items for a theft to be worth all the trouble.

Underinsured museums are probably more common than outsiders believe. The Boston museum that lost 12 paintings in what is believed to have been the costliest case of art theft in U.S. history had no insurance to cover the lifted pieces.

Museums’ tendency to leave insurance gaps in place speaks not only to the low frequency of theft in these artistic environments but also to the high level of non-insurance risk management that is typically practiced there. Money and time that could go toward securing scheduled coverage for paintings is often spent alternatively on security systems and fire prevention strategies.

The Arts and Artifacts Indemnity Program

After eight million people in seven cities came to marvel at the wonders of King Tut’s tomb between 1976 and 1979, traveling exhibitions featuring paintings, antiques and artifacts started passing through the United States on an increasingly regular basis. But with so much that could go wrong while irreplaceable items are transported around the globe, these tours are understandably difficult to insure through traditional channels.

In an effort to promote the lending of historically significant items from other countries to the United States, the federal government (through the National Endowment for the Arts) introduced the Arts and Artifacts Indemnity Program in 1975. The program provides exhibit-specific insurance to importers and exporters of eligible items when the importer or exporter is a U.S. museum or an American non-profit organization. According to the program's Web site, eligible items can include art, artifacts, historical documents, photos, video tapes and seemingly anything else that is certified by a government designee as being "in the national interest."

Federal insurance can cover an eligible exhibit for up to $1.2 billion and cover multiple exhibits for up to $10 billion at a time. Recipients of the coverage are responsible for a deductible, which can range from $15,000 to $500,000 depending on the exhibit's insured value. As is the case with most commercially available kinds of insurance policies, higher benefit limits require higher deductibles.

Payouts from the Arts and Artifacts Indemnity Program, which are subject to congressional approval, have proven to be very rare. By the early 21st century, the program had insured more than 700 exhibits and paid only two claims for a total of just over $100,000.

Perhaps that thin claims history stems from strict underwriting guidelines. To be eligible for federal coverage, an applicant must already have some experience at coordinating an international exhibit. Applicants must also agree to ship eligible items properly and display them in a secure environment. Fragile items, including glassware, some oil paintings and pieces made of parchment, may be considered too delicate for federal coverage.

If a museum is denied coverage by the federal program, it will need to examine its options with commercial insurers.

Covering Jewelry

An unaltered homeowners insurance policy contains a sub-limit that applies collectively to jewelry and furs. Often this sub-limit is no bigger than $1,000 or $2,000 for both kinds of items, though some companies will increase this amount to $10,000 for an additional premium. Unlike other common sub-limits which are enforced when claims relate to damage or theft, the limit on jewelry and furs is only enforced when covered items are stolen.

Even in high society, furs are not bought as commonly as they used to be. Jewelry, though, continues to be treasured by the general public. Therefore, we will set the subject of furs aside at this point and concentrate on the ways in which insurers cover diamond rings, necklaces and all the shiny, showy decorative pieces in between.

"Jewelry" is a broad term, often undefined in insurance contracts, that can be used to describe seemingly any item that adorns a person's body for a decorative purpose. Belongings that fall into the basic jewelry definition are often made of precious or semiprecious stones or metals, but less-valuable items may be thought of as jewelry, too. Though a fake fur is treated like regular contents in a homeowners policy and is therefore not subject to the aforementioned sub-limit, an imitation piece of jewelry (such as a cubic zirconia) is still jewelry from an insurance perspective and will be subjected to a sub-limit if it is ever stolen.

The good news for many insurance customers is that their jewelry's value is often no higher than their policy's sub-limit, particularly when coverage has been increased to $10,000. The bad news is that the limited number of covered perils in their homeowners policy still leaves them with a major insurance gap.

Because jewelry is usually small, it lends itself well to several kinds of accidents around the house, most of which would not be covered by the typical homeowners insurance policy. A piece that falls on the floor and is sucked up by a vacuum cleaner wouldn't be covered, nor would one that is chewed up or swallowed by a mischievous pet. A woman who loses her cherished engagement ring while washing dishes, only to realize that it has gone down the drain, wouldn't be covered either.

Jewelry Policies and Add-Ons

Add-ons and special policies that insure people's jewelry are similar to those that insure art and antiques. They can insure jewelry for its appraised value, or they can cover a collection and contain a per-item benefit limit. There is often no deductible to worry about, and benefits are available on an all-risk basis.

Besides providing financial protection against countless other perils, the all-risk feature allows the policyholder to file valid claims for "mysterious disappearance." This peril (which might not be covered by the most basic kinds of homeowners policies) is not as narrow as it sounds. A mysterious disappearance can indeed involve a loss that has perplexed the jewelry's owner, but it can also involve a disappearance that an owner can easily attribute to a specific accident. For example, when an owner knowingly but unintentionally drops an insured ring down a drain, the loss is covered as a mysterious disappearance.

One major difference between insurance for jewelry and insurance for art relates to how benefits are calculated at claim time. A work of art is usually considered unique and therefore irreplaceable by an insurance company. So a claim for a total loss under a fine arts policy is likely to result in a settlement that is equal to an item's insured value. However, from an insurer's point of view, jewelry can be replaced by other jewelry of like kind and quality.

The insurance community's attitude toward replacement jewelry permits an insurance company to avoid paying the benefit limit of a jewelry policy, even after a total loss. In this case, the claimant is still entitled to a replacement item of like kind and quality, but the insurer can possibly purchase the replacement at a wholesale price.

Considering a Jewelry Appraisal?

Like all other valuables, pieces of jewelry can only be insured properly if the owner has a good sense of their true value. There are at least a few things to keep in mind if a non-expert is thinking about having jewelry appraised.

Above all else, the owner should have confidence in the jewelry appraiser's expertise and trust that the appraiser's verdict will not be influenced by a conflict of interest. A jewelry store that has sold an item to a customer may be willing to include an appraisal with the item, but the buyer and the insurance company might prefer an appraisal from another source. After all, it is possible, if not probable, that the seller will inflate the appraised value in an effort to make the buyer feel like a savvy and satisfied shopper.

People who possess jewelry made out of gold and silver ought to remember that those metals are common investment vehicles. Their value can rise one day and drop the next. Fluctuations in their value might make expensive appraisals of gold and silver jewelry impractical, but they also give insurance customers a reason to evaluate the size of their coverage on a regular basis.

Product Warranty

Insurance for jewelry can be a great relief when an item is lost or stolen, but damage to a piece does not need to result in an insurance claim on every occasion. Before they contact their insurers, owners of damaged jewelry should recognize that some jewelers offer a limited lifetime warranty for their products. Most likely, this warranty extends to cases in which a stone has become unattached from the rest of the item. In order to keep the warranty in place, the owner might need to bring the jewelry back to the jeweler for regular inspections.

Jewelry Theft and Premiums

Jewelry theft is more common than art theft. This is reflected, to some degree, in the cost for jewelry coverage and in the discounts that are available to extra-careful insurance customers.

While annual premiums for special art coverage are likely to amount to a few cents for every $100 of insurance, annual jewelry premiums can amount to a few dollars for every $100 of insurance. For some applicants, the size of the premium will depend on where they live. Clients who reside in rural areas may be offered lower premiums than clients in urban areas, where theft is considered a higher risk.

People in any community can probably reduce their premiums by agreeing to store their jewelry in a safe deposit box for extended periods. When owners agree to this arrangement, they will need to contact their insurer when the jewelry is removed from the box and contact their insurer again when the jewelry has been put back in its safe place. The premium will be pro-rated to reflect the amount of time that the jewelry was not locked up.

Jewelers Block Insurance

Since the 1880s, insurance companies have tried to address the needs of professional jewelers by selling a product known as “jewelers block insurance.”

Jewelers block insurance covers the inventory of jewelry shop owners and wholesalers. Annual premiums may equal a few percentage points of the inventory’s insured value, but coverage and cost can be adjusted so that they are in step with a policyholder’s business cycle. For instance, a shop owner may decide to have one level of coverage for 11 months of the year and an increased level of coverage in December, when approximately one-third of all diamond sales take place.

Before issuing coverage, underwriters who deal with commercial jewelry are likely to evaluate an applicant’s premises and daily procedures. Security systems and the manner in which inventory is displayed to the general public will be especially important.

To be eligible for coverage, a jewelry store may need to have at least two employees on site while the store is being opened or closed. Showcases will need to be equipped with locks, and items may need to go into a safe if the store is going to be unoccupied at any time. While showing pieces to customers, an employee might be permitted to unlock only one case at a time, and the store itself might limit the number of individual items that can be taken out of an unlocked case for a customer’s perusal.

If jewelers block policyholders misrepresent their commitment to security, or if they do not follow an insurer’s security requirements, their theft claim can be denied.

Covering Stamps, Coins and Other Collectibles

There are many reasons why Americans collect things. A stamp collection might be a cherished item that represents a bond between the parent who started it and the son or daughter who kept it growing. A baseball card collection may be something that has nostalgic value for people who miss the summers of their youth. Or, at a basic level, a box of movie memorabilia might just be something that helps introduce like-minded strangers to one another and nurtures some lasting friendships.

Unfortunately, an insurance company cannot reimburse owners for all the love and time that went into a lost, stolen or damaged collection. But it can offer policies that cover the monetary value of people’s favorite things.

All collectibles can be insured up to a point through a typical homeowners insurance policy. However, some of the most traditional kinds of collections may not be covered for all that they’re worth. Stamps and other fragile items made out of paper will only be covered up to a certain dollar amount if they are damaged or stolen. Depending on the policy, this sub-limit can range from a few hundred dollars to a few thousand dollars. Similarly, a homeowners insurance policy will have a sub-limit of a few hundred dollars for collectible paper money and coins.

Additional coverage for stamps and coins might not be important to people with small collections, but big-time collectors might have an interest in it. Deals on special policies for these items are sometimes available to members of hobby associations, such as the American Philatelic Society (which is comprised of stamp collectors) and the American Numismatic Association (which is comprised of coin collectors).

Insurance for other collectible items (stuffed animals, toys, memorabilia, etc.) usually does not involve any sub-limits. Still, owners sometimes buy add-ons and special policies for these things in order to obtain all-risk coverage.

Shopping around for special insurance for collectibles has its plusses and minuses. On one hand, an insurer might have reason to view some collectibles as low risks for theft. After all, a common thief probably doesn’t have his or her pulse on the market for mint-condition action figures and, therefore, probably wouldn’t waste

valuable time sifting through a victim's toys. That said, the claims history for various collectibles is relatively thin, making the magnitude of other risks unclear to many underwriters.

If an insurer does not specialize in covering collectibles, the cost of insuring unconventional items with that company may be relatively high.

Covering Musical Instruments

In some cases, an instrument can be just as valuable as a work of art. A violin, in particular, can be worth a large amount of money depending on who made it and how many similar pieces are thought to exist.

Unlike a work of art, an instrument often cannot maintain its market value if it is kept in storage or put on display in a glass case. Optimum sound may only be achievable if the instrument is played regularly. Of course, playing an instrument on a regular basis opens the door for accidental breakage, a risk that is not covered by a basic homeowners insurance policy.

Professional musicians have it even tougher since their instruments are considered business property, which receives only minimal coverage under a homeowners insurance policy. A property insurer may have an income-based cutoff point that separates professionals from non-professionals. If so, a musician may be able to play occasionally for money and still have some losses covered by homeowners insurance.

Musicians of all skill levels can buy an add-on or a separate policy to eliminate these coverage gaps. An insurance contract that specifically caters to musicians is likely to cover instruments and musical equipment on a worldwide, all-risk basis.

Beyond that, policy features may be unique to each insurer. Some policies have a deductible for each loss, while others do not. Some policies will cover theft from an unattended vehicle, while others will exclude it.

Covering Fine Wines

A wine collection can be a financial asset as well as a source of rich dinnertime enjoyment. But maintaining a fine assortment of flavors can be a risk-filled challenge if the owner is not careful.

People who collect expensive wine need to keep their bottles in a controlled environment in order to allow for the natural aging of the grapes. The ideal environment has very little light and an ideal temperature between 55 degrees and 60 degrees. Owners also need to keep everyone's clumsiness in check so that a highly valued vintage is not dropped or knocked over.

Because neither a temperature problem nor accidental breakage is usually covered by homeowners insurance, a collector will sometimes purchase special coverage for wine in the form of an add-on or a separate policy. Wine collectors can schedule each bottle for its own amount of coverage, or they can insure every bottle for the same amount with blanket coverage. If they wish, they can even combine the two methods by scheduling a particularly valuable bottle and covering everything else with a blanket policy.

Whichever way they choose to cover their collection, owners who drink a bottle of wine or give one away as a gift will want to inform the insurance company of their action. That way, the owner will not continue to pay for coverage that is no longer necessary.

Conclusion

Admittedly, many of the add-ons and special policies that have been the stars of the last several pages can be thought of as niche products. With the possible exception of jewelry, they cover items that the typical American family might not own. They do, however, demonstrate how well insurers have recognized the uniqueness of each possible applicant.

By offering special products that can be adjusted or formulated to cover seemingly all types of personal property, insurance companies are building relationships with people who have intriguing passions. Their commitment to offering these products to all kinds of collectors is likely to help the industry add to its own collection of satisfied customers.

CHAPTER 7: THE IMPORTANCE OF FAIR CLAIMS PRACTICES

Introduction

Insurance producers are taught to analyze people's needs, explain important policy provisions and engage in other ethical sales practices. But the well-intentioned efforts of an agent or broker at the front-end of an insurance transaction won't matter much if a policyholder ends up having a negative claims experience. Consumers who have just suffered a loss are unlikely to care how little they may have paid for coverage or how friendly an agent acted toward them when they purchased their policy. All they will want at that moment will be a quick, fair settlement from their insurance company.

Claimants who don't receive the kind of compensation they expect from their insurer are likely to take their business elsewhere. A survey released in 2012 by J.D. Power and Associates found that property insurance claimants who reported low satisfaction with their insurer's claims process were nine times as likely to switch carriers than claimants who reported a high amount of satisfaction. The same document, known as the "J.D Power and Associates 2012 Property Claims Satisfaction Study," also said lowly satisfied claimants were roughly five times more likely to at least shop around for a different insurer within the next year than highly satisfied claimants. Even if a dissatisfied policyholder decides not to look for other coverage or switch insurers, that person is unlikely to recommend the carrier to anyone and may even harm the company's reputation through bad word of mouth.

As long as we assume a claimant is not engaging in fraud, it shouldn't be difficult to understand why a denied or held-up request for insurance money can provoke so much anger. An insurance policy is, after all, a contract between the entity paying for coverage and the company issuing it. The entity paying for coverage agrees to pay premiums on time and to not misrepresent material facts. In return, the company issuing the policy agrees to provide money after a loss in accordance with the policy's language. Rightly or wrongly, an insurer that denies a claim or waits a long time before paying it might appear to be breaching its contractual obligations to the consumer.

Courts and regulators who believe an insurer has acted in bad faith toward claimants might have the power to impose serious sanctions on the company. Arguments over a small amount of money can result in tremendous penalties. For example, a 1992 dispute in California regarding nonpayment of $192 ended in a $30,000 fine being imposed by the state's insurance commissioner.

The Producer's Role in Claims

Although producers are paid mainly to market and sell insurance products, they may be called upon to assist with the handling of claims. In some cases, the producer might have direct involvement with a claim, including the ability to authorize small payments. At other times, the producer will have no authority to provide compensation but will be asked by a consumer to intervene in a claims dispute.

Producers who receive questions from claimants don't need to provide an opinion regarding whether a loss should be covered, but they should at least be able to provide a general explanation of what the claims process will entail. Once a claimant has been informed of what to expect, the producer can contact the adjuster assigned to the case and try to obtain some answers.

Producers who are hesitant to engage in the claims process might want to think about how their behavior could jeopardize renewals. The aforementioned study from J.D. Power and Associates found that a claimant's level of satisfaction increased with greater involvement from agents. Greater satisfaction with the outcome of a claim makes it more likely that a policyholder will remain with his or her current insurance company.

Meanwhile, independent agents who resist involvement with claims shouldn't assume that an angry claimant who switches insurers will still want to work with the same independent producer. An insured may decide that an agent who doesn't help with claims isn't an agent worth having.

Producers should also keep in mind that the people who purchase insurance have invested some trust in them. Because they lack much insurance-related experience, typical consumers are likely to believe an agent or broker who oversells a positive policy feature and fails to mention contingencies or exclusions. For example, a first-time homeowner who is told she has replacement-cost coverage might not be aware that

this kind of coverage, in and of itself, does not guarantee there will be enough money to completely rebuild a building. Similarly, she might not understand how losses from hurricanes might be exempted from coverage on the basis of a flood exclusion. Unless she takes the time to carefully examine her policy (something consumers are not likely to do), she will only learn about these things if the person selling the insurance mentions them or if she actually experiences these kinds of losses.

Providing thorough and compassionate service during the claims process might not be enough to fully satisfy a confused policyholder, but it might reduce the producer's chances of being verbally attacked for allegedly poor disclosure.

The Claims Process

Because the claims process is designed to help policyholders receive the benefits they've been paying for, producers may find it helpful to explain ahead of time how the process works. At the very least, when an insurance policy is delivered to an insured, a producer can explain where information about claims can be found. Mentioning the process at that time might make it more likely that the insured will review those sections of the policy carefully and be more prepared if a loss ever arises.

Duties of the Insured

Consumers who experience a loss should report the situation to their insurance company as soon as possible. In most cases, this is accomplished by calling a toll-free number that is being staffed by customer service representatives. However, a policyholder who has a good relationship with an insurance agent or broker might turn to that particular producer first. An increasing number of companies are also letting their customers report claims online.

Once the loss is reported to the insurance company, the policyholder should receive a reference number for the claim and contact information for the insurer's claims department. Regardless of whether a loss is first reported to an agent, customer service representative or claims adjuster, the claimant should receive clear instructions regarding what to do next and what to expect. Providing detailed instructions to claimants as soon as possible is important because there are usually deadlines for submitting proof of a loss to the insurer.

The duties of the insured will depend in part on the nature of the insurance claim. A claim for a life insurance settlement might not be approved until the claimant has given the insurer a death certificate or other evidence of death. If the claim in question relates to casualty insurance, the insured might need to submit copies of any formal demands for money by third parties. For some health-related claims, including those for disability or workers compensation, a sick or injured person might need to consent to having his or her medical records examined by insurance representatives. Property insurance claimants will need to grant the insurer access to the damaged property and must take reasonable steps to keep the damage under control. These steps might include putting boards over broken windows or moving personal property away from a leaky ceiling.

The more information provided to the insurer at claim time, the faster the process will be. With this in mind, policyholders should be encouraged to keep good records long before they ever experience a loss.

Detailed home inventories—whether written down or comprised of photographs—make it less likely that an insurance company will dispute ownership of damaged items. Meticulous accounting by business owners can minimize problems if a company ever needs to close due to a natural catastrophe and files a business interruption claim.

Careful recordkeeping should continue after the main loss has occurred and should include documentation of any loss-related expenses. For example, homeowners should keep receipts for hotel and restaurant bills if they have been displaced by a weather-related disaster. Extra expenses that businesses incur in order to begin operating soon after an interruption should be documented, too. Unless the homeowner or business is severely uninsured, reimbursement for at least some of these expenses is available.

The insurance policy itself will, of course, be another very important record during the claims process. In today's business world of comprehensive databases, a claimant who loses the policy or doesn't have the policy number readily available shouldn't experience major problems when reporting a loss. Still, the

document can be an immeasurably helpful reference for someone who keeps it in a safe place. It may serve as a refresher to the claimant regarding his or her duties after a loss. And perhaps more importantly, it can help the claimant anticipate how a particular claim is likely to be treated by the insurance company.

Insurance Adjusters

After a claimant notifies the insurance company of a loss, the person's case will often be passed along to a specially trained "claims adjuster." A claims adjuster evaluates whether the loss should be covered at all and, if so, for how much. Good claims adjusters must have extensive knowledge of policy language, an up-to-date understanding of how value is measured, and an ability to make fair decisions in a reasonably quick amount of time. Adjusters can be involved in seemingly any kind of insurance, but they tend to be most commonly associated with property and casualty losses.

Adjusters can be classified by the kind of relationship they have with insurance companies. For instance, some adjusters are employees of a single insurance company. These adjusters may or may not need to be licensed, depending on the particulars of state law.

Adjusters known as "independent insurance adjusters" work on behalf of an independent "adjustment bureau" and are called into action when an insurance company either doesn't have enough of its own adjusters in an area or needs someone with special expertise. Many states require these adjusters to be licensed, but licensing rules are sometimes relaxed temporarily after a natural disaster.

Individuals known as "public adjusters" represent claimants during the claims process and do not work for or on behalf of an insurance company. Public adjusters typically must be licensed in their state of business and will earn a percentage of whatever settlement a claimant receives from the insurer.

An adjuster who is set to receive a percentage of a settlement might feel tempted to inflate loss estimates in order to make more money. Similarly, adjusters who receive bonuses from insurers might put pressure on themselves to keep the size of settlements down. Despite the loyalties adjusters might owe to insurers or claimants, they obviously shouldn't let compensation have an inappropriate influence on their valuations.

Communicating With Claimants

Insurance company representatives must communicate with claimants in a timely manner during various stages of the claims process. This duty, of course, includes paying valid claims soon after liability has been made clear to the insurer. It also exists in regard to returning messages left by claimants and making sure they receive the necessary paperwork to properly report a loss. Even if the insurer's liability for a claim is uncertain, the claimant should be made aware of what's happening and the reason for it.

Many deadlines and other requirements for communicating with claimants are set by state law. Most states base the deadlines on model regulations created by the National Association of Insurance Commissioners (NAIC). The NAIC's Unfair Claims Settlement Practices Model Regulation is intended to apply to practically every insurance company and mentions the following deadlines and responsibilities:

- Within 10 days of receiving an inquiry from a claimant, the insurance company must respond.
- Within 10 days of being notified of a loss, the insurance company must provide necessary claim forms to the claimant.
- Within 30 days of being notified of a loss, the insurance company must complete its claim investigation.
- Within 15 days of receiving proof of loss forms from a first-party claimant (a claimant seeking coverage through his or her own policy), the insurance company must inform the claimant whether the claim has been approved or denied.

The model regulations provide some leeway when an insurer legitimately needs more time to make a claims decision. An insurer that can't easily determine its liability for a first-party claim can send the claimant an explanation within 15 days of receiving proof of loss forms instead of having to make a hasty decision. However, if the delay lasts another 45 days, a second notice with an explanation must be sent to the claimant.

Keep in mind, though, that the requirements mentioned here are merely model regulations. Each state has the authority to reject the NAIC's recommendations in their entirety or in part. Deadlines and other requirements tend to differ slightly from state to state.

Despite the importance of laws, obeying them right down to the letter won't guarantee a good relationship between an insurer and the public. Consider a situation in which a claimant has suffered a major loss and has contacted a claims adjuster or an insurance agent. If the adjuster or the agent assures the claimant that insurance money will be provided by a specific deadline, the claimant will treat this news like a promise. Even if there is a legally legitimate issue that delays payment beyond the provided deadline, the claimant may have a right to be angry and may complain. This sort of problem can easily be managed by not making promises that can't be guaranteed or by informing the claimant as soon as possible when promises need to be broken.

In cases where claims need to be delayed or denied, providing as much communication as possible is usually the best policy. In fact, claims rules in the United States typically say a notice of denial must include detailed information about the reason for the rejection. The required information for this type of notice includes references to the portion of the claimant's insurance policy on which the denial is based. First-party claimants who receive this notice and have kept a copy of their policy can then refer back to the whole document and determine whether their insurer is reading the contractual language fairly. Third-party claimants (such as an injured person making a claim against another driver's insurance) usually don't have the right to receive this specific information about other people's insurance policies.

Settling Disputes With Consumers

When consumers believe a claims decision is unfair or inappropriate, they often have the ability to appeal the decision through some kind of internal review board. A written explanation and other documents might need to be provided to the entity conducting the review. In many situations, this or another internal process is enough to settle the claim. In some cases, for example, the insurer might conclude that all or part of a claim was inappropriately handled because of a clerical error or an honest misunderstanding.

If disputes with an insurer can't be resolved internally, arbitration is another possibility. In arbitration, the carrier and the consumer both pay to have the matter settled by a third party. By engaging in arbitration, both sides agree to abide by whatever arrangement the arbitrator produces.

When disputes aren't settled through arbitration or internal reviews, consumers can file a complaint with their state's insurance department. A claimant might also take legal action in order to make sure that the contractual provisions of the insurance policy are enforced. In some jurisdictions, claimants can sue for bad faith and receive judgments beyond the amount of their insured losses. We'll go over this issue in greater detail later in this chapter.

Claims Issues in Specific Lines of Insurance

Many ethics-related claims issues touch professionals in all areas of insurance, but others are specific to certain lines. Some concerns that are mainly relevant to particular corners of the business are addressed in the next several sections.

Property Insurance Claims

Small property insurance claims might be settled entirely through the sending and receiving of paperwork, but larger ones will require an onsite inspection by an adjuster. During an inspection, the adjuster might snap several photos and scribble several notes. Unless they are absolutely necessary, no repairs should be done until the inspector has viewed the damage.

Access to damaged property will be granted to the insurance company as part of the owner's policy. Consumers who deny access after a loss are in danger of not receiving the insurance money they might otherwise deserve. Still, the access required by the contract might not need to be unlimited. In fact, according to NAIC model regulations, insurers who deny claims because of a claimant's failure to provide access must prove the claimant was being unreasonable. Presumably, this could protect a claimant who denies access at a particular time for personal reasons but is very willing to reschedule.

Catastrophic Claims

A hurricane, tornado, terrorist attack or similarly major event can produce thousands of claims. Even if an insurance company pays a large percentage of them, the sheer number of claims makes it inevitable that a large number will be denied. Insurers who aren't proactive during the rebuilding of hard-hit communities will expose themselves to potentially unshakable public relations problems. Companies taking unreasonable positions toward claimants after a catastrophe are also at great risk of being named in a class-action lawsuit.

The importance of dealing with claims in as timely a manner as possible is at its greatest following a major or total loss. Dissatisfaction with an insurance company is certain to increase if a delay in the claims process means that a business can't re-open its doors or that a family needs to remain in temporary housing. In some cases, claims from major disasters such as Hurricane Katrina have gone unresolved for several years.

Although insurers have the right and the obligation to ensure that money isn't provided to perpetrators of fraud, they should recognize that delays in providing legitimate compensation can ultimately lead to more losses. The sooner a family can start rebuilding their home, the less the insurer will have to pay for additional living expenses like hotel and restaurant bills. The quicker a business is able to get up and running with the help of insurance money, the smaller its business interruption claims will be.

One of the simplest yet most effective actions an insurer can take after a catastrophe is to be noticeably present in the affected area. These days, it's customary for companies to set up several mobile offices in damaged communities and bring in additional adjusters by the busload. In order to expedite claims processing, states will often loosen licensing requirements so that out-of-state adjusters can give quick service to residents.

Some ethics-based decisions might need to be made before adjusters arrive at a disaster area. Questions for managers and top-level insurance professionals to answer include the following:

- Should claims be processed on a first-come, first-served basis, or should a major loss take precedence over a comparatively minor one?
- Should grace periods be extended for disaster victims who are late in paying their premiums?
- How aggressively should the insurer enforce controversial exclusions, such as an anti-concurrent causation clause? (An anti-concurrent causation clause prevents a claim from being paid if it is linked to both a covered peril and an excluded peril.)

The answers to those questions will need to be found very carefully, with attention paid to the concepts of fairness, good will and the insurer's financial stability.

Auto Insurance Claims

Disputes regarding auto insurance claims often involve replacement parts or the insurer's relationship with auto-related businesses. Arguments over replacement parts arise when an insurer initially offers to pay for parts that are inferior to what was originally in the vehicle. For example, the insurer might offer to pay for the poor-fitting part instead of the more appropriate part available through the vehicle's manufacturer. Some companies might not be totally opposed to replacing a part with a true replacement, but they might make the process difficult for the repair shop by requiring multiple approvals and inspections. The use of cheaper parts may save the insurer money in the short term, but it can lead to future losses if the cheaper part is truly inferior and breaks down.

Insurers may be accused of unethical behavior if they engage in a practice known as "steering" during the claims process. In the context of auto insurance, steering occurs when an insurance company refers claimants to other businesses with which it has a financial relationship. Examples of steering include cases where drivers are referred to body shops that will accept lower payments from the insurance company. A similar situation might occur in a rental scenario in which a claimant needing a replacement vehicle is referred to a rental company willing to take less money.

For many consumers, the ethical issues involved with steering come down to a matter of choice. Most claimants probably understand that an auto insurance company has well-established relationships with body shops and rental-car providers. As long as they receive good service at minimal or no cost, many claimants

won't be opposed to working with an insurer's favored businesses. However, drivers who have a preference for a particular body shop or rental company shouldn't be misled into thinking they don't have other options.

In many states, it is illegal for an auto insurer to only cover repairs when they are completed at a favored shop. Even when insurers give the consumer the choice of going elsewhere, they shouldn't influence the claimant's decision by making potentially false statements. For example, it may be unethical (or even illegal) for the insurer to stress that repairs done by a different shop are unlikely to be completed properly or quickly.

Casualty Insurance Claims

Casualty insurance often calls on the insurer to cover the cost of defending the insured. The insurer's duty to provide a defense is generally considered to be broader than its duty to pay for a settlement or court-awarded damages. In other words, unless it is already clear that the situation surrounding the claim is excluded from coverage, the insurance company is expected to pay for a defense. The insurer generally cannot refuse to defend an insured in a situation in which its liability is still uncertain.

Conflict often arises in casualty situations when the party taking legal action against the insured has proposed a settlement but the insured and the insurer can't agree about whether to provide it. In most of those cases, it is the insured who is hesitant and the insurer who wants to offer the settlement. A doctor being sued for malpractice, for instance, might not want to settle a case because a settlement is sometimes seen as an indirect admission of guilt.

But there have been instances in which the insurer has been the reluctant party and been convinced that a judge or jury will rule in the policyholder's favor. This stance must be analyzed with tremendous care. Again, suppose a doctor has been sued for malpractice. The plaintiff has offered a $500,000 settlement, but the doctor's insurer has rejected the offer because the case against the doctor seems frivolous. If the insurer misjudges the case and loses in court, the awarded damages are likely to be higher than the rejected $500,000 settlement and could even be greater than the doctor's insurance limits. In some cases like this one, courts have ordered casualty insurers to pay the entire amount of any judgments, including amounts beyond a policy's limit.

Third-Party Claimants

Casualty insurance claims might be made by the insured or by a "third-party claimant." A third-party claimant is a person or entity making a claim against somebody else's insurance. For example, a driver who is involved in an accident in which another driver was at fault might make a claim against the at-fault driver's insurance.

Situations involving third-party claimants can create ethics-related difficulties for insurers. If fault regarding an accident is in dispute, the insurance company might have to deal with a third party who wants his or her claim to be covered and a policyholder who wants the same claim to be denied. In auto insurance, for example, a third-party claimant who doesn't have comprehensive insurance on his own vehicle might demand that another driver compensate him for property damage. At the same time, the other driver might not believe she caused the accident and might worry that a successful claim against her insurance will boost her premiums.

Disputes with third-party claimants often cause insurers to think about contractual relationships. The contractual relationship established through an insurance policy is generally between the insurance company and the policyholder. Since a third-party claimant lacks a contractual relationship with the policyholder's insurer, the third party might not be obligated to receive the same level of cooperation with the carrier. For example, although insurance companies often need to disclose which portion of a policy was used to deny a claim, this requirement typically doesn't apply to third-party claimants. In certain situations, the details of a policyholder's coverage might be privileged and private information and won't be disclosed to others without consent.

Still, the lack of a contractual relationship with a third-party claimant doesn't entirely excuse the insurer from certain requirements. In states where the NAIC's Unfair Claims Settlement Practices Model Regulation has been adopted, insurers might not be allowed to advise third-party claimants to make claims against their own insurance when the insurance company's customer is clearly the one at fault.. So, if it is reasonably

clear that a homeowner suffered damage due to a neighbor's negligence, the neighbor's insurance might not be allowed to tell the homeowner to make a claim against his own insurance.

Options for dissatisfied third-party claimants differ from state to state. At the very least, a third-party claimant who is receiving unethical service from someone else's insurer can file a complaint with the state's insurance department. A minority of states let third-party claimants sue insurance companies for unfair claims practices.

Unclaimed Life Insurance

Life insurance claims tend to be significantly easier to settle than property or casualty insurance claims. Presumably, a lot of the relative ease involved with life insurance claims exists because the policies contain simple face values. Proof of death, such as a death certificate, makes it nearly certain that the insurance company will need to compensate a beneficiary, and the clearly defined face amount makes it obvious how much the compensation should be. Unless there is a dispute regarding a double indemnity provision (in which the beneficiary may be entitled to double the death benefit) there is usually little or no argument over the size of the settlement.

This assumes, of course, that the beneficiary is aware of the life insurance policy in the first place. Life insurers face an ethics issue when a policyholder has died but no one has stepped forward to make a claim. Beneficiaries may be unaware of their right to life insurance benefits if they weren't closely involved in the deceased's finances or if the policy in question was purchased several years ago.

Though specifics differ by state, unclaimed life insurance benefits will remain with the insurance company for at least a few years after a death. During that time, the insurance company is able to invest the money within reason and keep the resulting interest. At the end of this period, the money is usually transferred to a state fund, and the state will earn interest on the death benefit until a beneficiary claims it.

Critics of the life insurance industry sometimes wonder if the potential to earn interest on unclaimed death benefits discourages companies from confirming deaths and contacting beneficiaries. Among other evidence, they cite cases in which insurers have searched through death records from Social Security in order to cut off annuity payments but not to determine whether someone covered by life insurance has died. In their defense, insurers point out that policy language only requires payment of death benefits when a beneficiary has filed a claim.

Over the past decade, several states have passed laws or implemented rules requiring that life insurers make a good-faith effort to contact life insurance beneficiaries by a certain time.

Regulation of Claims Practices

The options for consumers who believe an insurer hasn't handled claims fairly will depend on state law and related court decisions. However, the ability to file a complaint with a state insurance department exists across the country.

In accordance with the NAIC's Unfair Claims Settlement Model Regulation, insurance companies are expected to maintain detailed records. These records are meant to help the insurance department determine how a claim was handled and for what reasons. The model regulations also call for insurers to respond to inquiries from regulators as fully as possible and within 15 days of a request.

Some state insurance departments will only take disciplinary actions against an insurer for poor claims handling if they have received multiple complaints about the same carrier. If the department determines that an insurer's unfair response to a claim is a general business practice rather than an isolated incident, it may impose fines amounting to several thousands of dollars. Not all complaints will lead to fines, but even the threat of a state-conducted audit is sometimes enough to get a disputed claim paid.

The ability to take action against an insurer in a manner other than complaining to the insurance department can differ significantly by state. In general, policyholders have the right to sue the insurer for breach of contract, but this route has a few potential roadblocks to consider.

One major drawback to suing for contractual liability is that the amount awarded to the policyholder might be limited to the amount of the disputed claim. The party filing the lawsuit might not be allowed to receive compensation for punitive damages or pain and suffering.

In cases where this kind of cap exists, a claimant might not be willing to take an insurer to court over a relatively small loss. Furthermore, third-party claimants—such as an accident victim making a claim against another driver's liability insurance—might not have the option of suing for breach of contract. After all, the contractual relationship established through an insurance policy is between the insurance company and the policyholder. In general, the contractual relationship isn't between the insurance company and someone who sues the policyholder.

Realizing how much a delayed or unpaid claim can impact consumers, several states have either written or interpreted unfair claims laws in a manner that lets policyholders seek damages beyond the contractually owed amount. Still, states don't always agree on the rights of third-party claimants in these situations. They also differ on whether a consumer needs to prove that the insurer acted unfairly as part of a general business practice.

The removal of barriers to suing an insurance company is often encouraged by consumer advocacy groups, but insurers often claim that allowing more legal action against them could result in negative consequences. Mainly, if insurers are constantly worried about being taken to court over claims, they might become less inclined to investigate fraudulent losses. Then, if the insurer provides more money to perpetrators of fraud, the cost of coverage for honest consumers could go up. You'll read more about the fine line between fair claims practices and fraud prevention later.

Unfair Claims Settlement Practices

Claims-related penalties are more likely to be above and beyond the amount actually being disputed if the insurer is accused of an "unfair claims settlement practice." This kind of accusation can be made if an insurer unfairly denies a claim or in situations where the insurer makes a claimant wait an unreasonable amount of time before finally providing payment.

Many of the specific actions that rise to the level of an unfair claims settlement practice are set by state law or state rules. Several of the more commonly prohibited practices are mentioned in this section. Each mentioned practice is followed by a basic example:

Denying a claim without conducting an appropriate investigation: Following a combination of an earthquake and a fire at his home, Joe files a property insurance claim. Joe has coverage for fire losses but not earthquake losses. Instead of sending an adjuster to determine how much each peril contributed to the damage, his insurance company denies his entire claim outright.

Failing to settle a claim when the insurer's liability is reasonably clear: Wayne and Mary are involved in a car accident in separate vehicles. Although Wayne freely admits the accident was his fault, his insurance company delays compensating Mary for her losses and instructs its legal team to find a loophole in the policy so it can deny all claims.

Intentionally offering to settle for an amount below what the claimant actually deserves: Laurie's home was broken into by robbers, who stole most of her personal possessions. She has kept good records of what she owned and was sure to purchase coverage that was in line with what her belongings were actually worth. However, her insurance company views the settlement process as a negotiation and decides to offer her a much smaller amount. (This practice is often referred to as "lowballing.")

Withholding money for a covered portion of a claim while disputing the rest of a claim: Sarah's home was damaged by a hurricane. She and her insurer agree that at least a portion of her losses are covered. Coverage of her other losses are in dispute and depend on the wording of a flood exclusion. Rather than at least give her the money for the uncontested portion of her losses, her insurer decides to give her nothing until the flood-related dispute has been settled.

Requiring a deadline for providing proof of loss that isn't stated within the insurance policy: Ben was listed as a beneficiary on his father's life insurance policy. The policy wasn't discovered until nine months after the father's death. Although the policy lists no deadline for providing proof of a death, the insurance

company denies Ben's claim and says he should've provided a death certificate within six months of his father's passing.

Refusing to pay a claim because other sources of compensation may be possible: George slips on a neighbor's steps and hurts his back. His health insurance company refuses to pay his medical bills because it holds the neighbor responsible for the accident. George's insurance policy makes no mention of this kind of situation, yet his insurer tells him he has no choice but to sue his neighbor.

Failing to make claimants aware of statutes of limitations: Roberta has been fighting with her health insurance company over unpaid doctor bills for nearly two years. After those two years, she will not be allowed to take legal action against the insurer. The insurance company knows her deadline is approaching but doesn't disclose it in a timely manner. The deadline passes, and Roberta is left without the ability to have the matter settled in court.

Reducing or eliminating policy benefits in order to facilitate a quicker settlement: Jean's home requires major repairs after a fire. The amount offered by the insurer won't be enough to restore the home to its prior condition. In order to convince Jean to accept this amount, the insurance company stops paying for the apartment where she and her family are temporarily residing.

Fraud and the Producer's Role

Some insurers believe an increasingly strict interpretation of claims laws might discourage adjusters from fighting fraud. If the cost of being sued is higher than the amount of a suspicious claim, it might make short-term economic sense to pay the claim and move on. The risk of an expensive lawsuit, along with the desire to avoid public relations disasters, creates an awkward situation for insurers. No matter what decision they make in regard to a claim that shouldn't be covered, the insurer's financial outlook may be damaged.

Whether they realize it or not, producers may have a few chances to reduce the stress felt by fraud-conscious adjusters. Since the producer is often the insurance representative who has had the most personal interactions with a consumer, the producer may be able to vouch for the person's character. Although a producer's positive opinion about a claimant might not be a good enough reason to abandon a fraud investigation, it may be one of many tools that can lead to a fair decision.

While meeting with applicants and noting their character, producers can explain and debunk many insurance myths. By reminding property insurance applicants that their policy won't cover losses from floods or earthquakes, producers reduce the chances of a flood-related or quake-related claim causing dissatisfaction. You can't force a consumer to read an insurance policy, but you can take time to judge the person's comprehension of the important points.

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