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TABLE OF CONTENTS

CHAPTER 1: RISK MANAGEMENT PRINCIPLES

Introduction

A lot can go wrong on any given day. We might oversleep and be late for an important meeting. Slick roads and irresponsible drivers might cause us to be the victims in a costly car accident. Our newest employee might make an innocent mistake that ends up costing our business thousands of dollars. Customers might opt to leave us and obtain products or services from our competitors. Exhaustion might contribute to a testy conversation with our significant other and lead to an ugly shouting match. Distracted by our foul mood, we might unintentionally cut ourselves while making dinner and require medical attention. But no one knows for sure. We can't predict the future, and life offers few guarantees.

Every moment comes loaded with many different risks, and we can neither fully ignore nor become completely consumed by them. To be productive and even the least bit happy, we must be mindful of our own safety without letting uncertainty paralyze us with fear. In both our personal and professional lives, we need to engage in risk management.

The good news is we already have some experience at managing risk, even if we haven't acknowledged it yet. For example, you might already set an alarm clock so you wake up on time. You probably have insurance in case you're ever in an auto accident or need emergency medical care. You almost certainly treat your customers well in order to earn their loyalty. If you hire a new worker, you might place limits on the person's authority until he or she demonstrates sufficient competency and judgment. And if you're in a bad mood, maybe you try your best to avoid confrontation by thinking before you speak.

We can become even better at managing risk by reviewing some of the formal, systematic procedures that experienced risk managers often use to identify, lessen and cope with the unknown.

As an insurance professional, you already understand how the products you sell can address major risks. This chapter is intended to let you build upon that existing knowledge. It will help you see the bigger, broader picture of risk management, where insurance appears in it and—despite our potential biases—why insurance might not be the only solution to a problem.

The Money-Making Argument for Risk Management

Given all the other demands on our time and wallets, many people might dismiss risk management too quickly and view it as a waste of resources. However, greater attention to this discipline doesn't necessarily come at greater expense. In fact, risk management can often be part of a smart financial strategy for the following reasons:

- Investing in non-insurance forms of risk management—such as burglar alarms, sprinkler systems, wellness programs and employee training—can make insurance applicants more attractive to insurance companies and thereby result in lower insurance costs.
- Thinking ahead about how to handle risks that could result in significant losses can reduce the severity and duration of those losses. For example, a business that already has a disaster plan in case of fire is likely to reopen quicker after a blaze than a business that remains oblivious to this risk.
- Knowing more about the risks involved with a proposed new venture can actually make people more comfortable pursuing the opportunity. For example, an investor who has extensive knowledge about the economy might actually feel more

comfortable taking chances in the stock market than someone who knows nothing about current financial issues.

- Worrying about risk can create tremendous stress, which can distract people from important goals, including those that could lead to greater wealth. Similarly, if people are forced to constantly react to the negative consequences of small risks due to poor planning, they might not be able to devote adequate resources to bigger problems that are more worthy of their attention.

Although taking risk management to an extreme can produce inefficiencies and diminishing returns, most of us—not to mention your insurance customers—can benefit from more education about risk and how to handle it.

Risk Management vs. Insurance

In general, the risk management process involves identifying risks, measuring those risks and figuring out what to do about them. Based on that description, you can probably already see why there is a strong link between risk management and the insurance industry. You'll be reminded of those important connections at various points in this chapter, but let's first highlight the important differences between the two fields.

Risk management has always been practiced to some degree, but its roots as a formal discipline reach into the corporate environment and the challenges faced by commercial insurance buyers in the mid-twentieth century. Crises involving safety, pollution, natural disasters, lawsuits and financial busts caused tightening in the insurance market, with higher prices and shrinking coverage. Awakened to new threats to their livelihood, business owners turned to their organizations' insurance experts and hoped to uncover solutions to problems that even a good insurance policy was unlikely to fix.

Risks might be uninsurable for any of the following reasons:

- The size or likelihood of losses associated with the risk cannot be calculated by insurance actuaries. (This is common when relatively new risks emerge and tends to last until insurers have enough time and experience to gather sufficient loss-related data.)
- The probability of losses associated with the risk is too high. (This explains why insurance applicants with a spotty claims history often struggle to obtain good coverage.)
- The size (as opposed to just the probability) of potential losses is considered too high. (This concern is at least partially responsible for the non-competitive insurance market for property situated in coastal areas or on fault lines, where natural disasters are abnormally possible.)
- The risk cannot be spread or diversified across a broad enough range of policyholders. (This is demonstrated by the way insurance companies often use standard coverage forms rather than rewriting their policy language for each customer. Similarly, it somewhat explains why tailor-made insurance solutions might only be available to an applicant at a significant, added cost.)
- The risk could result in a gain rather than just a loss. (This explains why it's nearly impossible to insure against an unwise business decision and is what separates the uncertainties in insurance from the uncertainties in gambling. Risks that can result in a gain are called "speculative risks" and will be addressed in greater detail later in this course.)

As highlighted by author and risk management expert Emmett J. Vaughan, the evolution toward modern-day risk management was also prompted by changes at business schools, where concepts such as cost-benefit analysis gained greater emphasis. Upon being charged with managing risk, former students from those schools realized that if organizations have a limited budget for insurance, those dollars should be spent as efficiently and thoughtfully as possible.

Risk management still values, respects and often utilizes insurance, but it doesn't assume that buying insurance is the starting point for handling all uncertainty. Instead, it treats insurance as one critical tool among many others. It recognizes that insurance products have a needed role in the lives of businesses and individuals, but it also emphasizes enhanced safety measures, careful research, detailed contingency planning and constant teamwork.

Many insurance professionals find that knowing more about risk management strategies lets them offer increased services and advice to clients. Particularly among agents and brokers in commercial lines of insurance, professional designations associated with risk management expertise might be essential to standing out from the competition.

Of course, providing different services can also expose insurance producers to additional professional liability. Yet for those licensees who don't wish to expand into offering risk management services and prefer to remain safely in their lane of selling insurance products, studying risk management still has its benefits. By exposing yourself to alternate ways of handling uncertainty, you might actually gain a keener sense of what your products are really designed to accomplish. If nothing else, you can become more confident that you are truly selling insurance based on someone's needs rather than because it's all you can offer.

Understanding Risk

Now that we've explained some of risk management's background and basics, it will probably be helpful to consider a few definitions of "risk.' In addition, we'll explain the many different types of risk, including some that can be managed well by insurance and some that commonly call out for non-insurance expertise.

Risk Defined

"Risk" can be defined as the uncertainty surrounding either the likelihood or impact of an event. Outside of insurance, risk might involve a range of possibilities that includes something good possibly happening, something bad possibly happening or something neutral possibly happening. However, at least one of the possibilities must be less desirable than the rest.

In insurance, the same principle generally applies, but the range of possibilities must include only something bad happening (such as becoming ill) or something neutral happening (such as maintaining current health). As a result, we can say that a more specific definition of risk within an insurance context is the uncertainty surrounding a potential loss. The uncertainty surrounding a potential loss may be tied to any of the three following questions:

- Might a loss occur at all?
- When will a loss occur?
- How big might a loss be?

Note that a risk can still exist even if one or two of those questions are already answerable. For example, insurance companies already know losses will occur among their mix of customers and that they will ultimately need to honor some claims. So, the risks that insurers face are more focused on when and how big those losses will be rather than whether they will occur at all. Specifically, uncertainty for insurers relates to whether actual losses will ultimately be in line with an actuary's data-driven estimates and whether the premiums charged to customers by underwriters will be enough to adequately offset claims.

What's a Loss?

"Loss," within an insurance context, may be defined as an expense or decrease in value that occurs at an unpredictable moment. (By contrast, decreases in value at predictable times—such as property's natural depreciation—are not usually intended to be addressed by insurance.) Losses might be direct, such as theft of or damage to property. Alternatively, a loss can be indirect, such as the extra cost of child care that a stay-at-home parent might need to pay upon being forced into the workforce by a spouse's unexpected death.

Risk vs. Uncertainty

If you find a definition of risk, it's a safe bet that it will include the word "uncertainty." However, some scholars who specialize in risk management believe terms like "risk" and "uncertainty" shouldn't be used as synonyms for each other. Risk, as distinguished by University of Chicago economist Frank Knight and explained further by author and risk manager J. Davidson Frame, deals with unknowns that can be estimated based on statistical probability. Uncertainty, on the other hand, might describe unknowns that cannot be estimated with the help from data and mathematics.

Although this difference might seem impractical or overly academic, it's still worth mentioning here in order to reemphasize how insurance is intended to only manage risks that can be assessed through sufficient loss-related data and statistical estimates. If data about a risk either doesn't exist or can't be plugged into statistical formulas, the risk typically can't be managed through insurance.

Informal Definitions of "Risk"

We've already made some distinctions between how risk is defined inside and outside the insurance community, yet it's worth noting that some insurance companies and insurance professionals tend to define risk in additional ways depending on the conversation. For example, some companies and individuals might use the word "risk" loosely to mean an applicant for insurance ("That person is a good risk.") or as a synonym for a peril. ("We insure against the risk of fire.")

Hazards and Perils

Since we're already examining definitions and terminology, let's review a few more words that tend to come up in discussions about risk.

What's a Peril?

A "peril" is the cause of a loss. Examples of perils include fire, flood and illness.

Insurance companies are concerned about the risk of perils. In fact, insurance policies will either list the perils that can result in post-loss compensation to the carrier's customers or at least include a special section that explains any excluded perils. If a peril is excluded

from a policy, losses caused by it will not result in any insurer-provided compensation for the insurance customer.

What's a Hazard?

A "hazard" isn't the cause of a loss but is something that increases a loss's likelihood or scope. This can be important in insurance underwriting because an applicant who is surrounded by too many hazards can struggle to find affordable insurance even if that applicant has not yet suffered any losses.

The broad category of hazards can be broken down into at least three subcategories:

- Physical hazards.
- Moral hazards.
- Morale hazards.

Physical Hazards

A "physical hazard" is an environmental factor that increases the likelihood or severity of a potential loss. Simple examples of physical hazards include frayed wiring (which increases the likelihood and severity of loss by fire) and either poor lighting or wet floors (both of which increase the likelihood and severity of loss by slip-and-fall accidents). Eliminating as many physical hazards as possible can significantly reduce risk and make insurance more affordable.

Moral Hazards

"Moral hazards" are character issues that make people more likely to cause a loss on purpose, such as dishonesty that temps them to commit insurance fraud. These hazards are often carefully monitored by the insurance community and have resulted in several long-standing practices within the industry. Several techniques employed by insurance companies to manage moral hazards appear next:

- Requiring policyholders to have an "insurable interest" in the people or things they intend to insure. (An insurable interest is a desire for a person or thing to remain unharmed.)
- Constructing insurance contracts so policyholders are made financially "whole" again after a loss, but not any better than they were prior to a loss.
- Refusing to cover damage caused intentionally by an insured.
- Enforcing suicide clauses, which typically prohibit a beneficiary from receiving life insurance benefits if an insured takes his or her own life within two years of purchasing a policy.

Morale Hazards

"Morale hazards" (not to be confused with moral hazards) are cases of indifference that make a consumer not care about preventing or reducing losses. Morale hazards don't involve deception or evil intent, but they foster an environment in which people act irresponsibly without considering how their attitudes or inaction might negatively impact others. In a business environment, this might be seen when an employee doesn't bother to report a potential problem because he or she views the task as someone else's job. In an insurance example, a homeowner might believe he or she doesn't need to worry about

maintaining property because any eventual damage is likely to be covered by a generous insurance policy.

Insurance carriers have attempted to manage morale hazards by incorporating cost-sharing requirements (such as deductibles, copayments and coinsurance fees) into their products rather than paying for insured losses in full. The assumption is that if the insured is required to pay out of pocket for at least a small portion of a loss, the person will work a bit harder to prevent the loss from occurring (such as by reducing physical hazards and engaging in other risk management strategies).

Types of Risk

The next several sections explain many different categories of risk. You should pay particular attention to how each mentioned type might or might not fit into the way insurance companies view risk. In some cases, you'll clearly see that certain risks are compatible with the purpose of insurance products. In others, it will be obvious that risks can't be managed well entirely by insurance and that other solutions, mentioned later in this chapter, might be better options.

Pure Risks

A "pure risk" is a risk in which none of the potential outcomes are beneficial. At best, this type of risk will result in either a loss occurring or no loss occurring. Unlike with some other risks, there cannot be a chance of gain. Pure risks are generally what most people think of when the subject of risk comes up.

Examples of pure risks include the potential for fire, flood, death, liability and accidents. At worst, these risks will lead to perils and ultimately result in a loss. At best, these risks will merely remain possibilities, won't lead to perils and won't ultimately result in a loss.

The concept of pure risks (and, in particular, their lack of potential gain) is important within the context of your profession because pure risks are generally the only risks that can be managed by traditional insurance products. Many business risks—such as the risk of a new product being either successful or very unsuccessful—have the potential for gain and, therefore, are not insurable.

A Few Side Notes on Pure Risks

Despite the connection between pure risks and insurance, two additional points about that connection deserve to be made here.

First, although a risk generally must be a pure risk in order to be managed by traditional insurance, not all pure risks will be acceptable to an insurance company. For instance, although the risk of terrorism is a pure risk, many insurance companies initially deemed it uninsurable in the months following the World Trade Center attacks on September 11, 2001. Only government intervention and the establishment of a government-backed safety net for catastrophic losses eventually made this pure risk an insurable one.

Second, just because a risk is considered a pure risk doesn't mean it can't also be included within another category or subcategory of risk. For example, you'll soon learn about personal risks, property risks, liability risks and many other risk groupings. Some risks that might fall into those groupings can also be considered pure risks, even if some others cannot.

However, recognize that a pure cannot also be what's called a "speculative risk."

Speculative Risks

Speculative risks are the opposite of pure risks because, although they involve uncertainty, there is a chance of success or gain rather than just the chance of a negative or neutral outcome. In some circles, speculative risks are also known as "opportunity risks."

Some examples of speculative risks are listed below:

- The risk of gambling at a casino.
- The risk of investing in the stock market.
- The risk of introducing a new product.
- The risk of changing jobs.
- The risk of committing to a romantic partner.

Although bad outcomes are possible in the above scenarios, the possibility for good outcomes exists, too. These risks are actually very common in life, but they don't receive much attention from the insurance community because they typically cannot be managed through traditional insurance. Instead, a risk manager who is tasked with managing speculative risks might recommend other solutions, such as risk avoidance or risk reduction. You'll learn more about these and other non-insurance techniques later in this chapter.

As insurance professionals, we might be biased against speculative risks and view them in an entirely negative light. But taking the occasional speculative risk breaks us away from stagnation, boredom and even depression. If we want to grow, we honestly must avoid the extremes of taking on too many risks or too few.

With all this in mind, risk managers who are charged with evaluating speculative risks shouldn't necessarily discourage their employers from pursuing every risky opportunity. Instead, they can help decisionmakers understand the many possible outcomes and then design a plan based on the chosen path. In these cases, it's possible that a risk management plan will attempt to find a balance between maximizing the profits that are possible from a speculative risk and minimizing (but not necessarily eliminating) the impact of potential losses.

Of course, this doesn't mean a risk manager should go against his or her educated guesses and not firmly advise against taking certain risks. Not taking a risk, a method actually known as "risk avoidance," has an important role in maintaining personal and business stability and will deservedly get more attention here in a later section.

Dynamic Risks and Static Risks

"Dynamic risks" are risks that are tied to the economy and are largely beyond a person's or business's control. These risks are speculative to a large extent because changes in the economy (such as movements in interest rates, employment rates or the supply and demand for a product) might help the person or business or might produce negative outcomes. Like other speculative risks, dynamic risks usually can't be managed via traditional insurance and instead require careful attention to other risk management tools.

By contrast, "static risks" are risks that aren't tied to the economy and are comparatively more within a person's or business's control. Some static risks will be pure risks and can be managed with insurance. Others will be speculative and should be viewed through a non-insurance lens.

Personal Risks

"Personal risks" are risks to your body and well-being, such as the risks of illness, injury and unexpected death, as well as the risk of financial loss tied to those negative events. Insurance is often used to help manage the risk of the financial consequences surrounding personal risks, but other risk management strategies—such as risk reduction techniques linked to eating a good diet, getting enough exercise and having regular medical checkups—might also be encouraged. In some contexts (but not in this course) personal risks might have a broader definition that includes all risks faced by individuals, as opposed to those risks faced by businesses.

Property Risks

"Property risks" involve the potential that something owned will be lost, stolen, damaged or otherwise subjected to a decrease in value. Insurance commonly plays a role in managing property risks because the severity of property losses can be easier to estimate than other losses, such as those related to being sued. Meanwhile, engaging in non-insurance forms of risk management—such as using locks, burglar alarms, sprinkler systems and various other safety and security measures—can make property insurance more affordable.

Liability Risks

"Liability risks" involve uncertainty surrounding whether a person or entity will be held legally responsible for someone else's losses or for unlawful activity. These risks can be particularly challenging for risk managers because there might not be limits on potential legal judgments or fines, thereby making liability's financial consequences nearly incalculable. In addition, most risk managers lack a legal background and therefore must rely on help from other experts to identify, reduce and otherwise manage these risks effectively.

Risks Related to Public Relations and Perceived Character

Particularly among businesses, risk management might focus not only on preventing and controlling direct losses to property and earnings but also on avoiding harm to an entity's internal and external reputation. A business that wants to recruit and retain the best workers will likely want to promote a safe and stable work environment where everyone can focus on the tasks at hand. Similarly, a business that wants to project a positive message to customers will likely want to seem like a responsible, welcoming participant in its community and will certainly want to avoid being the subject of embarrassing reports about accidents, financial infractions or managerial chaos.

Although risk management tools like insurance, hold-harmless agreements and even a good attorney might shield a business from suffering direct financial loss after a crisis, those tools can't change perceptions of how the crisis was handled. For example, a business that successfully avoids legal liability for a serious injury at the workplace must still consider how the incident might impact staff morale. Likewise, a business accused of pollution violations might technically be able to blame a vendor for the problem, but this shedding of responsibility is unlikely to foster good relationships with current and potential customers.

Just as risk managers might consider consulting with a legal team to address liability risks, advance assistance from human resource and public relations professionals might be in order so that negative events aren't exacerbated by risks associated with slow or

incoherent communication. In most cases, failing to be transparent with employees or the public about relevant, obvious problems will only expose the business to even greater risk.

Particular Risks

"Particular risks" are uncertainties that are likely to only impact one person or a relatively small group rather than the larger society. Examples include the risk of a single business failing or the risk of a close family member passing away. Although these risks might be scary for the small group who could be effected by them, they don't spell potential trouble for the broader population.

Since particular risks don't have a societal impact, they tend to be managed—if at all—by either one person or a small team. If a team is used, specially trained professionals (such as insurance producers, risk managers and attorneys) might be consulted in exchange for compensation. Free or partially subsidized risk management assistance from the local or federal government might not be available.

Fundamental Risks

"Fundamental risks" are the opposite of particular risks and involve uncertainties that are more likely to impact society. Examples include the risk of unsafe food manufacturing, the risk of unclean water and the risk of widespread poverty in retirement.

Because fundamental risks can cause serious problems for a broad population, they are often managed via public policy rather than just by buying insurance or employing a risk management team. For example, the government might respond to fundamental risks by employing the following types of risk management:

- Enforcing laws and rules that prohibit risky activities.
- Implementing government insurance programs (such as Medicare and Social Security).
- Providing incentives (such as tax credits) to encourage certain behaviors.
- Offering educational opportunities (such as information sessions or free online resources) to individuals who want to learn more about a risk.

Although we'll go into slightly more detail about fundamental risks, these risks generally aren't a professional risk manager's main focus and therefore won't receive significant emphasis in this chapter.

Internal Risks vs. External Risks

The ability to carefully manage a risk will depend partially on whether the risk is internal or external.

"Internal risks" can generally be defined as those that exist within someone's own environment, such as a person's own body, own home or own business. Although internal risks can't always be fully controlled, they allow for more careful and flexible planning than external risks.

"External risks" exist largely within an environment that is beyond a person's control. Examples of external risks are as follows:

- Risks associated with third-party vendors used by a business.
- Risks associated with new regulations that could impact current or future goals.
- Risks associated with a competitor's unknown plans.

Despite being harder to manage, external risks can still be addressed successfully. For example, concerns about a particular external risk might prompt a business to create a detailed contingency plan in case an outside event occurs. More broadly, a business that is flexible and careful to not rely too much on one client, one vendor or the success of one product will likely be more capable of confronting external risks than a business that operates in a more rigid and narrow manner.

Managing Risk

We've spent significant time reviewing the many types of risk and how they might relate to insurance. Now let's learn about what risk managers do and the various strategies they often employ.

Goals of Risk Management

At its simplest level, risk management is an attempt to identify potential losses, determine the likely cost of those losses and create a path toward recovering from them. Alternatively, we can view risk management as a multi-faceted method for maintaining stability despite the presence of loss or uncertainty.

Some slightly more specific goals of risk management are listed next:

- Making losses less common and/or less impactful.
- Minimizing the likelihood of catastrophic events.
- Devising ways to further important goals while avoiding major setbacks.
- Combatting threats in an efficient, cost-effective manner.
- Implementing procedures that help an entity uphold its ethical and legal obligations to workers, customers, regulators and the general public.
- Creating an environment where decisionmakers aren't distracted by constant problems and breakdowns and are, instead, allowed to focus on what matters most to them.
- Putting people in a position to be resilient and proactive in response to losses.
- Understanding how seemingly small issues can lead to serious stress.

Role of Risk Managers

As mentioned earlier, a risk manager's role within a business has evolved from a time when companies employed someone to focus mainly on purchasing commercial insurance products. Today, someone in this position will also be required to plan around risks that either can't be managed affordably through insurance or aren't insurable at all. Analyzing available insurance options will certainly still be part of a risk manager's job, but it won't necessarily be the person's primary focus.

Large businesses can sometimes afford to employ one or several people whose tasks are dedicated solely to risk management endeavors. However, smaller entities will typically need to wrap the responsibilities for risk management together with a worker's other job functions and have the person serve in a dual role. By default, and whether they realize it or not, owners at smaller companies typically act as risk managers themselves.

Availability of Risk Management Services

If an organization lacks the budget to employ a dedicated risk manager, risk management evaluations and related services can be provided by third parties for a fee. Interested

businesses can find qualified professionals by searching databases available through risk management trade associations. These associations typically require advanced training as a condition of membership. Alternatively, risk management services are often available to a commercial insurance company's customers. Whether they provide those services for an additional charge or at no extra cost, insurers partner with risk managers because they understand how promoting safety and preparedness can reduce their own risk and prevent insured losses.

Bringing in a risk manager from outside an organization can sometimes be helpful because the person will be able to view risk with a fresh yet professional set of eyes and won't have the same unconscious biases that can infect someone who is comfortable with an entity's longtime procedures. Still, it's important for businesses to assist third-party risk managers enthusiastically so that the outsider will be able to understand all relevant particulars and what makes each business unique. If a risk manager encounters resistance to receiving data or other information from a business's leaders, the risk manager won't be able to make solid recommendations, and the money spent on the outside risk manager will be wasted.

The Risk Management Process

Let's look more deeply at the common steps in the risk management process. The process must be a proactive one that anticipates potential problems and then looks to halt those problems if they ever actually arise.

Prior to a loss, the risk management process involves spending wisely on insurance and non-insurance safeguards, reducing stress about uncertainty for others in the organization and perhaps even considering how to comply with legal, ethical or company-set standards of practice. Since no entity will have unlimited resources to manage risk, this pre-loss portion of the process will undoubtedly require careful compromises along the way.

After a loss, the risk management process incorporates short-term and long-term plans for an entity to recover quickly, such as how a business can stay open after major damage to its building or how a family can pay its bills after a wage earner's sudden death. As mentioned earlier, this phase in the process might also include a public relations strategy if the loss is likely to harm someone's reputation. Finally, the process should require a review of what happened and whether changes should be made to the existing risk management plan as a way of avoiding future losses.

No matter the stage in the process, a good risk manager's focus will be not only on all the things that could go wrong in a situation but also on all the things that must go right.

Identifying Risks

The first step in the risk management process is identifying potential risks. At first glance, this might seem like a task that could involve an hour or two of brainstorming and creating a checklist. But for this step to be effective, more discipline, patience and communication are required.

This step must be designed so that major categories of risk aren't accidentally dismissed. Although it might be easy enough to identify major yet basic risks, such as losses from a fire or weather-related disaster, other risks often get ignored until losses are already occurring. For example, many businesses don't consider the impact that a key employee's death, disability or departure can have on the organization until the person suddenly becomes unavailable. Similarly, external risks—such as uncertainty surrounding an entity's relationship with an important client, regulator or vendor—tend to be addressed

uncomfortably late in the process rather than being addressed early through proactive contingency planning.

Identifying risk also requires broad participation across an entire organization so that possible losses and their potential severity can be understood from different perspectives. Rather than merely requesting input from an entity's top management team, a risk management plan should incorporate detailed feedback from mid-level players and even entry-level team members. Whereas top management might have a general idea of a risk and where it exists, individuals at that level might not be in positions to understand all the daily nuances of procedures, including any specific inefficiencies or red flags that could make a risk even bigger than top management expects.

Organizations that want to manage risk well can benefit from holding regular meetings with representatives from all major departments. By talking about each department's goals and current projects, members from other parts of the organization can better understand how their own work fits into a team concept and, especially, how the seemingly small problems noticed by them can actually indicate bigger concerns for other participants. At the same time, even if a risk-heavy task has been assigned primarily to one department, other attendees at these meetings might have feedback or suggestions that can lighten the burden.

Despite generally being considered the first step in the risk management process, risk identification should remain a nearly constant task. With every change—be it a change in projects, a change in personnel or a change in procedures—comes a different set of risks. Therefore, risk managers must be flexible in their planning and make it a point to encourage continued communication about an organization's new challenges.

Determining Frequency and Severity

Once a risk has been identified, a risk manager should analyze it to determine the possible frequency and severity of a loss. Depending on the type of risk, the type of organization and the budget allowed for risk management, this might incorporate some complicated math, loss-related data and even loss simulations, in which computer programs estimate the cost of losses that are likely to occur from a particular peril. (Such modeling is particularly useful among property and casualty insurers when determining their exposures to natural disasters.) But if the risk manager lacks access to enough data for any reason, educated guesses will need to suffice.

Detailed analysis of frequency and severity should consider losses that could occur at different times. For example, rather than merely considering the general impact that a power outage might have on a business, the analysis might include estimating the frequency and severity if the outage were to occur during the business's busiest season compared to a slower period. The variables to explore during this process are seemingly endless, so the risk manager must prioritize what to examine and keep the overall plan moving forward.

To aid in this step, many risk managers will create a matrix showing where each risk essentially ranks with respect to frequency and severity. Picture, for example, a graph that shows a loss's likelihood on the horizontal "x" axis and the loss's severity on the vertical "y" axis. The resulting graph provides a visual representation of the overall threat of each

risk. For example, each potential loss resulting from an analyzed risk might be graphed and thereby identified as follows:

- Low frequency and low severity.
- Low frequency and high severity.
- High frequency and low severity.
- High frequency and high severity.

Seeing potential losses identified in this way can help risk managers ultimately determine what to do about the corresponding risk:

- Losses that are likely to be low in both frequency and severity might result in an entity merely accepting those risks and deciding not to worry too much about them.
- Losses deemed low in frequency but high in severity are sometimes best handled with insurance because coverage is likely to be available and affordable.
- Losses shown to be high in frequency but low in severity might indicate internal problems with administration or procedures that could benefit from some adjustments.
- Losses considered high in both frequency and severity are less likely to be insurable and might be best handled by not exposing the entity to a risk at all.

Even if a risk manager has a strong bias that favors insurance, determining frequency and severity can increase someone's chances of spending their insurance money as efficiently as possible. This is possible by calculating both the "maximum probable loss" and the "maximum possible loss." Whereas the maximum probable loss considers a loss's likely severity, the maximum possible loss considers the absolute worst-case scenario.

With respect to insurance, picking a coverage limit equal to the maximum probable loss can allow a consumer to get efficient use out of his or her insurance budget but will still expose the consumer to some potential uninsured losses. On the other hand, picking a coverage limit equal to the maximum possible loss will shield the consumer from losses in one area but could result in that person not having enough financial resources left over to manage risks in other areas. Even for an experienced risk manager, walking the fine line between being potentially underinsured and potentially over-insured requires delicate balance.

Risk Management Strategies

After identifying risks and analyzing the likely frequency and severity of possible losses, a manager must choose an appropriate technique to manage each risk. In general, those techniques fall into the following categories:

- Risk avoidance.
- Risk retention.
- Risk reduction.
- Risk transfer.

Note, however, that the same risk can be managed by employing multiple strategies at once. For example, consider the risk of burglary at your home. To manage this risk, you

might purchase homeowners insurance (which is a form of risk transfer). At the same time, you might also lock your doors after you leave (which is a form of risk reduction).

Let's go through each risk management strategy in more detail.

Risk Avoidance

"Risk avoidance" is a risk management strategy in which a person entirely eliminates a risk by choosing not to engage in an activity. For example, someone who wants to avoid the risk of dying in a plane crash can refuse to ever fly. Someone who wants to avoid the risk of losing money in the stock market can refuse to invest in it. Someone who wants to avoid the risk of putting money into a business and then watching the business fail can choose to always work for someone else rather than being his or her own boss. A company that wants to avoid burdensome regulation in a particular industry can choose not to branch out into that industry in the first place.

Risk avoidance is often employed as a risk management strategy when losses related to a risk are likely to have both a high frequency and a high severity. Few people will feel comfortable accepting those types of risks on their own, and no reputable insurance company is likely to cover them. Risk avoidance is also commonly used when the likely frequency is low but the likely severity is still high enough to keep risk managers in a panic.

Although risk avoidance can literally be beneficial to our survival, it has its limits. Avoiding some risks is natural and wise, but avoiding too many risks can result in someone passing up too many opportunities and not getting enough satisfaction from life. For instance, avoiding planes can prevent someone from traveling to a desired destination where no other transportation options exist. Avoiding business opportunities can prevent people from reaching their fullest financial potential. In moderation, there's certainly something to be said for overcoming our fears and accepting some risks.

In other cases, risk avoidance might not be an option at all. For example, we'd all presumably like to avoid the risk of becoming disabled or of dying prematurely. Yet we only have limited control over our health and can only manage that aspect of our lives via risk reduction (not avoidance), such as by exercising and maintaining a healthy diet.

Risk Retention

"Risk retention" (sometimes called "risk assumption") occurs when someone decides to accept a risk and to essentially live with the consequences. For example, a driver might choose to retain the risk of damage to his or her old car by not buying collision coverage for the vehicle. Someone might choose to retain the health risk of eating red meat by enjoying a steak whenever he or she chooses and deciding not to worry about the potentially negative dietary effects.

Risk retention is a common strategy when both the likely frequency and likely severity of a loss are low. Putting together safeguards to minimize these losses might not be an efficient use of time, and paying money to transfer these risks—such as by purchasing insurance—might not be the best use of an entity's limited budget.

Often, risk retention is forced upon people in conjunction with another form of risk management, such as risk transfer. This commonly occurs when risk transfer involves insurance. Although a consumer will pay premiums to transfer most of a risk to an insurance company, the insurer will require that the policyholder retain some risk via deductibles, copayments and coinsurance fees. By combining mandatory risk retention with insurance, policyholders are expected to be more risk-conscious and more careful. In other words, this required risk retention helps minimize some of the moral and morale

hazards mentioned near the beginning of this chapter. Some retention, in theory, should also reduce the cost of insurance, since higher deductibles and copayments typically translate to lower premiums.

Some risk managers believe retention is the most common form of risk management because it can be done either by choice or by accident. In the latter case, people and organizations might retain risks unknowingly by not recognizing that a risk even exists, such as by not understanding that they might be breaking a law or by not knowing that their insurance is subject to a particular exclusion. For professional risk managers, this subconscious type of risk retention should be avoided whenever possible by enlisting help from assorted experts, such as attorneys, engineers and insurance professionals.

Although risk retention might seem like a scary solution, it can be a valuable tool when other strategies seem unrealistic or unreasonably expensive. However, before recommending risk retention, a risk manager should do his or her best to calculate how much risk should be retained and how much should be addressed via other options. It is sometimes possible to retain a portion of a risk but still manage the remaining fraction in another way.

Risk Reduction

"Risk reduction" (sometimes known as "risk mitigation") occurs when steps are taken to reduce either the likely frequency or severity of a potential loss with the understanding that the risk can't be entirely eliminated. Although risk reduction is commonly recommended when losses are likely to have a high frequency and low severity, it can be employed in several other scenarios, too. Some common examples of risk reduction are listed next:

- Performing preventive maintenance on a house so it is less susceptible to major damage.
- Locking doors and installing alarms so property is less susceptible to burglary.
- Installing sprinkler systems, smoke alarms and fire extinguishers so small fires are less likely to turn into unmanageable ones.
- Diversifying financial investments so downturns in the stock or bond markets don't entirely wipe out someone's savings.
- Implementing mandatory procedures, adequate training and reasonable safeguards at workplaces to reduce human error.
- Exercising and eating well to fight against illness, disability and premature death.
- Setting an alarm clock to reduce the chances of oversleeping and being late for an important appointment.
- Adding warning labels to products in order to reduce lawsuits from a business's customers.

Risk reduction also provides positive outcomes from an insurance standpoint. The more an applicant can show a dedication to risk reduction, the easier it will be to obtain affordable coverage. Similarly, an entity that implements extensive risk-reduction methods might be able to get away with buying less insurance than an entity that pays little attention to safeguards.

Contingency Planning

Many aspects of risk reduction involve taking care before a loss is capable of occurring, but other parts should address how to handle losses that are already in progress. To manage risk effectively, consideration should sometimes be given to "contingency planning."

In essence, contingency planning entails having a backup procedure in place so that important work toward goals can resume soon after a loss. Basic examples of contingency planning include the following:

- Deviating from your usual route when a car accident ahead of you has already made you a bit late.
- Establishing a temporary business location or work-at-home arrangement when a fire, flood or other peril has already caused a business to unexpectedly close its doors.

Risk Transfer

"Risk transfer" (sometimes called "risk shifting") occurs when the consequences stemming from a risk are taken from one party and moved to another. Although risk transfer doesn't eliminate risk, it absolves the original party from certain responsibilities and can let that party concentrate on other goals. Risk transfer is often recommended when potential losses are expected to be low in frequency but high in severity. For other risks, risk transfer can be financially inefficient or hard to accomplish because few candidates will want to receive the transferred risk.

As an insurance producer, risk transfer is probably the method of risk management with which you have the most familiarity. In fact, insurance is one of the most common forms of risk transfer. The policyholder is allowed to transfer the financial risk of premature death, bad health, property damage, costly legal bills and several other possible problems to an insurance company in exchange for paying premiums. Other common examples of risk transfer include warranties, hold-harmless agreements and other contracts.

As demonstrated by insurance, risk transfer can sometimes be done entirely by choice or sometimes by force. For example, some people choose to buy life insurance because it helps them feel better about their family's financial situation, whereas others might buy life insurance because it is mandated by a divorce settlement or child-support arrangement.

Risk Transfer and Contracts

Contracts that bestow certain responsibilities and liabilities on each party by mutual consent are perhaps the earliest example of risk transfer. If something goes wrong and results in a loss, a well-written contract gives the harmed party a way to possibly be made whole again, either through a court proceeding or via an out-of-court settlement. However, anyone who has ever puzzled over the language in an insurance policy can attest to the fact that contracts aren't always clear. Interpretations of contractual provisions—and even whether those provisions are enforceable—will sometimes depend on the legal authority reviewing the language, as well as on the state or other jurisdiction in which legal action is taken.

In short, although getting contractual agreements in writing is often an extremely wise method of risk transfer, risk managers should consider other safeguards, too, in case those agreements don't withstand unexpected legal scrutiny.

The Role of Insurance

Given your professional experience, you probably don't need to be told how insurance can be a great tool for dealing with many risks and losses. Although some emotional risks (such as the pain of losing a loved one or the discomfort of dealing with an illness) can't exactly be transferred to insurance companies, the right insurance product has a chance at relieving the money-related burdens imposed by those unwanted events.

For a risk manager charged with helping a business or other organization, insurance responsibilities are likely to include consultations with agents and brokers, along with completing the following tasks:

- Determining which specific risks should be transferred by insurance.
- Determining which producers and carriers to engage in insurance transactions.
- Determining preferred dollar limits, deductibles, copayments and coinsurance fees that simultaneously satisfy the organization's risk tolerance and fit within the allowed budget for risk management.
- Determining whether existing insurance arrangements should be terminated, altered or kept in place.
- Reporting losses to insurance companies.
- Deciding whether insurance represents the best way to manage a risk.

If a risk seems highly likely, buying insurance to manage it might seem like an obvious decision. However, as mentioned earlier in this chapter, some risks will not be acceptable to an insurance company. As a reminder, a risk will generally not be considered insurable if it fits into any of the following categories:

- The size or likelihood of losses associated with the risk cannot be calculated by insurance actuaries.
- The probability of losses associated with the risk is too high.
- The size (as opposed to just the probability) of potential losses is considered too high.
- The risk cannot be spread or diversified across a broad enough range of policyholders.
- The risk could result in gain rather than just a loss.

Implementing the Program

Upon identifying risks, determining the likely frequency and severity of losses and then picking the best plan of attack, a risk manager will focus on implementing his or her plan. This might seem like an obvious step in the process, but it deserves special mention here because implantation is sometimes treated too casually. The result is often a lot of wasted time and an ultimately ineffective approach to risk management.

Supporting the Risk Management Program

Compared to merely buying insurance, implementing a risk management plan will require greater involvement across an organization and some collaborative responsibilities. Expecting a single risk manager to understand all potential risks and to be on high alert for every single warning sign of potential loss is both unfair and impractical. A risk manager

can lead the risk management process but must receive support from an organization's leaders.

In addition to providing the necessary attention, funding and information to help facilitate a smooth risk management process, an organization's leaders must work at creating a culture where sensitivity to risk becomes common. No matter where a team member falls within an entity's hierarchy, he or she should be made to feel comfortable reporting problems to supervisors without fear of being reprimanded, ignored or embarrassed. Similarly, when lower-ranking individuals are asked to participate in identifying or evaluating risks, upper management must make them feel empowered to share honest feedback and should not sway them to agree with whatever their supervisor believes. Again, because upper management is sometimes distant from the day-to-day processes within their organization, contributions from workers at other lower levels are often essential to identifying and solving problems.

The Human Factor in Risk Management

We live in an increasingly technological society that is placing more and more importance and reliance on automation and other forms of non-human contact. And even before this major shift toward technology, some risk managers spent considerable time focused primarily on risks related to engineering, natural disasters and equipment breakdown.

Those concerns should certainly remain high among a risk manager's priorities, but they should not distract a risk management professional from also considering the human element in avoiding and controlling losses. Innumerable problems can still be traced back to human error, so any organization that wants to manage risk properly must be mindful of who it invites in as members, including employees, volunteers, business partners and vendors.

An entity is more likely to assemble an appropriately risk-sensitive team if it keeps the following realities in mind:

- Noticing the potential for risk requires attention to detail. Someone who cannot grasp how seemingly minor issues can mutate into huge problems might lack the necessary skills for monitoring risk.
- Significant investment in training can lead to significant risk reduction. However, this correlation is more likely to be achieved if education is provided on a continuing basis rather than during a one-time session.
- Unfortunately, sometimes all the training in the world cannot compensate for incompetence. At a certain point, leaders must honestly evaluate whether poor-performing individuals are truly the best people for their assigned tasks.
- Distraction or boredom can reduce our ability to spot and react to increased risk, including something as simple as poor data entry that could lead to an inaccurate assessment of risk. Eliminating unnecessary stimuli and keeping a team motivated can help keep everyone alert.
- Having rules or policies about how to perform tasks and how to report problems won't be of much help if those rules and policies aren't enforced. Leaders who react casually when rules aren't obeyed will subconsciously encourage those who follow them to act in a dangerously casual way toward risk.
- Even the most skilled people will sometimes freeze or panic in an emergency. Having emergency plans already in place—and conducting periodic training about

the agreed-upon procedures—can minimize these understandable lapses in action and can get an organization closer to managing a realized loss.

Evaluating the Program

Identifying risks, determining the frequency and severity of losses, choosing a risk management strategy and implementing a risk management plan can't be one-time occurrences. Effective risk managers must reevaluate their work and their decisions on a regular basis so important adjustments can be made before a new loss arises. Commitment from upper management is essential so that risk managers have the time and resources to identify and make those adjustments as quickly as needed.

As part of the evaluation process, a risk manager should at least consider the following questions:

- Have we encountered risks that we failed to identify during the planning stage?
- Have losses been as severe and as frequent as expected?
- Have changes in our organization (such as different personnel) created or eliminated some risks?
- Have changes in our procedures, goals or customers' expectations created or eliminated some risks?
- When losses occurred, did training and contingency planning reduce those losses to a satisfactory degree?
- Were the chosen strategies for each identified risk (avoidance, retention, reduction, transfer) suitable for that risk, and should they continue?
- Should the pool of participants who contributed to previous risk management planning be deepened or reduced?

Risk Management Principles in Insurance

Throughout this chapter, we've attempted to emphasize the links between risk management and insurance. Let's spend some time making more specific connections between those topics and highlight some areas in which insurance companies apply risk management principles for their own protection. For example, we'll explain concepts such as the pooling of risks and the law of large numbers.

Pooling of Risks

The "pooling of risks" is a method by which insurance companies (as well as any other entity running an insurance program) attempt to spread either the same or similar risks across a larger group. For instance, rather than insuring just one person against the risk of premature death, an insurance company will insure several similar people against that risk. Pooling of risks rather than insuring just one person allows the insurer to be less reliant on the not-entirely-predictable mortality of that one person. In property insurance, the same concept is applied so that damage to a single property doesn't cause catastrophic loss for the carrier.

Often, each group of insurance customers who are pooled together will be put into the same "rate class," with all members of the rate class being charged a similar amount.

The pooling of risks is tied closely to a mathematical concept known as the "law of large numbers."

The Law of Large Numbers

Insurance companies try to measure risk and more closely predict losses by applying the law of large numbers to their business. The law of large numbers essentially states that the probability of an occurrence (such as a loss) becomes clearer as it is tested against an increasingly larger sample of data.

Consider, for example, a coin flip and the likelihood of the coin landing "heads" or "tails." If we flip a coin only twice, it's possible that it will land on "heads" both times. Based only on those two flips, we might incorrectly assume that the probability of a coin landing on "heads" is 100 percent and that the probability of it landing on "tails" is 0 percent. However, if we flip the coin 100 times, 1,000 times or even more, we are likely to see that the coin will land on each side on a fairly even basis and that the real probability is 50 percent for "heads" and 50 percent for "tails."

Insurers use the law of large numbers by pooling together a large number of similar risks and using historical data to determine the amount of losses that will likely occur during a given timeframe. Rather than insure just two homes in a city against fire losses and hoping for the best, they will insure hundreds of homes in that city and (due to the larger sample size) be able to more accurately predict how many customers who will suffer a fire-related loss.

Risk Management and Government

Although this chapter has focused largely on risk management in the private sector, it's worth noting that innumerable government efforts have been instituted to manage larger societal risks. For example, laws are a form of risk management designed to guard against losses caused by people who behave without enough respect for others. Programs such as Social Security and Medicare are government-run examples of the pooling of risks, where the risk of poverty and illness among senior citizens is spread and shared across the broader population. And of course, some government attempts at risk management have encouraged the private purchase of insurance, such as requirements to have auto liability insurance, workers compensation insurance and health insurance.

OSHA

In some corporate environments, a risk manager may be tasked with monitoring OSHA compliance. Under laws and rules enforced by the federal Occupational Safety and Health Administration, most private-sector employers must provide a safe workplace for their labor force. If a work environment becomes hazardous, employers must first take reasonable steps to remove hazards rather than exposing their employees to unsafe conditions. For example, if an environment could result in major head injury, the employer should first try to remove the source of potential injury before making workers wear protective headgear.

OSHA regulations also require that employers report workplace deaths and injuries that reach a certain threshold of severity. Workers who wish to report unsafe work environments must be allowed to do so without facing discipline from their employer.

Conclusion

As you can see, there's much more to risk management than simply buying insurance. But because many risks are best handled by transferring them to an insurance company, insurance producers will likely forever be an important piece of the risk management puzzle.

CHAPTER 2: LIFE INSURANCE CONCEPTS

Introduction

In early America, many people could provide posthumous financial support to their heirs merely by relying on wills and common law and passing farmland along to their descendants. As prized as real estate inheritances might be today, these kinds of property transfers were even more important to beneficiaries 200 years ago.

In Jeffersonian times, farmland symbolized more than a neat asset that could be sold for residential, commercial or industrial purposes. It was often a multi-dimensional safety net for families who had depended on loved ones for financial security. Heirs could have certainly tried to make up for the deceased's income by selling the property, but they also had the attractive option of living on the land for as long as they wished and growing various crops to sustain themselves and sell to neighbors. In short, a fortunate beneficiary could receive a home, potential nourishment and a potential source of income for the rest of his or her life, all in the form of a few acres.

The 19th century's Industrial Revolution instigated a slow, steady movement away from these resourceful farming communities and toward the cities. Along with that movement came a change in the way breadwinners managed risks related to untimely death.

With fewer people possessing assets that could be transferred and used on as many levels as farmland, Americans needed to find a new way to protect their loved ones from tragic, financial disaster. This desire for risk management has ultimately led millions of men and women to purchase what is still one of your industry's most popular and, perhaps, most beneficial products: the life insurance policy.

If we wish to validate how highly the public regards life insurance, several studies can provide us with evidence. The Life Insurance and Market Research Association (LIMRA) has reported that 68 percent of Americans have some form of this coverage. Other reports put that number even higher, at 80 percent or so.

As much as the public seems to like life insurance, the product's policy language often confuses prospective buyers. As a contractual agreement between the policyholder and the insurance company, a life insurance policy frequently contains commonly misunderstood passages and incomprehensible legalese. This is often true even in cases when an insurer claims to have presented its terms and conditions in plain English.

Legal disputes between policyholders and insurers confirm that the public is occasionally perplexed by language pertaining to policy loans, investment features and other contractual provisions. Insurers, too, are sometimes surprised by courts' interpretations of policy terms and conditions and sometimes find themselves having to honor claims that were never meant to be covered in the first place.

In order to minimize ugly and costly disputes between the customers they encounter and the companies they represent, insurance producers must know more about contractual terms and conditions than just what is spelled out in a sales brochure. They must school themselves in the details of provisions and restrictions to the point where they can answer any questions they would have about a policy if they were the ones shopping for coverage.

While exploring many common life insurance contractual features in this material, students will learn or be reminded of what these policy elements mean, why they exist and how they have been interpreted by courts in various circumstances. Readers will also review the various kinds of life insurance products and the importance of analyzing each prospect's unique needs.

The reader should note, however, that insurance texts, longtime agents and other reputable sources often contradict one another when listing the most common policy components and the ways an insurer can properly word a policy. These contradictions arise for several reasons.

The insurance industry's state-level regulatory structure represents the most obvious cause of conflict, with insurance laws in California differing from those in Illinois, with Illinois insurance laws differing from those in Indiana and so on. In states where a particular insurance law is less stringent than other states or does not exist at all, each individual insurance company might have its own way of wording and interpreting a particular clause in the insurance contract.

Market demands play a role in non-conformity, too, as companies go beyond a law's minimum requirements in order to attract preferred policyholders. Meanwhile, new products can influence even the most basic policy provisions and have, in fact, been created over the years in response to popular demand for improved policy features.

With all this in mind, preemptive apologies might be in order for the student who wants absolute answers about how policy provisions are written, interpreted and applied. The main point to derive from the following factual presentation is not that a court with jurisdiction in another region of the country ruled in favor of or against an insurer in a specific policy-related case. Instead, we hope you are reminded of how important these contractual elements can be and that you always consider this importance when working with customers, colleagues and supervisors.

Why Buy Life Insurance?

Modern insurance companies offer several kinds of life insurance policies with numerous product features. Offering policies with various provisions and riders makes good business sense because different people buy life insurance for different reasons. Even when two prospective buyers articulate the same general reasons for wanting life insurance, each person might have ordered those identical reasons differently on their individual lists of priorities.

For the sake of review, we should briefly mention some of the important roles a life insurance policy can play in people's lives.

Historically, people have bought life insurance in order to ensure that a dependent or other loved one will not suffer financial hardship after a death. 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 otherwise 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 disabled 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 will not 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

On average, according to Advisor Today (the official publication of the National Association of Insurance and Financial Advisors), agents will handle 10 death claims during their time in the business and will therefore have at least that many chances to witness what life insurance can do for beneficiaries.

Those occurrences are bound to bring positive or negative "what if" scenarios to mind. Agents might recognize a death benefit's positive effects on a grieving family and think, "Thank goodness! What if that person had not bought this policy?" Or, in a more troubling scenario, they might meet people whose lives are unnecessarily worse due to either a bad policy or no policy at all. In these instances, they might think, "How awful! What if this person had been properly covered?"

These examples of good and bad experiences help explain why all people who express interest in buying life insurance need more than just a salesperson. Customers deserve a knowledgeable insurance representative who takes the time to understand their unique needs and who attempts to sell them only the products that could reasonably meet those needs.

In keeping with this service attitude, 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.

For many years, life insurers pounded home the idea of purchasing coverage equal to five times one's income. These days, the five-year standard conflicts with the advice of insurance representatives who say people should buy coverage that is equal to eight, 10 or even 12 times their income.

Depending on the customer, the old five-year figure might be too high, or the 12-year figure might be too low. Although software programs and worksheets can help buyers and sellers arrive at a potentially adequate amount of death benefits and assist the two parties in policy selection, the numbers used to calculate a suitable death benefit are unlikely to protect the insured's present and future interests unless the seller raises important issues and receives honest responses from the applicant.

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 do not 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.

A needs analysis might weigh the cost of a proposed policy against its potential benefits. This will be a particularly important consideration if a low-income buyer would need to make significant financial sacrifices in order to pay premiums. The insurance community remains divided, if not evenly so, in its approach to these low-income customers. Whereas some agents and brokers are likely to convince people with modest incomes that purchasing a policy with decent, nearly guaranteed death benefits is well worth the expense, others will appeal to these consumers by highlighting policies that offer extremely affordable premiums in exchange for few benefits.

A final factor to consider in a needs analysis is the potential buyer's eligibility for a particular policy. The good and bad news for buyers in this regard is that eligibility requirements will probably differ depending on the insurer, with the only near certainties being that someone who has been diagnosed with an aggressive terminal illness, such as AIDS (as opposed to someone who is merely HIV-positive) and certain cancers, has probably waited too long to pursue coverage.

The task of understanding industry-wide eligibility guidelines is made even more complicated by non-uniformity among the 50 states and their respective insurance laws.

Though many companies will disclose the exact reasons for rejecting a life insurance applicant, insurers have not always needed to do so in every part of the country.

Note, however, that life insurers are concerned with life expectancy rather than pure health. As long as a person is likely to live long enough for an insurer to make a profit on a policy, a pre-existing condition that is not known to be life threatening will not necessarily disqualify someone for coverage.

Regardless of their exact criteria for eligibility, life insurers have traditionally placed healthy, low-risk applicants in a "preferred" or "preferred-plus" class and granted lower premiums to those customers. People with smoking habits, weight problems, high cholesterol and a record of personal or family health problems have found themselves paying higher premiums as part of a "standard" or "substandard" class.

Addressing Business and Tax Issues

Before moving further toward our course objectives, we ought to address two topics that appear frequently in trade literature but do not fit into our particular educational agenda. These topics—corporate-owned life insurance and tax issues—will certainly be relevant to some producers and their careers, but only a few specifics about them exist in the main body of this text. The following summaries are intentionally basic and have been included merely for background purposes so that the reader will more easily comprehend some concepts and facts discussed later in this chapter.

Corporate-Owned Life Insurance

Some companies purchase life insurance that protects their financial interests in the event of a key employee's death. In its traditional form, "corporate-owned life insurance" pays no death benefit to an employee's family or to any other worker-designated beneficiary. Proceeds from the policy go to the company, which may use the money in several ways, including as a subsidy for the business while it searches for a replacement, or as a source of funding for employee benefit programs.

A "corporate split-dollar policy," allows the company and the employee to share benefits as stipulated in the contract. Typically, upon the employee's death, the company receives compensation that is the greater of the amount of premiums paid for the policy and the policy's cash value. (In basic terms, a policy's "cash value" represents the amount of money that would be payable to the policyholder if he or she were to cancel or "cash in" the policy.) Any remaining death benefits from the corporate split-dollar policy go to the employee's chosen beneficiaries. In exchange for allowing the employee to designate a beneficiary, the business also reserves the right to borrow money from the policy's cash value at any time during the employee's lifetime.

Life Insurance and Taxes

As long as a policyholder does not borrow money from or cancel a policy, life insurance proceeds are generally exempt from income taxes. This tax break serves beneficiaries well, but the policy might be taxable as part of the deceased person's estate. The value of life insurance might be taxed against the deceased's estate if the deceased owned the policy within three years of death or if the estate is the beneficiary.

The federal estate tax (generally due within nine months of a death) can drastically reduce compensation for legal heirs. To combat this situation, many financial advisers champion the use of insurance trust funds. An insurance trust puts the policy irrevocably under the control of an executor. This person acts on the deceased's behalf by giving policy proceeds to beneficiaries at designated times and in designated amounts.

On occasion, policyholders look to avoid estate taxes by transferring policy ownership to heirs. In order for the proceeds to receive an exemption from estate taxes, such transfers must occur at least three years before the original policyholder's death.

Transferring ownership of a life insurance policy can still require the original policyholder to pay gift taxes. In general, in 2018, a person could pass along assets worth up to roughly $15,000 to non-spouses, without fair compensation, and avoid gift taxes.

This course's reduced emphasis on the federal estate tax stems not only from the daunting complexity of modern tax law but also from the issue's arguably minimal relevance to the majority of consumers. The federal government allows each person's estate to exempt a set dollar amount from taxation, and these exemptions tend to grow as the years go by. At the time of this writing, a person could exempt roughly $11 million from federal estate taxes, and perhaps much more depending on his or her marital status. Estates valued below this amount were exempt from federal estate taxes in 2018.

With this and the "needs analysis" concept in mind, an insurance producer could probably serve clients best by emphasizing a policy's tax advantages to people with large estates and deemphasizing them to people with few assets.

Kinds of Life Insurance

Before we begin to investigate the purpose and intention of various life insurance provisions, terms and conditions, we will first review the most common kinds of life insurance policies.

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 policy are likely to be higher than premiums under the old policy. 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 one of the several permanent life policies we will discuss later.

Term life insurance policies may be categorized based on the way consumers pay for them. An "annual renewable" term life policy might attract buyers who can see themselves canceling the insurance in the not-too-distant future. Premiums for these policies are at their lowest in the first year of coverage and can go up for each additional year.

Technically, people with annual renewable term policies enter into a new contract with the insurer for every year of coverage, but the insurer can change nothing but the premiums throughout the term. The insured does not need to medically qualify for the annual renewable policy every year. He or she must only continue to pay the company's asking price.

"Level term life insurance" lets policyholders maintain their term coverage at the same price for several years. Companies that sell these policies work around age-specific mortality risks by charging customers a consistent average of the cost that would be charged for all years in an annual renewable contract.

Suppose, for example, the insured's policy costs $40,000 over a 20-year term. Instead of paying a low first-year premium of $500 and a twentieth-year premium of $5,000 under an annual renewable contract, the level term customer could pay $2,000 each year for the entire term.

A level term insurance policy will probably cost more than a standard annual renewable policy near the beginning of the term when the insured person is younger, but it will cost less than a standard annual renewable term policy near the end of the term when the insured person is older.

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.

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 (or at least remain untouched) in tax-deferred accounts until the policyholder decides to use the money. In general, this money 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.

Some policies' cash surrender values and premiums are impacted by dividends. In the context of insurance, a "dividend" is a yearly partial return of premiums that insurance companies believe is in excess of their operating needs. Policyholders who receive dividends often have multiple options regarding what to do with them. For example, dividends might be paid to the policyholder in cash, held by the insurance company for the purpose or collecting interest or (in most cases) used to offset the cost of future life insurance premiums.

It is important to note that not all permanent life insurance policies pay dividends. Insurers that are configured as stock companies share profits with stockholders and usually do not incorporate dividends into their policies. Mutual life insurers, on the other hand, share their profits with their policyholders and do incorporate dividends into their cash-value contracts. This distinction helps explain why policies from mutual insurance companies are often called “participating policies” and why policies from non-mutual insurance companies are often called “nonparticipating policies.”

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.

Types of Permanent Life Insurance

Unlike the different kinds of term life insurance, the various types of permanent life insurance policies differ significantly in ways beyond their premiums. The three main varieties of permanent coverage are whole life insurance, universal life insurance and variable life insurance.

Whole Life Insurance

Whole life insurance contracts can usually remain in force at least until the insured person reaches age 100, and premiums for these policies usually stay the same as long as the policyholder pays them on time. The price for whole life insurance pays for more guarantees than a person will find in a typical universal life or variable life policy, and the product remains popular among people who want permanent coverage but remain fearful of possible economic downturns.

Unless the policy’s owner borrows against the policy’s cash value, whole life policies will pay guaranteed minimum death benefits and feature guaranteed minimum increases in cash value. Guaranteed increases in cash value are achieved through investments in low-interest bonds and other low-risk ventures. The insurer takes responsibility for managing the investment portion of the policy, allowing customers to develop a financial asset without forcing them to wade through numerous investment options.

In some respects, the modest performances and common guarantees involved with whole life insurance can encourage saving among consumers who would not normally conserve much of their money. Many parents have utilized whole life’s relative security as a foundation for college funds.

Still, among other clients who favor growth potential over security, the investment features of basic whole life insurance can seem insignificant. When interest rates on policy loans are low, some whole life customers borrow money from their policies and put that money into high-growth opportunities. Though this strategy has certainly not paid off in every instance, it has absolutely encouraged carriers to develop different life insurance products that give buyers more control over how their premiums are invested.

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.

Group Life Insurance

Though it can perform other functions, "group life insurance" is most commonly used to insure several people who work for the same employer. Premiums for group coverage usually depend on the collective age of the group participants and help pay for limited death benefits in the neighborhood of one or two times an insured person's annual salary.

Group life insurance involves very little underwriting and, therefore, can allow an ill or older individual to obtain some coverage at a low price. Some employers even offer limited group life insurance benefits at no cost to their workers. The typical employer-funded group plan will pay at least enough death benefits to offset funeral and burial expenses and perhaps some debts.

Unfortunately, many consumers do not realize that group life insurance is unlikely to help beneficiaries meet their long-term financial needs. Death benefits from these policies are not likely to sustain a young child for several years and might not satisfy outstanding debts on a home.

Laws and products that address insurance portability have allowed people who leave a group to convert their group life coverage into an individual policy under certain circumstances.

Accidental Death Insurance

"Accidental death insurance" is often bought by consumers who want to pay low premiums for at least some level of coverage and by travelers who are buying plane tickets. Many employers offer accidental death coverage as a free employee benefit.

This insurance can be purchased in combination with dismemberment coverage, or it can be bought as a rider to another policy. As a rider, the coverage will generally pay double the death benefit if the insured's life ends in an accident. This explains why accidental death benefits are often associated with the term "double indemnity."

In order for accidental death policies to pay benefits, there must be clear evidence that a death occurred because of an accident and not because of other factors or some combination of accidental and non-accidental factors. Most policies will only pay benefits if the undisputed accident occurred no more than three or four months before the insured person's death.

Deaths that are unlikely to be covered by this product include death by sunstroke, drug overdoses, suicide by insane persons and deaths suffered by people aboard non-commercial aircrafts.

Credit Life Insurance

"Credit life insurance" is typically included in an umbrella-like policy that also covers unemployment and disability risks for people who are in debt. This product is similar to mortgage insurance, but beneficiaries can use its death benefits to eliminate debts that have nothing to do with real estate.

Though no specific numerical limits exist regarding the face value of a credit life insurance policy, the face value is nearly guaranteed to be low because the insurance is only

designed to cover outstanding debts and any interest owed to a lender. The policy usually does not include a death benefit that can replace income or provide for a dependent.

Premiums for credit life insurance are likely to remain the same throughout the coverage period, but the policy's face value drops as the insured person pays down debts. Insurers price the coverage as if it were an extremely inclusive group policy, with eligibility rarely jeopardized by a person's age or health status.

Funeral Insurance

Funeral insurance remains a multi-billion dollar industry despite criticism from some consumer advocacy groups and is commonly targeted at low-income families. For a few dollars each month, this insurance offers a modest death benefit (usually anywhere between $5,000 and $10,000) that families can use to pay for burial and other death expenses. The death benefit from a funeral insurance policy is rarely intended to replace the deceased's income.

Funeral insurance companies have stressed that, unlike term life insurance policies, claims on many funeral insurance policies can be paid no matter when the person dies. Other insurance workers believe a consumer should purchase a funeral policy only if he or she is ineligible for other life insurance products.

Joint and Survivor Life Insurance

Joint and survivor life insurance policies extend coverage to two or more people (usually a married couple), but they only pay one death benefit. Because only one death benefit goes to beneficiaries, a joint or survivor policy can cost significantly less than two individual permanent life products.

"Joint life insurance" is often called "first-to-die" coverage because the death benefit comes when the first person among the insureds passes away. This product became popular initially as a tool to help ensure that one spouse could pay off a mortgage loan and remain in a family home after the death of the other spouse. Some joint life insurers offer a "survivor purchase option," which might allow the survivor to trade in the death benefit for another first-to-die policy or an individual policy of equal value.

"Survivor life insurance" is often called "second-to-die" coverage because the death benefit comes when the last of the insureds passes away. This product became popular initially as a tool to help ease estate tax concerns for heirs.

Parts of a Life Insurance Policy

Now that we understand the general differences among the various life insurance products available in today's market, we can explore the intricacies involved with policy terms and conditions.

The Face Page and the Entire Contract Clause

Perhaps the most important element to understand throughout our exploration of these issues is that a life insurance policy is a legally binding contract between the policyholder and the insurance company. This point is usually stressed somewhere on the policy's "face page" or within the policy's "entire contract" clause.

The face page explains the duties that the insured and the insurer are expected to perform throughout the policy's lifespan. It declares that the policyholder will be held accountable for filling out a valid, honest application and for paying premiums. Meanwhile, the insurer

will be held accountable for paying benefits on any valid claims, as long as the policyholder fulfills his or her end of the agreement.

An entire contract clause can be found within the actual policy (as opposed to within a policy summary or other document). This clause alerts all involved parties to the fact that the delivered policy contains all the terms and conditions related to coverage. It says the terms and conditions within the policy cannot be changed by the insurer to the detriment of the consumer during the policy period. It also states that the policy application, as filled out by the applicant, is considered part of the contract.

Minding the Application

The life insurance application and any personal medical records used by the insurer to underwrite a policy become part of the contract. The policyholder who makes false statements on these documents might risk either a reduction in his or her coverage or full termination of the contract.

Policyholders will typically receive copies of the completed application no later than when they receive a copy of the full policy. By retaining and reviewing copies of these documents, insurers and their clients can substantiate or dispel various alleged misstatements that could affect a person's right to death benefits.

Providing copies of the completed application to the consumer does not entirely eliminate the potential for disputes between insurers and the public. In order to reduce additional legal problems, insurance producers must make an effort to explain how customers should fill out applications and how incorrect information on the application could have a negative impact on coverage.

Ownership Clauses

A life insurance policy might mention "pre-maturity rights," also known as "ownership" rights. The policy owner (who might or might not be the person insured by the policy) is the individual who is legally held to the consumer's responsibilities that are spelled out in the life insurance contract.

Other than the insurance company, the policy owner is the only party who controls how the policy is set up. The owner is also the only person capable of choosing beneficiaries.

Once the policy is issued, the owner reserves the right to do any of the following:

- Borrow money from the policy.
- Use the policy as collateral for a loan.
- Access the policy's cash value within the limits of the contractual agreement.
- Utilize accelerated death benefit features.
- Designate and change beneficiaries.
- Make any other permissible changes to a policy, such as deciding how much to pay for a universal life insurance product or how to invest premiums for a variable life insurance product.

The owner may also transfer some or all pre-maturity rights to another entity without needing consent from beneficiaries or the insured.

The insured individual and the owner of the life insurance policy will often be the same person. Yet it is possible for a beneficiary or a third party to own an insurance policy on another person's life.

Practical reasons exist for this kind of arrangement. For example, even though some children are covered by life insurance or are listed as beneficiaries on policies, laws might prohibit anyone under the age of 18 from owning a policy. Other reasons for transferring policy ownership tend to involve probate and tax issues. Some applicants grant ownership to a trust in order to avoid estate taxes.

Insurable Interest

In general, a person can take out a life insurance policy on another person if the proposed owner can demonstrate an "insurable interest" in the other person's life. In simple terms, insurable interest within this context is a reasonable desire, on the owner's part, for the insured person to remain alive.

Ever since insurable interest became an industry issue, insurers have assumed that an individual has a reasonable desire to remain alive. Therefore, people are allowed to own life insurance policies on themselves. Insurers have also traditionally assumed that close family members (such as spouses, parents and children) and business partners have reasonable desires to see one another remain alive. So these people are usually allowed to own policies on one another.

Over time, the definition of insurable interest has become broader. Employers can now own policies on key personnel, and former spouses can often take out policies on each other, particularly when alimony and child support factored into a divorce settlement. Some insurers will even allow an unmarried person to own a policy that insures a significant other.

Despite the flexibility that is sometimes allowed by insurable interest, the insured person often must consent to another person owning a policy on his or her life. This consent might or might not be required when there is a spousal relationship between the policy owner and the insured. If people wish to void life insurance policies that have been taken out on their lives by another person or corporate entity, they should seek out local legal counsel.

Assignment Clauses

The owner's option to transfer his or her rights to another entity is spelled out in a life insurance policy's "assignment clause." In general, insurers put few restrictions on assignments, but some insist that the new owners either demonstrate an insurable interest in the insured's life or pay fair market value for the policy. Even when the insurer sets conditions for assignment, the company typically warns it will not be liable for any negative consequences that may arise as a result of the assignment.

Collateral Assignment

There are a few kinds of assignments that the owner can choose from. In a "collateral assignment," the policy owner uses the insurance strictly as a means of obtaining credit from a lender. Collateral assignments are meant to be temporary, with the end date dependent on when the policy's owner repays a loan.

Rather than granting the lender major ownership rights, a collateral assignment only allows the creditor to collect a portion of the death benefit and to access part of the cash value if the owner never repays a debt. If the owner dies, collateral assignees who are listed as beneficiaries are entitled to a death benefit equal to any remaining debt.

A collateral assignment agreement will be made in writing and will state whether or not the lender has assumed any responsibility for paying policy premiums. If creditors take on responsibility for paying premiums, they might be able to borrow money from the policy's cash value in order to keep the policy active.

Absolute Assignment

In an "absolute assignment," the original owner transfers all rights to a different person or entity, thereby losing control of the coverage and its cash value.

Absolute assignments can greatly affect insured persons and beneficiaries. The new policy owner is under no obligation to continue paying for the coverage and can exchange the policy for its cash value at any time. Depending on the insurer and the policy, an absolute assignment might either remove beneficiaries automatically from the contract or give the new owner the opportunity to revoke the existing beneficiary designations.

Other Forms of Assignment

Other transfer-related options exist somewhere between collateral and absolute assignments and allow the original policyholder to retain certain ownership rights. The original owner might, for instance, insist on preserving his or her right to receive dividends on a participating life insurance policy but be willing to forfeit all other pre-maturity rights.

Incontestability Clauses

The "incontestability clause" specifies how long an insurer may investigate possible frauds or misstatements on an application and deny coverage after the policy has been issued.

Incontestability clauses typically give the company two years to probe for untrue statements that affected the price and scope of coverage. These untrue statements are known as "material misrepresentations." When an insurance company refuses to cover a person based on alleged material misrepresentations, it must usually return all premiums to the policy owner in exchange for voiding the insurance.

Depending on state laws and judicial opinions, an insurer might be able to lean on the incontestability clause to deny a death claim based on a material misrepresentation even if the misrepresentation was not a factor in the insured person's death. This means, for example, that someone who lies about not having cancer, for example, can jeopardize death benefits for beneficiaries even if he or she ends up dying in an accident or from a disease other than cancer.

Insurers generally cannot rescind a policy after the contestability period has passed, even if they realize a policyholder has clearly engaged in material misrepresentation. Exceptions to this rule might include cases in which the policyholder bought the coverage with intent to murder the insured, lacked an insurable interest in the insured or recruited an impostor to impersonate the insured in a medical examination. In these situations, it is often assumed that no valid contract ever existed and that the insurer is therefore not liable for overstepping the incontestability clause's boundaries.

The incontestability clause protects policy owners from some potential instances of "post-claims underwriting," in which an insurer does not fully judge an insurance applicant's risk potential until after a policy has been in effect and after beneficiaries have requested compensation for a loss. With the incontestability clause in effect, the insured does not need to spend several years worrying about having made an innocent mistake when he or she applied for coverage. The incontestability clause has proven to be broad enough to even protect some applicants who intentionally defrauded insurance companies.

Some Incontestability Clause Case Studies

In order to comprehend the significance of the incontestability clause and the varying legal interpretations of other clauses, the reader is asked to examine the real-life case studies in this chapter. These examples were chosen in order to show students how different policies, laws and circumstances can lead to different legal outcomes even if two given situations seem very similar. Our first two case studies deal with alleged medical misrepresentations and an insurer's limited right to deny death benefits.

Incontestability Case #1

A man bought a $2 million life insurance policy on himself for use as collateral for his business. He listed the business as the intended owner and beneficiary.

On an application, the man was asked if he had ever had cancer, and he answered, "No." The application stated, "The statements and answers are true to the best of my knowledge," and also said, "No insurance shall take effect unless and until the policy has been physically delivered and the first full premium paid during the lifetime of the insured and then only if the person to be insured is actually in the state of health and insurability represented in … this application."

The man took a physical to obtain coverage, and the insurance company received copies of his medical records from a physician. The insurer believed the man's health was satisfactory and issued the policy on April 26. On May 1, the man filled out an identical application for a policy that listed a trust, rather than his business, as the owner and beneficiary. This new policy was delivered to him 24 days later, and the initial policy never went into effect.

The application from May 1 contained no mention of an April 18 physical examination that revealed blood in the man's feces. On June 20, the man was diagnosed with colon cancer and later died from the disease. The insurance company learned that the man had had a tumor at least since January, roughly three months before he ever applied for the coverage, and it decided to void his policy.

The man's wife sued for breach of contract, but the insurer claimed it was within its rights because the man had misrepresented his medical condition. The wife argued that even though her husband had misrepresented his health, he had not intended to commit fraud. Though he might have had cancer when applying for coverage, he had not been conclusively diagnosed with the disease by that time.

The United States Court of Appeals for the 8th Circuit ruled in the insurance company's favor, determining that the man's good faith was not the issue at hand. Instead, the coverage had been denied because the information given to the insurer about the man's health turned out to be factually inaccurate.

Incontestability Case #2

In another case, a Michigan woman filed a $44,000 death claim after her husband died in a swimming accident. Despite the expiration of the policy's contestable period, the insurance company denied the claim and offered to return premiums to the wife after it learned the man had not disclosed a heart condition when applying for coverage.

Both parties agreed the heart condition did not play a role in the husband's death, but the insurance company claimed it was within its rights to deny benefits because the man would not have received coverage in the first place if he had properly told the insurer about his health.

Though judges acknowledged that laws in other states might contradict their ruling and that misrepresentations need not relate to death in order to merit a denied claim, the state Supreme Court ruled in the wife's favor.

In its opinion, the judiciary said the incontestability clause "balances the concerns of insureds that years after the application date an insurance company would refuse to pay benefits and desire to avoid contracts, no matter how old, if there was material misrepresentation at the time the contract was made."

Incontestability Case #3

Our next two case studies demonstrate different interpretations of how the incontestability clause can protect either the insured or the insurer when relatively obvious instances of fraud are revealed.

A New Jersey man applied for disability insurance on January 20, 1987, and claimed, on his application, he had not been treated, observed or examined by a doctor in the preceding five years and had not been alerted to any possible eye diseases he might have developed. The insurer issued the policy less than two months later and used an incontestability clause that said, "After your policy has been in force for two years, excluding any time you are disabled, we cannot contest the statements in the application. No claim for loss incurred or disability beginning after two years from the date of the issue will be reduced or denied because a disease or physical condition existed before the date of issue, unless it is excluded by name or specific description."

When the man filed a disability claim on January 7, 1991, for loss of vision, the insurer denied benefits and said its action was based on material misrepresentation. According to an attending physician, the man exhibited symptoms related to an eye disease in late 1989 and had sought similar treatment from two other doctors in 1985.

The man admitted playing a role in insurance fraud, yet he reasoned the insurance company could not deny his claim since the contestability period had ended.

The Supreme Court ruled in the insurer's favor and said incontestability clauses were created to protect policyholders who made "technical" mistakes on their insurance applications. According to the court, "Statutory language that precludes a defense based on a pre-existing disability does not protect insureds who make fraudulent misrepresentations in their applications. Rather, the language is intended to protect those insureds who are unaware of their diseases."

Incontestability Case #4

A different outcome surfaced in a decision from the Supreme Court of California. In this instance, a man with AIDS lied about his condition in order to obtain a life insurance policy and recruited an impostor to take a medical examination in his place.

On his application, the man claimed he was 5'6", weighed 142 pounds and did not smoke. But the man who gave a physician an HIV-negative blood sample stood 5'10", weighed 172 pounds and produced urine that proved he was a smoker. The examined person had no identification to match him with the applicant, and the insurer's medical examiner documented this fact.

The insurance company opted to issue a policy for the applicant on May 1, 1991, which said, "We will not contest coverage under the certificate after it has been in force during the life of the covered person for two years from the certificate effective date, if all premiums have been paid."

The applicant eventually sold his policy in the secondary market, and the policy's new owner received confirmation from the insurer that the contract's contestability period had expired. The applicant died on June 11, 1993, and the new policy owner filed a death claim with the insurer.

A tip eventually alerted the insurance company to possible fraud, and after conducting a handwriting analysis, the insurer denied the claim. The new policy owner sued for compensation, and the court ruled against the insurance company.

The court acknowledged that fraud is bad but also said the insurer only has a limited time to look for it. The judiciary reasoned that the insurer had all the evidence it would have needed to void the policy within a two-year period and said the company squandered that chance by just accepting premiums rather than investigating the matter promptly.

In response to the insurer's impostor defense, the court said the sick man was the one who applied for coverage and was the person who the company intended to cover. Therefore, the covered person was not an impostor.

According to the court, "When the named insured applies for the policy, and the premiums are faithfully paid for over two years, the beneficiaries should be assured they will receive the expected benefits, and not a lawsuit, upon the insured's death."

Suicide Clauses

Since self-inflicted deaths factor into the mortality tables that insurers use to underwrite coverage, it would be illogical for insurance companies to exclude all suicides in their life insurance policies. But insurance professionals still hope to discourage people from taking their own lives in order to create income for beneficiaries.

Similar to the incontestability clause, the "suicide clause" usually states that an insurer will not pay death benefits when insured people kill themselves within two years of obtaining coverage. A clear and complete suicide clause will also mention the company's claim responsibilities in cases when the insured commits suicide while sane or insane.

Contrary to tradition, some modern courts have put the burden of proof on the insurance company's' shoulders in regard to denying death claims based on suicide. This means an insurance company that wants to deny a claim on suicidal grounds might need to prove that a person's death was a suicide and had nothing to do with any accidents or medical problems.

A Suicide Clause Case Study

Firm disagreements between insurers and beneficiaries in regard to an alleged suicide are very likely to push the arguing parties into a courtroom. For a real-life example, we will turn our attention to a case heard by a U.S. district court.

A depressed man went to a physician, who prescribed anti-depressant medication for him. According to the doctor, the man did not seem suicidal during the appointment.

At some point, the doctor doubled the dosage, and the man shot himself two days later without leaving a note. His wife filed a claim with the company that insured him through an accidental death policy.

The accidental death policy did not cover "suicide or any intentionally self-inflicted injury," but the wife claimed the policy should have paid benefits because it failed to differentiate between sane and insane suicide. She said her husband did not intend to kill himself and that the anti-depressant medication was to blame for his actions.

The wife, who also sued the drug company, conceded that a statement on the policy summary said the insurer had the power to interpret the policy, but she also claimed this statement did not exist within the policy itself and that the actual policy's content ought to have overruled the content of the policy summary. She brought the insurance company to court, alleging it needed to prove the policy did not cover her husband's death.

The court disagreed, concluding that the burden of proof was on the wife. If she wanted the death to be covered by an accidental death policy, she would first need to prove that the death was, indeed, an accident.

Misstatement of Age or Sex Clause

Age and gender are important underwriting factors for life insurers. After all, on average, younger people will live longer after qualifying for coverage than older people, and women will generally live longer than men.

The "misstatement of age or sex clause" allows an insurance company to adjust coverage appropriately when an insured's supposed age or gender turns out to be inaccurate. The clause forbids cancellation of a policy based on these inaccuracies, unless the policy and local laws allow an exception when the owner or an insurance representative has clearly and intentionally tried to defraud the company.

If an insurance company can prove a misstatement of age or sex, the policyholder will typically need to pay an adjusted premium in order to avoid a change in coverage. When the insured's age is actually higher than originally thought, either premiums will rise or the death benefit will be reduced. When the insured's age is actually lower than originally thought, the insurer will either return a portion of premiums or increase the death benefit.

Sometimes uncertainty arises when an insurance company confirms a misstatement of age. The client and the salesperson might understand that the premiums and coverage will be adjusted. But how will this be done?

Suppose a client has been covered by a life insurance policy for 20 years, and the insurer finally recognizes that the person's stated age is incorrect. Will the coverage and premiums be adjusted based on the insurer's current rates, or will the adjusted premiums and coverage be based on prices from 20 years ago? A proper misstatement clause will explain how the insurer will handle this sort of situation.

Adding to possible confusion is the fact that insurance companies treat age in different ways, even before misstatements are realized. Some insurers base their rates on a person's actual age upon application for coverage, while others round the person's age to the nearest birthday.

Note that misstatements of age do not always stem from an applicant's conscious desire to receive a lowered premium. They also can grow out of confusion and mistakes. These mistakes can apply to the producer as well as to the applicant.

In one documented case, a person applied for life insurance, received an issued policy and had a birthday in between. In error, the insurer used the age listed on the application and gave the insured a lower premium than he deserved.

When discussing age-related errors, experts have offered precautionary suggestions to their peers. The suggestions include the following:

- Making space on applications for a person's age AND birthday.
- Requiring an applicant to submit a birth certificate to the company before a policy may be issued.

Dividends, Vanishing Premiums and Policy Illustrations

As we learned earlier, certain types of insurance companies pay back a portion of premiums to policyholders in the form of dividends when profits exceed business needs. These dividends might be possible because an insurer priced a product too high or because the company made more than enough money in a year to meet requirements related to its reserve and surplus accounts.

Technically, only mutual insurance companies (which share company profits with customers rather than stockholders) give out true dividends to policyholders. When people use the term "dividends" in connection with policyholders at stock insurance companies, they are probably referring loosely to interest earned on permanent life insurance policies.

Mutual insurance companies calculate dividends by looking at mortality rates, interest rates, business expenses and other statistics. Due to the variable nature of those numbers from year to year, dividends are not guaranteed.

If a mutual company experiences an unfavorable investment outcome, the insurer may choose to lower dividends or to temporarily not offer them at all. Yet careful insurers have found ways to compensate for unknown economic results and have always been able to offer some dividends to policyholders, even if those dividends are lower than expected.

Insurance companies give customers several options when it comes to utilizing their dividends. These options are typically as follows:

- A policyholder can receive a check from the insurance company and use the money created through the dividend to pay for private expenses.
- A policyholder can keep the money with the insurer and allow it to gather interest.
- A policyholder can use the money to increase a policy's death benefit on a cash-value policy.
- A policyholder can exchange the dividend for a term life insurance policy.
- A policyholder can repay a policy loan by giving the dividend back to the insurance company.
- A policyholder can use the money to offset current or future premiums.

That last option became very popular during the 1980s and relates to a life insurance feature called a "vanishing premium." When owners pay premiums for an extended period of time, an insurer might allow premiums to "vanish" by using policy benefits to pay for coverage. Rather than billing participating policyholders directly for coverage, the carrier might take premiums out of accumulated dividends and interest.

When everything goes as planned, a policy with vanished premiums can create convenience for people who expect to hang onto their permanent life insurance for a long time. These policy owners might believe that they possess fully "paid-up" coverage.

Unfortunately, a vanished premium can sometimes reappear if dividends from a participating policy become too small to cover the cost of the insurance.

It's also important for insureds to know that dividends—no matter how steady they might seem at any given time—are not guaranteed to remain stable forever. When a policyholder depends on them to vanish premiums, dividends that go up or down even a single percentage point can mean the difference between the policy paying for itself and the buyer needing to pay more money to the insurance company.

A few major insurance companies have been accused of overstating the probable size of future dividends to older customers in order to make policies with vanishing premiums seem attractive to retirees on fixed incomes. One company was accused of making retirees think the money they were actually paying to vanish a life insurance premium was funding an annuity. In the end, the company faced fines of up to $20 million and was forced to give millions of dollars in refunds to policyholders.

In a real-life example from a district court in Mississippi, a man bought three $230,000 vanishing-premium policies. An insurance producer allegedly showed the man an illustration that suggested the policies would be paid up after two years if the prospect paid at least a $2,800 annual premium for each policy.

After two years, the man received a letter from the producer, as well as documents from the insurer's home office, which said the financial plan had worked successfully and that the premiums had vanished. Over the next three years, the man received premium notices from the insurer, and the producer told him dividends and policy loans would continue to cover the cost of coverage.

The man later learned the vanished premiums could return and that the illustrations used to demonstrate policy dividends had been based on overly optimistic investment projections. He accused the insurer and the producer of fraud, breach of contract, intentional interference with contract rights and negligent misrepresentation, and he instigated a class action lawsuit that included plaintiffs who had bought whole life or universal life policies from the company from 1982 through 1996.

Courts ruled the producer had no fiduciary duties to the policyholders in this case, cleared the producer of charges related to deceptive sales practices and dismissed the contract-related charges. They did not, however, dismiss fraud charges against the company. In response to the suit, the insurer offered a settlement to 240,000 policyholders that was worth $55 million in increased benefits and other compensation.

As lawsuits of the real and threatened varieties became more prevalent, the insurance industry responded to the vanishing-premium controversies. One insurer accused of wrongdoing stopped using the words "vanishing premium" and substituted "premium offset by policy values" in their place. The National Association of Insurance Commissioners (NAIC), which creates model industry regulations, has supported the following measures:

- Stopping the use of the term "vanishing premium."
- Forcing insurers to have dividend illustrations approved by a special actuary who has no connection to sales or marketing.
- Requiring the agent and the consumer to sign a document that says the consumer understands the illustrations and the potential benefits and consequences that could materialize based on the policy's structure.

The legal disputes over dividends and vanishing premiums have lent themselves to a broader discussion about fairness and policy illustrations. Professionally constructed illustrations can help consumers visualize how permanent life insurance policies can grow in cash value over time. But because policy illustrations should ultimately serve as a buyer's tool rather than as a salesperson's weapon, some insurance producers have called on the industry to forbid agents and brokers from emphasizing interest rates and dividends that are not guaranteed.

Some among this group would still allow salespersons to discuss an insurer's past interest rates and dividends with clients but would not allow salespersons to use these numbers on illustrations or even discuss them without emphasizing that past dividends are not guarantees of future dividends. Other people suggest that an insurer should be able to use non-guaranteed interest rates and dividends in illustrations as long as the company lowers its projections by a percentage point or two. Most state regulators have adopted the stricter of those two positions and require insurers to emphasize that dividends are not guaranteed.

Policy Loans

Several reasons exist for policyholders to take advantage of a contract's loan features. For example, prospective borrowers are unlikely to be turned down by their insurance company as long as their policies serve as adequate collateral for a loan. Along with this privilege come fewer questions on a loan application and greater overall privacy than a person would receive from a traditional lending institution, such as a bank.

Though the federal government has tightened tax laws pertaining to life insurance loans over the past several decades, borrowing from a life insurance policy is still likely to incorporate fewer tax issues than borrowing from a person's 401(k) or other retirement account. Also, unlike other credit situations, a loan from a life insurance company usually comes with a low-pressure obligation to pay off the debt. If a person dies or cancels a policy without paying off a loan, the company can simply take money out of the policy's cash value.

For a long time, policy loans were considered a great bargain for consumers because interest rates were fixed throughout the industry near 5 percent, a much lower rate than what banks were offering to borrowers at the time. By the 1970s, so many people had taken out policy loans that life insurers had become a bit nervous. As an insurer passed out loans, it had to work harder to maintain adequate reserves. The strain on reserves, in turn, limited insurers' investment options by forcing companies to keep their money in safe, low-interest bonds rather than in higher-risk and higher-growth markets like real estate. Insurers eventually gained the ability to give loans at variable interest rates.

Many companies give policyholders a few choices in regard to interest rates on loans. These choices relate to a concept called "direct recognition," in which coverage and benefits will depend on a policyholder's lending preferences and outstanding debts. Because borrowing money from an insurance company temporarily deprives the company of money it could invest, participating clients who take out policy loans might watch their dividends drop. Borrowing money could also affect the interest rates that are applied to a policy's cash value. A client can lessen these negative consequences by agreeing to a larger interest rate on a loan. Someone who chooses higher interest rates on a loan might also have the ability to obtain more overall coverage at a cheaper price.

A number of borrowers lose sight of the fact that, like most other unpaid debts, the amount of money owed to an insurer will increase if a person does not pay off a loan in a timely

manner. This forgetfulness or lack of understanding can spell trouble for people who take out major loans on policies with insufficient cash values. When left unpaid, loans plus accumulated interest on those loans can impact the amount of death benefits payable to beneficiaries.

Automatic Premium Loans

A policy feature known as an "automatic premium loan" permits the insurance company to use part of a permanent life insurance contract's cash value to keep a policy in force when the owner misses a premium payment. Most insurers do not place limits on automatic premium loans in regard to either amount or frequency, as long as the policy's cash value is large enough to cover the cost of coverage. Other companies might have rules that prevent an owner from utilizing automatic premium loans too frequently. Their policies might state that owners can only take out a specific number of consecutive loans to pay premiums, or they might say owners cannot take out any more than a specific number of automatic premium loans in the same year.

Life Insurance Premiums

The cost of life insurance to the consumer will depend on several factors, including mortality rates, lapse rates, administrative expenses and an insurer's investment performance. A person can buy a policy with one lump sum, secure the coverage permanently through a set number of premium installments or pay premiums on a steady schedule until a policy reaches its maturity date.

Insurance companies reserve the right to charge policyholders interest when premiums do not arrive on time, but many carriers are lenient and do not bother to follow through. For life insurance policyholders, the chief risk involved with not paying premiums in a timely fashion is that the insurer might revoke coverage. If an insured person dies without having paid a premium, the company will recoup the cost of coverage by deducting it from the death benefit.

Free-Look Periods

A policy provision called a "free-look period" gives new policyholders a short period of time to possibly reconsider their purchase, cancel the policy and receive a refund of that first premium with no questions asked. In order to receive a full return of the first premium and not face any surrender charges, the owner must return the policy to the home office or to the agent or broker before the free-look period expires.

The free-look period begins on the day the policy's owner receives the newly issued policy from the insurer. The deadline for a complete return of premium and other related fees will depend on state laws and policy language. Some insurers limit the free-look period to 10 days. Others allow for a 20-day period. In some states, people over the age of 60 have received a 30-day free-look period for life insurance policies and annuity contracts.

Policies meant to replace previous coverage will usually feature longer free-look periods than other policies. Universal life insurance contracts, which commonly replace other life insurance policies, tend to give consumers longer free-look periods than other life insurance products.

Variable life policies deserve special mention in any discussion of life insurance and free-look periods. People who own these policies obviously want their cash value to grow quickly, yet a fast, negative return on an investment would complicate matters if the owner were to ask for a return of premium in accordance with a free-look provision.

Perhaps this explains why initial premiums for variable life insurance are often put in money market accounts, where policyholders' invested funds are very unlikely to decrease in value. When insurance companies decide to put an initial premium into special accounts during free-look periods, they might need to disclose this fact in the policy, so that policyholders are not surprised by early investment performances and are able to allocate their investments at their own discretion immediately after the free-look period passes.

Grace Period

Even if a policyholder misses a premium payment, the insurer must keep coverage intact until the policy's "grace period" has ended. This grace period typically lasts anywhere from 30 days to 60 days.

A Grace Period Case Study

A grace period can certainly ease insurance concerns for policy owners who either forget about a payment or find themselves on too tight a budget to pay a required premium. But as a case study from the U.S. Court of Appeals for the 8th Circuit proves, this policy feature can also offer unexpected comfort to life insurance beneficiaries.

A married couple in Arkansas had bought a group-rate accidental death and dismemberment policy worth $150,000. On June 30, the husband talked to an insurance representative and intended to cancel the policy. The insurer gave the man two options: He could receive an immediate refund from the company, or he could simply not pay the next premium—due August 13—and allow the policy to quietly lapse. The man opted for the latter. He and his wife died in an automobile accident on September 11 that same year.

State law, at the time of the deaths, said, "The group policy, excluding an annuity policy, shall contain a provision that the policyholder is entitled to a grace period of 31 days for the payment of any premium due except the first, during which grace period the death benefit coverage shall continue in force unless the policyholder shall have given the insurer written notice of discontinuance and in accordance with the terms of the policy."

The couple's children argued, based on the law, that their parents' policy should have remained in force until September 13. Meanwhile, the insurer argued that the husband's phone call served as adequate notice of his intent to cancel, based on company practice, and refused to pay any death benefits to beneficiaries.

The insurer said the state law did not apply to the couple's policy because the law concerned group life insurance coverage and not group accidental death and dismemberment coverage.

The insurer's argument did not satisfy the court. State law defined "life insurance" as "insurance on human lives," and the judiciary said it had "no reason to exclude from that definition a human life lost to an accident or by accidental means."

Cancellations and Nonforfeiture Benefits

Sometimes, rather than worrying about the continuance of coverage, consumers might decide that they no longer want their life insurance policy. As anti-insurer as this might sound, these people might have good reasons for getting rid of their coverage. A person might have little concern for estate planning and believe enough assets exist to leave dependents and loved ones a substantial financial cushion. People with average or modest savings might have managed to pay off debts and raise a family to a point where they no longer need to worry about dependents' financial futures. When people grow older,

they might not have potentially needy beneficiaries, and they might feel like cashing in their permanent life insurance policy in order to fund their retirement.

Permanent life insurance policies feature “nonforfeiture benefits,” which give longtime policy owners some level of compensation when they either cancel or reduce their coverage. In a bit of a give-and-take situation, these benefits tend to increase as an in-force policy ages and as the policy’s cash value grows. This gives owners an incentive to not terminate their coverage after only a few years.

Different insurers will have their own variations of nonforfeiture options, but we are at a point in history when those options, across the industry, can be narrowed down to three choices.

One option involves a clean break between the insurer and the consumer and sees the policyholder surrendering coverage in exchange for its cash value. When a person asks for the cash value, the insurer will deduct unpaid premiums and outstanding loans from the total surrender value. As good as this option might sound, it can entail a few drawbacks. Surrendering a life insurance policy could involve surrender fees, and people who cash in their policies might have to count a portion of the cash as taxable income if investment gains have pushed a policy’s cash value above the amount of money a client actually spent on premiums.

Other options merely modify the relationship between the insured and the insurance company and continue coverage in some form. A popular nonforfeiture benefit allows the policyholder to exchange permanent life insurance for paid-up term life insurance. In a third arrangement, a person who still prefers to own at least some life insurance but worries about outliving term coverage can trade in a policy’s cash value for a lesser amount of paid-up permanent insurance.

A policyholder often has the right to choose among these three basic nonforfeiture options upon cancellation or reduction of coverage. However, a life insurance contract may list a default nonforfeiture benefit that will go into effect if coverage is canceled and the buyer takes no further action.

Term life insurance boasts a comparatively clean-cut cancellation process. Because term life insurance has no cash value, a policyholder who no longer desires coverage can simply ignore premium notices, take advantage of a grace period and allow a term life insurance policy to lapse. Income tax issues should be non-existent in this case, and any cancellation fees will generally be smaller than surrender charges for permanent life insurance. A person who actively cancels an annually renewable term policy might even be entitled to a partial refund of premiums.

Each policy might feature important details regarding cancellations. Consumers would benefit from consultations with unbiased financial experts before deciding whether or not to cancel their life insurance.

Reinstatement Clauses

When an insurance company rescinds coverage because of unpaid premiums, the policyholder often has the right to regain coverage within a certain period of time. Conditions for this option are found in a policy’s “reinstatement clause.”

Through reinstatement, the policyholder might be able to regain the previously cancelled policy’s cash value. Plus, when the policy is reinstated, the owner will often be charged the same premiums that were in place at the time of cancellation instead of a higher premium based on the person’s age.

However, the owner will need to pay all premiums that would've been due between the point of cancellation and the point of reinstatement. Also, the insured might need to medically qualify for coverage again and, therefore, might run into problems if he or she has experienced serious medical issues in the interim.

Replacement Policies

Buyers might replace life insurance policies because their needs change, because they recognize a better policy from a different insurance company or because they feel most comfortable working with their longtime agent who has moved to another carrier. At other times, salespersons have been known to instigate policy replacements in the hope of receiving fresh and large commissions. No matter the motive behind the replacement, insurance customers and producers must understand the risks involved with swapping policies.

It is almost always unwise for customers to cancel one insurance policy before they have been approved for a replacement policy. An older, sicker person who forfeits an old policy might never again be able to find equally affordable or sufficient coverage. Even a brief gap in coverage for a younger, healthier person can put dependents at risk, given the unpredictability of death.

A Replacement Policy Case Study

From the insurance company's perspective, replacement policies can also create unexpected problems when someone files a claim. A case study courtesy of the District of Columbia Court of Appeals showcases how claims and replacement policies can cause confusion.

In 1979, a man purchased a $35,000 life insurance policy, which said, "In the event of suicide of the insured while sane or insane within two years from the issue date, the amount payable under this policy shall be limited to the amount of premiums paid."

By 1985, the man was considering getting rid of the policy, but the agent who handled the initial sale convinced him that the policy's cash value and the family's decreased insurability were decent-enough reasons to maintain the coverage.

Three years later, the agent suggested that the family increase its coverage to $50,000. The man agreed to the increase without viewing the policy or discussing anything other than premiums with the agent. The insurance company signed and issued a new policy for the man on November 8, 1988, but the man did not sign the contract.

The new policy said, "For the first two full years from the date of the issue, the company will not pay if the insured commits suicide, while sane or insane. The company will terminate the policy and give back the premiums paid less any loan and any partial surrender amount [previously paid]. A like limitation applies to any increase in benefits and the effective date of such increase."

When the man killed himself 20 months later, his wife filed a claim for $35,000; the amount that would have been owed to her under the 1979 contract. The insurer denied the claim, saying the husband had died during the 1988 policy's contestability period, but it paid back premiums that turned out to be in excess of the premiums paid for the 1988 policy.

The wife sued, claiming the 1988 replacement policy should have been treated as an extension of the older policy and that only the original suicide clause applied in this case. The court ordered the insurer to honor the claim and commented on the wife's reasoning.

"By not claiming the $15,000 increase agreed to within two years of (her husband's) suicide, (she) implicitly recognizes the reasonableness of the term of the 1988 policy…that expressly excludes payment of the amount of any increase in benefits if the insured commits suicide within two years of the effective date of the increase."

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 does not clearly list a valid, identifiable beneficiary, death benefits will become part of the deceased's estate, and, 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." These designated individuals will remain beneficiaries even if the policy owner changes his or her mind and wants someone else to serve in that role. 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.

In rare cases, a policy might contain a "survivorship clause" that could cause a change in beneficiaries even after the insured person dies. This clause might state that a beneficiary must outlive the insured by a specific number of days before the person can receive any money from the insurance company.

When adding or removing beneficiaries from a life insurance policy, the owner must provide written notice to the insurer and complete any additional company-mandated paperwork. Some insurers will wait for owners to request these forms, but others send out change of beneficiary forms every few years in order to give their clients regular opportunities to update their policies.

A Beneficiary Case Study

A case from the U.S. Court of Appeals for the 5th Circuit shows how an understanding of beneficiary forms might help prevent legal trouble. A man purchased a $20,000 accidental death and dismemberment policy through his employer, along with $126,000 in supplemental life insurance.

On the beneficiary form, the man listed his former wife in a section for primary beneficiaries and wrote "100%" by her name. Below his ex-wife's name, but still in the space for primary beneficiaries, he listed his sister and wrote "100%" by her name, too. In a section for contingent beneficiaries, he listed his son and indicated the son should receive 100 percent of the death benefits if none of the other beneficiaries were alive at claim time.

The policy said, "If more than one beneficiary is named and you do not designate their order or share of benefits, the beneficiaries will share equally." It also stated, "When

making a benefit determination under the summary of benefits, (the insurer) has discretionary authority to determine your eligibility of benefits and to interpret the terms and provisions of the summary of benefits."

When the man died from a heart ailment, his ex-wife filed a death claim and received roughly $95,000 from the insurance company. The insurer decided to hold onto the remaining death benefits and review the claim. The man's sister insisted that her brother intended for her and his ex-wife to split 100% of the death benefits as primary beneficiaries. She claimed she was not specifically listed as a contingent beneficiary and that she was entitled to half of the policy's face value. She said the insurance company should have been held responsible for making sure her brother understood how the death benefits would be disbursed.

In response, the insurer said it could not have determined the man's intentions ahead of time because his employer had held onto the beneficiary forms until the death claim arrived. The court ruled against the sister, concluding that the man had, indeed, put the beneficiaries in order and had listed percentages for each person. In the court's opinion, the insurance money would have only belonged to the sister if the ex-wife had passed away before the man's death. This case highlights the importance of clearly stated desires when listing beneficiaries.

Beneficiaries and Divorce

Of all the factors that contribute to beneficiary disputes, divorce seems to receive the most attention from the judiciary. Laws and insurance practices among all the states are far from uniform in regard to this topic, making it even tougher for insurance professionals and their customers to understand how a failed marriage might affect a former spouse's right to death benefits and policy ownership. On one hand, many divorce courts force people to maintain life insurance on themselves if a former spouse or a former spouse's child is listed as a policy's beneficiary. Other state laws effectively remove former spouses as beneficiaries on life insurance policies.

Divorce Case Study #1

In a case heard by the Missouri Court of Appeals, a husband and wife divorced after having four children. The divorce settlement called for the husband to take out a $100,000 life insurance policy on himself and to list his former wife as the beneficiary until all their children came of age.

Three years later, the man finally bought a policy and listed his ex-wife as a revocable primary beneficiary and his new wife as a contingent beneficiary. According to court documents, the new wife paid premiums for the policy.

Later, the man changed beneficiaries on the policy without alerting his ex-wife to the situation. In its revised form, the policy listed his new wife as the primary beneficiary and his stepdaughter as the contingent beneficiary.

The man and his new wife eventually got divorced, but they continued to live together, and she continued to pay for the life insurance. Their divorce settlement gave the second wife control over some of their assets but did not specifically mention the policy.

The man later died when the youngest child from his first marriage was 9 years old. This set up a court battle between his estate and his second wife. According to the estate, the change in beneficiaries should not have been allowed, the second wife should have lost her beneficiary status in the divorce, and the death benefits should have gone to the estate.

The court ruled initially in the second wife's favor, saying the first wife had no power in regard to the policy because she was not married to the man when the contract was issued. The court also said evidence—such as the fact that the man and his second wife continued to live together even after their divorce—suggested the man had no intention of revoking his second wife's beneficiary status.

But, just two months later, the same court withdrew its opinion and ruled in the estate's favor. This time, the ruling centered on a state law, which said, "If after an owner makes a beneficiary designation, the owner's marriage is dissolved or annulled, any provision of the beneficiary designation in favor of the owner's former spouse or a relative of the owner's former spouse is revoked on the date the marriage is dissolved or annulled, whether or not the beneficiary designation refers to marital status. The beneficiary designation shall be given effect as if the former spouse or relative of the former spouse had disclaimed the revoked provision."

This eliminated the second wife as a beneficiary and left the proceeds of the policy to the deceased man's estate.

Divorce Case Study #2

In a case that made it all the way to the U.S. Supreme Court, a man listed his second wife as the beneficiary on a $46,000 life insurance policy bought through his employer.

The couple divorced, and according to the man's first wife, the second wife knew he intended to remove her as a beneficiary. The man's children from his first marriage—who would have received the death benefits under the intended change—sued the second wife when she filed a death claim.

The children argued the second wife's beneficiary status was invalid due to state law, which said, "If a marriage is dissolved or invalidated, a provision made prior to that event that relates to the payment or transfer at death of the decedent's interest in a nonprobate asset in favor of granting an interest or power to the decedent's former spouse is revoked. A provision affected by this section must be interpreted, and the nonprobate asset passes, as if the former spouse failed to survive the decedent, having died at the time of entry of the decree of dissolution or declaration of invalidity."

Although a court ruled against the children on legal technicality, this case again highlights the need for clarity when listing beneficiaries and keeping these provisions current.

Divorce Case Study #3

In yet another example, a man bought a joint life insurance policy and listed himself as the primary insured and his wife as the primary beneficiary. The couple later divorced, and the former spouses were allowed to keep their personal property, with no mention of the insurance policy in their divorce settlement.

The husband eventually remarried, but he neither cancelled the policy nor removed his ex-wife as the primary beneficiary. When the man died, his ex-wife and his estate fought over the death benefit, with the estate claiming the former spouse nullified her beneficiary status at the time of the divorce and that the divorce settlement gave her no clear right to policy benefits.

When the man bought the policy, state law called for the removal of former spouses as beneficiaries, but the law had changed by the time of the man's death. Although a trial court granted the insurance money to the ex-wife, an appeals court ruled in favor of the estate. According to the appeals court, a legal agreement should be based on the laws that were in force when the agreement went into effect.

Divorce Case Study #4

Shared finances between spouses can also create uncertainty when divorce and beneficiary issues arise. A husband and wife in Illinois paid $50,000 each for two universal life insurance policies. One policy insured the husband for $81,000, while the other contract insured the wife for $100,000. They listed each other as revocable beneficiaries on their respective policies and paid for both contracts with a single check.

The couple divorced, and both the man and the woman altered their policies so that their respective children (all from other relationships) became beneficiaries. The man eventually died of cancer, and his ex-wife tried to collect the death benefit made available through his policy. She argued that her ex-husband's illness might have prevented him from realizing what he was doing when he changed beneficiaries and that she was entitled to the insurance money because marital funds had paid for the two policies.

An appellate court disagreed and pointed out that both parties had the legal right to change beneficiaries on their policies and that even the ex-wife had exercised this right.

Life Insurance Claims

Different insurance companies have different ways of dealing with death claims. Some home offices will handle the sending and receiving of claim forms on their own. Other companies ask a life insurance agent to put claim forms in the mail to beneficiaries, and many insurance professionals visit beneficiaries personally in order to deliver paperwork and answer any questions that beneficiaries or families might have.

Agents who handle death claims have yet to arrive at a consensus regarding how this part of their job should be done. While some producers prefer to give survivors considerable breathing room by not emphasizing sales and by sticking primarily to the claims process, others view these situations as opportunities to stress the importance of financial planning and the benefits of annuities and other products offered by insurance companies.

Beneficiaries who can locate a policy should be prepared to give the insurance company the policy's identification number and the insured person's date of death. Policy language might require that an insurer receive a copy of the death certificate, but special circumstances can cause insurers to waive this requirement. After the September 11, 2001, terrorist attacks on U.S. soil, for instance, most insurers allowed victims' beneficiaries to collect death benefits without a certificate.

If the insurance company sold multiple policies to the insured and concludes that the person has actually died, it might have an obligation to contact beneficiaries who are named in those additional contracts.

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 one 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 invest 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 invested funds via check-writing privileges. Be aware, however, that interest earned by the beneficiary on death benefits might be taxed as income.

Life Insurance Riders

Life insurance riders are policy features that may be added to a contract (often at an additional cost), either at the application stage or after the policy has been issued. In this portion of the course, we will examine a few of the many riders offered by life insurers. But please be aware that not all insurance companies offer these mentioned additions, and many insurance companies might include the benefits described here within their basic policies. Also, as is the case with policy terms and conditions, a rider available from one company might go by a different name at other companies.

Waiver of Premium

Some experts say a “waiver of premium” is the most common and most essential rider available from life insurance companies. This feature protects disabled or terminally ill individuals by not charging the policy owner for coverage after he or she has lived with life-altering medical conditions for an extended period of time. If a policy owner were to suffer a debilitating stroke, for example, and could not physically pay or afford premiums because of the medical condition, the waiver of premium would likely prevent the insurance contract from lapsing. Meanwhile, the policy’s cash value would remain untouched.

When consumers replace one life insurance policy with another, the new policy might automatically include a waiver of premium if the original policy had the feature. At other times, policyholders can request in writing that a waiver of premium rider be added to a replacement policy.

Living Benefits

When a Canadian wing of Prudential Financial introduced a “living benefit” several years ago, this feature catered almost exclusively to terminally ill people with only a few months left to live.

Today, many insurers allow policyholders to access anywhere from 25 percent to 100 percent of a life insurance policy’s face value if they are struggling with terminal or non-terminal medical problems, such as surgery, serious illnesses, doctor bills or assorted long-term care expenses. As more insurers have offered them and expanded their scope, living benefits have taken different names, including “accelerated death benefits.”

The insured will need to prove medical hardship in order to qualify for these benefits, but the money given out by the insurance company does not necessarily need to go toward medical expenses. These benefits are different than policy loans because they do not create an interest-enhanced debt that is owed to the insurance company. Instead, living benefits are usually subtracted directly from a policy’s death benefit.

Other Riders

Other popular riders over the years have included the following:

- **Cost of living rider or guaranteed insurability rider:** These riders allow policyholders to increase their life insurance's face value on a periodic basis without needing to medically qualify for the additional coverage.
- **Paid-up additions rider:** This rider attempts to create a vanishing premium by using some of today's premiums to pay for tomorrow's coverage.
- **Accidental death rider:** This rider, mentioned earlier in the text, generally pays double the death benefit if the insured dies in an accident (a concept commonly known as "double indemnity").

Conclusion

By now, you should be able to comprehend the versatility of life insurance products. From term life all the way to the latest hybrid contracts with variable life insurance features, the insurance industry has done its best to develop fresh provisions that cater to a broad base of consumers. But a wide variety of products and consumer options might do little to promote lasting business relationships between insurers and the public if insurance workers forget to explain some of the complexities of these products.

CHAPTER 3: UNDERSTANDING HEALTH SAVINGS ACCOUNTS AND HIGH-DEDUCTIBLE HEALTH PLANS

Introduction

In addition to creating the federal program known as "Medicare Part D," the Medicare Prescription Drug Improvement and Modernization Act of 2003 gave consumers the option to fund their health care through "health savings accounts" (HSAs). When used correctly, these accounts can reduce the size of insurance premiums, increase patients' knowledge of the health care system and provide some unique tax benefits. But if pushed onto an audience that doesn't understand them, health savings accounts might result in higher-than-expected medical bills and won't live up to their full potential. Therefore, improving one's knowledge of these accounts should be an important goal for health insurance professionals as well as health insurance buyers.

According to the Employee Benefit Research Institute (EBRI), approximately 20 million HSAs existed in 2016, valued at a combined $37 billion in assets. The increasing acceptance of these accounts has been influenced, to a large degree, by their ability to bring down insurance costs for businesses and their resulting prominence in employer-sponsored health plans. Among companies ranging in size from 10 to 500 workers, 25 percent of businesses offered an HSA-related option as part of their employee benefit packages in 2016. For companies with more than 500 workers, according to the EBRI, that figure jumped up to 61 percent.

Meanwhile, HSAs have been part of several proposals aimed at making high-quality health care more affordable for all Americans. Although this certainly isn't the appropriate forum for evaluating those assorted proposals, both the heated debate surrounding them and the aforementioned numbers from the EBRI should lead us to essentially the same conclusion: HSAs have become a common option for individuals and families, and they're not likely to go away anytime soon.

If you are new to HSAs, this chapter will introduce you to the important basics. If you are already familiar with these accounts, we hope this will serve as a helpful reminder of the HSA-related choices that many insurance buyers are facing.

However, it's important to remember that an HSA—though linked to particular types of health insurance plans—is a tax-favored savings account and is not, in fact, insurance. Health insurance professionals certainly need to be capable of conversing with a prospect or client about HSAs, but they also must avoid overstepping the boundaries of their license and acting as unqualified attorneys or tax advisers.

Similarly, this chapter should be viewed as general information within an insurance-focused education course and not as an authority on federal or state tax issues. For up-to-date answers to specific tax-related questions, please consult an appropriate expert in your community.

Tax-Favored Health Insurance Accounts

Many types of tax-favored accounts have been introduced in the United States to encourage more "consumer-driven health care." This type of health care typically involves providing tax breaks and savings opportunities as incentives for patients to be more careful about how they spend their health-care dollars. For example, some proponents of consumer-driven health care believe that if patients receive a set amount of tax-favored dollars each year for medical care, those patients will make more cost-effective medical decisions, such as using generic medications instead of name-brand drugs and, when

possible, opting for treatment at stand-alone immediate-care facilities rather than using hospital emergency rooms. Consumer-driven health care still utilizes various types of insurance as a backstop against costly, catastrophic ailments, but it is designed to shift more of the initial care decisions (and often the initial costs) to the patient.

The most common consumer-driven health care plans in today's market combine a high-deductible health plan with a health savings account. However, these plans are often misunderstood by consumers due to the number of other tax-favored, health-related accounts in existence, the names of which can create a confusing bowl of alphabet soup. For example, in addition to HSAs, some consumers might be eligible for HRAs and FSAs.

Before turning our attention back specifically to health savings accounts, let's look at what some of those other types of accounts have to offer.

Health Reimbursement Arrangements

A "health reimbursement arrangement," also known as a "health reimbursement account," (HRA) is a method of paying for health care in which an employer reimburses its employees for qualified medical expenses after treatment has been rendered. Reimbursements from the employer are tax-free to the employee up to a certain amount. Although money reserved by the employer for reimbursements can be carried over from one year to another, HRA funds are not portable and therefore do not follow employees when they leave the business.

Flexible Spending Accounts

A "flexible spending account" (FSA) lets employees use pre-tax dollars to pay for various medical expenses through a combination of salary deductions and employer contributions. Withdrawals for qualified medical expenses are not taxed, but FSAs are subject to an important "use-it-or-lose-it rule," which prohibits most money within an FSA from being carried over from one year to the next. An FSA's "use-it-or-lose-it" feature is one of the most important distinctions between this type of account and a health savings account.

Health Savings Accounts

A health savings account lets individuals and employers make tax-free contributions to an investment account that can be used to pay for qualified medical expenses. Unlike an FSA, an HSA belongs fully to the individual and is not subject to a "use-it-or-lose-it" rule. Money left over at the end of a year can remain in the person's account, where it can earn tax-free interest until the person withdraws it. According to a survey reported by the insurance trade journal Rough Notes in 2013, nearly 70 percent of respondents believed, incorrectly, that money deposited in an HSA would be lost if not spent within a given year.

HSA contributions can usually only be made by enrollees in a special high-deductible health plan, but the insured retains ownership of any HSA funds upon leaving the plan, including upon leaving an employer.

Now that you're familiar with the simplest traits of HSAs, let's look at their crucial connection to high-deductible health plans.

High-Deductible Health Plans

In order to understand HSAs, a health insurance professional must first know the purpose and features of a "high-deductible health plan" (HDHP). As its name suggests, a high-deductible health plan is a health insurance plan that has a larger-than-usual deductible and a certain, specific cap on a person's out-of-pocket medical expenses for the plan year. As a reminder, a "deductible" is the amount of money, stated in dollars, that an insured

must pay for otherwise covered care before the insurer will start providing any financial benefits.

The minimum deductible and out-of-pocket limits for an HSA-eligible high-deductible health plan tend to change from year to year, based on inflation, and will differ depending on whether the insurance covers an individual or a family.

According to a survey from human resources consulting firm Mercer (and as reported by the publication Crain's Chicago Business), roughly 30 percent of workers were enrolled in a high-deductible health plan in 2016, a huge increase from 3 percent just 10 years earlier. Some enrollees in these plans like them because the higher deductibles and out-of-pocket expenses allow insurance companies to charge significantly lower premiums. The low premiums tend to attract younger people with few or no immediate medical problems and are also purchased by relatively unhealthy consumers who can't afford the higher premiums for traditional health insurance. Businesses tend to like these plans, too, due to their comparatively lower costs and are likely to include an HDHP as either the only or one of several health plans available to employees.

No matter the potential benefits of a health savings account, anyone who is thinking about opening one should first carefully consider the potential positives and negatives of enrolling in a high-deductible health plan. Proponents of HDHPs tend to emphasize the lower premiums and the ways in which the plans might turn patients into discerning buyers of health care. For example, if the insured will be responsible for a larger deductible and higher out-of-pocket expenses, that patient might be more inclined to research the cost of prescribed care (such as the cost differentials between a name-brand drug vs. a generic drug, an MRI performed at a hospital vs. at a stand-alone clinic, or non-emergency treatment at an immediate-care facility vs. at an emergency room) and choose a cheaper option. Detractors sometimes worry that, because of the high deductible and because comparing the price of treatment options isn't always easy, these plans might ultimately discourage cost-conscious patients from seeking important care and thereby contribute to negative health outcomes.

High-deductible health plans are essential to determining the suitability of health savings accounts because a person generally cannot open or contribute to an HSA unless he or she has insurance through an HDHP. Note, however, that not all high-deductible health plans are compatible with HSAs and that, in fact, millions of enrollees in high-deductible health plans do not own a health savings account.

In 2018, an HSA-eligible high-deductible health plan required a deductible of at least $1,350 for individual-only coverage and at least a $2,700 deductible for family coverage. A person whose heath plan had a deductible below those figures in 2018 was generally not allowed to open or contribute to a health savings account. You'll learn more about deductibles and other out-of-pocket expenses related to HSA-eligible HDHPs later in this chapter.

Basic HSA Tax Advantages

Assuming their owners follow all applicable rules from the Internal Revenue Service, health savings accounts can result in what are often called "triple-tax advantages." These advantages are available to HSA owners regardless of whether they itemize on their federal income taxes or claim a standard deduction.

The basic three-pronged tax benefits of HSAs are as follows:

- Typical contributions to HSAs are treated as pre-tax dollars, generally exempting them from federal payroll taxes and federal income taxes.
- Contributions kept in an HSA can be invested into subaccounts, similar to mutual funds, where any interest or other investment gains are allowed to grow on a tax-free basis.
- Withdrawals from an HSA, including interest or other investment gains, are generally tax-free if they are used to pay for qualified medical expenses.

The tax incentives available within HSAs are intended to encourage owner contributions and help consumers plan a careful budget for upcoming health care. In addition, they've prompted people in higher tax brackets to pay for health care with non-HSA dollars but still contribute maximum amounts to their HSAs in order to reduce current taxable income and to grow an IRA-like account specifically intended for health care in later years.

Although health insurance professionals should understand the basic tax benefits of HSAs, it's worth noting again that a license to sell health insurance is not a license to provide tax advice. Also, be aware that the general tax information found in this course is based on federal rules. Tax implications for HSA owners might also exist at the state or local level.

HSA Eligibility

Despite the growing number of health savings accounts in the United States, the ability to open an HSA isn't available to everyone. For example, a person generally cannot open or contribute to an HSA if any of the following statements are true:

- The person is claimed as a dependent on someone else's federal income taxes.
- The person is covered by a health plan other than an HSA-eligible high-deductible health plan. (This prohibition includes other coverage through an employer, a spouse and even the federal Medicare program, regardless of whether the other coverage is the person's primary insurance or secondary insurance. However, it generally doesn't include coverage through disability, long-term care, dental or vision insurance.)

Although IRS rules put restrictions on who can open and contribute to HSAs, the rules mentioned above do not force owners to forfeit money in existing HSAs when changes in their insurance or employment status occur. For example, someone who opens an HSA in connection with a high-deductible health plan and later enrolls in a different health plan will continue to own and have access to the HSA, even though he or she might not be allowed to make any additional contributions to it.

Deductible Requirements and Out-of-Pocket Limits

In order to open and continue contributions to a health savings account, the insured must be enrolled in an HSA-eligible high-deductible health plan. To qualify for HSA-eligibility, the plan must have a deductible that is at least as high as a dollar amount set by the federal government and must feature an out-of-pocket limit that is at least as low as a dollar amount set by the federal government. Both numbers tend to change from year to year based on inflation-related adjustments and will depend on whether the insurance is for an individual or a family.

As mentioned previously, the minimum allowable deductible for an HSA-eligible plan in 2018 was $1,350 for single coverage and $2,700 for family coverage. Some preventive care, such as annual physicals, immunizations, routine prenatal care and disease screenings, might be completely exempt from the deductible requirement or might be subject to a lower one. Although patients are ultimately responsible for paying their deductible, they can use money from a health savings account to fund this part of their care.

Along with the necessarily large deductible, an HSA-eligible plan must have a specific yearly cap on an insured's out-of-pocket expenses. This cap generally applies cumulatively to deductibles, copayments and coinsurance fees. It generally doesn't apply to insurance premiums, costs associated with using out-of-network health care providers and care that is otherwise not covered by the high-deductible health plan. The ability to use HSA funds to pay for these various out-of-pocket expenses will depend on the specific type of expense.

In 2018, an HSA-eligible plan could not have an out-of-pocket limit higher than $6,650 for an individual or $13,300 for family coverage.

HSAs and the Employer's Role

High-deductible health plans that allow employees to open health savings accounts have become a very common part of employers' benefit offerings. Even if traditional PPO and HMO health plans remain available to its workers, a company might include an HSA-related option during annual open enrollment periods. At other businesses, if traditional group health insurance is unaffordable, a high-deductible health plan that is compatible with health savings accounts might be the only employer-sponsored plan available for workers.

When sponsoring an eligible high-deductible health plan, an employer has the option—but not the obligation—to contribute to each enrolled employee's health savings account. Contributions ranging from $500 to $1,000 are commonly offered to entice higher enrollment in the plan and ease the transition for people who aren't accustomed to such a high deductible.

No matter the exact contribution chosen by the employer, the amount of the contribution generally must be the same for all similarly situated employees. This typically means that the employer will contribute either the exact same dollar amount or the exact same percentage of the plan's deductible to each employee's account.

Most new owners of health savings accounts will open them with help from an IRS-approved "custodian" or "trustee" affiliated with the employer-sponsored group health plan. (This custodian or trustee might be an insurance company or some other financial institution.) In these cases, contributions made by employees to their own accounts will usually be deducted directly from their paychecks and deposited into the accounts. However, employees also have the right to open an HSA with an IRS-approved custodian or trustee that has no relationship with their employer or their insurance company.

Unlike some other types of tax-favored accounts intended for health care, HSAs are portable from job to job, and none of the money contributed to them belongs to the employer. Yet in order to continue making contributions to an existing HSA, an employee who changes jobs must continue to be covered by an HSA-eligible high-deductible health plan.

Setting Up an HSA

A person interested in opening an HSA can do it via an IRS-approved trustee or custodian. Common financial institutions that can serve in a trustee or custodial role include banks, insurance companies and credit unions.

In exchange for holding and managing money held within an HSA, the owner's chosen trustee or custodian may charge various fees similar to those imposed against IRAs and other investment accounts. Fees, including their size and frequency, may differ from one financial institution to the next.

As part of opening a health savings account, the owner will likely be asked to name a beneficiary, who will receive any remaining HSA funds when the owner dies. If the chosen beneficiary is a spouse, the HSA ownership will generally be transferred to the spouse upon the original owner's death and can continue to be used by the surviving spouse as an HSA. If a beneficiary receives HSA funds and is not the owner's surviving spouse, the money will no longer be considered part of an HSA and will be taxed accordingly.

Keep in mind, too, that some HSA-eligible individuals choose to never open a health savings account. Although a person must be enrolled in high-deductible health plan in order to open an HSA, a person does not need to open an HSA in order to enroll in a high-deductible health plan.

Making HSA Contributions

HSA contributions can be made by the owner or by another party on the owner's behalf, such as an employer making contributions to an employee's account. In most cases, contributions will be deducted directly from the owner's paycheck, but the owner can also bypass his or her employer (or be self-employed) and make contributions directly to the trustee or custodian.

Federal rules put a cap on the amount of contributions that an owner can make to an HSA each year. Like the numbers for deductibles and out-of-pocket limits for an owner's high-deductible health plan, contribution limits tend to change each year and are impacted by whether the owner's insurance is just for one person or for a family.

For example, most owners with self-only coverage in a high-deductible health plan could contribute up to $3,450 to their HSA in 2018. For owners with family coverage, contributions could rise up to $6,900.

As a method of preparing for looming retirement, HSA owners who are 55 or older can contribute a special "catch-up" amount each year. In 2018, these older HSA owners could contribute an additional $1,000.

Note that these contribution limits—regardless of the owner's age—include contributions made directly by the owner as well as contributions from another party, such as an employer.

Contribution limits can become confusing if both members of a married couple choose to open HSAs, particularly when one or both of those spouses opts for family coverage rather than individual coverage. Specifics of these scenarios are beyond the scope of this course and should be understood with the help of careful research and tax experts.

Despite the limits on annual contributions, there is no overall limit on the value of an HSA. Similarly, money left over from one year can roll over in the account to the next year and generally isn't subject to a dollar limit. However, as mentioned previously in this chapter,

contributions to an HSA generally must stop when the owner no longer receives health insurance from an HSA-eligible high-deductible health plan.

Investing Within HSAs

Rather than parking their contributions safely in a health savings account and treating them like cash, some HSA owners take advantage of potential investment opportunities made available by HSA trustees and custodians. In these cases, the process, benefits and drawbacks are similar to investing in mutual funds within a traditional retirement account. By choosing to invest their HSA contributions in something other than cash, owners might receive compounded interest or other increases their account's value. On the other hand, choosing this option might expose the account to economic volatility and could require payment of additional administrative fees.

Each HSA trustee or custodian will likely have its own rules regarding the minimum amount needed to invest in options besides cash. In fact, some of these HSA administrators don't offer non-cash options to account owners at all.

Even with some investment choices at their disposal, the overwhelming majority of HSA owners opt to ignore them. According to the Employee Benefit Research Institute, only approximately 4 percent of HSA owners kept their contributions outside of cash accounts in 2017. This suggests that most owners are using their HSAs in a more traditional way by saving for short-term medical costs (such as yearly deductibles) rather than viewing their accounts as long-term tax shelters. This conclusion seems even firmer when paired with multiple press reports from 2014 through 2017, which estimated that the average value of an HSA was somewhere between $1,000 and $1,500.

Making HSA Withdrawals

Upon opening a health savings account, the owner will typically receive a debit card or checkbook in order to use the assets from the account to fund various medical expenses. This is a convenient change from several years ago, when owners often needed to send receipts to their HSA custodian or trustee and await reimbursement. Money withdrawn from an HSA will be tax-free to the owner if applicable IRS rules are obeyed.

To avoid significant penalties, withdrawals from HSAs usually must be used to pay for "qualified medical expenses," as defined by law and the current tax code. In 2017, for example, qualified medical expenses included (but weren't limited to) the following items:

- Health insurance deductibles.
- Health insurance copayments.
- Health insurance coinsurance fees.
- Premiums for Medicare, COBRA insurance, disability insurance and—based on age—long-term care insurance (but generally NOT premiums for other health insurance).
- Vision and dental costs.
- Prescription drug costs (but NOT over-the-counter medications that haven't been prescribed by a physician, other than insulin).

Be aware that the items included within the definition of "qualified medical expenses" are a source of seemingly constant debate among legislators and that the definition can change due to new laws and new IRS rules.

There's also plenty of confusion among the public regarding these expenses. For example, a survey reported by the trade publication Benefits Selling in 2014 found that over half of respondents wrongly believed HSAs could be used to pay for insurance premiums and over-the-counter drugs. Anyone who is providing answers to consumers about what counts as a qualified medical expense should ensure that their information is coming from an up-to-date and expert source.

Withdrawals used for purposes other than qualified medical expenses will be typically treated as taxable income to the owner and will also result in a 20 percent tax penalty. (The penalty rose from 10 percent in 2011 as part of the Patient Protection and Affordable Care Act.) However, the 20 percent penalty can be waived when the owner dies, becomes disabled or turns 65. In most cases, owners who escape the 20 percent penalty will still need to pay income taxes on their withdrawals if the money goes toward items besides qualified medical expenses.

To comply with HSA rules and provide defense against an IRS audit, owners are required to keep records of their spending. It is generally the responsibility of the HSA owner—not the HSA custodian or trustee—to ensure that withdrawals are used for qualified medical expenses.

HSA Portability

As mentioned earlier in this chapter, the dollars invested in health savings accounts are portable from job to job and from health plan to health plan. An employee who leaves an employer or moves from an HSA-eligible health plan to a non-eligible health plan still keeps ownership of any funds inside an existing HSA. Those funds can be accessed at any time to pay for qualified medical expenses. Even though they might contribute to workers' HSAs, employers don't own any of the money within their employees' health savings accounts.

Conclusion

More than a decade after their introduction as an option for funding consumers' health care, health savings accounts continue to be a topic of great interest among policymakers, health care advocates and other interested parties. Arguments in favor and against HSAs seem to be made just as passionately as in years past and can often be based on how the exact same studies are interpreted.

For example, an extensive study conducted by the Employee Benefit Research Institute using data from 2009 through 2014 attempted to determine the impact for consumers who moved from a traditional health plan to a high-deductible plan with an HSA. Persons in favor of HSAs could point to the fact that patients with HSAs ended up spending roughly $300 less on health care per year and did not spend more days in hospitals than patients with traditional insurance. Meanwhile, those more opposed to health savings accounts could reference the study's finding that lower-income patients with HSAs were at least temporarily more likely to utilize emergency rooms than lower-income patients with traditional insurance and that—regardless of income level—patients with HSAs tended to receive less preventive care, even when such potentially important care was exempt from plan deductibles.

Despite the debates, it might be fair to argue that, just like any other type of insurance-related product, a high-deductible health plan paired with an HSA should be judged within the context of each individual person's unique situation and goals. In order to better understand the suitability of these common health care accounts, health insurance

professionals—as well as health insurance buyers—must maintain a commitment to product-related education.

CHAPTER 4: COMMERCIAL PROPERTY INSURANCE

Introduction

Running a business is difficult enough without having to worry about theft, accidents or natural disasters that could result in the loss of property. Good property insurance will not be able to stop those unfortunate events from occurring, but it can certainly help a business get back on its feet.

The most common kind of property insurance for businesses is based on contractual language from a document called the "Building and Personal Property Coverage Form." The form was created by the Insurance Services Office (ISO), a private company specializing in information about property and casualty insurance. This course material contains explanations of the ISO form. However, be aware that some companies use policy forms that are broader or more restrictive.

The Basics of the Building and Personal Property Coverage Form

Before going into great detail about specific clauses in the Building and Personal Property Coverage Form, we ought to address a few simple insurance topics that might be important to a new business. These topics include the purpose of the declarations page, the length of the policy period and the definition of a loss. Although insurance professionals are probably familiar with these concepts, they should not forget that elementary insurance matters are often foreign to the buying public. Since agents and brokers might need to review these concepts with potential clients, it seems appropriate for us to briefly mention them here.

The Declarations Page

The "declarations page" is a basic summary of the insurance policy and can be thought of as the policy's cover sheet. Often found on the policy's first page, it usually contains the following information:

- The name of the insurance company.
- The name of the people insured by the policy.
- The location of insured property.
- The length of the policy period.
- The cost of the insurance.
- The policy's deductible.
- The policy's dollar limit.

A policy's dollar limit is also known as the insurance company's "limit of liability." Depending on the policy, the insurance company might list multiple limits of liability. For example, the insurer might have one limit for damage to a business's building and another limit for damage to a business's personal property. When a declarations page lists multiple limits of liability and a loss is larger than one of those limits, the business generally cannot dip into another limit of liability to make up the difference.

A declarations page for a commercial property insurance policy will also contain important information pertaining to whether specific kinds of losses will be covered in their entirety. For example, it will mention the causes of loss that the business's property is insured against and may list a coinsurance requirement that the business must satisfy. Causes of

loss and the importance of coinsurance clauses will be addressed in later portions of this course.

The Policy Period

The time between the policy's issue date and expiration date is known as the "policy period." The length of the policy period can be found on the declarations page and typically spans one year. All losses that occur during the policy period and are not otherwise excluded in the insurance contract will be covered.

Near the end of the policy period, the business and the insurance company may choose to renew the coverage by mutual consent. Alternatively, either party can refuse to renew the policy and insist on a new contract with different terms and conditions.

When coverage is renewed, a new policy period begins. Like the original policy period, the period for the renewed insurance is usually 12 months.

Policy Premiums

Insurers base premiums for commercial property insurance on the level of risk posed by the business. Premiums may be paid annually or on some other schedule that the carrier and the insured have agreed to.

In general, the named insured on the declarations page is the person or entity that must pay the first premium and all subsequent premiums. Although the insurance company will gladly accept money from people other than the named insured, it will hold the named insured responsible for any missed or late payments. The named insured on the declarations page is also the person who will receive money from the insurance company if a refund is ever in order.

What Is a Covered Loss?

Defining the term "covered loss" isn't as simple as you might think. After all, if it were absolutely clear what a covered loss was, honest carriers and policyholders would never fight over an insurance claim. The prevalence of insurance disputes proves that the public's definition of a covered loss is often different from the insurance industry's definition.

Before we define what a covered loss is, let's mention what it is not. In the context of the Building and Personal Property Coverage Form, a covered loss is not indirect harm to the insured's property. It is not, for example, the amount of income a company loses due to an interruption in its business. If a company wants to insure itself against these indirect kinds of losses, other coverage forms—not the Building and Personal Property Coverage Form—are appropriate.

Under the Building and Personal Property Coverage Form, a "covered loss" can be defined as direct physical elimination of or damage to covered property that is caused by a covered peril. Though that definition isn't especially long-winded, it requires an extensive amount of explanation. What exactly is covered property? And what causes of loss are considered covered perils? Those are important questions, and we will attempt to answer them throughout the remainder of our study.

What Is Covered Property?

There are three basic kinds of covered property, with each one having its own dollar limit. These three are listed below and will be addressed one at a time in the next few sections:

- The business's building.
- The business's personal property.
- Personal property of others that is in the business's possession.

The Business's Building

The building is the place of business described on the policy's declarations page. Although we generally view buildings as singular structures, a "building" can mean any of the following things:

- The entire structure at a single address.
- Multiple structures described on the declarations page.
- A single unit in a multi-unit building.

Building coverage is for more than just walls, ceilings, windows and doors. It is broad enough to include additions the insured makes to the building and various fixtures, equipment and machinery that are permanently installed in the building. Depending on the carrier's interpretation of the term, "permanently installed property" might have any of the following definitions:

- Something merely attached to the building.
- Something that can't be removed without changing the building's structure.
- Something that was specifically listed in the real estate contract when the owner bought the building.

Building coverage even insures many personal items that the business owns and uses to maintain the building and the surrounding area. Here are a few items that are commonly insured through the policy's building coverage:

- Carpeting and other flooring materials.
- Fire extinguishers and hoses.
- Outdoor furniture.
- Refrigeration and ventilation equipment.
- Appliances used for cooking, dishwashing or laundering.

Unless coverage already exists through another policy, building coverage can be applied to incomplete additions to the business premises. Tools and materials that are used to complete these additions can be covered, too, if they are lost or damaged within 100 feet of the building.

If a business rents space from a property owner, it might not be responsible for insuring the building. Tenants should review their leases carefully and discuss their insurance obligations with their landlord. Then they should determine what additional insurance ought to be purchased for their own protection.

The Business's Personal Property

Coverage for a business's personal property generally applies to any item inside the insured building or within 100 feet of the premises. More specifically, the typical policy states that the following items are insured:

- Office furniture and fixtures.
- Machinery and equipment used to conduct business.
- Property the insured owns and uses for business purposes.
- Outdoor signs (valued up to $2,500).
- If the insured is a tenant, any improvements the insured has made to the building that were not paid for by the owner.
- Leased property that the business agrees to insure.
- Improvements made to other people's property, such as replacement parts that are installed by the business.

Items in stock could also be part of the above list. In regard to the Building and Personal Property Coverage Form, "stock" can be defined as follows:

- Items currently being sold by the business.
- Items the business plans on selling but is keeping in storage.
- Items the business is in the process of producing.
- Any raw materials the business uses to make its products.

Businesses are also covered for the materials that they use to ship their stock, including padded envelopes and crates.

Property of Others

Commercial property insurance can cover other people's property while it is in the business's possession. For this kind of property to be covered under the Building and Personal Property Coverage Form, it must be either inside the insured building or within 100 feet of the building. If the property is outside the building, it can be either out in the open or in a vehicle.

The insurance for property of others is explained in an early portion of the Building and Personal Property Coverage Form and typically has its own dollar limit, as chosen by the business. It can be capped at any amount and is designed for businesses that commonly keep customers' property on their premises.

Alternatively, if a business doesn't normally take possession of other people's property and doesn't want to spend extra money to manage a comparatively small risk, it may be able to apply a small amount of its own personal property coverage to "personal effects" and "property of others." This option is available at no additional expense and reimburses the policyholder and various employees when their personal items are lost or damaged at the business premises. The coverage also applies to the property of others that is in the business's care. However, items pertaining to this optional, extended insurance are only covered for up to $2,500 at each premises.

Replacement Cost v. Actual Cash Value

Property can be insured for either its "replacement cost" or its "actual cash value." A business that does not understand the difference between the two may be in for some unpleasant surprises after a loss.

Property's "replacement cost" is the amount it would take to rebuild or replace the property without taking depreciation into account. If the property is to be replaced, the replacement property and the old property must be of like kind and quality. When a building is to be replaced at its replacement cost, the new building and the old one do not need to be identical in every little way. However, the essential features must be the same.

An item's "actual cash value" is its replacement cost minus depreciation. The actual cash value may be determined by taking the replacement cost and multiplying it by the remaining amount of time that the item would otherwise be expected to last. For the purpose of an example, pretend a new computer costs $800 and is expected to last 10 years. If the insured has owned a similar computer for five years (50 percent of 10 years) and loses it in a fire, the insurer might calculate the item's replacement cost as $400 ($800 multiplied by 50 percent).

A few states have multiple definitions of "actual cash value" with regard to structures. In California, for example, actual cash value generally means replacement cost minus depreciation. But if a structure in that state is covered for actual cash value and is completely destroyed, the owner might receive the structure's fair market value or the policy's dollar limit, whichever is less.

By default, most kinds of commercial property will only be covered up to their actual cash value. Replacement-cost insurance can be included for an additional price. Annual adjustments for inflation are also available.

Coverage for Specific Kinds of Property

Now that we understand the basic kind of insurance available through the Building and Personal Property Coverage Form, we can get into some specifics about special items. There are some forms of business property that the insurance company will only cover under specific conditions. There are others that the insurer will not cover at all. The next several sections attempt to present these conditions and exclusions as comprehensively as possible.

Outdoor Property

Even though the Building and Personal Property Coverage Form generally covers outdoor property when it is within 100 feet of the business premises, some items can only be insured while they are inside the building. A partial list of belongings that must remain indoors appears below:

- Crops.
- Fences.
- Antennas.
- Satellite dishes.
- Trees, shrubs or plants (other than stock).

Before moving on to another kind of property, we should mention that some of the above items can be covered outdoors if a policy contains a coinsurance requirement of at least

80 percent. (You'll read more about coinsurance in a later section.) In exchange for accepting the proper coinsurance clause, a business has the option of extending its personal property coverage to include all of the outdoor items mentioned above, other than crops. This extended insurance is limited to $1,000 per occurrence and only applies when property is lost or damaged due to the following perils:

- Fire.
- Lightning.
- Explosion.
- Riot or civil commotion.
- Aircraft.

The Building and Personal Property Coverage Form, like the most common homeowners insurance policy, puts a cap on reimbursement for single trees, shrubs or plants. The exact limits are featured elsewhere in this material.

Off-Premises Property

The most basic version of the Building and Personal Property Coverage Form only insures property within 100 feet of the business premises, but extended coverage is available to some applicants. Like other kinds of extended coverage, off-premises property can be covered (for up to $10,000) if the insured is willing to accept at least an 80 percent coinsurance requirement.

Through this extended coverage, property is covered beyond 100 feet of the business premises if it is being stored temporarily at places the insured does not own, operate or lease. The property can be held in storage at a leased location if the lease went into effect after the beginning of the policy period. The property can also be stored temporarily at a trade show or exhibit.

Off-premises property generally is not covered beyond 100 feet when it is in a vehicle or under the care of a business's salesperson. However, the property remains insured under a salesperson's care while it is stored at a trade show or exhibit.

Newly Constructed or Acquired Property

Coverage for newly constructed or acquired property is available if the business satisfies an 80 percent coinsurance requirement. If a business constructs a new building during the policy period, damage to that building, while under construction, can be covered if the new building is on the premises described on the declarations page.

A newly acquired building can be covered by the same policy if it is used for the same purpose as the building described on the declarations page. Alternatively, the business may cover a newly acquired building if it is used only as a warehouse.

The business also has the option of extending coverage to include its personal property at these new locations. Personal property of others is not covered in these buildings if it is being serviced in some way by the business.

This extended insurance for newly constructed or acquired buildings is limited to $250,000 per building. The extended insurance for a business's personal property at these buildings

is limited to $100,000 per location. The insurance expires when any of the following events occur:

- The policy period ends.
- Thirty days pass after either the time of acquisition or the beginning of construction.
- The insured reports the new property's value to the insurance company.

Property in Transit

For the most part, the Building and Personal Property Coverage Form doesn't cover business property while it is being transported from the insured building to another place. The lone exception to this rule is when property is in a vehicle that is no further than 100 feet from the business premises. If businesses are concerned about property while it is shipped to and from various locations, other insurance products (such as an inland marine insurance policy) might be appropriate.

Land, Water and Crops

The physical property on a piece of land is covered by the Building and Personal Property Coverage Form, but the land itself is not. If the insured owns the land surrounding the business premises, there will be no coverage for any decrease in the land's value.

The policyholder is also not covered for damage to ponds, lawns or crops, even if crops could otherwise be thought of as stock. Crop damage can be covered by other kinds of commercial insurance.

Paved Surfaces

There are a few items the insurance company will view as neither personal property nor part of the building. These items are excluded by the Building and Personal Property Coverage Form. Specifically, the policy does not cover patios, sidewalks, driveways or any other paved surfaces. Bridges, wharves, piers and docks are also excluded.

Trees, Shrubs or Plants

As we mentioned earlier, the optional extended coverage for outdoor property provides some insurance for a business's trees, shrubs or plants. Though there is a $1,000 overall limit for this outdoor property, there is also a per-item limit. In a manner similar to most homeowners insurance contracts, the Building and Personal Property Coverage Form insures single trees, shrubs or plants for no more than $250 each.

Valuable Papers and Records

The business premises is likely to contain valuable documents that are susceptible to various risks. The cost of replacing these documents can be high, and the time spent on reproduction can be long.

Account records, deeds and various manuscripts can be covered by a bit of insurance if the commercial property policy contains an 80 percent coinsurance requirement. When the business agrees to that condition, valuable records and papers are covered for as much as $2,500 per location. This extended insurance can help the business pay for replacement documents if duplicates do not exist.

This extended coverage does not apply to electronic data. Records that are accessible by computer receive limited coverage under another portion of the policy.

Electronic Data

With so many aspects of business being run by computers these days, policyholders are probably thankful that the Building and Personal Property Coverage Form covers at least some electronic data. "Electronic data" basically means any kind of information or program that can be stored or accessed on a computer. This includes data on CDs, floppy disks, hard drives and USB drives.

The insurance for electronic data is limited to $2,500 per year, regardless of the number of occurrences and the location of those occurrences. If a loss is less than $2,500, the business may use the remaining insurance to handle similar losses during the same year. However, electronic data coverage generally cannot be carried over from one year to the next. This is additional insurance and has no impact on the insurer's limit of liability for other personal property.

In addition to being covered for the same kinds of losses as other personal property, electronic data is insured against viruses unless they are caused by someone working for the business. Some insurers will include collapse as a covered peril for electronic data even if the rest of the business's personal property is not insured for that peril.

Money

The Building and Personal Property Coverage Form does not cover money or anything similar to it. This means there is no insurance for cash, food stamps, securities or un-cashed checks. The form makes an exception for unsold lottery tickets, which are treated as if they were part of a business's stock.

Animals

For the most part, the Building and Personal Property Coverage Form does not cover animals, even if they are hurt or killed by a peril such as fire, lightning or explosion. The policy makes exceptions to this rule when the business boards animals for other people or has animals as part of its stock. The first exception might provide coverage to kennels, while the second might provide coverage to pet shops and some meat suppliers.

Vehicles

The Building and Personal Property Coverage Form generally does not cover vehicles that are either licensed to be used on public roads or used beyond the business premises. Even car dealerships, which could argue that vehicles are part of their stock, will need to look elsewhere for adequate protection.

Commercial property insurance can cover vehicles at the business premises if the business manufactures them or keeps them in a warehouse. Small watercrafts, such as rowboats and canoes, are not excluded from coverage, and non-auto vehicles being sold by the business can be treated as stock.

Trailers

Under limited circumstances, businesses that agree to an 80 percent coinsurance requirement can have trailers treated as personal property. In order for a trailer to be covered for as much as $5,000, all of the following statements must be true:

- The trailer is not owned by the business.
- The trailer is used by the business.

- The trailer was at the business premises at the time of the loss.
- The business is required to pay for the loss.

Trailers are not insured by the Building and Personal Property Coverage Form while they are attached to a vehicle of any kind. It makes no difference whether the vehicle is in motion or not.

Contraband

Unsurprisingly, the Building and Personal Property Coverage Form does not cover the loss of illegal or stolen property. In effect, this means illegal gun shops cannot insure their stock, and a business is not covered for any banned fireworks or narcotics that it sells in backrooms.

Glass

Even if a business opts for replacement-cost coverage, the insurance company might not pay to replace real glass with something identical. Instead, where ordinances require it, the insurer will pay to replace regular glass with safety glass.

Improvements and Additions by Tenants

Relationships between business tenants and their landlords will depend on the people involved. While some tenants will be allowed to make their own improvements at the business premises and receive compensation from the property owner, others will have to pay out of pocket for any non-essential work they want done to the building. The tenant's financial responsibility for repairs, improvements and additions may also be determined on a case-by-case basis.

Both landlords and their tenants can be insured through a Building and Personal Property Coverage Form, but it is highly unlikely that the insurance company will compensate both parties for the same exact loss. Additions to the building are generally not covered by a landlord's policy if a tenant paid for them and was not compensated by the landlord. Similarly, additions aren't covered by a tenant's policy if they were financed by the building's owner. If a tenant suffers a loss and property is repaired or replaced at the landlord's expense, the tenant's insurance company can deny a claim for the damage.

Covered Perils

Along with choosing how much insurance to buy, a business needs to decide which "perils" or causes of loss should be covered. There are usually three options to choose from.

The most basic kind of property insurance will typically cover businesses against losses caused by the following perils:

- Fire.
- Lightning.
- Explosion.
- Windstorm or hail.
- Smoke.
- Aircraft or vehicles.
- Riot or civil commotion.

- Sinkhole collapse.
- Volcanic action.
- Vandalism.
- Sprinkler leakage.

An intermediate form of property insurance will also help pay for losses caused by four additional perils:

- Falling objects.
- Weight of snow, ice or sleet.
- Accidental discharge of water or steam (from a system or appliance).
- Sudden collapse.

Most businesses go a step further and purchase all-risk property insurance. This covers them against all perils other than those specifically excluded in their policy.

Let's spend the next several sections looking at how the Building and Personal Property Coverage Form deals with the most basic kinds of losses.

Fire

The Building and Personal Property Coverage Form does not define the word "fire," but insurance professionals and legal experts generally agree that coverage only applies when both of the following statements are true:

- The fire involves a visible flame.
- The fire was either unintentional or was at least unintentionally allowed to spread beyond the confines of safety. (Since a fire in a fireplace is within its proper confines, the insured might not be covered if personal property accidentally falls into the flames.)

Lightning

The inclusion of lightning as a covered peril ensures that fires caused by natural electricity are covered. It also is meant to differentiate between losses that are caused by natural electricity and losses caused by artificially produced currents.

Explosion

In general conversation, it's easy to assume that bursting and exploding are essentially the same thing. But as far as commercial property insurance is concerned, explosions are generally limited to blowups that are caused by interactions between various gases. Explosions caused by water or pressure might not be covered by insurance unless the business has purchased a boiler and machinery policy.

Common forms of commercial property insurance usually do not cover explosions of steam pipes, steam boilers, steam engines or steam turbines. However, if the explosion of one of these items causes a fire or some kind of combustion, the insurer will often pay for damages caused by the fire or combustion.

Windstorm or Hail

When a business chooses to insure itself against damage from windstorms and hail, it is managing risks related to several kinds of weather disasters, including tornadoes and

hurricanes. However, the inclusion of windstorm or hail as a covered peril usually does not insure a business when losses are caused by snowstorms, ice or sleet.

Damage done to property inside a building by rain, snow, dust or sand will not be covered unless wind or hail has created an opening in the walls or roof.

Smoke

Smoke damage can be covered at the business's request, but it must be sudden and accidental. Losses related to industrial smoke or agricultural smoldering are usually excluded.

Aircraft or Vehicles

Commercial property insurance can cover losses when a business's building or personal property is damaged by a vehicle or aircraft. This coverage includes losses brought on by spacecrafts, missiles or anything that is propelled by a vehicle and makes contact with the business's property.

Unless all-risk insurance is purchased, businesses cannot use the Building and Personal Property Coverage Form to cover damage done by a vehicle when the vehicle is used by them or belongs to them. So if a company's delivery driver were to accidentally back a truck into the wall of the business's warehouse, reimbursement would not be available from the insurance company.

Riot or Civil Commotion

"Riot or civil commotion" includes damage done by a business's striking workers, as well as any looting during a moment of civil unrest.

Sinkhole Collapse

As soil erodes, sinkhole collapse can become a concern for businesses in many states. Businesses can extend their property insurance to include sinkhole collapse, but the insurer will usually still not pay to fill any sinkholes. Collapses related to manmade holes might also be excluded.

Volcanic Action

Volcanic activity is one of the trickier perils that businesses and insurance professionals might need to deal with. Insurance based on the Building and Personal Property Coverage Form does not cover damage from "earth movement," and volcanic eruptions are generally considered one kind of earth movement. Still, optional coverage is available for "volcanic action," which we will generally define as the effects of eruption that do not include sinking, shifting or rising of earth. Among other things, volcanic action might include lava flow and the blowing of ash or other debris onto property.

For the removal of volcanic debris to be covered, the debris needs to have damaged covered property. For example, the insurance company might pay to remove ash from a business's building, but it might not pay to remove ash from a business's walkways. After all, walkways are not considered covered property under the Building and Personal Property Coverage Form.

Volcanic action and eruptions are often followed by additional action and eruptions. For the purpose of calculating the appropriate deductible, commercial insurers will usually treat all instances of earth movement within a seven-day period as one cumulative event.

Vandalism

"Vandalism" occurs when a person causes damage on purpose with malicious intent. Basic and intermediate kinds of commercial property insurance do not cover theft committed by vandals, but they often will cover repairs when thieves enter the premises by damaging the building.

Sprinkler Leakage

Though most water damage will not be covered without flood insurance, businesses can use their regular property insurance to cover leakage of automatic sprinkler systems. The reason for this flexibility is simple: By agreeing to cover sprinkler leakage, insurers hope that sprinkler systems will be installed in buildings to prevent fires.

Excluded Perils

Even insurers offering all-risk commercial property insurance will exclude some perils from their policies. The next several sections address those commonly excluded risks. Businesses concerned about excluded losses might want to purchase another type of insurance.

Water Damage

Other than sprinkler leakage, the Building and Personal Property Coverage Form is not designed to cover water damage. This includes losses linked to any of the following causes:

- Floods.
- Waves.
- Mudslides.
- Seepage.
- Sewer backups.

Fungus, Rot and Bacteria

Basic kinds of commercial property insurance do not cover losses related to fungus, rot or bacteria unless the fungus, rot or bacteria is caused by a covered peril. There is no special limit of liability when fungus, rot or bacteria is caused by fire or lightning. When fungus, bacteria or rot are caused by other covered perils, the insurer's limit of liability is no more than $15,000. Insurance money can be used to remove fungus, rot or bacteria, tear a building apart in order to remove those things, or conduct tests to ensure that the removal of those things has been successful.

No matter which covered peril actually causes fungus, rot or bacteria, covered businesses must do what they can to prevent its further spread. If a business does not take reasonable steps to keep fungus, rot or bacteria under control, the insurance company can deny the claim.

Earth Movement

Significant kinds of earth movement can include earthquakes, landslides, volcanic eruptions and sinking. Separate insurance is necessary if a business is concerned about earth movement. However, a business can choose to insure against sinkhole collapse and volcanic action. (Details regarding those two perils appeared in previous sections of this material.) Fire damage remains covered even if the fire is caused by earth movement.

Pollutants

Standard kinds of commercial property insurance do not cover pollution losses, other than the cost of cleanup. Furthermore, the cleanup is only covered when it results from a covered peril. Some substances that might qualify as pollutants are listed below:

- Smoke.
- Soot.
- Fumes.
- Acids.
- Chemicals.
- Waste (including waste being held for recycling).

The most the insurer will pay for cleanup of pollutants is $10,000 per year. This is additional insurance and has no impact on the insurer's other limits of liability. To have a claim for cleanup covered, the business must report any cleanup expenses to the insurer within 180 days of the triggering loss.

Nuclear Reactions and Radiation

Damage done by any kind of nuclear reaction or nuclear radiation is excluded. This exclusion still allows businesses to be reimbursed for fire losses when a nuclear reaction causes a blaze.

War

Commercial property insurance generally does not cover damages caused by war or military action. This exclusion applies during declared war, undeclared war, civil war and rebellion.

The Terrorism Risk Insurance Act of 2002 (commonly known as "TRIA") requires that insurance companies offer terrorism coverage to their commercial policyholders. This coverage is available for an additional cost. By signing the appropriate forms, businesses can decline this insurance.

Power Failures and Surges

Businesses receive no insurance benefits when a power failure can be traced back to problems at a utility company. There is also no coverage when artificial current does damage to personal property.

In general, some coverage remains intact when a power failure or power surge causes damage from a covered peril. In other words, if a business experiences a power surge, computers damaged by that surge will not be covered. But if that surge were to cause a fire, the business would still be covered for fire losses.

Theft

Losses from theft can often only be covered through all-risk insurance or crime insurance. If a business rejects both of those options and a burglary occurs, the insurer might only pay for repairs to the building. Replacing any stolen items will probably be the business's responsibility.

Additional Benefits of the Building and Personal Property Coverage Form

The Building and Personal Property Coverage Form has a few other uses for businesses besides insuring what they own. The next two sections explain these additional benefits.

Debris Removal

If a covered peril produces debris of covered property at the business premises, the insurance company will pay to have the debris removed. This provision in the policy does not cover the removal of pollutants, and it does not cover debris removal when damage is caused by something other than a covered peril.

The amount of money available for debris removal will depend on the size of the loss and the insurer's limit of liability for the damaged property. In general, until the insurer's limit of liability for the property has been reached, a business may file a claim for debris removal that is equal to as much as 25 percent of the policy's deductible plus the covered portion of the loss that created the debris.

Suppose a windstorm has created damage and debris at a hat store named Jim's Brims. The owner, Jim, has insurance with a $500 deductible. Jim's covered, non-debris losses amount to $49,500. By adding his deductible to his covered non-debris losses ($500 + $49,500) and multiplying the sum by 25 percent, we can see that Jim's insurance will pay up to $12,500 to remove the debris.

In rare catastrophic situations, businesses may be eligible to receive up to an additional $10,000 for debris removal. Eligibility for these additional benefits depends on some relatively complex math, which we will not address here.

Fire Department Charges

If a business is charged for assistance from the fire department, the insurance company will pick up at least a portion of the cost. This is extra insurance equal to $1,000. There is no deductible involved.

This insurance can only be used when the fire department was called to help prevent a covered cause of loss. In other words, a business is covered when it calls the department to help put out a fire. A business would probably not be covered when it calls the department to help get an animal out of a tree.

Barriers to Full Coverage

Even when covered property is damaged by a covered peril, full coverage of the loss is still unlikely. There are several reasons why this is true. At this point, we'll examine the assorted barriers that can reduce the size of an insurance settlement.

Deductibles

The policy's "deductible" is arguably the simplest and most obvious reason why legitimate claims aren't paid in full. The deductible is the dollar amount that the business must pay out of pocket before a loss can be covered by the insurance company. Usually found on the policy's declarations page, the deductible can often be as low as $250 or as high as the insured wants it to be. Generally, the higher the deductible, the lower the premiums.

As an example, let's assume a business has a commercial property policy that insures personal property for $50,000 and has a $500 deductible. A fire occurs, and damages to personal property are calculated at $50,100. In this case, the insurance company would deduct $500 from $50,100 and pay the business $49,600 for its losses.

If a loss occurs at multiple buildings that are covered by the same policy, the deductible usually only applies once. So if two buildings are insured by a policy with a $500 deductible and both are damaged at the same time, the deductible will still be $500, not $1,000.

Coinsurance

Earlier sections of this course mentioned "coinsurance requirements." A coinsurance requirement usually states that if property is not covered up to a certain percentage of its actual cash value (or, in some cases, its replacement cost), the insurance company will not fully compensate the business for a loss. Instead, the insurer will pay a prorated amount based on how close the business was to meeting its coinsurance requirement.

Even for insurance veterans, coinsurance requirements can be confusing. Let's look at a few examples of how the requirements might affect a business. In all examples, let's assume there is an 80 percent coinsurance requirement.

A business owner purchased insurance that covers his property for up to $80,000. After a fire, it was determined that his property was actually worth $100,000. Since the policy limit ($80,000) was equal to 80 percent of the property's value ($100,000 × 80% = $80,000), the owner met his coinsurance requirement and his entire claim will be paid.

Another business owner purchased insurance in the amount of $90,000. After a windstorm damaged the business's roof, it was determined that the value of covered property was actually $100,000. Since the amount of coverage ($90,000) was greater than 80 percent of the property's value ($100,000 × 80% = $80,000), the owner met her coinsurance requirement and had her claim paid.

A third business owner purchased insurance in the amount of $60,000. After a major hailstorm, it was determined that the value of his property was $100,000. Since the amount of insurance ($60,000) was less than 80 percent of the property's value ($100,000 × 80% = $80,000), the business did not meet its coinsurance requirement and was only covered for a portion of its losses.

Prorated Settlements

When a business fails to satisfy a coinsurance requirement, an insurance professional can help calculate the covered portion of a loss. The first step is to determine the size, in dollars, of the coinsurance requirement. This is accomplished by multiplying the coinsurance requirement by the property's value at claim time. For a business that has a $60,000 policy, an 80 percent coinsurance requirement and property worth $100,000, we would multiply 80 percent by $100,000 and get a result of $80,000.

In the next step, we need to divide the amount of purchased insurance by the size of the coinsurance requirement in dollars. For the business mentioned in the previous paragraph, we would divide $60,000 by $80,000 and get a result of 0.75. This means the business would be covered for no more than 75 percent of a loss.

Now all we have to do is multiply our answer from the previous step by the actual loss. Suppose a hailstorm caused $40,000 of damage to the business's building. In that case, the insurance company would multiply $40,000 by 75 percent and get a result of $30,000. Leaving deductibles out of the equation, this is the amount the business would receive from its insurer. The remaining $10,000 would be considered an uninsured loss.

The preceding steps can be combined to form the following equation:

- Pro-rated settlement = [Coverage limit ÷ (80 percent × property value at claim time)] × actual loss

Coinsurance and Extended Coverage

As if the possibility of a partially denied claim wasn't enough, there are plenty of other reasons why a business would consider accepting a coinsurance requirement of at least 80 percent. If the coinsurance percentage on the declarations page is less than 80 percent, there will be no coverage for the following kinds of property:

- Newly constructed property.
- Newly acquired property.
- Personal effects and property of others (the insurance with the $2,500 limit).
- Valuable papers and records.
- Off-premises property.
- Outdoor property.
- Trailers.

Agreed Value

Insurance companies will typically waive their coinsurance requirements if a business chooses the "agreed-value option." When the agreed-value option is selected, the insurance company considers the property owned by the business before issuing a policy and arrives at a seemingly suitable dollar limit for the business. This limit is known as the "agreed value."

The business can then choose the agreed value or any other value as the policy's dollar limit. If the business opts for the agreed value or a higher number, the insurer will pay 100 percent of claims up to the policy's dollar limit. If the business opts for a dollar limit below the agreed value, the covered portion of all claims will be determined by dividing the policy's dollar limit by the agreed value.

Like coinsurance, the agreed-value option can probably be best understood by looking at a few examples. First, let's imagine that an insurance company has evaluated a business's property and arrived at an agreed value of $100,000. If the business decides to insure its property for at least $100,000, it will be covered for 100 percent of losses up to $100,000 after satisfying any deductible.

Now imagine that the same business has decided to insure its property for $80,000 instead of the agreed value of $100,000. Since the business is only purchasing insurance equal to 80 percent of the agreed value, it will only be covered for 80 percent of any losses.

The agreed value will only remain in effect until a specific date, which may or may not coincide with the end of the policy period. After that date (unless the insurer is contacted), losses will be subject to the coinsurance requirements.

Vacancy

The insurance company can sometimes deny an otherwise valid claim if the business's building had been vacant for an extended period at the time of the loss.

The vacancy clause doesn't impact building owners and tenants in the same way. In the case of an insured tenant, the vacancy clause can go into effect only when the tenant's portion of a building does not contain enough property for a tenant to conduct normal business operations. In the case of an insured building owner, it can go into effect when 70 percent or more of the entire building is neither rented to tenants nor used by the owner

to conduct regular business. Buildings are not vacant if they are under construction or being renovated.

The vacancy clause is also applied differently depending on the cause of a loss. When a loss is caused by vandalism, theft, water damage or broken glass, the insurance company can deny coverage entirely if the building was vacant for more than 60 consecutive days. For all other perils, a vacancy period beyond 60 days will decrease the insured portion of a loss by 15 percent.

Ordinances and Building Codes

Local building and fire codes are often updated to make buildings safer and more energy-efficient, but existing structures are often exempt from the new requirements. When a building that had been exempt from the new requirements is destroyed, any replacement building must be built in full compliance with current law.

When buildings are destroyed relatively soon after they have been built, owners are not likely to be burdened by the changes in building ordinances. Any changes that might have been made to local codes since the original building's construction are likely to be few in number, and the cost to construct a new building will probably not be far away from the destroyed building's insured value. But if the destroyed building was several years old, the owner might need to comply with many changes to the codes and could be significantly underinsured.

The extra cost of complying with ordinances and building codes can be covered if the business has insured its building at replacement cost. The most the insurer will pay for these additional construction expenses is $10,000 or 5 percent of the building's insured value, whichever is lower.

Getting Through the Settlement Process

A significant loss of property can be a stressful experience. Stress and unpleasantness can be reduced if the insured has a good idea of what to expect after a loss occurs and during the settlement process.

Duties After a Loss

Assuming the insured's personal safety is not at risk, a business's first priority after a loss should be to keep damage under control. For example, if a windstorm has created openings in a roof, the business should take reasonable steps to protect interior property. This might mean putting a tarp over the roof, or it might involve moving interior property to another location. If the property is moved, it will remain covered while at the offsite location for 30 days.

The business should document any costs that it incurs from managing the damage. The insurer may take these expenses into account when calculating an appropriate settlement. If a business does not take reasonable steps to reduce the scope of a loss, the insurer might have the right to deny claims.

Once steps have been taken to minimize the loss, the business should start contacting people about the occurrence. If there is evidence of criminal wrongdoing, such as vandalism, the business's first phone call should be to the police department. If there is no evidence of wrongdoing, that first call can go to the insurance company or one of its

representatives. Though the exact details are not necessary for the initial phone call, the business should provide the following information to the carrier in a timely manner:

- The magnitude of the damage or loss.
- The property that was damaged or lost.
- The location where the damage or loss occurred.
- The time when the damage or loss occurred.
- The cause of the damage or loss.

After being made aware of the loss, the insurer will probably ask the business to complete a "proof of loss form." This form must be completed, signed and returned to the insurer within 60 days of the carrier's request, although state law might call for a looser deadline. The insurer then usually has 30 days to respond with a proposed settlement.

Insurer Access to Company Records

Despite all the claims that are made for losses by honest businesses, instances of fraud still occur. To help itself fight this problem, the insurance company is allowed to access and make copies of the business's records.

The policyholder must cooperate in all reasonable ways while the insurer is investigating a claim. In some cases, the policyholder might have to answer the insurer's questions under oath and in writing.

Insurance Inspections

The insurance company is allowed to inspect damaged property to determine the scope of a loss. Building owners should understand that an insurer's inspection is for coverage purposes only. It is not meant to be a safety inspection. The insurer isn't responsible for the safety of a business's customers or employees at the building, and it isn't responsible for checking to see if everything is compliant with local building codes and ordinances.

Appraisals and Legal Action

If there is a disagreement regarding a loss, the business or the insurer can demand an appraisal. Each side of the dispute will hire its own appraiser. If the appraisers cannot come to an agreement, the case can be sent to an arbitrator.

Coverage for Mortgage Lenders

Mortgage holders, including trustees, can be compensated in a manner that reflects their ownership interest in a damaged building. In order to be paid by the insurer, the mortgage holder must be listed appropriately on the policy's declarations page. The mortgage holder is entitled to compensation even if a loss occurs while it is in the process of foreclosing on the covered property. The insurer also has the option of buying the mortgage from the lender.

If an action or inaction by the policyholder causes the insurer to deny a claim, the mortgage holder can still get its share of insurance money. To receive compensation after a claim has been denied, the mortgage holder should take all of the following actions:

- Pay the insurance premiums if the policyholder has not done so.
- Submit a proof of loss form within 60 days of a request if the policyholder has not done so.

- Disclose all relevant risk factors that relate to the property if the policyholder has not done so.

Recovered Property

As unlikely as it may seem, there really are times when lost property is recovered long after an insurance settlement has been finalized. When this happens, the insurer and the recipient of insurance benefits are usually obligated to contact each other. The insured can then choose one of two options. Either the insured can return the insurance money and retain ownership of the recovered property, or the insured can keep the money and pass ownership of the property along to the insurance company. These options are usually spelled out in the policy's "recovered property" clause.

Conclusion

In printed form, a commercial property policy can amount to less than 30 pages. But each of those pages contains a lot of important information. Even if agents and brokers don't deal with it specifically on a daily basis, the Building and Personal Property Coverage Form can help them recognize various commercial risks. By applying their knowledge of risks to a business's specific situation, insurance sales professionals are more likely to keep policyholders satisfied and well-protected.

CHAPTER 5: EMPLOYMENT PRACTICES LIABILITY INSURANCE

Introduction

Changes in local, state and federal laws over the past 50-plus years have made it easier for employees and job applicants to fight back against discrimination and harassment in the workplace. Yet the presumed positive goals of those laws—to ensure that individuals be evaluated fairly and treated with respect by employers—have also increased the risks of "employment practices liability" (EPL) for many businesses.

This liability, which exists when a business is accused of violating someone's employment rights, is rarely top of mind for an organization. Small businesses, in particular, tend to lack the resources to keep up with consequential changes in employment law and might not fully understand their legal responsibilities pertaining to hiring, firing and supervising a workforce. Small organizations might also fall into the trap of viewing their employees as a second family, the members of which would never engage in seriously inappropriate behavior or take their bosses to court.

Through education and legal counsel, entities such as the federal Equal Employment Opportunity Commission (EEOC) have helped make it easier and cheaper for workers to protect themselves from unacceptable conduct in the workplace. But whereas employees can file complaints with the federal government at no cost, businesses accused of discrimination or other illegal employment practices can spend thousands of dollars defending themselves against even meritless claims. Although insurance is certainly no substitute for running a law-abiding operation, it can help reduce the financial burden when employment-related misunderstandings or mistakes get out of hand.

This course module will offer detailed information about common coverage, exclusions and other important provisions within EPL insurance policies. If you hope to expand your knowledge of commercial lines insurance to better serve consumers, the material should provide an excellent starting point for your EPL education. If you're also an employer, perhaps the next several pages will cause you to reexamine your own insurance portfolio and any gaps that might personally expose you to employment practices liability.

Common Employment Liability Issues

No matter if you're considering buying or selling EPL insurance, your knowledge of the product will be inadequate if you don't understand the liability risks associated with the employer/employee relationship. Allegations linked to the following acts can be particularly damaging to employers:

- Sexual harassment.
- Discrimination.
- Retaliation.
- Privacy violations.
- Libel/slander.

As we review each of these acts and go into further detail about employment liability, please be aware that the provided information is intended to be general in nature and not a substitute for legal counsel. For specific concerns about employment liability and employment laws, readers should consult material written by legal professionals or speak to a licensed, experienced attorney. This chapter exists purely as a source of background

information for interested insurance professionals and is not a guide to avoiding employment liability.

Sexual Harassment

Sexual harassment may be occurring when workers or job applicants are either physically or verbally subjected to unwanted sexual advances. Whether unwelcome advances rise to the level of illegality will depend on a number of factors, including their severity and frequency. But even a merely inappropriate incident should be addressed quickly and carefully by management. A manager who ignores inappropriate conduct puts company morale at risk and increases the business's chances of being sued for future incidents.

Quid Pro Quo vs. Hostile Environment

Illegal sexual harassment occurs in employment when unwanted sexual advances are made "quid pro quo" or when they create a "hostile work environment." Let's learn more about the differences between these two types.

Quid Pro Quo

Quid pro quo sexual harassment exists when employees are expected to accept sexual advances in exchange for a tangible employment decision in their favor. For example, there might be an explicit or implicit understanding that an employee must have a sexual relationship with someone in order to be hired, promoted or given certain benefits. Unlike other kinds of sexual harassment, which can be caused by nearly anyone in a work environment, quid pro quo sexual harassment is committed almost exclusively by supervisors.

Hostile Work Environment

A hostile work environment is either a work situation that is highly offensive and intimidating or one in which sexual advances unreasonably interfere with an employee's job performance.

Existence of a hostile work environment usually requires more effort to prove than quid pro quo harassment, but the potential for it exists in a wider variety of situations. Whereas quid pro quo harassment almost always involves supervisors taking physical advantage of subordinates, a hostile environment can be created by victims' colleagues as well as their supervisors. Although physical contact can certainly be part of a hostile environment, an illegal amount of hostility can also result from sexually charged gestures, comments and jokes.

In judging whether a hostile environment exists, courts often try to determine how a reasonable person would feel under the specific circumstances. If a reasonable person would feel intimidated in the workplace because of a sexual advance, harassment is more likely to have been committed. If a reasonable person would merely feel awkward or momentarily uncomfortable after an advance, a judgment of harassment is less likely.

Preventing and Responding to Harassment Complaints

Businesses cannot protect their employees from harassment in every case, but they can significantly reduce the risk by taking a few important steps. The EEOC has made the following recommendations:

- Be clear about what kind of conduct is not acceptable in the workplace.
- Assure employees that they will not be penalized for reporting inappropriate behavior.

- Make employees aware of how to make a complaint (including what to do if the person who normally handles complaints is also the alleged harasser).
- Emphasize that the details of complaints will remain as confidential as possible.
- Develop a procedure for conducting quick and fair investigations.
- Take action if an investigation reveals that something inappropriate has occurred.
- Ensure that any corrective actions in response to a complaint don't penalize the alleged victim.

Discrimination

For several decades, most businesses have been prohibited from discriminating against workers or job candidates on the basis of race, religion age and gender. Over time, additional protections have helped disabled persons and pregnant woman achieve fairer treatment from current or prospective employers. More recently, we've seen antidiscrimination laws and rules protecting gay and lesbian Americans, and several states have either already approved or begun debating similar protections for transgender people.

Several federal laws aim to stop discrimination in the workplace. Due to their importance, many of those laws (including the Civil Rights Act of 1964 and the Americans With Disabilities Act) will be summarized later in this course. Be aware that additional protections often exist at the state or local level.

Retaliation

Within the context of employment practices liability, "retaliation" occurs when a worker receives punishment for exercising (or attempting to enforce) his or her employment rights. Examples of retaliation appear below:

- An employee is fired for complaining about unfair treatment or taking legal action against an employer.
- An employee is passed over for a promotion for testifying in support of a coworker who has accused their employer of wrongdoing.
- An employee is denied a raise because he or she refused to follow an illegal employment practice.

As explained well by insurance veteran Catherine M. Padalino in the trade publication National Underwriter, an employee's retaliation case can succeed even if the initial complaint that triggered it is groundless. For example, consider a scenario in which an employee files a discrimination complaint with the EEOC and that, upon an investigation, the government finds no evidence of discrimination. If the employer responds by firing the employee for making the original complaint, the employee might be able to win in a separate case by alleging retaliation.

Privacy Violations

Employers face potential liability if personal information they receive from an employee becomes unsecure and accessible by third parties. In their hiring process and roles as benefit administrators, employers often must take special care to safeguard employees' Social Security numbers, health information and other sensitive facts.

Relatively new privacy risks can also arise when an employer conducts online background checks on prospective or existing employees. Public profiles on social media platforms

might contain information about a person's religion, sexual orientation or other traits that typically won't appear in an applicant's resume or be discussed with a new boss. Viewing this information might expose the employer to allegations of discrimination if the employee/applicant believes it influenced an employment decision.

Libel/Slander

Unfortunately, some employment relationships will end on bad terms. A business with anger toward a former worker should control that emotion in order to avoid accusations of defamation. Written defamation is known as "libel," whereas spoken defamation is known as "slander."

The potential for libel or slander might exist when supervisors cast a former employee in a negative light when explaining the person's departure to other workers. Similar risks exist if a former employer is asked by a potential new employer to verify a job applicant's work history and provides too many sensitive or untrue details.

Employment Rights and the Federal Government

We've already mentioned some of the federal entities and laws that aim to promote and mandate a fair, professional and nondiscriminatory workplace. Those entities and laws deserve further explanation and will receive it in the next few sections.

Although risks related to many federal employment-related laws can be managed via EPL insurance, others will be excluded from EPL policies. (Common coverages and exclusions will be explained later in this course.)

Once again, it's important to note that the laws mentioned here aren't the only employment-related statutes for businesses and that additional worker protections usually exist at the state and local level. In addition, understand that these sections are meant to summarize federal workplace protections but aren't a comprehensive or authoritative source for interested employers. For the most up-to-date and relevant information impacting a particular business, businesses should seek out appropriate legal counsel. Similarly, insurance professionals should be careful not to promote themselves inappropriately as legal experts and should instead encourage their EPL prospects to learn more about employment laws from qualified attorneys or other trusted sources. We will state what should be obvious here and say that a license to sell insurance is not a license to offer legal advice.

The Equal Employment Opportunity Commission (EEOC)

The Equal Employment Opportunity Commission (EEOC) is a federal agency charged with investigating allegations of workplace discrimination and enforcing several workplace antidiscrimination laws. The agency also serves as a resource for businesses that want to know more about how to comply with those federal laws.

According to figures found at its website from 1997 through 2017, the EEOC has typically received anywhere from 75,000 to nearly 100,000 charges of workplace discrimination from employees and job applicants each year. When a charge is made, the agency has the authority to investigate it, file a lawsuit on the alleged victim's behalf or attempt to engage the accuser and the employer in mediation to settle the dispute. These actions are often taken at no cost to the person making the charge.

The Age Discrimination in Employment Act

The Age Discrimination in Employment Act prohibits workplace discrimination on the basis of age. Here are a few additional details about the law from the EEOC and AARP:

- The law makes it illegal to discriminate in hiring, firing or other employment matters on the basis of age if the impacted person is 40 or older.
- The law applies to businesses with 20 or more employees, although state laws might require compliance from smaller entities.
- The law generally does not apply to independent contractors or members of the armed services.
- The law does not prohibit age discrimination against people under 40, although state laws might offer this protection.
- Employers might be able to set age limits on some jobs but must take several factors into consideration and follow very specific rules to avoid liability.

The Civil Rights Act of 1964

The Civil Rights Act broadly prohibited various forms of discrimination in voting, education, employment and access to public accommodations. (This law should not be confused with the Civil Rights Act of 1968, which prohibited discrimination in housing.)

Antidiscrimination provisions in the Civil Rights Act of 1964 appear primarily in Title VII of the law. Here are some particulars, according to the EEOC:

- The law prohibits employment discrimination on the basis of race, color, religion, gender or national origin, although state laws might include additional protected classes.
- In time, the antidiscrimination protections based on gender were clarified to prohibit discrimination specifically against pregnant women.
- The law generally applies to businesses with 15 or more employees, although state laws might extend protections to workers at smaller entities.

The Americans With Disabilities Act

In addition to making public accommodations more accessible for people who lack traditional mobility, the Americans With Disabilities Act (ADA) prevents employers from taking negative actions against workers or job applicants because of a perceived or actual physical or mental disability. Here are some more basic facts from the EEOC and the online resource FindLaw.com:

- People with disabilities cannot be discriminated against in employment if they are otherwise capable of performing a job's essential tasks.
- People with disabilities cannot be discriminated against in employment if they merely require a "reasonable accommodation" to complete a job's essential tasks.
- People with disabilities cannot be discriminated against in employment if they cannot perform a job's unessential tasks.
- The law does not prohibit discrimination if a person cannot reasonably perform a job's essential tasks.

- The law does not exempt a disabled person from needing to satisfy other pre-requisites for a job, such as relevant experience, education, etc.
- A disabled job applicant cannot be denied an interview because he or she requires a reasonable accommodation in order to participate in the discussion.
- Disabled applicants or workers are generally expected to alert an employer when they require a reasonable accommodation.
- Although the law generally applies to businesses with 15 or more employees, state laws might extend protections to disabled persons at smaller entities.
- Although issues related to an applicant's or worker's drug use might create separate privacy issues between employers and their workers, drug use is not a protected disability under the ADA.

The Family and Medical Leave Act

The Family and Medical Leave Act preserves employees' jobs and their health insurance when they take a leave of absence to care for themselves or a family member. Employees covered by the law are entitled to 12 weeks of unpaid leave (and continued health insurance) per year under any of the following circumstances:

- They need time off to become acquainted with a newborn, a newly adopted child or a newly placed foster child. (Men who take leave for this reason are entitled to the same rights as women.)
- They need time off to care for a seriously ill child. (The child doesn't need to legally or biologically be their son or daughter. However, an employee must have assumed some kind of parental role.)
- They need time off to care for a seriously ill spouse.
- They need time off to care for a seriously ill parent or guardian. (The parent or guardian doesn't need to legally or biologically be their mother or father. However, the ill person must have assumed some kind of parental role when the employee was a minor.)
- They need time off to manage their own serious illness.
- They need time off for reasons related to a family member's involvement in the National Guard or Reserves. (In addition, family members may take 26 weeks of unpaid leave to care for a seriously ill service member.)

Not all businesses are impacted by the Family and Medical Leave Act. For the law to apply, all the following statements must be true:

- The employee has worked for the employer for at least a year.
- The employee has worked at least 1,250 hours for the employer over the past 12 months.
- The employer employs at least 50 people within 75 miles of the employee's workplace. (Individual states might provide similar protections to employees at smaller businesses.)

The Equal Pay Act

The Equal Pay Act provides additional antidiscrimination protections on the basis of gender and requires that men and women be paid an equal amount for equal work. Details from the EEOC are summarized below:

- Men and women must be paid equally (regardless of job title) if they are performing essentially the same tasks, possess essentially the same skills, have essentially the same experience, are given essentially the same responsibilities and work for the same employer.
- Unequal compensation can still be provided on the basis of experience, seniority, merit, quality of work or quantity of work.
- If an employer attempts to correct an unequal pay issue, the situation must result in increased pay for the discriminated worker rather than decreased pay for the non-discriminated worker.
- Although some businesses, jobs and scenarios are exempt from the Equal Pay Act, there is no exemption based on the number of employees.

The Pregnancy Discrimination Act

The Pregnancy Discrimination Act amended the aforementioned Civil Rights Act of 1964 to clarify that employment discrimination on the basis of pregnancy is a form of illegal gender discrimination. Here's some more information from the EEOC:

- Employers must allow pregnant employees to work as long as they are reasonably capable of performing their job duties.
- In general, employees cannot put restrictions on pregnancy-related leave that are different from other types of permitted leave.
- When providing health benefit opportunities to employee spouses, health plans cannot discriminate on the basis of a spouse's gender (such as by only allowing husbands, but not wives, to enroll in a plan).
- The law applies to businesses with 15 or more employees.

The Fair Labor Standards Act

The Fair Labor Standards Act, which is enforced by the federal Department of Labor, puts restrictions on mandatory work hours, sets standards for payment of the federal minimum wage and sets rules for overtime work.

The Employee Retirement Income Security Act

The Employee Retirement Income Security Act (ERISA) contains several requirements related to managing employer-sponsored retirement plans. The law's specifics are beyond the scope of this material.

The Occupational Safety and Health Act

The Occupational Safety and Health Act (OSHA) requires employers of all sizes to provide a safe work environment for their onsite employees. Specific compliance requirements may differ across various industries and can depend on number of employees. For example, some employers with 10 or more employees must maintain records of workplace injuries and illnesses. The law also created the federal Occupational Safety Health

Administration, which enforces the law's requirements and provides educational tools for workers and businesses.

The National Labor Relations Act

The National Labor Relations Act generally protects employees' rights to join and form unions and to informally bring coworkers' concerns to an employer's attention. Its specific impact is beyond the scope of this course.

The Genetic Information Nondiscrimination Act

In addition to providing some health insurance nondiscrimination protections to consumers, the Genetic Information Nondiscrimination Act (GINA) generally prohibits employers from requesting genetic information or family medical history from employees and job applicants. In rare cases where this information becomes known to an employer (according to the EEOC), the information must remain confidential and cannot be used as a basis for discrimination. The federal law applies to businesses with 15 or more employees, but several states have passed similar laws with broader applicability.

EPL Risk Management

Although the rest of our study will focus largely on EPL insurance and the way it can reduce employment liability risks, this important coverage shouldn't be the only tool for a concerned business. In fact, some risk managers believe other basic forms of risk management should be pursued before spending any money on EPL insurance. In addition to purchasing appropriate insurance, businesses might reduce—if not eliminate—some employment risks via the following steps:

- Review compliance with federal and state laws with a qualified attorney.
- Check for periodic legal updates and guidance from government agencies and other reputable sources.
- Create and distribute policy manuals regarding workplace professionalism to all employees, and obtain written confirmation that each employee has read the document.
- Provide initial and refresher training on issues like workplace discrimination and harassment.
- Promote a welcoming environment in which employees are encouraged to share concerns and complaints with supervisors without fearing retaliation.
- Document adverse actions taken against employees and job applicants, as well as the valid reasons for those actions.
- Use careful and clear job descriptions when advertising employment.
- If terminating someone's employment, treat the terminated employee with as much dignity as the situation allows, without creating unnecessary public embarrassment.

Insurance companies tend to agree with many of these recommendations and have proven it by offering free resources, such as legal assistance and policy manuals, to some of their EPL policyholders. These resources are more commonly available when a business purchases stand-alone EPL insurance rather than coverage that has been included as a rider to a different policy. More information about the differences between stand-alone coverage and "add-on" coverage will appear later in this course.

EPL Insurance Defined

Employment practices liability insurance aims to protect businesses when they are accused of violating someone's employment rights. The person whose rights might or might not have been violated could be a current or former employee or anyone who unsuccessfully sought work at the business.

Common EPL claims involve allegations of discrimination, retaliation or sexual harassment. Such allegations are often linked to the hiring, firing, layoff, promotion or demotion processes but can occur at seemingly any time.

With the online insurance trade journal Property Casualty 360 reporting in 2015 that only 30 percent of businesses had EPL insurance, it's obvious that this coverage isn't a top concern for most organizations. The apparent apathy means the product requires more effort to sell than other forms of commercial coverage, such as general liability or workers compensation insurance. But with enough patience and knowledge, it can become an important moneymaker for producers and an important safeguard for buyers.

Coverage Under Other Insurance

One of many reasons why most business don't pursue EPL insurance comes from the misconception that employment risks are covered by their existing insurance. Some carriers might've paid some EPL-related claims decades ago thanks to loopholes and borderline-ambiguous language in commercial general liability (CGL) and business owner's policy (BOP) forms, but those insurers largely stopped being so lenient as allegations of discrimination and harassment gained wider attention. Even among insurers that had never planned on covering EPL risks under CGL or BOP products, the industry opted to protect itself even further by adding exclusionary endorsements, which closed most of the potential loopholes and corrected the arguably ambiguous terminology.

In today's insurance market, CGL and BOP policies will typically only cover EPL risks if a business specifically requests that coverage be added to those products at an additional cost. Similar "add-on" options might exist in a few personal lines liability scenarios in which a homeowner employs domestic workers.

If adding onto an existing insurance product does not provide adequate protection for an employer, a stand-alone EPL policy might be advisable.

EPL Insurance Underwriting

As in any other line of insurance, carriers offering EPL products will evaluate each applicant carefully by asking questions about the buyer's past, present and future susceptibility to risk. Here are some questions that might be particularly important to an underwriter when evaluating EPL risks:

- Have you ever been accused of an illegal employment practice, and if so, what was the outcome?
- How many people do you employ?
- How often do you experience employee turnover?
- What level of hiring, firing or layoffs have occurred recently or are likely to occur in the near future?
- Do you have a company policy manual that promotes consistent professional conduct at the workplace?

- Do you have a team of employees working exclusively in human resources? If so, how much influence does the team have in company decisions?
- In which states does your business operate? (This can be a factor because employment laws differ by state.)
- What types of information do you request on employment applications?
- What type of (and how much) training do you provide to employees on an initial and ongoing basis?

Common EPL Insurance Coverage

We'll now turn our attention to common features and exclusions in EPL insurance products.

As you finish the rest of this chapter, please be mindful of the relative lack of uniformity in the EPL market. Whereas most commercial lines insurers offer similar coverage for CGL risks by basing policy language on standard forms from a third party called the "Insurance Services Office" (ISO), standardization across EPL product lines remains a work in progress. Despite the introduction of a standard ISO form for EPL stand-alone coverage and add-ons, many carriers still utilize their own coverage forms or at least offer products that differ from what's written in the ISO language. Never assume that any two carriers' EPL products will feature the exact same benefits and exclusions.

Stand-Alone Policies vs. Endorsements

For those businesses that really want it, EPL insurance can be obtained in several ways. In general, those options can be broken down into two broad categories: stand-alone policies and endorsements (or add-ons) to other policies.

Stand-alone EPL insurance products tend to offer the broadest protection on the market and have higher dollar limits that won't be reduced by other types of claims, such as a slip-and-fall claim under a CGL policy or a class-action claim brought by shareholders under a directors and officers (D & O) claim. The obvious tradeoff, though, is cost. Since stand-alone EPL insurance tends to have higher premiums than an EPL endorsement to another insurance product, stand-alone coverage is typically geared toward larger businesses with larger insurance budgets.

Smaller companies that have EPL concerns but want to pay less for insurance can compromise by adding an EPL endorsement to one of their existing insurance policies, such as a CGL policy, a BOP or a D & O policy. However, this typically results in the coverage limits being shared across a variety of different risks and might result in underinsurance.

For example, assume an EPL endorsement has been added to a CGL policy. Now imagine the policy has a $1 million coverage limit for each annual policy period. If the business is held responsible for a serious injury to a customer and is also sued for employment practices in the same year, the $1 million limit will need to be divided in some way between the injury claim and the EPL claim. If the combined losses from both claims exceed $1 million, the business might need to pay the excess amount out of pocket.

An experienced insurance broker who understands the intricacies of a business's risks should be able to help the business avoid inadequate coverage limits. You'll learn more about coverage limits later in this chapter.

Who Is "the Insured"?

A worker or job applicant who feels violated by an employer might take action against a broad range of individuals affiliated with the organization. In addition to filing a complaint or lawsuit against the company, the alleged victim might name high-ranking directors, middle-managers, low-level employees, former employees, shareholders, independent contractors or temporary workers and accuse any of those parties of inappropriate behavior. Businesses and their insurance advisers should pay close attention to the definition of "the insured" in an EPL policy so that liability protection exists for the appropriate people and not just for the business entity.

At minimum, EPL insurance will usually include coverage for the business entity and high-ranking employees who might be held liable for the illegal conduct committed by lower-ranking personnel. A mid-level approach to EPL insurance also provides liability protection for shareholders, current non-manager employees and people who formerly worked as employees and have since left the business. Even broader (but increasingly rarer) EPL insurance can define "the insured" to also include temporary workers, independent contractors and interns accused of discriminatory or harassment-level acts. Not coincidentally, products with broader definitions of "the insured" (and that thereby expose the insurer to a broader set of losses) tend to require higher premiums.

When evaluating the definition of "the insured" for the purpose of EPL products, the insurance professional should pay close attention to any specially defined terms within that definition. For example, even if a policy defines "the insured" to include "employees," a separate portion of the policy might further limit this definition by saying an employee is someone who works on a particular schedule, such as at least 30, 35 or 40 hours per week. In the event of a claim, the insurer's definitions of these terms—not the ones used casually by the business in workplaces or even within employment contracts—can make the difference between a covered loss and an uncovered loss.

Coverage Limits

EPL insurance tends to insure businesses for millions of dollars per policy period, with most policy periods lasting one year with the option of renewal.

Although this might seem like a lot of coverage, be aware that coverage limits are often divided into a per-claim limit and an aggregate limit. For example, assume a company has a $1 million per-claim limit and a $5 million aggregate limit. Next, assume the company is accused of discriminating against an employee and loses a resulting lawsuit for $5 million. Although the $5 million is within the policy's aggregate limit, the insurer will only agree to absorb $1 million of the cost, based on the per-claim limit.

Policy wording should be carefully reviewed when several claims are made by the same employee or when multiple claims from multiple employees all stem from the same incident (such as several employees being inappropriately fired at the same time). Depending on the scenario, a carrier might treat all interrelated claims as a single claim for purposes of coverage limits or treat each one as its own claim.

When choosing coverage limits, a business and its financial advisers should also pay attention to how the cost of defending a claim (no matter the claim's legitimacy) will factor into those limits. If defense costs will reduce the policy's coverage limits, there will be less money available for settlements, fines or any judgments imposed by a court. You'll read more about defense costs and their impact on coverage limits in a later section.

What Are Covered Acts?

Though still relatively limited in scope, EPL insurance has gradually evolved to respond to an increasingly broader range of "covered acts."

At first, covered acts that could trigger coverage were largely limited to discrimination or sexual harassment alleged by either regular full-time employees or applicants for regular full-time employment. These days, covered acts typically also include alleged retaliation and even accusations made by part-time employees, contractors and other types of workers.

Yet because we still lack a standard coverage form for EPL insurance, it's important to carefully review the definition of "covered acts" and who can make a related allegation. (Note that the parties who can allege a covered act might not be the same as those who can be insured for a covered act. For example, although a business might be covered if a part-time employee alleges sexual harassment, a part-time employee might not be insured under an EPL policy if he or she is accused of such harassment.)

The following list of potentially covered acts is intended as a general summary and should be cross-checked against any EPL product under consideration:

- Alleged discrimination under the Civil Rights Act, Americans With Disabilities Act, Equal Pay Act, Age Discrimination in Employment Act, or Pregnancy Discrimination Act.
- Alleged sexual harassment.
- Alleged retaliation for reporting discrimination or harassment.
- Violations related to the Family and Medical Leave Act.
- Alleged libel or slander committed by a supervisor about a current or former employee.
- Alleged privacy violations committed by employers against employees or job applicants.
- Alleged discrimination under applicable state law. (Note however, that some policies will name protected classes—race, religion, ethnicity, etc.—for the purpose of discrimination claims rather than referencing specific state laws. As a result, producers should be mindful of narrowly defined protected classes that are not as broad as those found in applicable state law or local ordinances. For example, know to ask questions when a policy does not include "sexual orientation" or "gender identity" as a protected class but is sold in a state where employment discrimination on those specific factors is prohibited).

Remember that a business is insured for defense costs related to covered acts even if an investigation or court determines that an employer committed no illegal activity. This protection against meritless or false claims is often one of the most attractive and certainly most important features of EPL insurance.

Third-Party Discrimination/Harassment Claims

Some EPL carriers will offer to cover claims of alleged discrimination or harassment that are made by third parties who don't work for the business. For example, imagine a scenario in which a business's employee refuses to serve a member of the public and is accused of discrimination. Or consider a case in which a business hires a repairperson for a single day's work, and the repairperson harasses one of the business's customers.

Although neither case involves violating someone's employment rights, EPL insurers might agree to add coverage for these risks at an additional cost. The cost and, of course, the need for this extra insurance will be higher the more a business engages directly with its customers.

Defense Costs

Like most types of liability insurance, EPL insurance provides coverage for defense costs, including the cost of hiring a qualified legal team. Basic EPL insurance will include defense costs within the policy's overall coverage limits. In other words, the more money spent to defend the insured, the less money there'll be to pay for settlements or court-awarded damages. If businesses have concerns about how this might create pressure to settle rather than defend a meritless claim, they can often pay extra to have separate limits for defense costs.

Many EPL policies give the insurance company a fairly broad "duty to defend" the insured. In essence, this means the insurance company must pay for and help organize the competent defense of a claim against the insured, as long as the claim is not obviously excluded by the policy language. However, if further developments (such as a judge's or jury's verdict) later make it clear that the claim is excluded by the policy language, the insurer can stop defending the claim and refuse to pay for any settlements or damages.

Due to its broad duty to defend the insured, the insurance company typically has the authority to choose the defense team or at least require that the insured choose a team from a carrier-approved list. Some EPL products will give the insured greater power over the choice of a defense team, but this might be done only in exchange for either a higher premium from the business or a narrower duty to defend from the carrier.

Deductibles

Compared to other types of liability insurance, such as CGL insurance, EPL insurance is more likely to require payment of a "deductible." The deductible is the amount of otherwise covered losses, in dollars, that the insured must pay out of pocket before the insurer will provide benefits.

EPL insurance deductibles will commonly amount to thousands of dollars, with higher deductibles typically resulting in slightly lower premiums. In choosing the deductible, the business should first understand how this number might apply to various claims. Here are a few questions worth considering:

- Will the deductible be enforced on an annual basis or a per-claim basis? (In the event of a per-claim deductible, the insurance company might treat interrelated claims—such as a class-action suit involving several former employees—as a single claim.)
- Will the deductible apply to defense costs or just judgments and settlements?

Coinsurance Fees

Along with paying a per-claim deductible, an EPL-insured business will likely be responsible for a per-claim "coinsurance fee." Within the context of EPL insurance, a coinsurance fee is the amount, as a percentage of each covered loss, that the insured must pay out of pocket. Research conducted during development of this course unearthed coinsurance fees as low as 5 percent per claim and as high as 35 percent per claim. As with the deductible, the higher the coinsurance fee, the lower the business will usually pay in premiums.

Claims-Made Policies vs. Occurrence Policies

Liability insurance policies can be either "occurrence policies" or "claims-made policies." The important distinction between the two types relates to the time period in which a claim and the action that prompted it must occur.

Occurrence Policies

Some older liability insurance policies were structured as occurrence policies. These products provided insurance protection to policyholders as long as the incident that led to a claim occurred during the policy period, regardless of when a claim (such as a demand for money) actually arose.

For example, assume a business had EPL insurance in the form of an occurrence policy during the entire time of its operations. Next, assume the business shut down two years ago and cancelled its insurance but has just been told that a former employee has decided to sue for harassment that occurred a decade ago. Since the EPL insurance was in the form of an occurrence policy and because the harassment is alleged to have occurred while the insurance was in force, the insurance company would still be required to defend the former business and perhaps cover any settlement or judgments.

Claims-Made Policies

By contrast, a claims-made policy will generally only respond if both the claim itself and the incident that led to it occurred while the insurance was in force. In the case of the business that shut down years ago and is just now receiving notice of alleged harassment, a claims-made policy would probably provide little or no protection.

Due to the shorter duration of potential liability for insurance companies, most EPL products in today's market are claims-made policies.

Retroactive Dates and Prior Acts

For coverage to exist under a claims-made policy, the claim must occur prior to the policy's expiration date, and the incident that led to the claim must occur on or after the policy's "retroactive date." When EPL insurance is purchased, the retroactive date will almost always be the policy's issue date and will not change unless the business ever cancels or lets its coverage lapse.

A business that wants a retroactive date prior to the policy's issue date might be able to purchase a limited amount of "prior acts coverage." However, even if this type of insurance might respond to claims in an alleged employment violation occurred deeper in a business's past, it will still not respond to cases in which the business already knew about the alleged violation. If prior acts coverage is available at all, it will only protect businesses against past events that had not yet been brought to their attention at the time of purchase.

Reporting a Claim

Failure to report existing or potential claims in a timely manner is one of the most common and harmful mistakes made by EPL policyholders. Too many businesses opt not to involve their insurance company until they have received a formal written notice of a lawsuit, thereby making it harder for insurers to provide an adequate defense and even making it possible for the carrier to deny the claim on account of late notice.

EPL policy language should clearly explain a business's claims-reporting responsibilities, as well as the specific definition of "claim." For example, some policies might define claim

to include certain instances that can happen prior to the filing of a lawsuit or a demand for money, such as notice of an investigation by the EEOC.

Also, some carriers might require reporting even the potential for a claim by a specific date, assuming the potential reasonably exists. For instance, a policy might call on the insured to report the possibility of a claim within 30 or 60 days of being aware of the possibility.

Regardless of specific deadlines, the insured will likely need to provide any documentation related to an actual claim (such as a written demand for money) or related to a potential claim (such as the date and details of an informal complaint made by an employee to a supervisor regarding alleged violations of employment rights).

Extended Reporting Periods

Let's assume an entity has decided to stop insuring itself against future EPL risks, either to reduce insurance costs or because it is either closing its business or will at least no longer employ anyone other than its owners. How can the business continue to protect itself against EPL claims that might arise soon after the traditional coverage is no longer in place?

The answer for many businesses involves an "extended reporting period." This common feature in casualty insurance gives the business a limited amount of time in which claims that arise after the end of the policy period can be covered as long as the incidents leading up to them occurred while the policy was in force. Or to put it another way, an extended reporting period can turn a claims-made policy into an occurrence policy for a very limited time.

As an example, let's pretend a restaurant shut down yesterday without any knowledge of potential EPL violations against its workers and has immediately opted to get rid of its EPL insurance. Despite no longer having traditional EPL insurance, the old policy's extended reporting period might help protect the business if alleged discrimination or harassment occurred while the restaurant was still open but was not known to the business owners until 30 or 60 days after they'd ended their insurance.

Often, this type of extended reporting period—lasting one to three months—is included at no additional cost. Businesses that want a longer extended reporting period (such as one allowing potential claims to be reported several months or even years after traditional coverage ends) might want to pay extra for what's known as "tail coverage."

Note, however, that even though extended reporting periods and tail coverage allow for more time to report claims, the alleged incidents leading up to the claims must still have occurred while the policy was in force, and timely notice of potential claims must still be provided to the insurer.

Settling a Claim

Being accused of illegal activity, particularly by a trusted current or former employee, can elicit extreme emotions for business owners and supervisors. EPL insurers understand this reaction but also want to manage claims so that the insured's anger, pride and concerns about reputation don't cloud the accused's judgment. Since even meritless allegations can cost businesses thousands of dollars in legal expenses and lost time, sometimes the most practical solution to an EPL claim is to pursue a settlement.

Settlements and Hammer Clauses

Usually, an insurer cannot settle an EPL claim without the insured's written consent. Instead, if the carrier wants to settle and the insured disagrees, the claim can continue to be fought in court or via other legal channels but might then be subject to a policy's "hammer clause." The hammer clause essentially allows the insurer to document the amount for which it wanted to settle the claim and makes the insured responsible for the portion of any eventual settlements or judgments in excess of that amount.

In a simple example, imagine the insurance company proposes a $500,000 settlement for a discrimination claim, but the insured refuses consent. Under a basic hammer clause, If the claim later results in a judgment against the insured for $700,000, the insured will need to pay the excess of $200,000.

Wage-and-Hour Violations

Before summarizing several common exclusions found in EPL insurance policies, we should focus on one particular issue that—while still commonly excluded—has become more prominent in EPL products due to consumer demand.

Most EPL insurance policies won't cover the insured against alleged "wage-and-hour violations." Essentially, these alleged violations involve failing to pay non-salaried employees for the amount they've actually worked or failing to pay them in accordance with applicable overtime rules. (One exception in which EPL coverage might be more responsive would be a scenario in which a wage-and-hour violation is tied to discrimination, such as paying men for overtime but not providing the same overtime opportunities to women.)

Despite the general hesitancy to involve themselves in wage-and-hour disputes, some carriers have begun offering limited coverage to certain applicants. For example, limited coverage for wage-and-hour disputes might be offered in the following manner:

- Offered with its own sublimit far below the EPL policy's overall coverage limits.
- Offered within coverage of defense costs but not as coverage for any settlements or judgments.
- Offered to smaller businesses but not to larger ones (unless a larger business engages the help of a special insurance broker with connections to offshore carriers).

Since this is an evolving coverage issue, insurance professionals might want to pay attention to the latest product options and pass along any relevant news to their customers.

Other EPL Exclusions

Other common exclusions in EPL insurance policies are listed in this section. However, be aware that each EPL insurance product will likely be a bit different from the next. So careful attention should be paid to the exact policy language when explaining gaps in coverage to prospects.

On a similar note, although the following types of claims are often excluded in today's market, some carriers will provide narrow coverage that requires attention to each exclusion's wording and its surrounding clauses. For example, some of the claims listed

here might still be covered, to a certain extent, if they are tied to discrimination or retaliation or might be eligible for help with defense costs but not with settlements or judgments:

- Assault and battery against workers.
- Disputes regarding unlawful strikes, walkouts or lockouts.
- Employee benefit liability under Employee Retirement Income Security Act.
- Blatant disregard for federal or state employment laws.
- Fines imposed by regulators (with coverage perhaps depending on the specific type of violation).
- Certain class action suits (with coverage perhaps obtainable as an endorsement to a carrier's standard policy).
- Punitive damages (unless allowed to be covered by law).
- Damage to employee property.
- Workplace injuries and workers compensation issues.
- Employment violations related to the OSHA, COBRA, the National Labor Relations Act or the Fair Labor Standards Act.

For the sake of a review, many of the laws mentioned in this list are summarized earlier in this chapter.

Conclusion

So, what's next for EPL insurance? As a guess, many observers point to the influence of social media and wonder if future issues related to alleged discrimination, harassment and other illegal employment activities will be tied to what employers find or prohibit on workers' personal online profiles. More generally, the assumption is that EPL issues will always gain in prominence and concern during difficult economic times, when the job market becomes extremely competitive and when businesses are faced with the tough decision to downsize their workforce. Society's increased attention to sexual harassment in the workplace is also certainly a growing concern.

While no one can predict exactly what's to come, it's clear that avoiding accusations of employment violations should always be an important part of a business's risk management plans. Along with promoting respectful workplace culture and paying attention to the latest legal developments, exploring the need for EPL insurance can improve those plans' effectiveness.

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