# INSURANCE CONTINUING EDUCATION

# UNDERSTANDING THE INSURANCE BUSINESS

**STATE-APPROVED CONTINUING EDUCATION**
**for**
**CALIFORNIA INSURANCE LICENSEES**

BOOKMARKEDUCATION

**BookmarkEducation.com**
**(800) 716-4113**

# UNDERSTANDING THE INSURANCE BUSINESS

**California Approved Course License Number 349113**



A considerable amount of care has been taken to provide accurate and timely information. However, any ideas, suggestions, opinions, or general knowledge presented in this text are those of the authors and other contributors, and are subject to local, state and federal laws and regulations, court cases, and any revisions of the same. The reader is encouraged to consult legal counsel concerning any points of law. This book should not be used as an alternative to competent legal counsel.

Printed in the United States of America.
▪P2▪

All inquiries should be addressed to:

Bookmark Education
6203 W. Howard Street
Niles, IL 60714
(800) 716-4113
**BookmarkEducation.com**

## CHAPTER 1: INSURANCE FUNDAMENTALS

### Introduction

There are many ways to manage risk in our lives. If we are concerned about the risk of a fire destroying our property, we might attempt to reduce the risk by installing smoke detectors in our homes and offices. If we worry about the risk of dying in a plane crash, we might attempt to avoid the risk entirely by refusing to travel on airplanes.

However, some risks are either too important or too complex for us to handle on our own. Sometimes, the best way to manage a risk is to transfer it to someone else by virtue of insurance.

### What Is Insurance?

In general, insurance is a contractual arrangement whereby one party agrees to absorb a risk in exchange for compensation. Typically, the party absorbing the risk is an insurance company, and the compensation given to the company is a set dollar amount known as a "premium."

Insurance technically can't prevent death, property damage, lawsuits or other bad events from happening, but it can help us recover from those unpleasant circumstances without suffering significant financial loss.

### Pure Risks and Speculative Risks

Insurance is meant to help people and businesses manage "pure risks." A pure risk is a matter of chance in which the only potential outcomes are a negative outcome or a neutral outcome. For example, in the case of auto insurance, the pure risk is that a driver will either experience the negative outcome of being in an accident or will have the neutral outcome of arriving safely at a destination, no better and no worse than when the driver got into the car.

In all but a few rare cases, insurance cannot be purchased to directly manage "speculative risks." A speculative risk is a matter of chance in which a clearly positive outcome is possible. For example, gambling at a casino involves speculative risk because a player has a chance of winning as well as losing. Similarly, investing in the stock market involves speculative risk because an investment can lead to a profit as well as a loss.

A few insurance products blur the line between pure risk and speculative risk because they are tied to performance of the financial markets. Some of these products are actually a combination of insurance and securities and can only be sold by people who hold the appropriate securities license.

### Perils

A peril is the basic cause of a loss. Examples of perils include the following:

- Fire (for property insurance).
- Death (for life insurance).
- Illness or injury (for accident and health insurance).
- Collision (for auto insurance).
- Theft (for many forms of personal and commercial property and casualty insurance).
- Flood (for flood insurance).

Insurance policies will list or define the perils that will trigger coverage (and thereby result in compensation) for the consumer. The same policies might contain a list of perils that will not trigger coverage and thereby won't result in insurance-provided compensation for the consumer.

Perils that won't trigger coverage under an insurance contract are commonly listed as "exclusions."

### Hazards

A hazard is something that increases the likelihood of a loss or at least has the potential to increase the size of the loss. In general, hazards fit into one of three groups:

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

### Physical Hazards

A physical hazard is an environmental factor that could increase either the likelihood or severity of a loss. Examples of physical hazards are as follows:

- Frayed wiring, which could eventually lead to a fire or electric shock.
- A wet floor or icy sidewalk, which could eventually lead to an injury and/or a lawsuit.
- A broken window, which could eventually lead to theft.
- A pollution-heavy workplace, which could eventually lead to illness, death and/or a lawsuit.

### Moral Hazards

A moral hazard is an incentive or opportunity for someone to commit unethical or even illegal activity. Within the context of insurance, moral hazards provide a temptation to use insurance for personal gain rather than for the transferring and management of risks. If an insurance product is not structured to eliminate or at least minimize moral hazard, the resulting negative outcomes might include:

- A life insurance beneficiary murdering the insured in order to collect death benefits.
- A property owner committing arson on his or her own property in order to collect insurance money.
- An antique dealer staging a robbery of his or her collectibles in order to receive insurance benefits.
- An employee faking an injury in order to receive workers compensation payments.

Although not all instances of moral hazard can be eliminated, insurance products have been structured to reduce them in reasonable ways. For example, you usually cannot buy life insurance on someone else's life unless you have a close, positive relationship with the person. (This concept is known as "insurable interest.") You typically cannot collect more than a damaged item's actual cash value (as opposed to its "replacement cost") and can't receive compensation that puts you in a better financial position than before the loss. (This concept is known as the "principle of indemnity.") Even the injured employee who receives workers compensation will be unable to receive as much money while on disability than when he or she was actually working.

You'll learn more about insurable interest, the principle of indemnity and other important concepts later in this chapter.

### Morale Hazards

A morale hazard exists when a person becomes overly reliant on insurance and therefore lacks the motivation to prevent or reduce losses in other ways. For example, a tenant who purchases renters insurance for her personal property might say to herself, "Since I have insurance, I'm not so worried about locking my door anymore." A person receiving disability benefits might conclude,

"I could probably try going back to work now. But since my insurance is still paying my bills, I think I'll wait another week and see if I continue to feel well." A doctor's patient might say, "I could probably beat this flu by staying home and resting. But since my insurance will cover my medical visit, I might as well make an appointment to see my physician."

Insurers use several techniques to reduce morale hazards. To encourage home security, property insurers might offer lower prices to people who purchase alarm systems or who install deadbolt locks. To discourage overuse of medical care, health insurers might require patients to pay coinsurance fees, deductibles and copayments for most health care services.

Although moral hazards and morale hazards might seem very similar, they involve very different thought processes. People who take advantage of moral hazards do so intentionally and consciously, and they are often willing to deceive an insurance company in exchange for personal gain. People who take advantage of morale hazards often do so on an entirely subconscious level and aren't actively trying to harm the insurance company.

### Evaluating and Calculating Risk

Providing insurance to the public requires careful attention to mathematical and actuarial principles. If an insurance company does not follow certain principles, it is likely to accept more risk than expected and could ultimately put itself in financial jeopardy.

#### Law of Large Numbers

In order to remain financially strong, insurance companies cannot agree to accept the transfer of a risk until they have a firm understanding of that risk. In order to offer life insurance, a carrier must have a firm understanding of life expectancies among potential customers. In order to offer fire insurance, a company must have a general idea of how often fires occur within certain geographic areas and the amounts of damage they usually cause.

A mathematical concept called 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 the amount of customers who will suffer a fire-related loss.

Based on this prediction from a large sample size, the insurer is in a better position to anticipate the cost of doing business and can price its products accordingly. If the law of large numbers is applied correctly, only an unforeseeable surge in losses (and not any single loss) should have the power to disrupt the insurance market.

#### Adverse Selection

Adverse selection occurs when insurance is purchased disproportionately by people who are at the highest risk of suffering a loss. Unless an insurer can balance its portfolio by attracting low

and moderate-risk customers, it will be unable to offer affordable products to the public and might even be unable to serve certain markets at all.

For an example of adverse selection, consider the buying habits that have typified the market for individual health insurance. The people who tend to be most interested in purchasing health insurance are those who already have health problems, whereas the people who tend to be least interested in health insurance are young people with no health problems. If a health insurance company is too good at attracting sick customers and unsuccessful at attracting healthy customers, too much adverse selection will exist, and insurance will become unaffordable or unavailable.

One way to combat adverse selection is to carefully evaluate each insurance customer's level of risk and then charge high-risk customers more than low-risk customers. In theory, lower prices should attract low-risk applicants, while higher prices will make high-risk applicants less likely to pursue insurance. Similarly, an insurance company might establish underwriting guidelines that clarify who is eligible for an insurance product (regardless of price) and who will not be issued a policy under any circumstances. However, these guidelines and pricing decisions must be based on an applicant's risk and must be supported by solid actuarial data. Decisions based on non-risk factors (such as race, ethnicity and—in some cases—gender) have the potential to violate state and federal antidiscrimination laws.

Adverse selection can also be reduced by requiring people to purchase insurance regardless of their risk. This method diversifies an insurer's pool of risks by bringing more low and moderate-risk customers into the market. Theoretically, those added low and moderate-risk customers can make it easier for an insurer to absorb high-risk customers. This approach to addressing adverse selection was implemented in much of the U.S. health insurance market in 2010 via the Affordable Care Act.

### Insurance Contracts

Insurance policies are contracts between the company issuing the policy and the consumer who is purchasing it. Although you certainly don't need a law degree in order to successfully sell insurance, a basic understanding of contract law and contractual provisions can make insurance fundamentals easier to grasp.

Although we will summarize some important legal concepts in the rest of this chapter, please be aware that the presented information is intended to be general in nature. The intricacies and enforceability of specific insurance contracts are topics that should be addressed by attorneys with a background in insurance law.

#### Unilateral vs. Bilateral Contracts

A unilateral contract is a contract in which only one of the parties makes a legally enforceable promise. In an insurance transaction, the insurance company promises to compensate a consumer for a loss, and the consumer agrees to pay premium to the insurer. If a loss occurs and the insurer does not deliver on its promise to provide compensation, the consumer can take the insurer to court in order to obtain a financial settlement. However, if a consumer fails to pay premium, the insurance company generally cannot take the consumer to court and demand payment. Instead, the insurer might respond to nonpayment by cancelling the person's insurance. Since the consumer can enforce the contract in a court of law but the insurer generally cannot, insurance policies are usually considered to be unilateral contracts.

The opposite of a unilateral contract is a "bilateral" contract. In a bilateral contractual arrangement, both sides promise to do something, and both sides can use the courts to enforce the contract if a promise is not kept.

## Aleatory Contracts

In order to insure a person or thing, the individual wanting the insurance must have an "insurable interest" in that person or thing. In essence, this means the person buying the insurance must have a reasonable desire for the person or thing to remain unharmed. The existence of insurable interest is one of the important elements that differentiate insurance from pure gambling.

Although insurance is not gambling, it does involve matters of chance. In general, although an insurance company promises to provide financial compensation after a loss, there is a chance that no loss will ever occur. Even life insurance can involve the chance of a loss not occurring, since many forms of life insurance are only in effect for a set number of years and then cannot be renewed.

Since compensation from an insurance company is contingent on a loss actually occurring, there is a chance that one party to the insurance contract will benefit significantly more than the other. For example, there is a chance that no loss will occur, in which case the insurer would benefit much more than the consumer. Conversely, there is also the chance that a loss will occur fairly early in the policy period and that the insurer will need to pay significantly more to the consumer than it collects from that person in the form of premium.

A contract that incorporates elements of chance (as is the case with most insurance contracts) is known as an "aleatory contract."

## Contracts of Adhesion

A "contract of adhesion" is a written agreement in which one party chooses the language of the contract and the other party merely has the option of either accepting the contract as written or rejecting it. A contract of adhesion involves little or no back and forth regarding the specific wording of the agreement.

Most insurance contracts are contracts of adhesion. Insurance carriers either write their own policy forms or use standard forms that are common in their line of business. For example, many property and casualty insurers use policy forms with wording from a company called the "Insurance Services Office" (ISO).

On occasion, a consumer will request that something be added or deleted from a proposed insurance contract, but even the wording that adds or deletes sections of the contract will usually be written by the insurance company or some other insurance entity.

Other than in rare cases involving insurance for very high-profile businesses, the consumer and his or her representatives won't be involved in the drafting of the contractual language. When a consumer or the consumer's representative plays an active role in the writing of an insurance contract, the contract is sometimes referred to as a "manuscript" policy and might not be considered a contract of adhesion by the courts.

Since contracts of adhesion are written by only one of the parties, disputes regarding ambiguities in their wording will usually be resolved in the other party's favor. Within the context of insurance, this means that if an insurer and a consumer are arguing about the meaning of an unclear word or an ambiguous phrase in an insurance policy, a court is likely to rule for the consumer. The general assumption is that the insurance company has more specialized knowledge than the consumer and, as the writer of the contract, already had an adequate chance to protect itself. Thus, when there is more than one way to reasonably interpret the policy, the consumer should generally get the benefit of the doubt.

## Warranties and Representations

When entering into an insurance contract, consumers are expected to act in good faith. Fulfilling this obligation requires honesty and a willingness to disclose information about the risk being insured. If information provided by a consumer to an insurance company turns out to be incorrect, the options available to the insurance company will depend on whether the incorrect information relates to either a "warranty" or a "representation."

In regard to insurance contracts, a warranty is a statement that must be literally true in order for the insured to keep the policy in force. Alternatively, you can think of a warranty as a promise (such as a promise that a particular fact is 100 percent correct) that the consumer agrees to never break. If information related to a warranty is discovered to be incorrect, the insurer might have the ability to void the contract even if the incorrect information seems fairly irrelevant.

For example, consider a disability insurance application that asks the consumer to disclose any pre-existing health conditions. Now imagine that the applicant suffers from acne but does not think to disclose this condition because it doesn't seem serious and is unlikely to result in a disability. If the failure to disclose the acne is considered part of a warranty, the insurance company might be able to cancel the person's disability coverage on this basis even if the acne never results in a claim for disability benefits.

By contrast, if incorrect information from a consumer is considered part of a representation (and not a warranty), the insurer cannot void the insurance contract unless the information is "material." In general, something is material if it is likely to influence the premium or the insurance company's decision to issue a policy in the first place.

An insurer's ability to act in response to incorrect information from the consumer is often determined by court precedents and state laws. For example, depending on the state and the type of insurance product, information from a consumer might be considered a warranty for a limited amount of time (such as one or two years after the date of application) and then become a representation. States and courts might also determine the specific types of information that can be considered warranties and the types that must be treated as representations.

## Concealment

Concealment occurs when, instead of directly providing false information, a consumer merely fails to disclose something to the insurance company. In order for concealment to jeopardize a consumer's insurance coverage, the nondisclosure usually must have been intentional and related to a material fact. However, this general rule might not apply in certain jurisdictions or in certain lines of insurance.

## Principle of Indemnity

Particularly in property and casualty insurance, benefits paid by the insurer to the consumer are commonly based on the "principle of indemnity." The principle of indemnity calls on the insurance company to compensate policyholders to the degree that they are neither worse off nor better off after an insured loss. Rather, within the confines of the contract, the insurer should attempt to make a policyholder "whole" again.

Most property insurance policies apply the principle of indemnity by only insuring items up to their "actual cash value." An item's actual cash value is the amount it would cost to replace the item minus depreciation. Coverage that does not subtract for depreciation is known as "replacement-cost coverage" and is sometimes available to consumers for an additional premium.

For an example of how actual cash value coverage works, imagine a scenario in which you have property insurance on your 10-year-old computer. If your computer is stolen, the insurance

company is unlikely to reimburse you for the cost of a brand-new machine. Instead, you are likely to receive an amount equal to the value of a computer that is already 10 years old.

## Valued Policies

The principle of indemnity has served as an important safeguard against fraud and other forms of moral hazard, but it is not applied in all lines of insurance. For example, life insurance and insurance for antiques tend to be issued as "valued policies." A valued policy compensates a consumer in an amount that was already agreed to in advance of a loss.

Valued policies are used in cases where either an insured item would be difficult to replace or (in the case of life insurance) the financial consequences of a loss cannot be calculated with certainty. But even though these policies don't directly incorporate the principle of indemnity, the carriers that issue them take other steps in order to address moral hazard. In property insurance, valued polices usually require an appraisal before coverage can be issued. In life insurance, a carrier might address moral hazard by putting a cap on the amount of death benefits that an applicant can purchase in proportion to the insured person's income, net worth or some other factor.

## Concurrent Causation

"Concurrent causation" occurs when a loss is created by more than one peril. It becomes an important issue in insurance when one of the perils is covered by the policy but another is not. For example, concurrent causation is a common concern after hurricanes because hurricanes typically produce wind damage and flood damage at the same time. Although wind damage is covered by practically all forms of homeowners insurance, flood damage is not. (Flood insurance is provided by insurers as a separate product.)

Some insurance contracts contain specific instructions as to how the carrier will respond to losses involving concurrent causation. However, absent contractual language to the contrary, many courts have ruled that a loss that is caused by both a covered peril and a non-covered peril should be covered by the insurance company.

## Insurable Interest

In order to insure a person or a piece of property, the party who is purchasing the insurance must have an "insurable interest" in that person or property. In general, an insurable interest involves a desire for the insured person or piece of property to remain unharmed.

Insurance companies require insurable interest in order to prevent moral hazard. Without it, unethical people could purchase insurance on the lives of complete strangers and on a stranger's belongings. Then, an unethical person would be tempted to harm the insured person or damage the insured property.

Originally, insurable interest was also made mandatory in order to prevent insurance from being used as a form of gambling and to make it clear that insurance was intended to manage pure risks rather than speculative risks. For a review of pure risks and speculative risks, refer to an earlier portion of this chapter.

Specifics regarding what qualifies as an insurable interest can differ among the various states. However, life insurance can usually be purchased on someone's life if the purchaser is the same person or if the purchaser is the insured person's close family member, business partner or creditor. (If the purchaser and the insured person are not the same, the insured person might need to provide written consent.) Similarly, property insurance can usually be purchased on someone's property if the purchaser is the owner of the property or if the purchaser has accepted the property as collateral in exchange for a loan.

In property insurance, insurable interest must exist at the time of loss. So, for example, if someone insures his or her home but then sells the home, that former owner will not be able to collect money from the insurance company if the house burns down. This follows the principle of indemnity, as discussed earlier in this chapter, and ensures that a policyholder is made "whole" after a loss rather than any better or worse.

In life insurance, insurable interest must exist at the time the policy is issued but not necessarily at the time of loss. This can be an important point when spouses own life insurance on each other but eventually get divorced. In this scenario, the former spouses might be able to continue to own insurance on each other even though they might not depend on each other for any type of support.

Note that insurable interest in life insurance is generally required of the policy's owner but not necessarily the policy's beneficiary. This allows the owner of life insurance to name practically any person or entity as the policy's beneficiary, including any friend, family member, charity or business partner.

Presumably, the non-requirement of insurable interest for beneficiaries exists because most life insurance beneficiaries are revocable. If the policy's owner no longer wishes someone to collect a death benefit as a result of the insurance, the owner can often simply contact the insurer and change the beneficiary. However, this flexibility also means that people who own insurance on their own lives need to be proactive if their relationship with the policy's beneficiary deteriorates. For example, if a husband buys life insurance on his own life, names his wife as the beneficiary, gets a divorce and marries someone else, he must contact his insurance company if he wants his new spouse added as a beneficiary and his ex-wife removed. If he dies without taking action, his ex-wife would collect the policy's death benefit and wouldn't need to share any of it with the new spouse.

## Damages

Damages that are paid on behalf of others by an insurance company are particularly relevant to liability insurance. Though there are several different types of damages that might be awarded by a court or included as part of a settlement, not all of them can be managed with the help of insurance.

Let's review two basic types of damages and whether each type can be covered by insurance

### *Compensatory Damages*

Casualty insurance can be purchased to manage potential liability for "compensatory damages." When one party is deemed responsible for another party's loss, compensatory damages are paid by the responsible party in order to make the wronged party "whole" again. These damages adhere to the principle of indemnity and are intended to make the wronged party no better and no worse than before the loss occurred.

Compensatory damages can be categorized as either "special damages" or "general damages." Special damages are damages that are easily quantifiable, such as those awarded to replace damaged property or damages awarded to reimburse an injured person for medical bills that have already been paid out of the injured person's pocket. General damages, on the other hand, aren't easily quantifiable. General damages might be awarded when someone else is held liable for a death, a long-term disability, a reduced quality of life or a harmed reputation.

### *Punitive Damages*

In addition to having to pay compensatory damages, a liable party might be ordered to pay "punitive damages" to the harmed party or to a government entity. Punitive damages are sometimes called "exemplary damages" because they are imposed in order to make an example of the liable party and to discourage society from engaging in the kind of activity that caused the

loss. Whereas compensatory damages are intended to make the wronged party "whole" again, punitive damages are intended to punish the liable party for instances of fraud, major negligence, abusive practices and other negative behaviors.

In order to ensure that punitive damages serve their intended purpose, they usually cannot be covered by liability insurance. Punitive damages might need to be excluded from insurance as a matter of law or might be excluded voluntarily by an insurance company in order to reduce moral hazard.

## Parts of Insurance Contracts

Now that you have a better understanding of some important insurance concepts, let's explore some of the most common parts of an insurance policy.

### *Declarations Page*

The declarations page is often one of the first—if not the very first—pages of an insurance policy. Although insurance policies are generally considered to be contracts of adhesion (and are written by the insurance company with almost no negotiation with the consumer), the declarations page is likely to list those aspects of coverage that the consumer had the ability to choose or that are unique to that person. For example, the declarations page might contain the following information:

- The name of the insured party.
- The overall dollar limit (or "face amount") of the coverage.
- The deductible, if any.
- The duration of the policy.
- Whether property is covered up to its actual cash value or its replacement cost.
- The policy number.
- The premium.

Many insurance policies make several references to the "named insured." With a few exceptions, the named insured is usually the only person or entity who will be covered by the insurance. The exact identity of the named insured will usually be the person or entity specifically named on the declarations page.

The identity of the named insured should be reviewed carefully by the consumer so that the insurance applies to all intended parties at all times. For example, if a business has several names or several subsidiaries or undergoes a change in its name, the declarations page should take those issues into account and list all of the appropriate names. Listing the wrong names can result in the consumer paying for too much coverage by accident or (more likely) not having coverage when it is expected.

### *Insuring Agreement*

An insurance policy's "insuring agreement" is the insurance company's basic promise to the consumer. For example, the insuring agreement might say something like, "We will pay for an occurrence of property damage or bodily injury during the policy period." Though this might seem like a fairly straightforward promise, it is impacted (and usually made more complicated) by other parts of the policy, such as definitions and exclusions. In the example referenced here, for instance, the basic promise of the insuring agreement will be dependent on what is actually meant by the terms "occurrence," "property damage," "bodily injury" and "policy period." In order to fully understand the scope and limits of the insuring agreement, the entire policy must be read in context.

Note that some insurance policies will contain multiple insuring agreements, particularly in the case of a "package policy" that is designed to cover multiple types of risk via the same contract. This is commonly done in homeowners insurance, in which one insuring agreement will pertain to property damage while a second insuring agreement will pertain to personal liability.

### *Endorsements*

An endorsement is an amendment to an insurance company's standard policy. It can either add benefits for the consumer (often in exchange for a higher premium) or subtract benefits in order to make the insurance more affordable.

Depending on the specific type of insurance being sold, an endorsement might be referred to as a "rider." The word "rider" is fairly common in life and health insurance.

### *Entire Contract*

In life and health insurance policies, an "entire contract" clause is typically included to clarify that both the insurance policy (including any endorsements) and the information on the consumer's application are the entire contract between the carrier and the policyholder. The clause protects insurers by allowing them to potentially cancel coverage if information on an application turns out to be false. It also protects the consumer by not allowing the insurer to cancel coverage after it has been issued as long as the application was completed fully and honestly. If the insurance company wants to amend the policy or charge a higher amount after it has been issued, the carrier generally must wait until the policy period ends and the coverage is up for renewal.

## Guaranteed Renewable vs. Non-Cancellable

Despite seeming very similar, the terms "guaranteed renewable" and "non-cancellable" mean importantly different things. This is particularly true in accident and health insurance, which might be purchased by people who are healthy when their policy is issued but who later experience significant medical issues.

Within the context of accident and health insurance, a guaranteed-renewable policy usually cannot be cancelled by the insurance company unless the insured person fails to pay premiums or has committed some kind of fraud. The insurance company must offer to renew the policy at the end of the policy period and cannot force the policyholder to pay more for the renewed coverage just because his or her health has deteriorated. However, the insurer might be allowed to raise prices on entire classes of customers at renewal time (such as an increase for all policyholders of a certain age who live in a specific geographic area).

By contrast, non-cancellable coverage must be offered for renewal at the end of the policy period and cannot cost any more than what has already been agreed to by the carrier and the consumer. Since this type of insurance leaves very little room for an insurer to guard against people's deteriorating health, non-cancellable coverage is usually expensive or unavailable for most shoppers.

In some markets, such as the individual market for major medical insurance, the consumer protections involved with guaranteed-renewable or non-cancellable coverage might be limited to a certain number of years (such as until the insured turns 65 and becomes eligible for the federal Medicare program).

## The Role of Insurance Producers

Licensed insurance producers act as intermediaries between consumers and insurance companies. Although there are many different ways in which producers and can do business, common tasks performed by nearly all active producers include:

- Selling insurance products to the public.
- Analyzing insurance-related needs of consumers.
- Collecting and/or facilitating the payment of premiums for insurance.
- Providing important insurance-related documents to applicants and policyholders.

Be aware that the title "insurance producer" is a relatively broad term that can apply to many different kinds of insurance professionals. For example, the term includes someone who acts as an "insurance broker" as well as someone who acts as an "insurance agent."

### Insurance Brokers

An insurance broker (unlike an insurance agent) legally represents the interests of consumers in insurance transactions. Brokers help their clients shop in some of the more complex parts of the insurance market and attempt to secure the best coverage at the best price. Unlike insurance agents, brokers aren't contractually obligated to place business with a specific insurance carrier, and they do not have the authority to accept a risk on behalf of an insurance company. (The ability to accept a risk on an insurer's behalf is known as "binding." Binding will be addressed later in this chapter.)

Insurance brokers don't often specialize in property and casualty insurance for individuals and families and are, therefore, unlikely to be utilized by most consumers. However, brokers commonly play a major part in selling the following types of insurance:

- Property and casualty insurance for businesses.
- Individual health, group health and other employee-benefit plans.
- Coverage for special items that isn't sold by typical personal lines insurance carriers (such as insurance for classic cars, art collections or antiques).

### Insurance Agents

An insurance agent (unlike an insurance broker) legally represents the interests of insurance companies in an insurance transaction. Although agents might have ethical obligations to analyze a consumer's needs and help the buyer secure the best coverage at the best price, the agent usually has a contractual duty to only place business with specific insurance companies rather than with any carrier that is willing to accept a risk.

Agents are typically required to engage in good "field underwriting" by not overburdening an insurance company with high risks. They also owe a heightened level of disclosure to the companies they represent.

Under the common rules of agency, information that is made known to the agent is generally considered by law to be known by the insurance company. In addition, some agents have the authority to issue coverage (known as "binding") on the insurance company's behalf.

#### *Captive Agents*

An insurance agent might represent a single insurance company or might have contractual relationships with multiple carriers.

A “captive agent” tends to work as an independent contractor for a single insurance company. That company might provide significant assistance to new agents in order to help them build their business. However, a captive agent is prohibited from helping consumers secure insurance from any other company. Assuming the caprtve agent works for a carrier that is willing to accept a risk, the agent must recommend that company’s products and cannot help the consumer get a potentially better deal elsewhere. If a captive agent’s customers decide to switch their insurance to a different carrier, the captive agent will not be able to collect any more commissions on that business.

### *Independent Agents*

Independent agents can represent multiple insurance companies at the same time. As a result, if they have contractual relationships with multiple companies that are willing to accept a risk, they are free to help the consumer choose the best coverage at the best price among those companies. Similarly, if a consumer becomes unhappy with his or her insurance carrier, the independent agent can shop the risk again among several companies and still continue to collect commissions if the risk is placed elsewhere. Compared to captive agents, independent agents tend to receive considerably less help from insurers with their training and startup costs.

The distinctions among brokers, captive agents and independent agents can be important to a producer’s relationship with the public. However, please be aware that the summaries provided here are meant to be general in nature. In reality, the practical day-to-day differences between brokers and the different types of agents can seem very blurry, and they might differ significantly from one line of insurance to the next. For example, the positives and negatives of being an independent life insurance agent might not be exactly the same as the positives and negatives of being an independent property and casualty insurance agent.

In addition to paying attention to who they technically represent in an insurance transaction, new producers should carefully weigh their options and choose a role (broker, captive agent, independent agent, etc.) that best suits their career goals.

## Binders

Some agents have the contractual authority to issue “binders.” Through a binder, an agent accepts a risk on a carrier’s behalf and gives temporary coverage to a consumer while an insurance policy is still in the process of being issued. If a loss occurs during the period in which the binder is in force (typically no more than 30 days), the insurer generally must cover the loss. If an agent has issued a binder but the carrier ultimately decides not to issue a policy, the binder will remain in effect until its expiration date or until the insurer cancels it in writing.

Although some binders might be provided orally, even an oral binder should be immediately followed by a written version delivered to the consumer. If there are conflicts between an oral binder and a written binder, the written version typically takes precedence.

Since binders impose contractual obligations onto insurance companies, agents must be very careful when issuing them and must understand the limits of their binding authority. If a binder is issued inappropriately and a loss occurs, the insurance carrier might take punitive actions against the agent.

In practice, binding authority tends to be more common among property and casualty agents than among life and health agents. In place of a binder, some agents might only be capable of providing a “conditional receipt,” which can help cover losses between the time it is received and the time a policy is issued. However, in order for the conditional receipt to provide any coverage after a loss, the insurer’s underwriting department must believe that the applicant would’ve ultimately been approved for a policy. If a loss occurs but the underwriting department discovers a serious

problem with the consumer's application (such as an undisclosed medical issue), the conditional receipt might be meaningless.

### Certificates of Insurance

A "certificate of insurance" is proof of insurance that is provided by the insured to a third party. Certificates of insurance are commonly requested in commercial lines when a business is attempting to secure work on a project as an independent contractor. For example, before a land developer hires a construction firm to build something on a vacant lot, it might request a certificate of insurance from the construction firm in order to verify that the firm has its own liability protection. For issues related to convenience and privacy, it is often simpler for an insured to give a third party a certificate of insurance than to provide a copy of the insured's entire insurance policy.

Although intended as evidence of insurance, a certificate will contain much less information than a full policy and won't always provide a clear picture regarding what kinds of losses would be covered by insurance and what types of losses are excluded.

Unlike a binder, a certificate is not a contract and does not alter any of an insurer's obligations under an insurance policy. If the party who requests or provides a certificate wants coverage to be altered or clarified in some way (such as adding a customer to a business's liability insurance for the duration of a project), changes must first be made to the policy itself. Changes made only to the certificate (and not to the policy) are generally not enforceable.

In the event that an agent alters a certificate in a way that contradicts the policy, the insured party or the party requesting the certificate is likely to get a false impression of the applicable coverage. Such false impressions could lead to charges of misrepresentation against the agent.

## Post-Loss Issues

The importance of some insurance issues might not seem relevant until the insured suffers a loss. We'll conclude this chapter by summarizing a few contractual provisions that can become critical at that time.

### Proof of Loss

An insured who suffers a loss is usually required to provide "proof of loss" to the insurance company. This is often done on special forms provided by the carrier and can involve itemizing various types of damage.

In order to manage its finances and keep enough money in reserve to handle future claims, insurance companies will require proof of loss within a certain amount of time, such as 60 to 90 days after a loss occurs. Deadlines for providing proof of loss might be extended in certain cases, such as following a major catastrophe that prevents owners from accessing their damaged property.

Despite the limited timeframe for providing proof of loss, insurance companies are discouraged from placing unreasonable burdens on customers as part of the claims-paying process. In fact, requiring excessive amounts of proof (and the filing of excessive paperwork) is often considered an illegal "unfair claims settlement practice" that can result in significant regulatory fines for carriers. Specifics about prohibited claims practices differ by state.

### Arbitration and Mediation

If a consumer and an insurance company can't come to an agreement about the size or insured nature of a loss, going to court doesn't need to be the next step. Instead, the parties can agree to try some type of "alternative dispute resolution," such as arbitration or mediation.

In mediation, attorneys, retired judges or other third-party participants attempt to get both sides of a dispute talking to each other in order to come to a resolution. However, recommendations or proposals that are made by those third parties aren't binding on the insurer or the consumer, so they don't guarantee an end to the dispute.

Conversely, if a dispute goes through arbitration, the parties generally must abide by what the impartial attorneys, judges or other third parties decide and cannot take the argument any further by filing a lawsuit.

### Subrogation

Many insurance policies contain a "subrogation clause" that takes the consumer's right to sue someone for an insured loss and transfers it to the insurance company.

To understand subrogation, imagine a scenario in which you are the victim of an auto accident. If your own insurance provides coverage for your own losses, your insurance company might compensate you and then attempt to be reimbursed for that amount by either the at-fault driver or the at-fault driver's insurance company. However, in accordance with the principle of indemnity, you would not be able to sue the at-fault driver for the amount you already received from your own insurer. Your ability to sue was transferred by you to your insurance company via subrogation.

Subrogation saves harmed consumers from having to take expensive legal action in order to collect money from liable parties. It also helps keep the cost of insurance down by providing a way for insurance companies to collect money from people who are truly at fault. But because subrogation can still require time and effort from an insurance company, a carrier will only exercise its right of subrogation when it is cost-effective to do so.

### Conclusion

Practically since its beginning, insurance has operated under several fundamental principles that protect carriers and consumers. By following these principles and enforcing common contractual provisions, the insurance community has played an immensely important role in risk management. Your commitment to being a knowledgeable insurance producer can help continue the mutually beneficial relationship between insurance entities and the public.

## CHAPTER 2: ERRORS, OMISSIONS AND INSURANCE PRODUCERS

### Introduction

Despite devoting countless hours to educating their clients about risk, some agents and brokers forget to look in the mirror every once in a while and acknowledge the ways in which insurance can help producers protect themselves. Just as they would encourage the general public to evaluate the various options for auto coverage, property coverage and liability coverage on a regular basis, insurance professionals should find time to review the appropriateness of their own errors and omissions (E & O) insurance.

Believe it or not, until the early 1990s or so, many insurance agencies believed they and their individual producers didn't necessarily need errors and omissions insurance in order to run their business. They often operated under the misconception that this important type of liability protection was mainly important for those in the industry who were less ethical, less careful, less knowledgeable or less experienced.

But as news of producers being threatened with lawsuits became more common, opinions about errors and omissions insurance underwent a significant shift. While admirable traits like professionalism, honesty and competence continue to be viewed as the main deterrent to

disputes with consumers, today's insurance producers generally understand that avoiding the threat of lawsuits is also a matter of luck.

Even the best of us will occasionally make a mistake as part of our work, and even our best efforts to correct an error won't guarantee that a client, customer or carrier will forgive us. We might be confident that we have done everything right, but there's always at least a small chance that the people with whom we interact will react negatively and forcefully when they don't get exactly what they want.

For these reasons and more, the right errors and omissions insurance is a critical component of a successful, long-term insurance career.

**The Professional Liability Market**

Before going into detail about the specifics of errors and omissions insurance, let's briefly address some key definitions.

Be aware that some people use the terms "professional liability insurance," "malpractice insurance" and "errors and omissions insurance" interchangeably. Others make the following distinctions among those three terms:

- Professional liability insurance is a broad category of liability insurance that includes malpractice insurance, errors and omissions insurance, directors and officers (D & O) insurance and more.
- Errors and omissions insurance is a type of liability insurance that covers various professionals when their services don't meet clients' or customers' expectations.
- Malpractice insurance is another name for errors and omissions insurance that is specific to doctors, lawyers and a few other professions with a long tradition of needing professional liability insurance.

Some experts have been even more specific with their language and have suggested that the interchangeability of these three terms creates the potential for confusion and unexpected coverage gaps. For example, Rough Notes magazine contributor Donald S. Malecki has interestingly raised the issue of errors and omissions insurance and its applicability (or lack thereof) in cases where liability stems not from a professional service (which is typically only offered by people with a license or special credentials) but from a clerical task (which might indeed be performed by a licensed or specially credentialed person but can also be done by relatively unskilled office workers). Should errors and omissions insurance be reserved for cases involving those clerical-type tasks? And should terms like "professional liability insurance" and "malpractice insurance" be reserved for cases involving activities that can only be performed by a specially licensed or specially credentialed person?

Though those questions might seem, at first, like parts of a merely semantic argument, they relate to a broader and very important point that will be emphasized throughout this chapter: Whether they are helping consumers with an E & O transaction or are buying an E & O product for themselves, insurance professionals must read coverage forms very carefully and confirm that they and the insurance carrier are in agreement about the types of scenarios that will be covered by a given policy.

**Who Needs E & O?**

Errors and omissions insurance is intended to help professionals when they are accused of negligence or incompetence in their work. This type of accusation might arise whenever a professional either provides services that do not meet a client's or customer's expectations or fails to provide an expected service at all. In general, for most types of errors and omissions coverage

to apply (assuming we are putting medical malpractice insurance in a separate category), the harm to the client or customer must be financial in nature rather than a case of property damage or bodily injury.

Basic examples of scenarios that might ultimately result in an errors and omissions claim include the following:

- Giving bad professional advice.
- Failing to complete an important task before an important deadline.
- Committing a seemingly minor but ultimately costly clerical error.
- Performing an inadequate analysis of a client's needs.

In 2006, the popular trade publication National Underwriter reported that there were more than 150 classes of business within the errors and omissions insurance market. That number has undoubtedly risen since then, along with the aforementioned fear of lawsuits. An abbreviated list of professionals who tend to be good candidates for E & O (or, in some cases, malpractice) insurance appears next:

- Medical professionals.
- Legal professionals.
- Accountants.
- Architects.
- Engineers.
- Funeral directors.
- Real estate agents.
- Stockbrokers.
- Insurance agents and brokers.
- Web and software designers.
- Various types of "consultants," who are typically hired for advisory roles because of their alleged expertise.

**Mandatory E & O Insurance**

Many of today's professionals will have an interest in errors and omissions insurance because they sincerely wish to reduce their own level of risk. Others might not particularly want this type of insurance protection but will ultimately need to secure a policy because of state laws, a mandate from their employer or a demand from an important client.

In cases where insurance is mandated by a state, the government's intentions are usually to ensure that harmed consumers have a way of being compensated for an alleged professional's negligence and also to stabilize the E & O market so that carriers have a healthy mix of low, medium and high-risk policyholders in their portfolios. Be aware, however, that the mandatory purchase of errors and omissions insurance might only apply to specific types of professions in specific states.

**Common E & O Scenarios for Insurance Producers**

Having addressed some of the many different types of professionals who might have an interest in errors and omissions (or malpractice) insurance, we will spend the rest of this chapter exploring the ways in which errors and omissions products can or cannot provide risk protection for you and other licensed insurance producers.

We've already mentioned some broad examples of customer dissatisfaction that might lead to an errors and omissions claim. Now let's narrow our focus and review some examples that are specific to insurance agents and insurance brokers.

Here are some hypothetical but fairly common cases in which good errors and omissions insurance might come in handy for you:

- A policyholder's claim is denied in whole or in part, and the policyholder accuses you of failing to secure adequate coverage based on his or her specific situation.
- You place a client's insurance with a carrier that ultimately becomes financially incapable of meeting its claims-paying obligations.
- You forget to process a renewal before a policy's expiration date and allow coverage to unintentionally expire.
- You sell property insurance to someone who fails to purchase flood or earthquake insurance and who later accuses you of not explaining that losses from those natural disasters are generally not covered by standard property insurance.
- You are asked to cancel coverage that applies to more than one person but fail to receive authorization from the appropriate party (such as the "first named insured").
- You are helping a client find special coverage from an E & S (excess and surplus) carrier and forget to consider the seemingly subtle but potentially significant differences among the products sold in this non-standard market.

## E & O Risks With Carriers

Concerns for producers pertaining to errors and omissions tend to center on perceived or actual mistakes that impact consumers. However, producers shouldn't forget their ethical and legal obligations to the insurance carriers that they represent or otherwise work with. In fact, according to statistics from Swiss Re and the Independent Insurance Agents and Brokers of America (as published in Best's Review), roughly 8 percent of errors and omissions claims against insurance producers are prompted by angry or otherwise dissatisfied insurance companies.

In general, allegations of unprofessional conduct from carriers against agents or brokers tend to involve the following issues:

- Failing to disclose risk-related information about an applicant or policyholder to the insurance company.
- Overstepping authority in regard to binding (or not binding) coverage for an applicant before an application has been fully reviewed and processed by the insurance company.

### Problems With Other Types of Liability Insurance

Much like the uninsured prospects whom they attempt to educate, insurance licensees might make the incorrect assumption that they are already covered for professional liability—including for errors and omissions—by other policies. Let's go through some common types of insurance and address why they are hardly ever the best option for producers who are concerned about E & O risks:

- **Homeowners insurance:** Although homeowners insurance typically includes coverage for personal liability, it tends to exclude liability arising from business activities (with the possible exception of a minor who is operating his or her own business on a part-time basis). Furthermore, liability coverage in homeowners insurance only applies to cases in which the insured is deemed responsible for bodily injury or property damage. It doesn't help an insured who is accused of harming someone in purely financial ways.

- **Personal umbrella coverage:** Personal umbrella coverage can help consumers who want even more personal liability protection than a homeowners insurance policy can provide. But since its focus is on personal rather than professional liability, negligence related to the insured's job duties might not be covered by this type of product.
- **Directors and officers (D & O) insurance:** This insurance can be beneficial to people who are on boards of directors or who are otherwise responsible for a business's major financial decisions. But even if an insurance professional has D & O coverage through his or her high-ranking involvement at a company or corporation, this insurance generally won't extend to the person's insurance-related dealings with applicants or policyholders. Whereas D & O is intended to protect business leaders when their decisions harm their own company, E & O is largely intended to protect professionals when their decisions harm their clients or customers.
- **Commercial general liability (CGL) insurance:** This form of insurance is fairly standard among a broad range of businesses and is intended to help business entities when they are held liable for bodily injury or property damage. (A classic example of a CGL-related claim would be a case in which a customer slips and falls at the insured's place of business and demands financial compensation.) However, since CGL coverage is generally geared toward bodily injury and property damage, it is widely considered to be insufficient for professionals who offer advice or who can be held liable for someone's financial losses. Admittedly, an unaltered CGL coverage form usually doesn't exclude liability stemming from "professional services" and therefore might seem perfect for medical professionals (who might be sued for bodily injury) or various types of engineers or architects (who might be sued for faulty services that result in property damage). But the vast majority of carriers selling CGL insurance amend the standard coverage forms in order to specifically exclude "professional services." In other words, for most professionals, even a good CGL policy won't be enough.

Clearly, while the insurance products mentioned in this section might play an important role in an insurance producer's personal and professional life, they have significant gaps that can make errors and omissions insurance a near necessity.

**Problems With "Going Bare"**

The importance of E & O coverage has risen to a point where not having the insurance has earned its own term. If you are an insurance professional without errors and omissions insurance, you are said to be "going bare."

The term "going bare" suggests that not having errors and omissions insurance leaves someone exposed and vulnerable. To be fair, it is nearly impossible to say that every single person is a good candidate for a particular kind of insurance. But before an insurance agent or broker dismisses the idea of purchasing an E & O product, that person should seriously consider the following questions:

- Even if I follow all the rules and treat people as well as I possibly can, am I likely to ever have a particularly demanding and litigious client?
- Even if I win every lawsuit filed against me, how will I pay for an effective defense team?
- Even if I never have a litigious client or get sued, am I likely to ever work for an agency or insurance carrier that might require me to have my own errors and omissions insurance?

Assuming you believe errors and omissions insurance is important to your professional life, let's spend the next several pages going through the ways to obtain such coverage and many of the important policy features that you might want to evaluate.

### Obtaining E & O Insurance Through an Employer

Insurance producers who are interested in obtaining and maintaining adequate errors and omissions coverage might want to examine their options with their current or prospective employer.

An insurance company or agency that has already bought errors and omissions insurance for itself might already have options in place for its employees or its captive agents. However, many insurance businesses require employees and captive agents to pay a portion of premiums in order to be covered under the business's policy or at least make them responsible for all or a significant portion of the policy's deductible.

Regardless of any required cost-sharing, producers who are offered errors and omissions insurance through their employer might want to consider the following questions before accepting it:

- How will the coverage respond if I'm accused of an error or omission by my employer rather than by a customer?
- If a complaint is made against me and my employer, am I comfortable with my employer having full authority to choose and direct our legal defense team?
- Am I engaged in any insurance-related activities (such as teaching or consulting) that aren't done on behalf of my employer and, therefore, might not be covered by my employer's insurance?

### Obtaining E & O Insurance on Your Own

If an insurance business does not offer errors and omissions coverage to its employees (or if the producer is self-employed), a risk-sensitive agent or broker will need to shop the market on his or her own. Although insurance businesses have the option of adding independent contractors (such as independent insurance agents) to their own E & O coverage, a business might only agree to do so for very valuable producers. Even then, coverage under one business's E & O plan wouldn't protect that producer in transactions for other insurance businesses.

If you need errors and omissions insurance and already have commercial general liability coverage in place for your own business, you may want to consider contacting the same carrier that issued the CGL policy. Ideally, having your E & O and CGL insurance from the same carrier (and serviced, presumably, by the same producer) will help reduce coverage gaps or at least make you more aware of risks that neither policy adequately addresses. In rare cases, you might even be able to add an E & O endorsement to your existing CGL policy instead of having to purchase an entirely separate product.

Decent errors and omissions coverage might also be offered through insurance trade associations. In fact, the ability to buy into a producer-centered E & O plan at a relatively affordable price is often a major reason why agents and brokers join such organizations in the first place. Even if the coverage offered by a trade organization isn't the best fit for your needs, your membership might help you save some money when applying elsewhere for your own insurance. After all, active members in these organizations tend to take their careers very seriously and are therefore viewed by some E & O underwriters as good risks.

No matter the route you take to find your own errors and omissions coverage, consider following the same kinds of advice that you would give to your own clients when evaluating their options from various insurance companies:

- Read all materials received from carriers (including marketing materials and policy forms).
- Don't be afraid to ask questions if something seems unclear or if an exclusion or policy limit seems unreasonable.
- Recognize that each product has its own benefits and drawbacks that can make all the difference when a loss occurs. Since there is no standard form of errors and omissions insurance, don't automatically assume that the cheapest policy is the best policy.

**Underwriting for E & O**

When applying for errors and omissions insurance, you will be asked to provide various pieces of information to the E & O insurance carrier. The following are some questions that a carrier might ask you. Depending on the carrier, your answers might have a significant impact on your eligibility for suitable insurance and the price you'll need to pay for it:

- How much business—based on premium volume—do you do every year in each line of insurance? (More business might mean more risk. Also, some lines of insurance are viewed as riskier than others. For example, someone who specializes in interest-sensitive variable life insurance might be viewed as a bigger risk than someone who sells term life insurance.)
- Do you plan on branching out and selling any new types of insurance in the near future?
- Which words do you use to advertise yourself and your credentials? (The higher the amount of expertise and trust associated with those words, the greater the potential risk. For example, producers who merely refer to themselves as "insurance agents" might be viewed as a lower risk than producers who refer to themselves as "insurance advisers.")
- Which specific services do you perform on behalf of clients, customers or insurance carriers? (Examples might include policy issuance, risk management advice, claims handling, underwriting and third-party administration services.)
- What sorts of procedures do you already follow in order to minimize your E & O risk? (For example, you might run an agency and require all of your producers to take courses about E & O issues on an annual basis. You might have systems in place that document all important communications with customers and clients.)
- Do you have any history of errors and omissions claims (or of being sued in a professional capacity)?
- Are there any recent events that have not yet resulted in legal action against you but might result in such action in the future?
- Have you ever done business under another name?
- Which insurance carriers do you represent or regularly do business with? (The E & O carrier will want to ensure that you are placing business with financially strong companies.)
- Do you have the authority to "bind" coverage for insurance companies, or are you only authorized to accept applications?
- If you are involved in commercial lines of insurance, which industries do you specialize in?
- If you are self-employed, how many people do you employ? (Some carriers will cover your employees unless you opt to exclude them.)

- If you are self-employed and hire independent contractors, do you require them to have their own errors and omissions insurance?
- Are you a member of any insurance-related professional organizations?
- How much errors and omissions insurance are you requesting?
- How high of a deductible are you requesting?
- Is this coverage intended to be your primary E & O coverage, or will it only be used when other insurance has reached its limit? (In general, excess coverage tends to be less expensive than primary coverage because it is less likely to be utilized.)

**Common Policy Issues**

At this point, we will look into some of the most important policy provisions, exclusions and features found in errors and omissions insurance. As you read through the next several sections, keep in mind that the information is intended to be general in nature. Since there is no standard coverage form for errors and omissions insurance, any E & O product that you encounter might differ in important ways from other products in the market.

**Who Is the Insured?**

Whether you are buying errors and omissions insurance for yourself or expect to be covered through your employer, it is critical that you understand who is actually considered an "insured" within the policy. Failing to understand the specifics of this issue can lead to significantly negative consequences at the worst time.

The broadest forms of errors and omissions insurance will cover the insurance business (or person) specifically named on the policy's declarations page, as well as all past, present and future owners, employees and independent contractors when conducting business on the named entity's behalf. However, agreeing to insure so many people under the same policy can raise the amount of risk to the carrier and, consequently, can require the named insured to pay relatively high premiums.

In order to reduce costs, insurance entities that purchase E & O coverage will commonly exclude independent contractors or might choose to only cover a few contractors who are especially important to the business. It is also possible for the insured entity to cover its owners but not any employees. As was mentioned earlier in this chapter, some businesses walk a middle ground in this regard by extending coverage to their workers, but only if a worker is willing to pay part of the premium and/or the deductible.

If a person or business already has E & O coverage, the definition of "the insured" should be reviewed again following an entity's change in ownership or name and at the end of someone's employment. A business will probably want to ensure that the new owners or the new business name are clearly included within the definition. A departing employee (or even a departing owner) will want to review the definition (as well as other important policy provisions) so that there is clarity regarding when the person will no longer be covered by the employer's insurance and whether the person will retain a limited amount of protection against claims arising from past activities.

**Covered Professional Services**

Once you confirm that you are an insured party under an errors and omissions policy, your attention should turn toward the types of activities to which the policy applies. In general, errors and omissions insurance is only applicable in cases in which the insured is performing "professional services" or "professional acts." If an error or omission arises from an activity that is

beyond the scope of professional acts or professional services, the insured will need to find another way to deal with any resulting damages.

Note that an E & O policy's definition of "professional services" is likely to be specific to a particular profession. For example, the definition might apply to various activities that are associated with selling insurance but not to the various activities that are instead commonly associated with accounting, selling real estate or providing legal advice. In the event that you work in multiple professions, you might need a separate errors and omissions policy for each one. At the very least, you might need to contact an agent and have your existing insurance adjusted to address your multiple jobs.

Today's insurance producers attempt to offer many different services in order to attract and keep good clients. Therefore, it is important for an insurance professional to analyze an E & O policy's definition of professional services very carefully. Ideally, the right E & O product will include a clear definition that addresses all of a producer's activities and all of the roles that the producer could potentially play in his or her dealings with the public. For example, a carrier's definition of professional services might include those activities that are performed by an insured while serving in the following capacities but not in any others:

- Insurance agent.
- Insurance broker.
- Insurance consultant.
- Insurance teacher.
- Insurance claims adjuster.
- Risk manager.
- Notary public.

**Coverage Limits**

Even a well-worded errors and omissions policy won't help the insured if the policy's dollar limits are too low. Those dollar limits might be imposed on a per-occurrence basis (with coverage for a single error or omission capped at a particular amount) or an aggregate basis (with coverage for multiple errors and omissions in the same coverage period capped at a different amount).

For a simple example, let's assume an insurance agent has E & O coverage with a $50,000 per occurrence limit and a $100,000 aggregate limit. Now pretend the agent has already settled two lawsuits against him for $50,000 each. However, the agent is in the process of settling a third suit for $25,000. In this case, even though the third settlement amount ($25,000) is less than the policy's per-occurrence limit ($50,000), the agent won't have coverage for the third settlement because his insurer has already paid a combined $100,000 as a result of the two earlier settlements. In other words, the policy's aggregate limit has already been reached, so the agent will need to pay out of pocket for the third settlement.

There are seemingly few rules regarding how to calculate appropriate coverage limits for your errors and omissions insurance. Some agencies and producers choose their limits largely on the basis of their business's estimated worth. Others consider the highest face amount of all the policies they have sold and choose limits that are comparable to that number. However, experts sometimes question the logic behind those strategies and suggest that policy limits be determined with assistance from an experienced E & O insurance specialist.

Due to risk management concerns from carriers, it is sometimes impossible to obtain all of the errors and omissions coverage you want from just one company. If a careful analysis makes you believe that you should have an especially high coverage limit, your most practical option might

be to obtain insurance up to a certain amount from one carrier (for use as your primary insurance) and apply for coverage up to an additional amount from a second carrier (for use as "excess" coverage if your primary insurance's limits are reached). Excess coverage tends to be easier (and cheaper) to obtain than primary coverage because it won't be utilized as often and, therefore, puts the excess insurer in a reduced state of risk. Primary insurance, on the other hand, will be utilized for practically every E & O claim involving the insured until the policy's limits are exhausted.

## Defense Costs

Errors and omissions insurance isn't just for cases in which a professional is officially deemed to be at fault for a loss. It can also be extremely helpful when an ethical, competent and law-abiding producer becomes ensnared in a frivolous suit with an overly combative customer. In fact, regardless of whether a producer wins a lawsuit, loses a lawsuit or agrees to an out-of-court settlement, errors and omissions insurance will usually help pay for the producer's defense and related legal fees.

Most forms of errors and omissions insurance include a duty to defend the insured. Note that this duty to defend is different (and significantly more beneficial to the insured) than a mere "right" to defend. Unless a scenario is excluded or obviously unrelated to professional services or the performance of professional acts, the duty to defend makes the insurer obligated to provide competent legal counsel. In exchange, the insured is obligated to cooperate with the insurance company in regard to his or her defense, which might include providing evidence to attorneys, appearing at legal proceedings and answering attorneys' questions.

The issue of defense costs should be a factor in evaluating and choosing an errors and omissions product's coverage limits. Though E & O insurance is purchased mainly to deflect the cost of judgments and settlements against the insured, significant legal fees might be incurred while a case or complaint is still being disputed. Whereas many other types of liability insurance will cover such interim expenses without impacting a policy's dollar limits, these costs might reduce the amounts available for judgments and settlements under an E & O insurance contract. If a carrier is willing to cover these costs in ways that won't reduce the amounts available for judgments and settlements, it will typically do so in exchange for a higher premium from the insured.

## Deductibles

A deductible is the amount, in dollars, that an insured must pay after a loss in order for the insurer to start paying benefits. If an insurance product has no deductible, the insured has what is known as "first-dollar coverage."

Deductibles help reduce the cost of insurance for some consumers and make it less likely that an insurance company will need to process and pay so many small claims. In the errors and omissions market, they also are used as an incentive for the insured to do his or her work as carefully as possible. Since E & O deductibles are typically higher than deductibles for other common types of insurance (often amounting to thousands of dollars), even an otherwise well-insured producer is likely to suffer financial consequences if poor service leads to a claim.

Your errors and omissions insurance might have a single deductible for the policy period or might have a per-claim deducible that essentially must be paid in connection with every single loss. Similarly, the deductible might only apply to settlements and judgments against the insured or might also need to be paid before the carrier will cover any defense costs.

Regardless of the specifics, the more the insured is willing to absorb in the form of a deductible, the lower the cost of insurance is likely to be.

## Exclusions

Reviewing the exclusions in your errors and omissions policy can help clarify your expectations in case of an eventual claim and can also alert you to instances in which you might need to take additional action in order to eliminate coverage gaps.

Several common exclusions that might apply to E & O insurance for producers are listed below:

- Libel or slander.
- Theft.
- Embezzlement, commingling or misappropriation of funds (including any premiums collected from consumers).
- Property damage and bodily injury. (Insurers generally prefer that liability for property damage or bodily injury be addressed via different types of coverage, such as commercial general liability insurance.)
- Fraud or dishonesty.
- Cyber liability (such as the loss or disclosure of personal data).
- Placing coverage with a carrier that ultimately becomes insolvent. (Many insurers will cover producers in this scenario if the insolvent insurer's financial rating was strong when the producer placed the coverage.)
- Intentional acts.
- Employment liability.
- Violations of antidiscrimination laws.
- Regulatory fines and punitive damages. (Depending on the state, insurance companies might be prohibited by law from covering these fines or damages.)
- Violations of securities laws.
- ERISA violations (if the producer is helping to administer employee benefit programs for businesses).
- Claims by the insured against another insured (assuming the policy covers more than one person).
- Any allegations that don't relate to professional services or professional acts (as defined elsewhere in the policy).

## Policy Periods

Errors and omissions insurance contracts are usually in effect for one year and are then eligible to be renewed on an annual basis.

As you will see in the next few sections, the effective dates and policy periods of your E & O insurance are very important. Depending on the specifics of the policy language, both a claim and the alleged error or omission that led to it might need to have occurred during the policy period.

## Claims-Made Policies vs. Occurrence Policies

Until the 1970s or so, E & O and other types of professional liability insurance were commonly issued as "occurrence policies." Under an occurrence policy, the insured is covered for liability as long as the alleged error or omission occurred while the policy was in force.

As an example, consider a professional who was insured under an occurrence policy and provided bad advice to a client a year ago. Since then, the professional has allowed his or her

insurance to lapse. If the client who received the bad advice suddenly decides to sue the professional tomorrow, the lapsed occurrence policy could still be relied upon to help pay for any judgments or settlements stemming from the advice.

Casualty insurers eventually determined that occurrence policies exposed them to too much liability and have stopped making these types of insurance products as widely available. Instead of offering occurrence policies to interested applicants, insurance companies might instead provide what are called “claims-made policies.”

Under a claims-made policy, the insured is covered for liability if the claim that resulted from an error or omission occurred while the policy was in place. (In general, within the context of E & O insurance, a “claim” is a written demand for money as compensation for the insured’s allegedly negligent actions.) In most cases, the alleged error and omission must occur during that timeframe as well.

Consider our previous example of a professional who gave bad advice a year ago, gets sued tomorrow and allowed his or her E & O coverage to lapse in the meantime. If the lapsed coverage involved a claims-made policy and not an occurrence policy, the insurer would generally be under no obligation to help the professional pay for defense costs, judgments or settlements stemming from the allegedly bad advice.

Admittedly, the mechanics of a claims-made policy are a bit more complex than our presented examples might suggest. Additional important information about claims-made policies can be found in the next few sections.

**Retroactive Dates and Prior Acts**

A claims-made policy’s “retroactive date” is the earliest date on which an error or omission can occur in order for the insurer to cover any resulting claim. In most instances, this date will be identical to the date on which the policy was first issued to the insured. If the policy is renewed on time, the retroactive date will remain unchanged and will continue to be identical to the date on which the policy was first issued to the insured.

If someone allows his or her errors and omissions insurance to lapse (or cancels the coverage in the middle of a policy period) and then decides to purchase a policy again at a later date, the retroactive date will be moved up and will usually be identical to the date on which the new policy (not the old one) is issued. A potential exception to this rule about having a new retroactive date after a lapse or cancellation might exist if the professional is merely having one carrier’s policy replaced with another carrier’s policy and is not going a single day without being covered by one policy or the other.

On rare occasions, a claims-made policy might have a retroactive date that is earlier than the policy’s original issue date. For instance, pretend you have just purchased an insurance agency from a retiring producer. You have done a reasonable amount of due diligence and aren’t aware of any errors or omissions by the retiring producer that could create trouble for you. However, you’d like an extra layer of protection just in case one of the retiring producer’s mistakes has evaded detection. In this case, it might be possible to pay a higher premium for an earlier retroactive date that would protect you from the retiring producer’s earlier activities.

Note, however, that E & O insurers typically won’t pay any claims for errors or omissions that the policyholder was already aware of (or should have been aware of) on or before the policy’s issue date. In other words, a currently uninsured producer should be able to obtain coverage for future errors and omissions but not for past ones.

## Tail Coverage and Extended Reporting Periods

Professionals who are retiring or who have another legitimate reason to cancel or not renew their E & O insurance might still want a limited amount of coverage in case an earlier error or omission comes back to haunt them. In these cases, it might be appropriate for the professional to purchase what is sometimes referred to as either "tail coverage" or an "extended reporting period."

Some errors and omissions products include a very small amount of tail coverage free of charge. For instance, if the insured voluntarily cancels or decides not to renew an E & O policy, the insurer might still respond to claims that are reported within 30 to 60 days after the policy's expiration or cancellation date.

Then, for an additional charge, the insurer might agree to respond to claims that are reported over a much lengthier period, such one year or even 10 years after the policy's expiration date. The insured will usually need to purchase this extra coverage within a limited time after the cancellation or non-renewal. The cost will depend on the length of the extended reporting period and will often be based on a percentage of the insured's most recent annual premium.

Regardless of the length of an extended reporting period, be aware that tail coverage is only applicable when a future claim relates to an error or omission that happened before the policy was cancelled or non-renewed. Therefore, if a retired professional decides to return to business and wants liability protection from future errors or omissions, a new policy must be purchased. The professional's tail coverage won't be enough.

## Reporting a Claim

Within the context of errors and omissions insurance, a "claim" is generally defined as a written demand for money in response to an insured's alleged incompetence. A claim might come from a producer's client or customer or even from an insurance company that the producer has worked with. Unless an extended reporting period applies, errors and omissions insurance will only cover claims that are reported to the insurer during the policy period.

Policy language will specify the deadline for reporting claims to the insurer. For example, a policy might say a claim must be reported within 30 days after the insured becomes aware of it. Ideally, claims should be reported as soon as possible so that the insurance company's legal team can evaluate the situation and begin collecting any relevant evidence. The sooner the defense team can speak with witnesses (especially the insured), the clearer those witnesses' recollections are likely to be.

If an insured is planning on cancelling or not renewing his or her errors and omissions policy and is aware of a situation that has the potential to produce a later claim, it is generally unwise to ignore the situation until a written demand for money actually materializes. Instead, the insured should inform the insurance company as soon as possible and provide all known specifics (including what happened and to whom) to the carrier. Depending on the policy, this preemptive notice to the insurer might be treated as a claim and can make the insured eligible for insurance protection even if a written demand for money isn't made until after the policy period. In other words, such preemptive notice might, in and of itself, trigger a form of tail coverage.

## E & O Settlements

When someone accuses us of wrongdoing, we naturally tend to become very emotional. We might feel anger toward our accuser and want to prove the person wrong at practically any cost, or we might even believe that there's truth to the accusation and want to fix the problem on our own. But with so much money at stake, the carrier behind our E & O insurance will want us to put our personal feelings aside and to keep our situation within the proper perspective.

If the insured is accused of wrongdoing and receives a demand for money, the insured's response should be communicated with great care. If the insured admits fault, proposes a settlement or agrees to mediation, the E & O carrier might refuse to cover any claims resulting from the situation.

After the E & O carrier becomes aware of a claim, it will attempt to determine the strength of the insured's case and whether it makes sense to settle the matter. Be aware that the carrier's job is to help limit liability-related costs for itself and its policyholders. So even if the insured has a good chance of prevailing in a court of law, the E & O carrier might determine that a quick settlement is the least expensive and best option.

### Hammer Clauses

An E & O policy's "hammer clause" is meant to address situations in which the insured disagrees with an insurer's recommendation to settle a claim. In general, the insured won't be forced to settle a claim against his or her wishes but will be held responsible for any eventual settlement or judgment beyond the carrier's originally proposed settlement amount.

For example, suppose an insurance company believes the insured should settle a dispute for $75,000. If the insured refuses to settle, loses his or her case and is ultimately ordered to pay $100,000 to the plaintiff, the insurance company would contribute no more than $75,000. The insured would need to pay for the rest out of his or her own pocket.

### Conclusion

Considering all the liability risks that exist for agents and brokers, a nervous observer may wonder why anyone would dare to pursue an insurance career in the first place. But a combination of care, competence and the right errors and omissions coverage can ease fears regarding professional risks. By being mindful of the kind of insurance you are buying for yourself, you can ultimately spend less time stressing about your own level of risk and devote more attention to helping consumers.

## CHAPTER 3: APPLYING LIFE INSURANCE CONCEPTS

### Introduction

Life insurance is not only one of the most popular kinds of insurance in society but also one of the oldest. The practice of providing financial assistance to dependents after someone's death dates at least as far back as ancient Mesopotamia, where the Code of Hammurabi required the state to provide compensation to families when a robbery resulted in a victim's death. Over time, life insurance concepts also found their way into guilds and religious societies. When a fellow tradesman or worshiper passed away, members of these organizations would pool their money together and help pay for funerals and other final expenses.

Early life insurance arrangements were relatively informal and would often only involve short-term contracts between two people. An individual who was scheduled to undergo a dangerous task or a risky journey would sometimes pay a single sum to a wealthy person in exchange for an agreement to provide death benefits to surviving family members. But if the person paying the sum to the wealthier person survived the particular ordeal, the wealthier person (known as the "underwriter") could keep the money and wouldn't need to pay anything to the family.

The creation of life insurance companies was the byproduct of consumer demand and actuarial principles. The world was becoming more industrialized, and fewer heads of households could adequately prepare for death by leaving valuable farmland to their heirs. Meanwhile, underwriters realized that they could reduce their financial risks by insuring several lives instead of just one. The need for life insurance became more broadly recognizable regardless of social class, and the businesses that were interested in offering this important product became bigger and bigger.

Today's life insurance companies have collectively underwritten trillions of dollars in coverage on millions of lives. And even among the relatively few adults with absolutely no life insurance, the idea of protecting their loved ones in the event of an untimely death has almost certainly crossed their mind. Many of them are just waiting for someone to explain how this insurance actually works.

**Purposes of Life Insurance**

Most life insurance purchases are made to help survivors deal with the financial consequences of a loved one's death. Long-term consequences typically include the loss of the deceased's income, which would have otherwise been used to maintain a family's standard of living and help achieve such future goals as repayment of a mortgage loan or funding of a child's college education. Short-term consequences might include the unexpected costs pertaining to funerals, burials and unpaid medical bills.

Unlike other major assets that might be passed down from the deceased to heirs, life insurance proceeds are typically exempt from the sometimes drawn-out probate process. As a result, beneficiaries usually don't need to wait too long after a death before receiving the money they might desperately need.

Over the past 50 years or so, life insurance has successfully served other purposes, too. These additional uses of life insurance might not be applicable or suitable for the average purchaser, but they can certainly help a buyer under the right circumstances. For example, a life insurance policy might play an important role in the financial plans of the following hypothetical consumers:

- Bill is a wealthy retiree who wants to leave as much of his estate as possible to family, friends and charities instead of losing a significant chunk of it to federal estate taxes after his death. With the right kind of life insurance policy, he might be able to help his family pay off the sizable estate tax bill or even avoid it altogether.
- Jan has just made the last mortgage payment on her home and is in the last few years of her career. She has two adult and financially independent children and is reasonably confident that her savings and Social Security will be enough to fund a modest retirement. However, she would like a third layer of income in case her projections end up being slightly inaccurate. With the right kind of life insurance policy, she might be able to earn some extra interest on her money or even exchange part of the policy's death benefit for emergency cash withdrawals.
- Mike has a high-risk, high-reward philosophy when it comes to investing, and it's served him and his family well. However, he knows he should park at least some of his money in a low-risk investment in case the market experiences a major depression. With the right kind of life insurance policy, he might be able to create some balance in his portfolio.
- Melinda and Brian are successful business partners who aren't sure what would happen if one of them were to die in an accident. They both have spouses, but it's not clear whether either spouse would ever want to take over part of the business. With the right kind of life insurance, Melinda and Brian can ensure that the surviving partner can purchase the deceased partner's portion of the business and that any surviving spouse is fairly compensated.

Over the next several pages, we will explore these big, small and medium-sized needs in greater detail and explain how life insurance might cater to them. To a lesser (but still important) degree, we will also be sure to acknowledge that as flexible as life insurance can often be, it isn't the best solution to every problem.

### Determining Life Insurance Needs

Despite the versatility and popularity of life insurance, the amount of coverage that is appropriate for a purchaser will be different from person to person. In fact, what's considered an appropriate amount at the time of purchase is likely to be different from the amount that is truly needed by the same person several years later.

Even when applicants recognize the importance of life insurance, they often misjudge the size of death benefits that they really need in order to accomplish their goals. In order to guide people to the right amount, life insurance producers must become familiar with each prospect's financial situation and continue to encourage an open dialogue in the years following a sale.

For several decades, the life insurance industry attempted to determine an applicant's needed amount of coverage by calculating the individual's "human life value." This calculation relied heavily on the insured person's income and unfortunately led to such broad recommendations as, "Everyone should purchase life insurance equal to at least five times their annual salary."

The focus on income was both understandable and a good start, but it didn't allow for variables in family structures (such as single-income families vs. two-income families) or for long-term goals that weren't necessarily tied to salary (such as a desire, regardless of current income, to fund a surviving child's education).

Rather than rely on basic calculations of human-life value, most of today's life insurance professionals estimate the suitable amount of coverage by conducting some kind of "needs analysis." Income is generally an important factor in a needs analysis, but it is far from the only variable that is considered. A common, thorough needs analysis explores the specifics of a person's financial goals and is likely to involve getting answers to the following questions, among others:

- 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 money from a policy's death benefit?
- 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 money 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 directly related to the insured person's death?
- How much money should be reserved for a favorite charity or some other non-traditional beneficiary?
- What other sources of income (such as savings, Social Security benefits, other insurance and survivors' employment income) are likely to be in place in order to accomplish the buyer's goals?

One potential drawback to a needs analysis is that it is subject to change in the years after a policy is issued. Mortgage loans are paid off. New children are born, and older ones (we hope)

become financially independent. Marriages begin and sometimes end. These occurrences are practically a part of life and are likely to have an impact on how much life insurance is really necessary for a given individual.

Producers should, therefore, feel obligated to make contact with their existing customers at least every few years and suggest conducting a revised needs analysis. If the revised analysis points toward a smaller need, the insured is likely to save a bit of money. And if the revised analysis shows a larger need, obtaining a larger death benefit can help keep the owner's goals on track.

### Is Life Insurance for Everyone?

If insurance professionals are going to trust the results of a needs analysis, they must be willing to acknowledge those relatively rare cases in which the need for coverage is very small or even nonexistent. If an individual has no dependents, life insurance might not truly be necessary. If someone's sole concern is having enough money for burial, funeral and other end-of-life expenses and the person is already covered under a modest group life insurance plan, the purchase of a separate policy might not be a legitimate priority.

Although it may be acceptable to emphasize some of the other positive features of life insurance (such as tax issues and the potential to receive dividends or low-interest loans from the insurance company), producers should never forget that the most important promise contained in a life insurance policy is the insurer's promise to pay a death benefit. If the size of the death benefit is not one of the buyer's major concerns, life insurance might not be the best solution to the person's problem. Or at the very least, the purchase of life insurance for this type of person should probably be considered within the context of the buyer's overall financial plan. Such cases might require knowledge beyond the typical insurance producer's realm of expertise and might need to include consultation with the person's attorney, accountant or other trusted adviser.

### Understanding Life Insurance Companies

Most life insurance in the United States is issued by large insurance companies. Policies might also be obtainable through fraternal organizations, banks and (to a considerably lesser degree) credit card companies. The same companies that sell life insurance are also likely to sell annuities and some forms of accident and health insurance.

Insurance companies can generally be categorized as either "stock companies" or "mutual companies." A stock company is owned by investors who might or might not have purchased insurance from that particular company. A mutual company, on the other hand, is owned by the same individuals who have purchased insurance from it. In other words, the company's stockholders and its policyholders are the same people. As stockholders, people who purchase life insurance from a mutual company might receive sums of money called "dividends," which can be given as cash or used to reduce future insurance premiums.

Life insurance policies that have the potential for payments of dividends are called "participating policies." Life insurance policies that do not include the potential payment of dividends to policyholders are called "non-participating policies" and are primarily sold by stock companies. Some mutual companies might also offer non-participating policies to the public. In exchange for the lack of possible dividends, non-participating policies tend to have lower initial premiums.

Regardless of whether they're organized as stock companies or mutual companies, life insurers rely on actuarial data called "mortality tables" to help them price their products and to decide how many lives to insure. Mortality tables are statistically–based representations of each age group's susceptibility to death each year. These tables usually break mortality rates down for insurers by giving them the annual, estimated deaths per 1,000 people in each age group. Although they can't necessarily predict how long a particular person will live, they help insurers make relatively

accurate predictions about how many of an insurer's policyholders will die over a given time period and, as a result, how much money will need to be paid to beneficiaries.

### Insurer Solvency

Regulators require that life insurance companies keep a significant amount of money in reserve in order to pay death benefits and to provide refunds to consumers who are entitled to them. However, an unstable company still might struggle to honor its contractual obligations during a bad economy or at any point when a significant number of policyholders suddenly decide to cancel their coverage. States generally have guaranty funds that can compensate beneficiaries if a life insurance company is unable to make good on a legitimate claim, but there are limits to the amounts that these funds will pay, and the wait can be long and inconvenient.

For these reasons and more, consumers and producers should focus not only on the price of life insurance but also on the financial stability of the company that is behind the given policy. Ratings organizations such as A.M. Best and Weiss Ratings can provide an evaluation of an insurer's financial health and can help producers determine which companies are more likely than others to become insolvent or are at least more likely to raise prices.

### Life Insurance Agents

A person who wants to sell life insurance to others must be licensed. The type of required license will depend on the type of life insurance being sold.

The basic life insurance license issued by a state's insurance department can be used to sell most kinds of life insurance. However, some kinds of life insurance are actually a combination of insurance and a securities product. These types of insurance are collectively known as "variable life insurance" and have a cash value that can increase or decrease in conjunction with the stock market or other economic factors. In order to sell variable life insurance, the seller must have a life insurance license issued by his or her state and must pass the appropriate federal exam pertaining to securities. (These exams are typically known by a series number, such as "Series 6" or "Series 7.")

In addition to being regulated by the state insurance department, an insurance agent who sells variable life insurance is also regulated by a national regulatory body called the "Financial Industry Regulatory Authority" (FINRA). Both FINRA and a state's insurance department require that life insurance professionals complete continuing education courses in order to renew their license.

### Duties of Life Insurance Agents

Along with explaining products and evaluating consumers' needs, life insurance agents often act as "field underwriters" for the insurance company. As a field underwriter, the life insurance agent is expected to consider a potential buyer's risk profile and determine whether the person is likely to be a good customer.

Although insurance companies employ other underwriters who do not also work in sales, good field underwriting can reduce an insurer's administrative costs and help an applicant maintain reasonable expectations about whether affordable coverage will ultimately be obtainable. As a result, producers should develop strong knowledge regarding an insurance company's underwriting guidelines and understand which types of applicants are probably too risky to insure.

When members of the public purchase life insurance, they typically refer to the person who sold it to them as "their agent." Technically, however, someone who is a life insurance agent represents the insurance company in the sales transaction. This is yet another reason why life insurance agents must be careful not to overburden an insurer with knowingly risky applicants.

If an applicant has a medical condition, hobby or lifestyle that he or she does not want to disclose to the insurer, the agent must disclose the information anyway. Despite being strongly associated with sales, an observant agent is also the life insurance company's first line of defense against insurance fraud. Agents have an obligation to only bring applicants and insurers together in good faith.

Upon receiving all necessary information (often including medical reports) from life insurance applicants, agents will collect an initial insurance premium and be responsible for sending these funds to the insurance company. When the applicant pays the first premium, the agent will also typically issue some kind of a receipt, which may be conditional or fully binding.

If the agent issues a fully binding receipt, the applicant will have immediate coverage under the life insurance policy and can't have the coverage rescinded by the insurer unless fraud is detected.

In most cases, the receipt issued by the agent is conditional upon all of the application information being reviewed and approved by the insurance company's underwriting department. If an applicant with a conditional receipt would have been approved by the underwriting department but dies before the approval takes place, the policy will be in force, and death benefits will be awarded to the deceased's beneficiaries. If an applicant with a conditional receipt wouldn't have been approved and dies before the underwriting department has completed its review of the application, the policy will not be in force, and no death benefits will be paid.

Before engaging in a life insurance transaction on behalf of an insurance company, agents should have a clear understanding of the types of receipts they may issue. They should also provide as much clarity to applicants as possible and not allow consumers to believe coverage is in place when it is still subject to an underwriter's approval.

**The Life Insurance Application**

Life insurance applications are intended to give underwriters the facts they need to either accept or reject a potential policyholder. In practically every case, the application is considered part of the contract (along with the insurance policy) between the insurer and the buyer. If the insurer later discovers that an application wasn't completed honestly, the policy might be cancelled (in a process known as "rescission"), or the owner might be forced to pay higher premiums.

While each insurer is likely to include different items on its applications, a modern life insurance application is still likely to ask the applicant to provide information about the following topics:

- Name.
- Age.
- Health.
- Amount of requested coverage.
- Gender.
- Address.
- Occupation.
- Hobbies.
- The applicant's relationship to the insured individual.
- The applicant's relationship to the policy's beneficiary.
- Other life insurance products that the person already owns.
- Other life insurance products that the person applied for but did not receive.

The applicant must sign the application and attest that the information on it is accurate to the best of his or her knowledge. A separate portion of the application also requires the agent's signature and provides space for the agent to leave any additional comments that might be helpful to the insurance company's underwriting department. Upon receipt, the underwriting department will review the application, evaluate the applicant's risk profile and request additional information as necessary.

## Evaluating the Application and Pricing the Policy

Prices for life insurance—and the factors that influence them—will differ from company to company. Though practically all life insurance carriers will care about risk-related issues such as age, health and tobacco use, the line between an insurable person and an uninsurable person isn't identical across the industry. Similarly, depending on the specific policy and the insurer's underwriting criteria, the same person might be eligible for relatively cheap coverage from one company but only qualify for relatively expensive coverage from another.

Still, we can make some basic generalizations about how life insurers categorize applicants and how they view certain types of applicant-related information. For the purposes of this course material, we will say that life insurance companies categorize insurance applicants into three broad groups:

- **Preferred risks:** These are applicants with an above-average life expectancy for their age. They will generally pay the smallest amount for life insurance.
- **Standard risks:** These are applicants with an average life expectancy for their age. They will generally pay a moderate amount for life insurance.
- **Substandard risks:** These are applicants with a below-average life expectancy for their age. They will pay the largest amount for life insurance. (In rare cases, someone who doesn't qualify as a substandard risk will be declined for life insurance.)

In practice, the various categories of applicants tend to be greater in number and more complex than the three mentioned here. For example, some companies have a category for "super-preferred" risks, which is essentially for applicants whose life expectancy is extremely high for their age rather than just above average. Several sub-categories might also exist based on whether an applicant is a smoker or a non-smoker.

## Life Insurance and Medical Information

Information about an applicant's health is central to life insurance underwriting. The more information an underwriter has at his or her disposal, the quicker and fairer the underwriting process can be.

As we will see in the pages that follow, life insurance producers and their clients must have an open dialogue about family histories, medical diagnoses and drug treatments, even as each party does its best to remain respectful toward the subject matter and preserve as much privacy as possible.

In order to evaluate an applicant's risk profile, life insurance agents must do more than simply ask if the person is in "good health." Many insurance veterans will tell you that most of their prospects claim to be healthy, even if their cholesterol and blood pressure levels are dangerously high and their medical files are abnormally thick. Unless they are suffering from a diagnosed and terminal medical problem, many potential buyers might assume that most of their health issues are minor and, therefore, don't really need to be disclosed.

For clarity's sake, a life insurance producer should ask the applicant to disclose any ailment or injury that required either hospitalization or prescription medication. The insurance company will

ultimately want to know the reasons behind any past or imminent surgeries, learn why applicants visited any medical specialists and find out the identities of people's current physicians.

In addition to inquiring about one's personal medical status, a life insurance company will probably ask about family history. For risk management purposes, the insurer will ask if an applicant's blood relatives—usually limited to parents and siblings—died young or were diagnosed with cancer, heart disease or other serious ailments. Note, however, that some states prohibit discrimination on the basis of genetics as long as the applicant has not been officially diagnosed with a genetic condition.

Life insurers use industry databases and attending physicians' statements to verify applicants' medical histories. But files obtained through the Medical Information Bureau, which we will study later, are not substantial enough to give an underwriter a guaranteed understanding of an individual's health situation, and the files sometimes contain errors or misleading facts. Meanwhile, attending physicians' statements might be too vague in some respects and overly detailed in other areas.

For these reasons and more, life insurance applicants are typically given space on an application to elaborate on their conditions as needed. They can explain, for example, that their cancer was diagnosed 10 years ago and has not been detected in recent checkups, or that a drug usually given to patients with liver problems was, in fact, prescribed for a completely different and less serious condition.

### *The Medical Information Bureau*

One controversial—and some would say misunderstood—source of applicants' medical information is the Medical Information Bureau (MIB). Founded in 1902, the Massachusetts-based organization claims to have saved the buying public millions of dollars by detecting consumer fraud in the life and health insurance markets. This nonprofit entity is funded by over 600 life and health insurers that pay dues to the MIB based on the number of times they access the organization's database and the number of policies they have on file with the bureau.

When a person applies for an individual life, health or disability policy, an insurance company that maintains membership with the MIB may choose to report medical information to the bureau. The bureau does not accept any information directly from hospitals or doctors. All information must come from member insurers, and the insurers' information must have come either from the applicant or from a physician who received the applicant's consent to disclose it. The applicant's consent usually comes from an item on the insurance application called an "MIB Pre-Notice," which explains the kinds of information an MIB member might report and the reasons why insurers access MIB files.

MIB records consist of codes, with each code representing one of 230 specific risk factors. The MIB does not intend for its codes to disqualify someone automatically for life or health insurance. Instead, it expects its members to view these codes as red flags and encourages insurance companies to investigate an applicant's specific health status independently. The meaning behind each code is not disclosed to the public or to unauthorized employees.

The MIB maintains files for seven years and also keeps an "Insurance Activity Index," which keeps track of the MIB members who access a consumer's file within two years. Access to the files is granted only to MIB members who either have a pending application or a pending insurance claim.

The MIB's low profile might explain why there has been confusion over the years regarding consumer's access to their MIB records. In fact, the bureau operates in a fashion similar to the major credit bureaus in the United States. Consumers are entitled to view their MIB file once each year by calling the organization and providing it with their name, address, birthday and other

identifying information. Consumers can also receive a free view within 30 days of a negative action taken against them by an insurance company. Additional copies of one's MIB file require a processing fee and a 30-day waiting period.

When people make a valid request for their information, the MIB will tell them what appears in their file, who reported all the information and the names of members who accessed their file. If consumers believe there is an error in their file, the MIB requires the insurer that reported the disputed data to reinvestigate the matter. When people are not satisfied with the results of a reinvestigation, they have an opportunity to add a note to their file that explains the dispute from their point of view.

### *Paramedical Exams*

Sometimes a life insurance applicant can be issued or denied a policy based on the information found in an application and an attending physician's statement. However, many companies require each applicant or certain applicants to go through a paramedical examination before a policy may be issued.

Examined applicants can expect to have their blood pressure taken, their height and weight measured and, perhaps, some of their blood analyzed. If an applicant is not required to submit to a paramedical examination, he or she has probably bought a somewhat pricy policy or opted for a relatively small death benefit.

## Life Insurance and Gender

Initially, societal views about gender and the idea of men being the financial providers for families meant that very few women purchased life insurance. As females took a greater liking to the product, they found that child-bearing risks created an unfavorable situation for them. According to a historical overview printed by Best's Review, if a woman was of child-bearing age, she was often denied life insurance or only offered it at a high price. Costs were even steeper if she applied during the first three months of pregnancy, and a one-year waiting period was common if she was any closer to giving birth.

As childbirth became safer, women began living longer on average than men. For instance, according to the Centers for Disease Control and Prevention (CDC), a woman's life expectancy in 2021 was 79.1 years, and a man's life expectancy was 73.2 years.

The difference in life expectancy between the sexes explains why gender-based prices continue to be allowed for life insurance. In general, if a man and a woman of the same age both apply for the same policy with the same death benefit, the man will be required to pay a bit more.

The opposite is true when a life insurance company issues an annuity. In that case, if a man and a woman of the same age both request to receive regular payments from the insurance company through an annuity, the woman will receive smaller regular payments than the man.

The different treatment of men and women in insurance has become increasingly unique to the life insurance side of the industry. Federal and state governments have moved to ban gender discrimination in health, property and casualty insurance in various ways.

## Underwriting and Smoking

America's relationship with smoking has changed quite a bit since the days when doctors puffed away in front of their patients and when celebrities hawked cigarettes on television. According to the CDC, in 2020, only about 14 percent of men smoked, compared to 11 percent of women. Life insurance companies have changed with the times and have given discounts to non-smokers at least as far back as the 1960s.

For a long time, most life insurance companies granted coverage at a discount if the applicant had avoided cigarettes for at least a year. Over time, some companies have flirted with different rating classes for smokers and charged people a little less if they smoked cigars or pipes rather than cigarettes. People have also been grouped based on the number of cigarettes they smoke in a day.

Tests for nicotine are a common part of the application and underwriting process. If the insurer discovers that an alleged non-smoker actually uses tobacco products, the person can usually still obtain life insurance by paying a higher premium.

**Underwriting and Hobbies**

What people do during their free time can say a lot about their chances of living a long life. In an era when extreme sports have their own televised events, life insurers have become increasingly careful when confronted with applicants who race cars, climb mountains, fly small planes or have other dangerous hobbies.

An extreme hobbyist's insurability will depend on the details of the activity. If a man climbs mountains, does he intend to find his way to one of the world's tallest structures? If a woman enjoys scuba diving, how deep does she plan on swimming? If the applicant is a pilot or race car driver, is his or her vehicle in excellent condition? Will the applicant be engaging in the hobby alone or in a group setting where help is more likely to arrive in an emergency?

Experience can also be a key underwriting factor in these cases. If someone has gone through some kind of licensing or certification process, the underwriter might view the applicant as someone who learned proper procedures and who is expected to adhere to a safety-first code of conduct.

When a dangerous hobby is likely to have a significant impact on an applicant's eligibility for life insurance, it might be possible to obtain affordable coverage by excluding the hobby as a covered cause of death or by paying a higher premium.

## How Life Insurance Policies Work

At this point, we will review the common parts of a life insurance policy and their importance to consumers. The policy is considered part of a contract between the person buying the insurance and the company issuing it. Therefore, it is very important that applicants, policyholders, agents and insurers all have a firm understanding of what a policy actually says.

Unlike many kinds of property and casualty insurance carriers, the life insurance industry does not use the same standard policy forms across all states and all companies. In other words, a policy from Company A in one state isn't guaranteed to be written the same way or contain exactly the same features as a policy from Company B in another state. However, regulatory trade organizations such as the National Association of Insurance Commissioners (NAIC) have drafted life insurance rules and laws that many states have implemented with minimal or no changes.

Even where guidelines from groups like the NAIC have not been followed, state rules often dictate the wording of certain policy sections as well as their placement and font size. Such rules aim to create at least some level of uniformity and consumer protection regardless of which company is actually selling a life insurance product.

## Ownership Rights

Besides the insurance company, there are at least three parties who are connected by a life insurance policy:

- The owner.
- The insured.
- The beneficiary.

The "owner" is the person who has "ownership rights" over the policy and is the only party, besides the insurance company, who decides how the policy is set up. In most cases, the owner is the same person who is responsible for paying the life insurance premium. This person will sometimes be referred to as the "policyholder."

The "insured" is the individual whose life expectancy is analyzed during the application/underwriting process and is the person whose death will result in payments to the policy's beneficiary. The insured and the owner are usually the same person, but it is also possible for one person to be the owner of a life insurance policy on another person's life. For instance, a husband and wife might have a life insurance policy that lists the husband as the owner and the wife as the insured or vice versa. You'll read more about possible arrangements between the owner and the insured in the section called "Insurable Interest."

The "beneficiary" is the person or entity who will receive death benefits when the insured passes away. Although there is tremendous flexibility regarding who can be a life insurance beneficiary, the owner is typically the only person who can make that choice. In fact, an owner even has the ability to change his or her mind and replace one beneficiary with another after the policy has been issued. You'll read more about how this works in the section called "Beneficiaries."

Other rights that belong to the owner (and not to the insured or the beneficiary) are listed below:

- The right to use the life insurance policy as collateral for a loan from the insurer or another lender.
- The right to withdraw money from the policy's cash value (if the policy has cash value).
- The right to terminate the life insurance policy or make changes to it (pending the insurance company's approval).
- The right to receive dividends from the insurance company (if the policy is a participating policy purchased from a mutual insurance company).
- The right to decide whether the beneficiary will receive death benefits in a lump sum or in multiple installments.
- The ability to transfer all or a portion of the ownership rights to someone else.

## Assignment

The ability to transfer a life insurance policy's ownership rights to someone else is known as "assignment." There are multiple types of assignment. In an "absolute assignment," the policy's original owner transfers all ownership rights. More commonly, though, an owner will only assign certain rights to other people and maintain control over other aspects of the coverage.

One of the most common types of assignment is a "collateral assignment." In this arrangement, the owner gives a creditor the right to name itself as the policy's beneficiary in exchange for a loan. If the owner pays the creditor back before the insured dies, the creditor's limited ownership rights end and are returned to the previous owner. If the owner's debt has not been paid off at the time of the insured's death, the creditor will be repaid from the death benefit, and any remaining death benefits will be paid to the owner's chosen beneficiary.

Regardless of the type of assignment or the reason behind it, the insurance company must be notified and approve of the assignment before it can go into effect. If the owner fails to alert the insurer to an assignment and a death occurs, the insurance company might not need to honor the transfer of ownership and might only need to abide by the version of the policy that it has on file.

## Insurable Interest

Before someone can purchase insurance, the insurance company must believe that the policy's owner will want the insured item or insured individual to remain unharmed. This desire to keep insured items or insured people out of danger is called "insurable interest."

Since most people would prefer to stay alive for a reasonably long time, they are considered to have an insurable interest in their own lives and are therefore allowed to purchase life insurance on themselves. The rare exception to this rule about insuring yourself might arise if you attempt to purchase a policy with an unreasonably high death benefit.

Insurable interest can also exist between two or more people. For example, it is generally assumed that family members and business partners have an insurable interest in one another. However, in the event that someone is purchasing life insurance on another person, both the intended owner and the intended insured will usually need to sign the application. One exception to this rule might involve a parent purchasing life insurance on a newborn, which would obviously not require signature from both parties.

For the purpose of life insurance, insurable interest only needs to exist at the point when the insurer receives the application. If circumstances change between then and the time of the insured's death, the owner has the option (but is not obligated) to assign the policy to a more appropriate party. As an example, consider a scenario in which a married couple purchased insurance on each other's lives but ultimately got divorced. Even if neither person is dependent on the other for palimony, alimony or child support, the divorce (and the possible loss of insurable interest) typically won't invalidate the old coverage.

It is important to note that insurable interest is only needed between the owner and the insured. A life insurance policy's beneficiary is likely to have an insurable interest in the insured person's life but is not technically required to have one. The owner can typically name any person or any organization as a beneficiary.

## Paying Premiums

Another decision left up to the owner is the schedule for paying the premium. Policyholders can usually opt among making monthly, quarterly or annual payments. Paying annual premiums is a common recommendation because it reduces the insurer's administrative costs and can actually make coverage a little cheaper. Single-premium policies are also available but are less common because few people have the disposable income to make such a large purchase in just one installment. Regardless of the payment schedule, premiums can typically be paid via check, a pre-authorized debit or bank account or (in the case of group life insurance) a payroll deduction.

Life insurance premiums are usually "level," meaning they remain the same for either the entire duration of the policy or for at least an extended period of time. If the policyholder has insurance that is intended to remain in force for the rest of someone's lifetime, level premiums tend to be the default option. If the insurance is only temporary but has the potential to be renewed for another period of time, the policyholder will typically pay level premiums equal to one amount until the renewal option is exercised. Then, level premiums equal to a different amount will be paid until the policy is either cancelled or renewed again. This temporary coverage (usually with

renewal options) is called “term life insurance” and will be explained in greater detail later in this chapter.

### *Paid-Up/Limited-Pay Policies*

Believe it or not, some life insurance products are designed to let the owner stop paying premiums at a certain point and still keep the coverage intact. These “limited-pay” or “paid-up” policies tend to cost more than other forms of life insurance during the first several years after they’re purchased, but they can be beneficial for consumers who want permanent life insurance protection without having to worry about premiums during retirement.

When an insurer sells a limited-pay life insurance policy, it is making assumptions about the policy’s future “cash value.” The cash value is essentially a combination of the premiums that have already been paid, plus interest earned on those premiums, plus (in the case of a participating policy) dividends from the insurance company. We will explore this concept in more detail later in this course.

With a limited-pay policy, premiums will stop being paid once the cash value reaches a certain amount determined by the insurance company. At that point, the insurer will expect the policy’s cash value to be large enough to offset the need for the premium.

A true limited-pay or paid-up life insurance policy will contain a contractual guarantee that the owner will, indeed, never need to pay premiums after a certain point. With this type of policy, it makes no difference whether economic factors end up being less favorable than the insurance company’s projections.

Unfortunately, some consumers have been confused by insurance company projections and have purchased similar kinds of policies that didn’t contain these guarantees. Instead, they relied on an agent’s verbal assurances or based their buying decisions on confusing charts from the insurance company. Assuming that their premium would permanently “vanish,” many of these confused or misled buyers eventually learned that they needed to pay premiums again in order to keep their coverage in force. For this reason and others, it is imperative that insurance agents communicate clearly regarding what a life insurance actually guarantees and what pieces of data are merely based on assumptions.

### *Grace Periods*

In the event that a consumer either forgets or chooses not to pay premiums on time, the life insurance policy usually will remain in effect for at least one month after the due date. (Some states allow even more time if the owner is a senior citizen.) This is the policy’s “grace period.” If the insured dies during the grace period, the insurance company will pay death benefits to the beneficiary minus the amount of unpaid premium.

### *Automatic Premium Loans*

Life insurance policies that are designed to insure someone for the rest of his or her life (as opposed to insuring the person for only a pre-determined number of years) have a cash value that can be utilized in case premiums still haven’t been paid by the end of a grace period. Usually at no cost, insurance companies will include an amendment or “rider” to these policies that allows for an “automatic premium loan.” When this type of feature is included in a policy, the insurance company will use part of the policy’s cash value in order to compensate itself for unpaid premium after a grace period. As long as the cash value is sufficient to pay the premium and a bit of interest on the loan, the policy will remain in force, and the insured will remain covered.

Note, however, that many insurance policies sold today are “term insurance” policies and do not have any cash value. The automatic premium loan option is one of several differences between

term coverage and permanent coverage. We will explore the other important distinctions between these two broad types of life insurance later in these materials.

### *Waiver of Premium*

Many life insurance policies include a "wavier of premium" provision, which excuses the owner from paying premium while he or she is significantly disabled. The ability to exercise this provision might be limited to owners of a certain age, such as those younger than 65. When it is exercised, it continues to waive the owner's premium as long as the disability can be verified.

Waivers of premium can seem like a neat addition to a life insurance policy, but they might not make the most financial sense if the owner needs to pay something extra in order to get it. Presumably, the same people who would struggle to pay life insurance premiums while disabled would also struggle to pay rent, mortgage debts, utility bills and other essentials, none of which would be helped by life insurance. For this reason, someone who is interested in a waiver of premium should probably take a step back and consider all the ways disabilities might impact one's financial health. Assuming the cost isn't overly prohibitive, this type of person should probably consider speaking with an agent about a separate disability insurance policy. Remember, for most people, life insurance should be about the death benefit.

### *Reinstatement Clauses*

"Reinstatement clauses" give people who cancelled their life insurance a chance to regain it under special conditions. The chance to reinstate a cancelled or "lapsed" policy generally lasts three to five years, depending on the insurer.

The good news about opting for reinstatement is that 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 premium that was in place at the time of cancellation instead of a higher premium based on the person's age.

The bad news for people who want to reinstate a cancelled policy is that 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 might run into problems if he or she has experienced serious medical issues in the interim. As a result, many people only pursue reinstatement if they are likely to earn back a significant amount of a policy's cash value. Insurable people who cancel one policy and later want life insurance again might simply consider applying for a brand-new policy instead.

## Death Benefits

The size of a life insurance death benefit is generally decided at the time of application by the policy's intended owner. Of course, there are some minor exceptions to this rule. For example, an insurer might be hesitant to issue a multi-million-dollar policy on a middle-income stay-at-home parent because the death benefit would seem significantly out of line with the person's needs and might be a red flag of insurance fraud. Similarly, applicants who only want a tiny bit of coverage might be required to purchase a bit more in order to cover the insurer's administrative costs.

The size of the death benefit that will be payable to beneficiaries is sometimes known as the policy's "face amount" or "face value." So a term life insurance policy with a $100,000 death benefit might be said to have a "$100,000 face." In order to properly calculate the appropriate death benefit for an insurance applicant, please review the section "Determining Life Insurance Needs" found earlier in these materials.

### *Settlement Options*

The ways in which death benefits can be paid to beneficiaries after the insured's death are called "settlement options." A settlement option can be chosen by the owner in advance of the insured's death or, if the owner decides not to pick one, left up to the beneficiary.

Most beneficiaries would probably prefer to choose the settlement option on their own after the insured has died, but there are cases in which having the owner pre-select the manner of payment is advisable. If the policy's beneficiary is a child or even an adult who is not particularly responsible with money, the owner can choose a settlement option that restricts access to death benefits but still provides necessary money to the underage or untrustworthy individual.

The most common settlement option gives the death benefit to the beneficiary in a single lump sum. In fact, if neither the owner nor the beneficiary voices a preference for a particular settlement option, this will likely be the insurance company's default way of paying policy proceeds. Other common settlement options are listed below:

- Leave the death benefit with the insurer and allow it to earn interest until a particular time or event.
- Leave the death benefit with the insurer but allow the beneficiary to receive periodic payments of dividends and/or interest.
- Break the death benefit into chunks of money that are given to the beneficiary at regular intervals until a certain date has passed.
- Break the death benefit into chunks of money that are given to the beneficiary at regular intervals until the money runs out.
- Convert the death benefit into an annuity that pays the beneficiary a set amount for the rest of his or her life.

No matter the chosen option, the insurance company will usually need to receive a valid death certificate before it will give death benefits to the beneficiary. Copies are usually available from funeral homes, cremation service providers and local government offices.

### *Beneficiaries*

The beneficiary on a life insurance policy can be a person, business, charity, trust or estate. It is usually chosen by the owner, who even has the right to name himself or herself as the beneficiary.

While it is sometimes possible for the owner and the beneficiary to be the same person, the beneficiary cannot also be the insured. This makes sense when we consider that the beneficiary receives money after the insured dies. In the event that the insured is listed as the beneficiary, the death benefits will technically be passed along to the deceased's estate, which can create probate and tax issues that will be explained later.

Most beneficiaries are "revocable beneficiaries" and can lose their right to death benefits if the owner completes the appropriate paperwork with the insurance company. Other beneficiaries are "irrevocable beneficiaries" and cannot lose their beneficiary status unless they first provide consent to the insurer. As much as the owner might want to replace this kind of beneficiary with someone else, the owner lacks the power to make this type of change. Common scenarios in which an irrevocable beneficiary might be used include those in which a lender is named as a beneficiary until a debt is repaid and those in which former spouses are required to keep their former husband or wife (or their children) as beneficiaries as part of a divorce settlement.

Other distinctions can be made between "primary beneficiaries" and "contingent beneficiaries." A primary beneficiary is the first person in line to receive death benefits when the insured passes away. As long as the primary beneficiary is alive at that time, the contingent beneficiary receives

no money from the insurance company. On the other hand, if the primary beneficiary passes away before the insured's death, the contingent beneficiary will receive the policy's face amount. Having a contingent beneficiary can be particularly helpful if the insured and the primary beneficiary die in the same accident.

Even if the person who is supposed to benefit from the life insurance policy is very obvious to the applicant, care must be taken to ensure that the designation of a beneficiary is absolutely clear. For example, generic phrases such as "my spouse" or "my children" should be replaced with the actual names of those intended beneficiaries. If the purchase of a policy is followed by divorce and remarriage to a different person, it may be unclear as to which spouse is entitled to the death benefits. Similarly, if the beneficiary simply contains phrases like "my children," there might eventually be a dispute as to whether each child should receive the same percentage of the death benefit or perhaps an argument over whether children from previous marriages should receive money, too.

Including a child as a beneficiary can cause problems if the insured dies before the child becomes an adult. Since this can cause the death benefits to be tied up for an unreasonable time in the court system, many life insurance professionals recommend that parents create a trust to receive and hold the money until the child turns 18 or 21. Similar recommendations are often made for adult sons or daughters who are intended to be beneficiaries but are significantly disabled. When these recommendations are followed, the death benefit for sons or daughters might be reduced in order to cover the cost of establishing and maintaining the trust.

## Entire Contract Clause

The "entire contract clause" is a seemingly minor portion of a life insurance policy that actually provides some important mutual protection to insurers and their customers. It essentially states that the entire contract between the insurer and the applicant consists of the policy itself, the application, any riders attached to the policy, and any medical report obtained during the underwriting process.

For the insurer, this means that any exclusions or restrictions relating to the policy must be disclosed in these documents and can't be added at a later date without the owner's consent. For the applicant, this means that even if the person attempts to hide certain medical issues by being vague on the application, the insurer can utilize information in the medical report to make a final decision about pricing and eligibility.

## Incontestability Clause

Many years ago, insurance companies began inserting "incontestability clauses" into their policies in order to strengthen the level of trust between the public and the life insurance community. The purpose of the clause is to assure policyholders that the insurer won't take unreasonable measures in order to deny death benefits to beneficiaries.

Under the most common type of incontestability clause, the insurance company has only two years from the policy's effective date to investigate potentially false information on the original application and rescind the policy. If the insurance company detects potential fraud on the application after this two-year period has expired, the insurance company usually must still keep the policy in force and pay the death benefit when the insured dies.

Exceptions to the two-year limit—though relatively few in number—are still important to know. They include, but are not necessarily limited to, the following circumstances:

- The insurance company determines that the beneficiary is planning to murder or has murdered the insured.
- The insurance company determines that an impostor was involved in completing the insured's medical exam.

If the insurance company determines that an applicant did not honestly disclose his or her age or gender, a different portion of the policy (and not the incontestability clause) will determine what happens next. This type of situation is explained in the next section.

**Misstatement of Age or Gender**

Under a "misstatement of age or gender clause," the insurance company is allowed to adjust the policy's face amount (effectively, the death benefit) if the applicant's stated age or gender turns out to be incorrect. This clause is separate from the incontestability clause and doesn't allow the insurer to rescind an entire policy. It can also be exercised regardless of whether the error in age or gender is discovered later than two years after the policy's issue date.

Believe it or not, many cases of incorrect ages and genders are honest mistakes committed by applicants and insurance producers. For example, an applicant who is asked for his or her age might be confused by the fact that some insurers care about the person's exact age at the time of application while others actually round up to the next age if the applicant's birthday is within the next few months. Meanwhile, a producer who is helping to insure a child might learn the child's name from parents and incorrectly assume that the name is only used by one of the two sexes.

These problems can be minimized by asking very exact questions on the application and during any fact-finding interviews. Instead of asking for ages, some insurers are clearer and ask for birthdates. Instead of asking for names of children and allowing themselves to make assumptions about gender, agents can simply ask the parents to identify the child's gender. This can prevent inconveniences and surprises in later years.

**Suicide Clause**

Similar to the incontestability clause, the "suicide clause" allows the insurance company to deny death benefits to beneficiaries if the insured commits suicide within two years of the policy's issue date. This clause is intended to prevent a problem called "adverse selection," in which insurance is primarily purchased by high-risk consumers who are certain that they will be using it.

By putting a two-year exclusion on suicides, insurers believe that they are protecting themselves adequately against buyers who intend on killing themselves soon after an insurance purchase. However, once the two-year period has ended, cases of suicide will generally result in death benefits going to the beneficiary.

If the suicide clause is to be exercised after the insured's death, the burden of proof regarding the suicide belongs to the insurer. In other words, the death is considered to not have been a suicide unless the insurer can prove otherwise. Instead of the death benefit, beneficiaries who are impacted by the suicide clause will often receive a return of all premiums paid by the policyholder to the insurer.

**Exclusions**

Although life insurance policies tend to have fewer specific exclusions than property and casualty insurance policies, a few causes of death that aren't covered deserve to be mentioned here.

### *Aviation*

Earlier in these materials, you read about dangerous hobbies and how they can sometimes be excluded as a cause of death. Depending on the policy, aviation might be considered one of those dangerous hobbies or might have its own exclusion regardless of whether the applicant engages in it.

When aviation exclusions appear in a life insurance policy, they typically exclude deaths that occur while flying or riding in a non-commercial plane. Deaths of passengers on commercial flights are usually not exempt from coverage.

For an additional premium, any aviation exclusion might be removable from the policy.

### *War*

War exclusions tend to be part of life insurance policies when the United States is engaged in dangerous international conflicts. When they are present, the exclusions might be reserved for cases in which the insured is within the allowed age range for joining the military. Policies issued during peacetime might not have any war exclusions at all.

## Dividends

Policyholders whose coverage was issued by a mutual insurance company are often eligible for "dividends." Within the context of life insurance, dividends are a refund of premiums paid back by the insurer to the consumer. These refunds are possible when an insurer underestimates its mortality risks, has a better-than-anticipated return on its investments or figures out a way to reduce its administrative expenses.

The policyholder (not the beneficiary) is the person who receives dividends and gets to decide how to use them. Common uses for policy dividends are as follows:

- They can be paid directly to the policyholder.
- They can be kept with the insurer and used to reduce or eliminate future premiums.
- They can be kept with the insurer and used to increase the policy's death benefit.
- They can be kept with the insurer and used to increase the policy's cash value (if the policy has cash value in the first place).

Since dividends are commonly used to offset future premiums and as a factor in long-term financial planning, it is very important to note that they are never guaranteed. Most mutual insurance companies do their best to provide dividends to policyholders each year, but the size of an annual dividend can rise one year and drop the next. It's even possible for participating policyholders to go a year or more without receiving any dividends.

Another important point to remember about life insurance dividends is that they are generally tax-free. This can be a confusing point because of the ways in which the term "dividends" is more commonly used by stockbrokers, financial planners and other investment professionals.

It can be simpler to understand the tax status of life insurance dividends if you remember that they are considered a refund of paid premiums. In most cases, people will pay for life insurance premiums with money that has already been subjected to income taxes. So if dividends are considered to be a return of those already-taxed dollars, the money won't be taxed again.

One relative exception to this rule about taxes involves cases in which dividends are allowed to accumulate with the insurance company and earn interest. When those dividends are paid out in the form of cash or as part of the death benefit, the dividends themselves will be free from income taxes, but the interest earned on them will usually be taxable.

## Free-Look Periods

A policy provision called a "free-look period" gives new policyholders a short amount 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, the owner must return the policy to the home office or to the producer before the free-look period expires.

The free-look period begins on the day the policy's owner receives the newly issued life insurance 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.

## Policy Riders

Now that we've gone through the basics of how life insurance policies work, let's focus on common add-ons to those policies. In the insurance community, these add-ons are referred to as "riders." Though they can technically be any amendment to an insurer's basic insurance policy (including an amendment that removes a consumer-friendly feature within the insurance contract), we'll focus on those beneficial riders that can give the buyer better coverage or, at least, greater flexibility.

Some riders might be offered for free by the insurer, but most are likely to be added to a life insurance policy only when the owner is willing to pay extra premium. The extra cost for each individual rider probably won't seem high, but costs can add up when viewed as an entire package. Just as they would with any aspect of an insurance product, consumers should weigh the cost of a rider's benefits against their needs. An experienced and honest life insurance producer can play an important advisory role during this process.

### *Guaranteed Purchase Option*

A rider allowing for a "guaranteed purchase option" gives the owner the opportunity to purchase additional life insurance at various points without needing to medically qualify for it. This rider typically can be exercised at specific intervals (such as every five years or every 10 years) or upon certain major life events (such as marriage or the birth of a child). The ability to exercise a guaranteed purchase option is usually restricted by age and is likely to disappear once the insured turns 65. (The exact cutoff for using the option will depend on the product and the insurer.)

The guaranteed purchase option is probably best suited for individuals who predict they will need more life insurance but are concerned about developing a major health problem before they have a chance to buy it. If, however, the buyer is interested in this rider simply because of the risk of being older and having to pay higher premiums because of age, the guaranteed purchase option won't alleviate the concern. When the guaranteed purchase option is exercised, any additional insurance purchased at that point will be priced on the basis of the insured's current age (known as "attained age") and not on how old the person was when originally applying for the policy (known as "issue age.") In other words, this rider prevents the insurer from charging the person more for new coverage because of health, but it doesn't stop the insurer from charging the person more for new coverage based on age.

### *Accelerated Death Benefits*

Life insurance that is designed to cover someone until they are very old typically has a cash value that can be used to borrow money against in case of an emergency. However, millions of life insurance customers have a product called "term insurance," which isn't meant for older people and doesn't have the flexibility of cash value. Furthermore, even among people with cash-value

life insurance, there are scenarios in which the amount of money available to borrow or withdraw is insufficient to meet the owner's pressing financial needs.

The desire to access a significant amount of money from a life insurance policy became particularly intense during the era of the AIDS crisis in the 1980s and 1990s. Many AIDS patients struggled to maintain their standard of living while paying for necessary medical care and often didn't have assets besides life insurance to help with those major costs.

Transactions called "viatical settlements" allowed terminally ill individuals to sell their in-force life insurance policies to investors in exchange for several thousands of dollars. In return for paying the insured significant amounts of money and agreeing to pay any remaining premiums, the investors were entitled to the death benefits when the ill person eventually passed away. Over time, viatical settlements evolved into "life settlements," in which the person selling his or her life insurance to an investor is a senior citizen rather than a terminally ill individual.

Viatical and life settlements allowed term life insurance customers to receive necessary dollars in connection with their policies and allowed those with cash-value life insurance to get significantly more from investors than they could receive from their insurance company. Although the life insurance industry generally frowned on these transactions, it eventually decided to adapt by offering "accelerated death benefits."

Someone with an accelerated death benefit rider has the opportunity to receive a portion of the policy's death benefit (not just the policy's cash value) when the insured is diagnosed with a terminal illness. In general, a terminal illness is defined as any illness that is likely to result in the person having less than two years to live. Similar riders are also available for cases in which money from the death benefit might be needed to fund long-term care services.

The recipient of accelerated death benefits can use the money to pay for whatever goods or services he or she deems necessary and doesn't need to spend it on medical care. When the insured dies, any portion of the death benefit that was not already provided as an accelerated death benefit will be passed along to the policy's beneficiary.

### *Double Indemnity*

A "double indemnity" rider is a popular add-on to life insurance policies that doubles the death benefit if the insured dies in an accident. The rider is often paired with "dismemberment" coverage, which pays a certain amount if the insured loses a limb or an eye but is still alive.

In order for the double indemnity rider to be exercised, the insured must die within a certain period (often 90 days) following the accident. Also, the death typically needs to occur before the insured reaches a certain age, such as 65.

The possibility of a doubled death benefit is very attractive to consumers, but that attraction tends to ignore statistics and the important concept of a needs analysis. Most deaths result from illnesses or natural causes, so the double indemnity rider usually doesn't pay off. Furthermore, consumers rarely consider the fact that the manner in which the insured dies is unlikely to have an impact on the beneficiary's needs. A family with one income, two children and a mortgaged house isn't likely to be in worse shape if the insured dies in a car accident instead of from a heart attack.

If a double indemnity clause is included in a life insurance policy at no cost, most insurance professionals won't object to it. But if it can only be added in exchange for a higher premium, the money used to purchase the rider might be better used by purchasing a higher overall death benefit. By spending the money in this fashion, the owner gains extra protection regardless of whether death is caused by an accident or by something completely different.

### *Cost of Living Adjustments*

The appropriateness of a death benefit can change as a result of inflation, deflation and other effects on the money supply. Rather than completing a new needs analysis every few years, some life insurance buyers might choose to address their concerns about inflation by purchasing a "cost-of-living adjustment" (COLA) rider. This type of rider can increase the death benefit in connection with an economic index (such as the Consumer Price Index) or can be formulated to add a specific percentage of coverage on a regular schedule.

### *Return of Premium*

A "return of premium" rider might be added to a term life insurance product if the owner believes the insured is likely to outlive the term of the policy. If the insured dies while the policy is in effect, the beneficiary receives the death benefit. If the insured is still alive when the policy expires, the beneficiary receives the sum of premiums paid by the owner to the insurance company.

This rider ensures that the owner doesn't lose much (if anything) if the policy never pays a death benefit, but it also can make term life insurance (generally considered the cheapest type of coverage) significantly more expensive.

## Types of Life Insurance

We've explored the basic need for life insurance, the most common policy provisions and some of the most popular riders to life insurance products. But there are still many specific types of life insurance that deserve to be explained here, all of which function in their own way and serve different purposes.

The next several pages will be devoted to a review of these various types of insurance products, beginning with a discussion of the differences between term life insurance and the many types of permanent life insurance.

## Term Life Insurance

"Term life insurance" is life insurance that is scheduled to remain in force for a set period of time and then expire. It is the least complicated form of life insurance and—if only kept for a relatively short period of time—the cheapest.

Term life insurance is a good fit for people whose need for coverage is temporary. It's also a potentially appropriate product for someone who may technically have a permanent need for coverage but is unwilling to pay higher premiums.

Common examples in which term life insurance might be a wise choice include:

- A spouse wants to provide death benefits for the other spouse in case death occurs prior to the survivor being eligible for Social Security.
- A parent wants to provide death benefits that will mainly be used to fund the cost of raising a child until the age of 18 or 21.
- An adult child wants to provide death benefits for aging parents in case the adult child dies before the parents.
- A homeowner wants to provide death benefits to a creditor in order to pay off the remaining balance of a mortgage loan or other debt.
- Business partners want to insure one another in case one of them dies but are unsure how long the partnership will last.

Term life insurance policies generally can cover people for anywhere from one to 30 years. During each specified term (number of years), both the death benefit and the premiums will usually

remain unchanged. Then, at the end of a term, the policyholder usually has the ability to renew the policy for another term regardless of the insured's health. However, coverage under the new term will usually be based on the insured's age at the time of renewal.

The ability to renew for another term (in exchange for a higher age-based premium) will often continue to be an option for the policyholder until the insured turns 65 or some other age established by the insurer. If the policyholder intends on keeping life insurance in force longer than that, permanent life insurance (and not term life insurance) might be the better choice.

Unlike the various types of permanent life insurance, term life insurance has no cash value. In practical terms, this means the policyholder is paying purely for the death benefit and not for the ability to utilize the policy in other ways. Since it lacks cash value, term life insurance can't be used as collateral for a loan from the insurer, can't be used to accumulate and withdraw interest, and can't be surrendered in exchange for a lump sum or series of payments from the insurance company. If the insured dies during the policy term, the beneficiary gets the face amount. If the insured dies after the policy term, or if the policy is cancelled, the beneficiary typically gets nothing.

Without cash value, term life insurance is generally less expensive and less complicated than permanent life insurance. This price differential is particularly likely when the policyholder does not intend to renew a term policy beyond middle age. Still, the consumer who saves money by purchasing term life insurance loses the flexibility that is provided by permanent life insurance. Producers owe it to their clients to make sure that this tradeoff is appropriate.

### *Conversion Options*

Even if consumers opt for term life insurance, they often have the option to convert their insurance policy to permanent coverage at a later date. This can be helpful for unhealthy policyholders because the conversion is not contingent on re-taking (and essentially passing) another medical exam.

Upon conversion from term to permanent life insurance, the difference in premium will depend on the product and the insurance company. While it is common for companies to base premiums for converted coverage on the insured's age at the point of conversion, some insurers will keep the premium the same unless the owner also wants to make changes to the death benefit. When the conversion doesn't change the policyholder's premiums, it is likely that the insurance company charged the owner in advance for the conversion option. When the conversion results in an increase in premium based on the insured's attained age, it is more likely that the conversion option was part of the policy all along and didn't force the owner to pay extra for it in advance.

### *Decreasing Term and Credit Life Insurance*

Most types of term life insurance are "level-term" products. A level-term life insurance policy has a death benefit that remains constant throughout the term of the contract. In rarer cases, though, consumers will purchase "decreasing term" insurance.

Decreasing term life insurance has a death benefit that shrinks over time. The death benefit might be designed to drop on a specific schedule, such as upon a certain date, or might be tied to a specific event. Even as the size of the death benefit goes down, the premium remains the same.

"Credit life insurance," which is purchased in case a borrower dies before paying off a loan, is arguably the most popular form of decreasing term insurance. This type of insurance is actually a form of group insurance that is often offered by banks and other financial institutions. There generally aren't many decisions for individual consumers to make in regard to how the product will work, and it is not commonly sold by insurance professionals unless they work directly for those financial institutions.

## Permanent/Whole Life Insurance

In contrast to term insurance, permanent life insurance is meant to insure someone for the rest of his or her life. There are many variations on permanent life insurance, a few of which will be covered in the next few sections.

Permanent life insurance is intended for individuals whose need for life insurance is unlikely to ever end. This kind of life insurance typically has premiums that don't change (unless the owner makes special arrangements with the insurer) and is capable of remaining in force until the insured reaches the age of 100 or more. In the event that the insured turns 100, 110 or some other advanced age, the policy's face amount will be paid to the owner. This payment to the owner is sometimes referred to as an "endowment" and releases the insurer from having to pay a death benefit when the insured eventually passes away.

Besides being capable of remaining in force until the insured reaches 100 or more, permanent life insurance differs from term life insurance in the following respects:

- In addition to paying for the death benefit, policyholders with permanent life insurance are also paying premiums that give their life insurance a "cash value."
- Policyholders with permanent life insurance can borrow money from the insurer in an amount close to their policy's cash value.
- Policyholders with permanent life insurance might be able to withdraw a portion of their cash value and still keep their insurance in force. (This is especially common if the owner has "universal life insurance" or "variable life insurance." We will explore these two types of permanent coverage later.)
- Policyholders with permanent life insurance might be entitled to interest that is credited to their cash value at certain points. (Note that this is different from the dividends received by policyholders at mutual insurance companies. A permanent life insurance policy purchased from a stock insurance company might not be credited with dividends but can still qualify for this other kind of interest.)
- Policyholders who cancel a permanent life insurance policy are entitled to "non-forfeiture benefits," which might include a refund of the policy's cash value or a temporary amount of free insurance.

Since life insurance death benefits are generally exempt from the probate process and can be structured to escape federal estate taxation, permanent life insurance is a common tool for relatively wealthy people who are concerned about estate planning. It's also a common financial vehicle for well-established businesses that are interested in creating long-term succession plans in case an owner dies. Some financial advisers even recommend it as a cushion for investors who keep most of their portfolio in the stock market and other riskier corners of the economy.

### *A Warning on Terminology*

It's important to note that some of the terminology used by the media and financial professionals to describe permanent life insurance can be confusing or inconsistent. For example, many people use the terms "permanent life insurance" and "whole life insurance" interchangeably. Others reserve the term "whole life insurance" for permanent life insurance policies that are essentially as plain as possible. Using the latter definition of "whole life insurance" can be beneficial in cases where the speaker or writer wants to emphasize the difference between a basic permanent life insurance policy and some of the more complex permanent life insurance products (such as universal life insurance and variable life insurance).

### *Arguments Over Permanent Life Insurance*

Despite the positive features of permanent life insurance, it is very common for insurance producers and other financial professionals to engage in fierce debates regarding whether permanent coverage is appropriate for the average person.

Proponents of permanent life insurance tend to point out that the need or desire to leave a death benefit to family members or charities doesn't always go away and that buying a permanent policy ensures that this need or desire can be fulfilled no matter how old or unhealthy the insured eventually becomes. They also often point to the flexibility involved with cash values and the ways in which the cash-value portion of a policy can essentially be used as an interest-bearing savings account for college tuition or some other expensive purchase.

On the other hand, many advisers favor a philosophy known as "buy term and invest the rest." These people believe that the price for permanent life insurance (particularly in the policy's early years) is too expensive for most buyers and that the growth of a policy's cash value is both too slow and too small to justify the cost. The "buy term and invest the rest" strategy recommends that consumers buy term life insurance for the death benefit and put the extra money that they would've spent on permanent life insurance into mutual funds or other interest-bearing opportunities.

The debates about permanent life insurance can get rather heated, particularly since the motives and expertise of people on each side of the argument are often called into question. Those who strongly stress the positives of permanent life insurance are often life insurance producers who claim they know more about these policies than other financial professionals and want to save their clients from the higher risks involved with stocks and mutual funds. Those who favor the "buy term and invest the rest" approach are often financial planners who question whether life insurance agents are recommending permanent coverage in exchange for large sales commissions.

Though the arguments over permanent vs. term insurance can be emotional, reasonable professionals should understand that no product is good or bad for everyone. Each type of insurance, including permanent life and term life, was created in response to a particular need. Since no two people's needs will be exactly the same, it is important to analyze each scenario carefully and admit that every product can be beneficial under the right circumstances.

### *Cash Value*

Permanent life insurance has a cash value, which can be used in a number of ways while the insured is still alive. It can be kept with the insurance company and credited with interest. It can be withdrawn in pieces in order to supplement someone's retirement income. It can even be withdrawn in a lump sum in order to pay for large expenses. When insurance professionals stress the savings component of permanent life insurance, they are referring to the likely growth of the policy's cash value.

Each payment of premium for permanent life insurance will be split into money meant to cover the cost of the death benefit (known as the "mortality cost"), money meant to cover the insurer's administrative expenses and money meant to be credited toward the policy's cash value.

In general, a policyholder who continues to pay premiums and makes no withdrawals from the cash value will watch the cash value increase over time. However, the degree of increases in the cash value will usually depend on how long the policy has been in force. Since the insurer incurs greater administrative expenses during the early years of a policy, a smaller percentage of the owner's premiums will be earmarked for cash value at that time. Similarly, since it is more expensive to insure older people than younger people, a larger percentage of premiums paid in

the later years of a permanent life insurance policy might be devoted to the mortality cost and not to the cash value.

Depending on the type of permanent life insurance being purchased, policyholders may have the ability to access their cash value in a lump sum or in smaller amounts. When they do, the insurance company might have the right to impose a surrender charge that reduces the amount available to the owner. This type of charge is also common in annuity contracts and is designed to prevent insurers from losing money that they would have ordinarily been allowed to invest. The surrender charge might only apply to withdrawals that are beyond a certain percentage of the cash value (such as 10 percent per year) and might only be enforced during the first several years after the policy is issued.

Regardless of any surrender charges, owners might need to wait a few months before their request for a withdrawal is honored. This common practice dates back to the days of the Great Depression and is meant to prevent the insurer from having to surrender a significant amount of assets unexpectedly during a period of economic panic.

This section on cash value is an appropriate place to re-emphasize the important role played by the policy's owner. The right to access or otherwise use the cash value belongs solely to the owner and not to the insured nor to the beneficiary. When a permanent life insurance policy is interrupted by a death, the beneficiary receives the death benefit. The beneficiary typically does not receive more money if the policy had a cash value and does not receive less money if the cash value is lower than the death benefit. Decisions about what to do with the cash value (including whether to use it to increase the death benefit) are made by the owner.

### *Policy Loans*

Policyholders with permanent life insurance have the option of using their cash value to get a loan from the insurer. Originally, loans to policyholders were offered at a fixed interest rate, generally around 8 percent. In order to protect their solvency, companies have since offered policy loans with variable interest rates that are dependent on an economic index.

Many borrowers find that loans from their insurance company are still cheaper than loans from a bank or other lender. And since the policy's death benefit can serve as collateral for the loan, policyholders wanting to use their cash value in this way might not be subjected to a credit check.

Loans from life insurance companies are relatively cost-effective and simple to obtain, but policyholders should be careful not to ignore their repayment obligations. Outstanding debts to the life insurance company will be subtracted from the death benefit. If the borrowed amount is relatively large and has been subject to a significant amount of interest, the beneficiary might not receive enough money to meet his or her needs.

### *Policy Illustrations*

"Policy illustrations" are charts or graphs that are meant to reflect premiums, cash values or other aspects of a life insurance product that can or will change. They are used to help applicants understand the differences between life insurance products and the ways in which those products might or might not meet people's needs.

Though they can certainly be used in sales presentations for term life insurance, policy illustrations are even more important to sales of permanent life insurance because the product itself is often more difficult to understand. The best illustrations supplement a life insurance agent's presentation and help producers set clear expectations regarding how much coverage will cost and how cash value will grow. The worst illustrations paint an overly optimistic picture of future costs and cash values and are often responsible for people buying unsuitable products.

In order to avoid dissatisfied customers and possible legal action, insurance professionals must use illustrations that make a clear distinction between the insurer's projections and its guarantees. Good life insurance professionals accept personal responsibility when they use illustrations and make sure that their verbal explanations reflect the content of these supplementary materials.

Instead of relying on consumers to notice any disclaimers on an illustration, agents should explain the information in the disclaimers as part of their conversation. Above all else, prospects should not be allowed to make a life insurance purchase unless they have been told what is guaranteed and what isn't.

### *Non-Forfeiture Options*

Many years ago, life insurers were under attack for poor market conduct. Among other things, companies were accused of tricking people into buying the wrong type of insurance. Even if the consumer had already paid a significant amount of premium for an inappropriate policy, a buyer who recognized the error and decided to cancel the coverage got nothing in return. The inclusion of "non-forfeiture options" was part of a larger effort to regain the trust of regulators and the public.

Non-forfeiture options allow policyholders to still utilize their insurance's cash value even if they decide to cancel their coverage. Since these options are tied to cash value, they are not available to people who only have term life insurance.

Upon cancelling a permanent life insurance policy, the owner typically can choose any of the following non-forfeiture options:

- Receive the cash value as a payment from the insurance company.
- Use the cash value to purchase "extended term insurance," which will provide temporary life insurance protection with the same death benefit as the cancelled policy. No future premium will be required.
- Use the cash value to purchase reduced "paid-up" permanent insurance, which will remain in force for the rest of the insured's life but with a lower death benefit than the cancelled policy. No future premium will be required.

If given a choice, most consumers are likely to opt for the cash value as a payment from the insurance company. Most insurers, on the other hand, prefer to hold onto the cash value as part of their portfolio and will make extended term insurance the default option.

## Variations on Permanent Life Insurance

The first wave of permanent life insurance products generally aligned with the features that have already been described in these materials. Over time, the insurance industry began catering to an audience that was either looking for more flexibility with regard to payment of premiums or willing to take more risks with their investments.

New types of permanent life insurance were introduced in the 1970s and 1980s, allowing for a wide range of options for applicants to choose from. Those options are too numerous to mention in detail here, but certain types (such as universal life insurance and variable life insurance) are too important and too popular for us to ignore.

### *Universal Life Insurance*

"Universal life insurance" is a type of permanent life insurance that is mainly intended to provide flexibility in regard to the required premium and the size of the death benefit. People with universal life insurance generally have the ability to adjust their premiums or their death benefit at various points in order to suit their needs. For example, a family undergoing some temporary financial stress might be able to reduce their premium in order to have more money for other important

expenses. Alternatively, an adult who purchased universal life insurance while single might decide to increase the death benefit upon starting a family.

These changes to a person's life insurance plan can be done in different ways even if the policyholder has something other than universal life insurance, but universal life makes these kinds of changes simpler.

*Transparency of Universal Life Insurance*

Buyers of universal life insurance gain a greater understanding of how their premium is actually spent. At least once each year, policyholders receive a statement from the insurer that shows how much of their payments have been applied to each of the following categories:

- Insurer's administrative expenses.
- Cost of the death benefit (also known as "mortality cost").
- Cash value.

This information can help consumers determine if they're paying a fair amount for the death benefit and can also help them make informed decisions about cash value. For example, an owner who is especially interested in growing a policy's cash value can decide to pay higher premiums. An owner who isn't as worried about cash value and is mainly concerned about the death benefit can decide to lower his or her premium to an amount closer to the policy's mortality cost.

*Limits on Universal Life Insurance*

Despite its flexibility, universal life insurance does have some limits that policyholders can't ignore. When an owner chooses to reduce the required premium without making proportionate reductions in the death benefit, the premiums that the owner chooses not to pay will come out of the policy's cash value. If the policy's cash value is insufficient to cover this amount, the beneficiary might receive a reduced death benefit. In some cases where cash value is too low, the policy can even lapse, and coverage will end.

There are also limits for policyholders who actually want to increase their premium. These increases are typically done in order to increase cash values and to allow more of the owner's money to earn tax-deferred interest.

The IRS is aware of this strategy and will only allow it to be used up to a certain threshold. If the owner increases premiums to an extremely high amount without also making similar increases to the policy's death benefit, the policy can lose its favorable tax status. In fact, when this occurs, the policy isn't even considered to be life insurance anymore. Instead, it will be deemed a "modified endowment contract."

The line between life insurance and modified endowment contracts can depend on complicated math and IRS rules. It is therefore the insurer's responsibility to enforce maximum limits on premium contributions. The average policyholder isn't expected to keep track of these limits on his or her own.

### *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 premium 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 rider for an added cost.

Since variable life insurance transfers risk to the policyholder, it is considered a securities product by state and federal regulators. As a securities product, it cannot be sold unless the applicant first receives a document called a "prospectus." The prospectus is intended to explain the non-guaranteed aspects of the policy and how the product has performed over short and long stretches of time. Variable life insurance products must also be approved for purchase by the federal Securities and Exchange Commission (SEC).

Life insurance producers who want to sell variable life insurance must also be licensed to sell securities. This includes not only the basic type of variable life insurance described here but also hybrid types of variable life products (such as variable universal life insurance). For more about licensing and regulation pertaining to securities, see the earlier section called "Life Insurance Agents."

## Life Insurance Options for Spouses

Special kinds of life insurance exist for married couples who want coverage for both spouses. Though not exactly cheap, these products are generally less expensive than separate policies for each spouse.

"Joint life insurance" pays a death benefit to the surviving spouse when the other spouse dies. It is generally used to help the surviving spouse deal with the financial impact of losing a life partner.

"Survivorship life insurance" only pays a death benefit after both spouses have died. It is generally used as an estate planning tool that can reduce the impact of federal estate taxes.

## Industrial Life and Burial Insurance

Decades ago, it was common to find insurance agents going door to door and selling "industrial life insurance." This type of insurance is essentially a small amount of life insurance that is intended to cover small funerals and burial expenses. Premiums for industrial life insurance would be collected on a weekly or monthly basis at the policyholder's home by salespersons known as "debit agents."

Industrial and similar types of very small life insurance policies tended to be marketed heavily in low-income communities because each premium installment was usually no more than a few dollars. But as the years went by, these types of products developed bad reputations among regulators and consumer advocates. While each premium payment may have seemed relatively

small, the total amount paid for these policies was widely considered to be deceptively high. Unethical salespeople worsened industrial life's reputation by encouraging people to purchase multiple policies instead of helping them obtain coverage under a single contract.

These days, industrial life insurance is rarely sold. Although similar types of insurance might still be available through the mail, most insurance professionals believe these products are only suitable for elderly or unhealthy applicants who can't obtain life insurance in any other way.

## Life Insurance for Children

Some insurance agents advise parents to purchase life insurance on their children. Reasons given for this type of purchase usually include the following rationales:

- Cash-value life insurance on a child can later be used to fund the child's college education.
- Buying life insurance on a child ensures that the child will have coverage as an adult even if he or she eventually develops a serious health condition.

A common life insurance product for children is a "jumping juvenile policy." This product has a relatively small face amount in the beginning but allows the death benefit to increase substantially when the child reaches adulthood.

Some life insurance professionals are skeptical of child-centered life insurance products. Most life insurance purchases are conducted in order to help dependents recover financially from someone's death. Since very few people are dependent on a child for money, it's not always easy to justify a policy on a son or daughter.

At the very least, parents who are considering life insurance on their children may want to first evaluate whether they have enough life insurance on themselves. After all, the financial impact of a parent's death is usually more detrimental to families than the financial impact of a child's death.

## Corporate Life Insurance

So far, most of our focus has been on the ways in which life insurance can help individuals and families. There are also cases in which life insurance can be beneficial for a business. Depending on the circumstances, a business might be wise to purchase life insurance on an employee or on an owner.

### *Key-Person and Corporate Split-Dollar Insurance*

A business can suffer major losses when an important employee passes away. Even if the deceased's position is later filled by someone else, the new person might need a significant amount of time to become as skilled and experienced as his or her predecessor. Waiting for the new person to catch up can cost the company a significant amount of money.

"Key-person life insurance" is meant for businesses that are worried about the financial impact of an important employee's death. The business is the owner of the key-person policy and usually lists itself as the beneficiary. Though the employee does not benefit from the policy, the insurance can't be issued without the employee's consent.

A corporate split-dollar life insurance policy has potential benefits from both the employee's and business's points of view. With this type of permanent life insurance product, the employee pays the portion of the premium intended to cover mortality costs. Meanwhile, the business contributes a portion of premiums to fund the policy's cash value. If the employee passes away, the company will receive a death benefit equal to the policy's cash value. Any remaining death benefit will go to a beneficiary designated by the employee.

### *Buy-and-Sell Plans*

"Buy-and-sell plans" aren't a type of life insurance, but they usually require a life insurance component in order to function properly. These plans are made among business partners and are an attempt to eliminate ownership problems when a partner dies.

Life insurance on each partner is often included in these plans as a way for surviving partners to purchase the deceased person's part of the business from the person's heir. Instead of needing to sell assets in order to purchase the deceased partner's share, the surviving partners can buy out the previous owner's heirs with money from the death benefit.

### Life Insurance Replacements and Exchanges

Replacing one insurance policy with another must be done with care. When done thoughtlessly, it can cause sick people to lose their coverage and put long-term tax benefits in jeopardy.

Still, the fact that someone already has life insurance doesn't mean there isn't a better, more suitable product out there. Policyholders should be encouraged to review their life insurance needs at least every few years to ensure that they have appropriate coverage.

In general, the IRS allows policyholders to replace one life insurance policy with another without having to pay taxes on the replaced policy's cash value. However, these swaps (known as "1035 exchanges") should only be done upon careful review of relevant tax rules and perhaps with the help of a qualified tax expert.

Even in cases where 1035 exchanges are done correctly, some insurers will impose a surrender charge on permanent life insurance policies. For example, a company might be allowed to keep 10 percent of a policy's cash value if a policy is cancelled within the first year of purchase. Since these charges are set by insurance companies and not by the government, they can vary from company to company or policy to policy. Documentation concerning these charges should be reviewed carefully prior to any exchange.

Practically every state has rules pertaining to life insurance replacement transactions. While these rules have the potential to differ across the country, they usually require that agents provide special disclosure forms and receive signed statements from policyholders.

### Life Insurance Tax Issues

In addition to providing potentially significant death benefits to survivors, life insurance is sometimes championed because of its positive tax features. Tax issues related to life insurance will be explained in the next few sections.

Be aware that the information provided here is meant solely as a summary of a much more complicated topic. For more specific details about life insurance and tax rules, you should conduct further research, preferably with help from a qualified tax professional.

### Income Taxes

Life insurance death benefits are generally tax-free to the beneficiary. One exception to this rule would be a case in which all or a portion of the death benefit is left with the insurance company and allowed to earn interest. When those death benefits are eventually paid out to the beneficiary, the beneficiary will owe income taxes on the interest.

Dividends received from life insurance companies are generally tax-free to the policyholder. This is because these types of dividends are actually considered a return of the owner's premium. Again, there is an exception if the dividends remain with the insurance company and are allowed to earn interest. When the dividends are received by the owner, income tax will be owed on the interest.

Cash values that are accessed by policyholders (in installments or a lump sum) are likely to require some payment of income taxes. The amount of tax owed will depend on the difference between the cash value and the amount of premium or dividends that the owner gave to the insurer. The difference between those numbers will be considered income and will be subject to federal income tax. However, cash value will grow on a tax-deferred basis until the owner receives it as payment from the insurance company.

### Estate Taxes

The federal estate tax can significantly reduce the amount of assets that can be passed along from the deceased to heirs or beneficiaries. This tax is generally due within nine months after someone dies, although it doesn't apply to all people or all kinds of property.

Life insurance policyholders who want death benefits to escape the estate tax must make sure that their policy is set up properly. Life insurance death benefits might be reduced by federal estate taxes if any of the following statements are true:

- The deceased owned the policy at the time of death.
- The deceased didn't own the policy at the time of death but transferred his or her ownership rights to someone else within the past three years.
- The deceased's estate is listed as the beneficiary. (Note that this can also subject the life insurance to the sometimes lengthy probate process even if the deceased's estate is exempt from the federal estate tax.)

Despite the effect of estate taxes and its link to life insurance, two important disclaimers should be made here.

First, the federal estate tax is primarily an issue for individuals who have a relatively large amount of assets. In 2022, the estates of people who died with assets less than $12.05 million were not taxed by the federal government. (Be aware that the dollar amount for exemptions from estate taxes tends to change from year to year.) So while estate taxes can be a major concern for many people, the issue is not likely to have a practical effect on the average life insurance applicant.

Finally, if estate taxes are a legitimate worry, the applicant or policyholder is likely to need more financial advice than a typical life insurance agent is qualified to offer. Insurance producers can play an important role in estate planning, but a concerned consumer is likely to also need the services of an experienced attorney or tax professional.

### Conclusion

By now, you should be able to comprehend the versatility of life insurance products. There are different kinds of life insurance for a wide range of scenarios. With the help of a trained and dedicated insurance professional, buyers are likely find a policy that grants them great peace of mind.

## CHAPTER 4: APPLYING AUTO AND PROPERTY/CASUALTY INSURANCE CONCEPTS

### Introduction

In the 1928 campaign for the U.S. presidency, one of the two major political parties assured the public that a vote for its candidate was a vote for "a chicken in every pot and a car in every garage." That pledge revealed just how quickly the automobile had become part of the American dream. Perhaps more so than any other group, people in the United States love their cars and often treat them as status symbols. In some social circles, the kind of vehicle you drive can seem as important as the kind of house you own or the kind of job you have.

Even for the less materialistic among us, car ownership is typically viewed as a necessity. Without our cars, we would find it impractical to live very far from stores, schools or hospitals. We wouldn't be able to juggle as many tasks within our busy day. We'd probably need to rely on our neighbors more often, and we wouldn't feel as independent as we'd like.

The benefits of having a car are so central to our culture that we often come to think of driving as a sacred, uncontestable right. Anyone who doubts the validity of that statement ought to try taking the car keys away from a newly licensed driver or from an elderly person whose sight and reflexes have deteriorated. It's not easy, and even when you succeed at it, the person who is suddenly not allowed to drive might resent you for the major inconvenience.

Still, it is important to remind ourselves from time to time that driving is a privilege and not an absolute entitlement. Drivers who cannot demonstrate an ability to safely operate a vehicle are prohibited from getting behind the wheel, and even safe drivers usually cannot take to the road legally without being covered by insurance.

Given our society's love affair with cars, it's easy to understand why auto insurance is the most popular kind of property and casualty insurance, accounting for approximately one-third of all P & C premiums, according to the Insurance Information Institute.

New policies aren't just being bought by the constant stream of freshly minted drivers. According to a leading insurance brokerage firm, roughly 20 percent of all drivers look into buying different auto insurance each year.

These days, drivers are turning more and more to the internet to fulfill their insurance needs. In fact, surveys show the number of auto insurance purchases conducted online has surpassed the number of purchases conducted by phone. Yet this recent shift in delivery methods shouldn't lead you to think it's no longer important for an insurance producer to be knowledgeable about auto-related issues.

Most people who shop for auto insurance online without assistance from a licensed professional tend to shop on price alone. They want the minimum required amount of coverage at the lowest possible price, and they can't be bothered with investigating the potentially important provisions and exclusions found in a coverage form. They'll focus on the size of a quoted premium but won't, for example, think to consider how a policy might cover them in a hit-and-run accident or in a situation in which their spouse has damaged a rental car.

That's where you—an assertive, professional and informed insurance licensee—can be helpful. After reading this chapter, you should have basic knowledge of how to ensure that a driver is well protected against liability and property damage. You should also have a solid understanding of how applicants might obtain that valuable protection at a fair price. And even if you decide not to sell auto insurance, you might become a better shopper for your own coverage.

**The Need for Auto Insurance**

The cost and frequency of auto accidents have led most states to pass mandatory auto insurance requirements that impact anyone who owns a vehicle. But the truth is, it would still be wise for drivers to purchase auto insurance even if the government didn't force them to do it.

At some point, every driver, regardless of skill or fault, will be involved in an auto accident. According to the American Automobile Association, a driver is almost involved in an auto accident every few months and, on average, is actually involved in one every six years. Out of those accidents, according to figures from the Insurance Research Council, roughly one-quarter of them result in bodily injury for which another driver is liable. The National Research Council reported that auto accidents caused more than 4 million injuries and 42,000 deaths in 2020.

Mandatory or not, auto insurance can help people recover financially from accidents. And perhaps just as importantly, it can provide financial assistance to victims who are physically harmed by a driver's mistakes.

### Personal Auto Policies

The most common auto insurance policy is the Personal Auto Policy, which was crafted by the Insurance Services Office in the 1970s and has been revised on several occasions. The policy was designed for private passenger vehicles (as opposed to business vehicles) and generally provides four kinds of coverage:

- Liability coverage.
- Medical payments coverage.
- Uninsured motorists coverage.
- Coverage for the policyholder's own car.

Although each auto insurance policy has the potential to be different from all the others, mastering the contents of the Personal Auto Policy will help you answer common questions from motorists and make it easier for you to assess people's insurance needs.

### Liability Coverage

When an auto accident occurs, an insurance company or a court will use common legal standards and state laws to determine who was at fault. When drivers are found to be at fault for an accident, damages are meant to be covered by their liability insurance.

Auto liability insurance covers motorists when they cause another person to suffer bodily injury or property damage. The term "bodily injury" can mean any harm to a person's body, including harm that involves an illness or causes death. "Property damage" usually involves harm to a person's vehicle, but it can also mean harm to other property, such as a house, a tree or items stored in a car.

The liability portion of an auto insurance policy does not compensate at-fault drivers for their own losses. Rather, it only provides money to other people who are harmed by a liable person's driving activities. Coverage for an at-fault driver's own losses is provided in other parts of the policy.

Auto liability insurance compensates victims for the actual size of their economic losses and can also provide money for their pain and suffering. Liability insurance for property damage is often less expensive than liability insurance for bodily injuries, possibly because awards for pain and suffering are less likely when an accident does not result in someone being physically harmed.

Auto liability insurance will also compensate drivers or pedestrians when they are faced with extra costs or losses of income that are thought to be the insured's fault. For example, the liable driver's insurer will pay for an accident victim's rental car while the victim's regular vehicle is being repaired. Or if the victim is unable to work because of an accident, the at-fault driver's liability insurance should cover the victim's lost wages.

The maximum amount of money an insurance company will pay on account of liability is listed on the policy's declarations page. The limit might be listed as a single dollar amount or as three separate dollar amounts. When the limit is listed in three amounts, the policy is considered to have a "split limit."

A policy with a split limit gives the insured different amounts of liability coverage, with each amount depending on the kind of loss and the number of people who experience that loss. The three different kinds of limits are as follows:

- A limit for all bodily injuries sustained by one person.
- A limit for all bodily injuries sustained in a single accident, regardless of the number of people.
- A limit for all property damage that occurs in a single accident, regardless of the number of people.

To demonstrate how split-limit policies work, let's imagine that Joe has auto liability insurance with a $15,000 per-person limit for bodily injury and a $30,000 per-accident limit for bodily injury. Now suppose Joe causes an accident that results in $30,000 of medical expenses for the other driver. Even though Joe's per-accident limit is $30,000, the fact that his per-person limit is $15,000 means his insurance will cover only half of the victim's expenses in this case. The rest will have to be paid out of Joe's own pocket.

Split-limit policies exist because many states do not make drivers purchase equal amounts of bodily injury liability coverage and property damage liability coverage. Therefore, split-limit policies allow drivers to use their cars without having to purchase coverage that isn't legally necessary.

Still, whether it's accomplished through a split-limit policy or not, drivers might be interested in purchasing more liability insurance than is mandated by law. Since medical expenses and awards for pain and suffering can be so unpredictable, consumer advocates often suggest that driver's purchase liability insurance in an amount equal to the value of their personal assets. Drivers who don't own much but still want to be in a position to fully compensate accident victims will also want to buy extra protection.

Consumers can often opt out of purchasing many major kinds of coverage that are contained in an auto insurance policy, but liability insurance is generally the exception. In most states, people are not allowed to own a vehicle unless they have an acceptable amount of liability protection.

### *Who's Covered and in Which Cars?*

One of the most important things to realize about auto liability insurance is that it doesn't just cover the driver who purchases it. With a few exceptions, the liability protection can apply to accidents caused by the policy's owner or any family members who live with that person. In most auto policies, the term "family member" refers to people who are related to the policy's owner by blood, marriage or adoption. In practice, the term even encompasses unlicensed family members who are too young to drive. People besides family members are covered, too, if they are driving the person's car with permission.

Drivers should also understand that their auto liability insurance extends to cars other than their own. If they borrow a friend's car, their own liability insurance can help pay for damages they cause while driving it. However, coverage beyond their own car generally does not extend to cases in which they are driving a vehicle that is readily available to them on a regular basis, such as a company car.

Liability protection for non-family members (as well as family members who do not live with the policyholder) does not apply if they are driving a vehicle that does not belong to the policyholder. Insurance also rarely offers any help to family members who live with the policyholder but get into accidents in their own cars.

Determining who can be covered under the liability section of an auto insurance policy can be a challenge. Therefore, it may be helpful to go over a few examples. If you have a personal auto policy, here are some hypothetical cases in which your liability insurance is likely to provide at least some financial assistance:

- You hit another vehicle while driving your car.
- Your spouse hits a pedestrian while driving your car.
- Your sister, who lives with you, borrows your car while hers is being repaired and crashes into your neighbor's fence.
- You accidentally hit another person's dog while driving a rental car.
- Your friend borrows your car and injures a bicyclist.

On the other hand, here are some examples in which your auto liability insurance probably wouldn't be of much help:

- You injure someone while driving a company car that is frequently available to you.
- Your son, who doesn't live with you, purchases his own car and causes an accident with it.
- A thief steals your car and hits a pedestrian while making his getaway.
- Your roommate rents a car and crashes into your neighbor's tree.

Please note that although auto insurance policies can cover a driver's family members, policyholders may have to inform the insurance company ahead of time about any licensed driver who will have regular access to their car. Parents, in particular, will want to check in with their auto insurer before giving their children the keys to the family car. At the very least, the policyholder may be required to update the insurer about the number of licensed drivers in a household before the policy is renewed.

### *Liability Deductibles*

When their auto liability insurer provides benefits to an accident victim, at-fault drivers typically do not pay a deductible. This is inconsistent with other types of auto coverage, such as coverage for an at-fault driver's own vehicle.

### *Defense Costs*

If drivers get into an auto accident and are sued for damages, their insurance company can pay to defend them. Defense costs have no effect on a policy's dollar limit for liability, but there are a few restrictions to be aware of. Most importantly, the insurance company will stop paying for a driver's defense if it has already provided compensation to victims in an amount equal to the policy's benefit limit.

As an example, let's suppose Jill has liability insurance that will pay up to $30,000 for property damage. Jill hits someone's $30,000 car, and her insurer pays for the loss. However, the other driver also claims Jill is responsible for $5,000 in damage to antiques that were stored in the trunk. Jill disputes this and ends up having to defend herself in court. But since the insurer already compensated the other driver in an amount equal to Jill's limit for property damage liability ($30,000), it will not pay her defense costs.

For defense costs to be covered by the auto insurance company, the legal dispute must relate to a loss that could reasonably be covered under the insurance policy. For instance, legal bills are likely to be covered if drivers accidentally hit another car with their vehicle. But because liability insurance does not protect them when they cause intentional damage, drivers probably would not

get help with defense costs after purposely ramming into a spouse's vehicle during a bitter divorce.

In exchange for paying their legal expenses, auto insurance companies expect defendants to help them in matters related to their case. At the very least, potentially liable drivers must send the insurer copies of any legal documents involving a demand for money. They may also be required to attend and make statements at legal proceedings.

If drivers incur expenses as a result of assisting the insurer, the company will reimburse them. Coverage of these expenses, such as the cost of travel or lodging, will have no impact on dollar limits for property damage or bodily injury.

Similarly, drivers can receive up to a few hundred dollars per day if their involvement in the defense process forces them to miss work. Like coverage of extra expenses, this benefit does not affect the overall dollar limits for property damage or bodily injury.

Since the insurer is the one paying the defense costs, it has the power to settle a legal dispute without the insured's permission. If a matter reaches a judge who rules against the insured, the insurance company is also responsible for paying any court-awarded interest that is applied to the victim's losses.

Finally, liability insurance will provide a certain amount of money (often $250) for a bail bond. This provision has no effect on dollar limits for property damage or bodily injury, but it does nothing for a driver if an accident has not occurred. For instance, if a driver runs a red light without hurting anyone and is arrested for arguing with a police officer, money for bail will have to come from another source.

### *Pain and Suffering*

We've already noted that monetary rewards for pain, suffering and other non-economic damages make having adequate liability insurance extremely important. If a driver were to have an accident that causes another person to lose a leg, the driver's financial responsibilities in regard to that person would almost certainly be greater than just the cost of pain medication and a prosthesis. The driver would probably have to pay reparations to the victim for permanently altering his or her quality of life.

Depending on where you live, though, there might be laws in place that prevent some accident victims from seeking payments for pain and suffering. These laws have been put in place to discourage motorists from breaking other laws. For instance, some states do not let a driver sue for non-economic damages if the person does not carry mandatory amounts of auto insurance. Other places forbid people from collecting this kind of compensation if they are hurt while intoxicated or while engaging in illegal activity.

To learn more about restrictions on pain and suffering in your area, you should speak with a local attorney.

## Medical Payments Coverage

Medical payments coverage is probably one of the least understood parts of a personal auto insurance policy. In fact, many motorists may not even know they have it.

If you have medical payments coverage, this insurance can be utilized when you, a family member or anyone else who is riding in or driving your car is injured in an accident. Regardless of who is at fault, this coverage is not for the other driver in an accident or for that driver's passengers. Medical payments for the other driver and people riding with that person are meant to be covered by either your liability insurance or the other driver's medical payments coverage.

Medical payments coverage provides a few thousand dollars or more on a per-person, per-accident basis. The money can be used to pay for all reasonable medical or funeral expenses that are related to an auto accident and are incurred within three years of the accident. It does not compensate anyone for pain and suffering.

This traditional form of medical payments coverage usually does not exist in states governed by no-fault insurance laws. Instead, policies in those states are likely to provide "personal injury protection" (PIP). PIP is very similar to medical payments coverage but can usually reimburse people for expenses besides medical ones. With PIP, injured motorists might be covered for non-medical household assistance while recovering from an accident, and they might receive payments for lost wages.

### *Who's Covered Where?*

As is the case with auto liability insurance, eligibility for medical payments coverage under an auto insurance policy will depend on who the injured person is and where the injury occurs.

Coverage is broadest for the policyholder and the family members who live with that person. With a few exceptions, these people can receive medical payments whenever they are hurt by a vehicle. This includes instances in which they are driving a car, riding as a passenger in a car, sitting in a parked car or hit by a car while traveling on foot.

People besides those family members can receive medical payments through the policyholder's insurance policy if they are injured while in that person's vehicle. This includes when they are driving it, riding in it or just sitting in it. They are not covered by the policyholder's insurance while in someone else's car or on foot.

This part of the policy provides some broad protection, but it does contain some notable exclusions. If you have medical payments coverage, here are a few things to keep in mind:

- There's no coverage if you're hit by a vehicle while riding something with less than four wheels on it. In effect, this means you might need separate insurance for bicycle accidents.
- There's no coverage if you're injured in your car while transporting goods or passengers for money. In these cases, you'd probably need a commercial auto policy.
- There's no coverage if you're injured while using your vehicle as a residence. In all likelihood, you'd need other insurance if you've parked your recreational vehicle and injured yourself while preparing a meal in it.
- There might not be coverage if you're injured while using your vehicle for business.
- There's no coverage if you're hit by a vehicle that isn't meant to be driven on public roads. Injuries caused by a snowmobile or golf cart, for example, are matters for your health insurer to deal with.
- There might be no coverage if you're hit by your own car. In other words, if your spouse runs over your foot in the driveway, don't count on your auto insurer to pay your bills.

### *The Pros and Cons of Medical Payments Coverage*

Some states make insurers offer medical payments coverage to all their customers, but not every state makes drivers buy it. To help drivers determine if medical payments coverage should be dropped in order to lower premiums, you'll have to know its various pluses and minuses.

Some of the positive aspects of medical payments coverage are listed below:

- Medical payments coverage is no-fault insurance. This means people are eligible for payments from their own insurer regardless of who caused the accident. Unless medical expenses are greater than the benefit limit of the injured person's own policy, there's no

need to deal with another driver's insurance company or instigate a messy lawsuit. If the injured person is not at fault for the accident, that person will receive payment from his or her own insurance company. Then the injured person's insurer will work with the at-fault driver's insurer to get its money back.

- Medical payments coverage can pay for things that your health insurance won't, such as funeral expenses.
- Medical payments coverage is available for drivers who can't afford or qualify for regular health insurance.

In spite of those attractive features, there are a few reasons why a driver might opt against paying for this insurance:

- Unlike health insurance, medical payments coverage only pays for treatment related to auto accidents.
- Most people already have health insurance that would cover injuries from an auto accident.

**Uninsured Motorists Coverage**

Whether we like it or not, there will always be people who believe the law does not apply to them and who will drive without liability insurance.

So what can people do if an uninsured driver hits them? They could, of course, sue the person. But that would probably involve finding a lawyer and rearranging their lives around court dates and other hassles. And even if they take legal action, victims might discover that the at-fault driver lacks enough personal assets to pay for damages in the first place.

A portion of an auto policy known as "uninsured motorists coverage" can help in situations like this one. It makes up for the liability coverage the other driver failed to purchase and can compensate victims for bodily injuries, pain, suffering, and (in some cases) property damage. It doesn't let the at-fault driver off the hook, but it gives injured people the money they need with a minimal amount of effort and frees their insurer to take action against the negligent motorist.

Auto insurers provide these benefits if any of the following circumstances arise:

- The policyholder is hit by someone who has no insurance.
- The policyholder is hit by someone who has less insurance than the law requires.
- The policyholder is the victim of a hit-and-run accident.
- The policyholder is hit by someone whose insurer becomes insolvent.

Uninsured motorists coverage is limited to a certain amount per person, per accident. By default, the benefit limit might be equal to the minimum amount of liability coverage that the other driver was required to buy. But drivers often have the option of raising the limit if they're willing to pay more in premiums. Some states require that insurers provide uninsured motorists coverage equal to a victim's own liability coverage.

Overall, the kinds of people and the situations that would be covered under the medical payments portion of an auto policy would also be protected by uninsured motorists coverage. If the policyholder or that person's family members are hurt by an uninsured vehicle while in any car or while on foot, they'll probably receive some insurance money. Non-family members (and family members who don't live with the policyholder) are also eligible for these benefits if they are hit while in the policyholder's car.

Policy exclusions for uninsured motorists coverage are nearly identical to those for medical payments coverage. For instance, drivers won't be helped if they're hit while carrying goods or

people for money, and they aren't covered for accidents caused by snowmobiles, golf carts and similar vehicles. The main difference, though, is that uninsured motorists coverage is not no-fault insurance. In order to receive payments, the insured must convince the insurance company that damages were caused by someone else.

Uninsured motorists coverage is mandatory in about half of the country, and most states at least force insurers to offer it. Historically, those mandates have been restricted to bodily injury coverage, but coverage for property damage has become more popular over the last few decades.

Some consumers decline uninsured motorists coverage because they doubt they will be injured by an uninsured driver. Others opt for the injury protection but ignore the property protection because their car's value doesn't justify the expense. You'll learn much more about covering a driver's own car in later portions of this course.

## Underinsured Motorists Coverage

A somewhat similar policy feature known as "underinsured motorists coverage" can help when an at-fault driver has the required minimum amount of liability coverage but still lacks enough to fully compensate a victim. When this coverage is purchased, the victim may be entitled to at least some of the difference between his or her losses and the other driver's liability limit.

For example, let's assume George has $100,000 of underinsured motorists coverage and gets into an accident that costs him $70,000 in medical services. The at-fault driver has complied with the law by purchasing $30,000 of liability insurance for bodily injuries, but this person obviously does not have enough to pay for all of George's medical bills. In this case, the other driver would pay his full $30,000 to George, and George's underinsured motorists coverage might handle some of the additional $40,000 (the difference between George's loss and the other driver's liability limit).

Although our example might make underinsured motorists coverage seem very simple, some important conditions must be met for the insurance to work. Most significantly, the victim's limit for underinsured motorists coverage usually must be greater than the at-fault driver's liability limit. If the victim has $100,000 in underinsured motorists coverage and the at-fault driver has $100,000 in liability coverage, this part of the victim's policy is likely to be irrelevant. Also, depending on the policy, underinsured motorists coverage might need to be equal to uninsured motorists coverage.

In most states, underinsured motorists coverage must be offered to all policyholders. However, in nearly every part of the country, drivers have the right to reject it. A few states only require that underinsured motorist coverage be included if the policyholder has also purchased a certain amount of uninsured motorist coverage.

### *Unsatisfied Judgment Funds*

Though not mentioned in auto insurance policies, unsatisfied judgment funds might be a last resort for accident victims who are hurt by uninsured drivers. Where available, these state-created funds provide compensation to injured people. They may be funded in a number of ways, including through the sale of license plates or through assessment fees from insurers. When a victim receives money from one of these funds, the at-fault driver may be barred from operating a vehicle until the money is paid back.

## Coverage for Your Own Car

In addition to providing important liability protection, auto insurance policies can cover damage to a driver's own car. Like the medical payments coverage mentioned earlier, this insurance can reimburse drivers regardless of who is responsible for an accident. If the policyholder files a property insurance claim for damage to his or her vehicle and the other driver was at fault, the

policyholder's insurer can pay the claim and take actions against the other driver to get its money back.

Property insurance for a driver's own car comes in two varieties. "Collision coverage" pays for damage from crashes. "Comprehensive" (or "other-than-collision") coverage protects the policyholder financially from many other perils, including theft and fire.

These two kinds of protection can be purchased individually or together. When both are in effect, a car is generally insured against most risks other than some tire damage, war-related losses, wear and tear and freezing.

Unlike other portions of the typical auto policy, insurance for a driver's car usually calls for a deductible, which must be paid by the policyholder whenever an accident occurs. If multiple cars are involved in the same accident and are covered by the same policy, the deductible only needs to be paid once. If the insurance company takes action against the other driver and wins, the deductible will usually be refunded to the policyholder.

Unlike liability insurance, property insurance on a driver's own car is usually optional. In fact, many of the low auto rates advertised online and on television are quoted under the assumption that the customer will not insure his or her own vehicle against theft or property damage.

Opting against property insurance for their own car does not prevent drivers from collecting from an at-fault driver's policy. However, it does bar them from receiving compensation for property damage if their car is damaged through no fault of another person. For instance, they would not be covered for repairs if they rear-end another car while following it too closely, and they probably wouldn't be compensated for their losses after skidding into a ditch or hitting a deer.

Drivers who don't insure their own cars against property damage aren't necessarily ignoring the probability of getting into an accident. In many cases, they might just already be aware that their car is constantly depreciating in value and that the cost of insuring their vehicle (plus the size of their deductible) exceeds whatever benefits they are likely to receive from their insurance company. Old cars, in particular, are often not insured for property damage unless the owner is fearful of even a relatively small loss.

### *Collision Coverage*

As you can probably tell from its name, "collision coverage" is for damage that is sustained when a car collides with another object. Of course, the most obvious kind of object in this case would be another vehicle, but other kinds of crashes are covered, too. For instance, this insurance is likely to come into play when a driver hits a tree or crashes into a telephone pole.

We tend to think of car crashes in terms of two or more vehicles being in motion at the same time, but collision coverage can still apply while a vehicle is stationary. If someone opens a car door in traffic and has it knocked off by another vehicle, a collision has taken place. The same is true when someone hits a parked car.

Practically the only thing a driver can hit and not have the situation count as a collision is an animal. Collisions with deer and other living things are addressed through comprehensive coverage.

### *Comprehensive/Other-Than-Collision Coverage*

"Comprehensive coverage" (now often referred to as "other-than-collision coverage") tends to be cheaper than collision insurance and protects the driver against more perils. Generally speaking, comprehensive insurance is designed to cover the driver against most major risks other than

collisions. Drivers who purchase this insurance are typically insured against at least the following causes of loss and often more:

- Theft (including property damage caused by thieves).
- Fire.
- Falling objects.
- Missiles.
- Explosions.
- Earthquakes.
- Wind.
- Hail.
- Floods.
- Vandalism or malicious mischief.
- Riots or civil commotions.
- Collisions with animals and birds.
- Broken glass.

Depending on the circumstances, broken glass can actually be covered by either comprehensive insurance or collision insurance. Broken glass that occurs because of a collision can be covered by collision insurance at the policyholder's option. This might be done in situations where a person has separate deductibles for collision coverage and comprehensive coverage and does not want to pay both of them on account of a single accident.

### *Actual Cash Value*

If something destroys a car, the owner's insurance company is nearly guaranteed to not cover the cost of a brand-new replacement vehicle. Instead, the car is probably covered up to its "actual cash value."

An item's actual cash value is its replacement cost minus depreciation. Since cars depreciate as soon as they're purchased, a vehicle's actual cash value might be significantly smaller than the owner realizes.

When a car is damaged, the owner's insurance company is expected to pay the cost to repair the vehicle, the cost to replace the vehicle or the vehicle's actual cash value. If these amounts are not equal (and they rarely are), the owner will receive the lowest of the three amounts.

Due to the rapid rate of depreciation, the cost of repairing a vehicle might be higher than the car's actual cash value. When this happens, the car is considered to be a total loss ("totaled") even if it is technically still in drivable condition. Instead of repairing it, the insurer will pay the owner the actual cash value.

If a vehicle is totaled, the insurer might reserve the right to take possession of it and sell it to a salvage yard or a similar business. The owner might have the opportunity to keep the vehicle for sentimental reasons, but the insurer might be able to deduct whatever amount it would have gotten from the salvage company from the settlement check.

Though relatively rare, some policies will cover an automobile at its replacement cost rather than its actual cash value. Special riders are also available for owners of restored classic cars.

### *Auto Accessories*

Modern automobiles have more nifty gadgets in them than ever before. A music lover might have a custom-made stereo system in his car. A mother might have a television in the backseat to entertain her children. A father might have a GPS system installed to help him find the location of his daughter's volleyball game. Some of these conveniences aren't cheap, so you might be surprised to learn that they tend to receive little protection under most auto insurance policies.

As a general rule, accessories like the ones mentioned above might be covered by a personal auto policy only if they are permanently installed in the vehicle. Whereas a radio that was put inside the car at the automotive factory will probably be covered if it is stolen, the same cannot be said for a personal MP3 player that is hooked up to the car via an adapter. Even covered items might be limited to a certain amount of coverage.

Items meant to be played on audiovisual equipment, such as cassettes, compact discs and DVDs, are specifically excluded from coverage in most policies. Limited coverage for these items might be found in a homeowners insurance policy. Alternatively, it may be possible for a driver to add them to an auto policy at an additional cost.

### *Creditors and Gap Insurance*

Up to now, we've been exploring auto insurance as if the policyholder were the outright owner of a vehicle. If a policyholder doesn't exactly own his or her car and purchased it with borrowed money, there are some additional coverage issues to consider.

In order to protect their interest in your car, lenders can list themselves on an auto insurance policy along with the driver. When this is done, their names can also appear on any checks the driver receives from the insurance company.

We noted earlier that property damage for a driver's own car is optional. Yet there is an exception when a vehicle is purchased with a lender's financial assistance. Until their auto loans are repaid in full, borrowers are required to maintain full coverage on their vehicles, including collision coverage and comprehensive coverage. Deductibles for property damage can be chosen by the lender.

When a vehicle is totaled and a driver is left without transportation, a lender will not forgive the debt out of sympathy. The driver remains responsible for the loan balance even if the vehicle's actual cash value (received as compensation from the insurance company) is less than the remainder of the loan.

To guard against this undesirable situation, a driver can purchase "gap insurance," which covers the difference between the remaining loan balance and the totaled vehicle's actual cash value. If a car is leased, the driver is probably already paying for this insurance in the form of a built-in fee.

## Kinds of Covered Autos

The auto market is loaded with many varieties of vehicles. A driver might own a station wagon for personal use, a truck for business use and a sport-utility vehicle for both. One way or another, all of those vehicles need to be insured.

Let's spend a few pages going over how insurers typically address these assorted vehicles, with a special emphasis on the distinction between personal vehicles and business vehicles.

### Personal Autos

The standard auto insurance policy can be used to cover just about any kind of car that a person owns and reserves for personal use. For insurance purposes, a leased vehicle can be insured as if it were the driver's own car if it is being leased for at least six months.

Though there are many situations in which an insurer will pay for damages associated with a car that doesn't belong to the policyholder, a personal auto policy probably doesn't cover that kind of vehicle as comprehensively as it covers the person's "covered auto." In personal auto insurance policies, all of the following vehicles tend to qualify as a "covered auto":

- The vehicle listed on the policy's declarations page. (This is probably the vehicle that prompted the policyholder to purchase a policy in the first place.)
- Any other vehicle the policyholder obtains during the policy period. (This allows someone to buy a second car without having to tell the insurer ahead of time. Details can be found in the next section.)
- A vehicle the policyholder uses on a temporary basis while the person's regular car is not available.
- A trailer meant to be pulled by an automobile. (Trailers are covered automatically in regard to liability, but damage to them is not. To ensure that property damage to trailers is a covered loss, ownership must be declared prior to an accident.)

Vans and trucks can be covered by a personal auto policy as long as they weigh less than 10,000 pounds and are not used as delivery vehicles. When these larger autos do not meet those criteria, they may be covered by a commercial policy.

Unless a driver pays an additional premium for the proper endorsement, vehicles with fewer than four wheels, such as motorcycles, will have to be insured by something other than a personal auto policy. That said, the policyholder remains covered for liability while operating one of these vehicles in an emergency.

### Coverage for New Vehicles

If a driver already has a personal auto policy, most new vehicles that the person buys during the policy period will be covered automatically on temporary basis. This ensures that currently insured drivers can buy new cars and drive them out of a dealer's lot without being in violation of the law.

### Replacement Vehicles

When drivers replace a car that was covered by their auto insurance policy, their new vehicle automatically receives the same amount of liability coverage as their old one. Their new car is usually covered by liability insurance for 14 days even if they don't tell the insurer about their purchase.

Drivers will be covered for physical damage to their replacement vehicle automatically for a limited time if their old car was also covered for the same kind of damage. In other words, if the old car was insured against collision losses, the new vehicle will be covered for those losses, too. This temporary coverage tends to last anywhere from a few weeks to a month depending on the policy. In order for physical damage to be covered for a longer period, the owner must contact the insurance company.

If the driver's previous car was not covered for physical damage, physical damage to the replacement vehicle will probably be covered for no more than a few days. Damage that occurs during that brief period might only be covered if the policyholder satisfies a deductible. If owners want coverage to extend beyond that short time, they must make arrangements with the insurance company.

### Additional Vehicles

When people buy a new car without replacing another one, their liability limit for the car will automatically be equal to the highest liability limit among their other cars. For example, if Ellen

already owns one vehicle covered by $100,000 of liability insurance and another car with $50,000 of liability insurance on it, her third car will temporarily be covered by $100,000 of liability insurance. In order to maintain this liability insurance on the additional vehicle, Ellen must contact the insurer within a set number of days (often 14 or 30).

Physical damage to an additional car is basically treated in the same way as physical damage to a replacement car. If any of a driver's other cars are covered for physical damage, an additional vehicle will be covered, too, if an accident occurs soon after the purchase. This insurance probably won't continue beyond a few weeks unless the owner specifically requests it.

If none of a driver's other cars are covered for physical damage, physical damage to an additional vehicle will probably be covered for no more than a few days. Damage that occurs during that brief period will only be covered if the policyholder satisfies a deductible. If owners want coverage to extend beyond that short time, they must make arrangements with the insurance company.

**Driving Other People's Cars**

As you already know, drivers remain insured while driving other people's cars with their permission. If a driver is involved in an accident while operating someone else's vehicle, the owner's insurance will usually pay for damages first. The driver's insurance will pick up whatever losses are above the owner's policy limits.

If drivers are involved in an accident while driving a vehicle that is not theirs but is regularly available to them (such as a company car), their auto insurer will probably not cover the losses. However, they still remain insured while driving a vehicle that is regularly available and owned by a household family member. So if spouses have separate auto insurance policies, they can borrow each other's cars without having to worry about being covered.

**Rental Cars**

Many travelers are unsure about whether they should purchase insurance from rental car companies. The decision to buy or not to buy the coverage is often made at the last minute, with some people choosing to leave themselves unprotected from major risks and others paying relatively large sums of money for something they don't really need.

Whether coverage is purchased or not, drivers should definitely consider the risks involved with rented vehicles. If someone has an accident with one of its cars, the rental company might be able to hold the person liable for all the damages regardless of who was at fault. Along with having to pay for another person's injuries and damage to any vehicles involved, the renter can even be held accountable for loss-of-use costs if the accident leaves the rental company without enough cars to meet customer demand. (It should be noted, however, that some states have passed laws that limit a person's liability while operating rented vehicles.)

Many of these risks can be managed by purchasing a "collision-damage waiver" (also known as a "loss-damage waiver") from the rental company. But such waivers might not always be helpful. For example, some waivers still leave renters liable for damages if they let a companion take the wheel or if they drive the rental car through rough road conditions. The waivers are also relatively expensive. If drivers buy all the insurance presented to them by the rental company, they might end up paying more for coverage than for use of the vehicle.

Before purchasing a waiver, drivers might want to see if the risks of renting a car are covered by other insurance. If they have a personal auto policy, they are usually already covered for liability while operating a rental car. Most kinds of damage to the car will be covered, too, if renters have collision coverage and comprehensive coverage for their own vehicles. Bodily injuries that drivers suffer in an accident will fall under their auto policy's medical payments coverage, and homeowners or renters insurance should cover any belongings damaged in the car.

Once drivers know how their own insurer treats rental cars, they can contact their credit card company and inquire about any additional protection. Most card companies provide free insurance for rental cars if the driver's own policy is insufficient. Of course, in order to receive insurance benefits from a particular creditor, the driver must pay for the rental with the appropriate credit card.

The options available from a renter's auto insurer and credit card company might make coverage from the rental company seem pointless, but these sources of protection do have some limitations. Some of the potential problems with auto insurance or free coverage from a credit card company are listed below and might be avoided by purchasing a loss-damage waiver:

- Damage to the rental vehicle might not be covered in full if the rental vehicle is a sports car or some other high-end model.
- Drivers might not have rental coverage if someone else is driving their own car while they're away.
- A personal auto policy might not cover a rental car if it is being used for business purposes.
- Coverage for a rental car might be limited to a specific number of consecutive days.
- A personal auto policy usually doesn't cover vehicles rented outside of the United States and Canada. Credit card companies offer broader protection but still tend to exclude vehicles in certain countries.

**Business Vehicles**

Personal auto policies are meant to cover people's personal vehicles. Coverage for automobiles that are used in business is either excluded from these policies outright or is only provided on a limited basis.

Admittedly, some circumstances that are indirectly related to business are not excluded under most policies. Driving to and from work is generally not considered a business activity, so a driver remains covered by his or her own policy while performing those tasks. Similarly, it is possible for an employee to remain covered by a personal auto policy while running an occasional errand for an employer in his or her own car.

Still, there are plenty of business-related exclusions that ought to be mentioned here. To manage these risks and avoid confusion, people who use their cars in business may want to purchase a commercial auto policy:

- Vehicles owned by a company or some other business-related entity (other than an automobile from a rental company) are usually not covered by a personal auto policy if they are regularly available to an employee.
- Drivers are not covered while using their personal auto to carry people or things for a fee. (For example, this exclusion has been known to cause problems for drivers who use their personal vehicle to deliver food.)
- A personal auto policy doesn't cover liability while a car is being operated by someone in the course of auto-related business. (For example, a mechanic probably isn't covered while road-testing a vehicle, and a valet might not be covered while parking a car.)

For specifics about business auto coverage, you may want to review the ISO's Business Auto Coverage Form.

**Carpools**

As a way to save on gas and share the stress involved with their daily commute, some employees band together and transport one another in one car. If drivers use their own vehicle as part of a

carpool and take money from passengers, their personal auto insurance remains in force. This is an exception to the general rule regarding business vehicles, which forbids people from being covered while transporting people for a fee.

### Exclusions

Personal auto policies have several exclusions besides the ones involving business vehicles. As is the case with all other kinds of insurance, making applicants aware of these gaps in coverage early in the buying process can reduce the chances of conflict between carriers and consumers at claim time. The most significant exclusions in the typical auto insurance policy are explained in the next several sections.

#### Wear and Tear

Automobiles don't remain in good condition forever. Parts periodically need replacing. Exterior features sometimes need retouching. Repairs and tune-ups are inevitable, and they can be expensive.

Unfortunately for owners, trips to the mechanic and all the costs of parts and labor are generally not covered by auto insurance unless they are needed after an auto accident. Coverage of weather-related damage and theft are probably the closest a policy comes to protecting an owner against perils other than accidents, and even those protections are only available to people with comprehensive coverage.

#### Intentional Acts

As should be expected, auto insurers will not compensate a driver who intentionally causes an accident. If drivers intentionally hit someone with their car, they will be stuck paying for their own property damage and medical expenses, as well as any other reparations that are awarded to the victim.

#### Driving Without Permission

Auto insurance doesn't cover people when they drive another person's car without permission. This exclusion often does not apply when the driver and the owner are relatives living in the same house.

#### Damage to Non-Auto Property

Other than the vehicle itself, property that a driver owns or is in the driver's possession at the time of an accident is not covered by auto insurance. For example, if a driver leaves a suitcase in a car and it is damaged by fire, the insurance company will not pay to replace it. Likewise, if a friend leaves a computer in a driver's car and it is damaged in a fire, the driver is not covered by auto liability insurance if the friend decides to sue. Personal belongings ought to be covered by some form of homeowners insurance or other type of personal property insurance.

In regard to liability, this exclusion does not apply to a home or garage. If the policyholder is renting another person's house and crashes into it with her car, her auto insurer can still pay for the homeowner's losses and handle the driver's defense costs.

#### Wars and Nuclear Accidents

Drivers are not covered for medical payments or property damage if an accident occurs because of war or a nuclear attack. In a somewhat related matter, the Terrorism Risk Insurance Act of 2002 required commercial auto insurers to offer government-backed terrorism coverage to their customers, but this requirement ended when Congress revised the law in 2005. The law is not applicable to personal autos.

## Other Restrictions

Finally, personal auto insurance typically does not cover people for liability and/or property damage in the following situations:

- When the government seizes or destroys their car.
- When they are involved in an accident while engaging in an automobile race.
- When they are acting as an employer and are liable for an employee's injuries.

### Underwriting Factors

When evaluating an applicant for auto insurance, underwriters might consider hundreds of pieces of information. Certain characteristics of a particular driver can have an impact on the price of coverage, the availability of coverage or both, depending on the company and what is allowed under state law.

Since each piece of information about a driver may be weighted differently by each insurer, it is impossible to make concrete statements here about how much insurance will cost for a specific person or who will or will not be eligible for coverage in the first place. Nevertheless, we can make some general statements about the kinds of information that auto underwriters consider favorable and the kinds that make them nervous.

As we go over some of the more common underwriting factors in the auto insurance industry, keep in mind that a person's eligibility for affordable coverage can be impacted greatly by major life changes. So even if a consumer is not interested in shopping around for a new policy prior to every renewal period, it may be wise for people to at least get a few new quotes when they move, change jobs, retire or get married. The reasons behind that strategy, as well as other potentially useful information, are explained in the next several sections.

## Driving Record

For obvious reasons, a person's driving record is one of the most important influences on the price of auto insurance. From an insurer's point of view, getting into a recent accident increases the likelihood of being involved in future accidents.

When calculating premiums, an auto insurer will examine an applicant's driving record over a set period of time (usually three years) and take note of any moving violations or any accidents for which the person was at fault. If family members in the same household have regular access to the person's car, their records will be examined, too.

Each blemish on someone's driving record is worth a certain number of points, and each additional point will increase the cost of coverage. The number of points for an accident or violation will depend on the severity of the event. Whereas getting a ticket for a broken taillight might be worth only a few points, being convicted of drunk driving or involuntary manslaughter with a vehicle will be worth several points and will seriously jeopardize a person's insurance status. Drivers may also be charged points if the damage they cause exceeds certain dollar thresholds.

Some policies contain "accident forgiveness" features, which permit drivers to get into the occasional accident without having it affect their insurance costs. For instance, policyholders might pay a little more in order to obtain a policy that gives them one free accident or moving violation from the start of the policy period, or they might be rewarded with a free accident or moving violation after compiling a clean driving record over a number of years.

Applicants should not try to hide past accidents from the insurance company. Insurers have access to state driving records as well as accident information from industry databases. If drivers lie about their record and are found out, the insurer might have the right to cancel coverage.

To an extent, not having a driving record is almost as bad as having a poor one. If an applicant has never had a license, an insurance company will not assume the person is safe and will charge him or her more for insurance than someone with years of experience. Be warned, though, that while experience can be used as an underwriting factor, it is illegal in some states to base an underwriting decision on the fact that a person has never had their own auto insurance. This might be an important point for younger drivers who have been covered by their parents' insurance.

**Vehicle's Age, Make and Model**

Despite the importance of a person's driving record in calculating auto insurance premiums, two equally skilled drivers can still expect to pay different amounts for insurance. This disparity is likely because insurance companies care not only about who is driving a vehicle, but also about the vehicle's characteristics.

When faced with insuring two similar vehicles, insurers will charge less for the older one. The vehicle's age matters because cars depreciate in value over time. A greatly depreciated vehicle will have a relatively low actual cash value, and a relatively low actual cash value means the insurer won't have to pay much if the vehicle is a total loss.

Of course, two different cars can have the same age and still have significantly different actual cash values. Since new luxurious cars can be worth so much more than the average automobile, they can have a large actual cash value even after a few years of depreciation. So, all else being equal, it would probably cost more to insure a five-year-old Rolls Royce than a five-year old Volkswagen Beetle.

When a driver chooses comprehensive coverage, an underwriter won't just be thinking about actual cash values in terms of accidents. The likelihood of theft will also be a concern. Though there are other factors (including location) that can help people calculate the probability of a car being stolen, the vehicle's make and model is certainly part of the equation. In part because of the difference in actual cash value, a sports car will almost always be more attractive to a criminal than a station wagon. Therefore, the owner of the sports car who wants comprehensive insurance will have a higher insurance bill.

A few insurers have even suggested that the kind of car people drive says something about their behavior on the road. For instance, beginning in the 21st century, some companies determined there may be a link between being environmentally responsible and being a careful driver. This has sometimes led to discounts for owners of hybrid vehicles.

Part of being a safe driver, though, entails making sure that you're driving a relatively safe machine. A vehicle that can't withstand much impact puts drivers' health at risk and won't score them any points with their insurance company. Cars that go above and beyond safety standards should be involved in fewer accidents and might be insurable at a reduced price.

**Vehicle Location**

For many auto insurers, the first underwriting factor to consider when calculating an appropriate premium is the location of the vehicle. For the sake of practicality and because so many auto accidents occur close to home, the insurer will care more about where a car is typically garaged than where it is being driven.

Insurers formulate different rates for different geographic areas. More often than not, the insurer will use a different rate for each ZIP code. Rates for city dwellers tend to be higher than rates for people in rural areas. This reflects the greater amount of traffic in urban communities, as well as

the higher frequency of theft. Other geographic factors that may be considered include the rate of uninsured drivers in the area and the effect local weather has on road conditions.

Underwriting on a geographical basis has become somewhat controversial in the last few decades due to the demographics of many cities. Since low-income minorities are especially likely to live in urban neighborhoods, some critics of the industry wonder if using location to set rates is unfairly discriminatory.

This practice, known as "territorial rating," is allowed across the country, but states have addressed some of the discrimination-related concerns by putting limits on its use. In some areas, insurers may only take a driver's location into consideration if other factors, such as one's driving record, are more important in the determining of premiums. If an insurer wants to use territorial rating to calculate premiums, it generally cannot just draw lines on maps and charge higher premiums in whichever neighborhood it wants. Insurance regulators must first agree that a particular area is eligible for its own rating.

### Miles Driven

Since the likelihood of having an accident increases the longer someone is in traffic, the number of miles driven can affect a person's premiums. To determine the appropriate rate, an insurance company will ask applicants to estimate how often they use their cars. If an applicant is unemployed or uses alternative transportation to get to work, premiums will probably be lower than for someone who drives a few miles each day to get to the office. Similarly, someone who drives just a few miles to get to work might be charged less than a coworker whose daily commute is 50 miles.

Yearly estimates from drivers, though, aren't always accurate, and some of the traditional ways of underwriting based on mileage have not always benefited people who drive less than the average person. In response to those concerns, a few insurers in several states have begun offering "pay-as-you-drive" coverage, which allows an insured's premiums to go up or down depending on the actual number of miles that they have recently driven. When a driver is approved for this coverage, a GPS-like device is sometimes installed in the covered auto, and the technology sends periodic readings to the company. While some of these devices are also used to judge whether a driver is obeying speed limits and demonstrating other signs of responsible driving, they are not designed to track a vehicle's location.

Proponents of pay-as-you-drive products argue that the coverage incorporates societal benefits, as well as money-saving opportunities for consumers. According to the Brookings Institution, a nationwide switch to a pay-as-you-drive system would encourage people to drive less and could result in roughly $50 billion in savings by reducing traffic, cutting pollution, lowering the amount of accidents and lessening dependence on fossil fuels.

Detractors worry that allowing insurers to collect mileage data in such a direct manner could put drivers' privacy at risk. Due to those concerns or just the relative newness of the concept, pay-as-you-drive insurance was not available in every state when this course was being written.

### Age of the Driver

A combination of experience, maturity and health makes age an important underwriting factor at certain points in a driver's life. When allowed by insurance regulators, an auto insurer will rate drivers depending on what age range they fit into. This practice results in higher premiums for people at opposite ends of the spectrum, namely people who are either younger than 25 or older than 70.

Despite the widespread use of age as an underwriting factor in many parts of the country, a fair warning is in order. A few states allow insurers to base premiums on a driver's experience but do not let insurers consider a person's age.

### *Insurance for Young Drivers*

Younger drivers pay the most for auto insurance because they are the ones who are most likely to be involved in auto accidents. The Insurance Institute for Highways Safety has said that drivers between the ages of 16 and 20 are involved in more accidents per mile than people in any other age range and that car crashes are the number-one cause of death among teenagers. Statistics also show that most teenagers who die in car crashes as passengers were being driven by someone in the same age group.

Statistics like those explain why adding a teenager as a regular driver on an auto insurance policy can often double the size of a parent's premiums. Still, the cost of adding a teenager to a parent's insurance is usually cheaper than insuring a young person through a separate policy. By adding a child to their insurance, parents with a respectable driving record will cancel out some of the high risk associated with a new driver. Also, if parents purchase a separate car for their child and insure it under their policy, they might benefit from a multi-car discount.

Even though personal auto insurance will often cover people who occasionally borrow a policyholder's car, parents should contact their insurer before giving a child regular access to a vehicle. In most cases, notice can be given once a teenager becomes licensed rather than at the time he or she is issued a learners permit. At the very least, policyholders may be required to report any newly licensed drivers in their household when coverage is being renewed.

Unlike health insurance and homeowners insurance policies, auto insurance policies do not have an age limit for sons and daughters who are protected by their parents' coverage. All that matters is that the son or daughter is licensed and lives in the same household. If a son or daughter is temporarily away at school, the student can still be considered an insured member of the household.

Auto insurance for young drivers is expensive, but there are many ways for new motorists and their parents to cut down some of the cost. Here are a few of the most common price-reducing strategies for consumers:

- Tell the insurer if the son or daughter has at least a "B" average or has received any academic honors at school. Since good students are considered safer drivers, most companies will give a teenager a discount if academic achievements can be verified.
- Tell the insurer if the son or daughter is attending school away from home and not using a car while there. Discounts are usually available if a student lives more than 100 miles away during the academic year and only drives the family car during break periods.
- In case a discount is available, tell the insurer if the son or daughter has successfully completed a defensive driving course.
- If a family owns more than one vehicle, consider only allowing the son or daughter to use the vehicle with the lowest actual cash value.
- If parents are in a position to choose a car for their son or daughter, they should consider a dependable, non-flashy one that is less likely to encourage reckless driving.

### *Insurance for Older Drivers*

People with good driving records will usually not be subjected to age-related penalties once they reach their late 20s. As they gain more and more experience and are therefore deemed more responsible, they may even qualify for a special senior discount during late middle-age.

Where available, age-related senior discounts on auto insurance are unlikely to be extended to people who are in their 70s or older. Though these older drivers tend to drive less than other adults and are still statistically safer than teenagers, accident rates are relatively high in this age group on account of health issues. Seniors who are interested in reducing their auto insurance costs might benefit from taking a defensive driving course.

**Credit Scores**

Examining an applicant's credit history has been commonplace in the lending industry for as long as anyone can remember. Since the 1990s, many auto insurers have done it, too, believing that people's ability to meet financial obligations says something about the number of claims they're likely to make.

In most states, what a driver pays for auto insurance can depend on something known as an "insurance score." Insurance scores are similar to the credit scores available from any of the three major credit bureaus. They tend to reflect the kinds of debts people have, the amount of credit available to them and many other variables related to a driver's financial situation.

However, even though an insurance score and a credit score can relate to the same data, a formula for computing a credit score might weigh each piece of data differently than a formula for computing an insurance score. As a result, it is technically possible to have a high credit score but a low insurance score, and vice versa. Each insurer might have its own way of calculating an insurance score, and the specifics behind that method are unlikely to be disclosed to consumers.

Through its increased emphasis on insurance scores, the industry has argued that a driver with a poor credit history represents a bigger risk than a driver with a good credit history. While studies show there seems to be a link between bad credit and insurance claims, the reason for that link is unclear. Some of the theories that have been proposed over the years include the following:

- If drivers have bad credit, they might not have the money to properly maintain their vehicle, which could lead to accidents.
- If drivers have bad credit, they might not have the money to pay for relatively minor auto accidents, which puts a greater burden on their insurer.
- If drivers have bad credit, they might be tempted to commit insurance fraud.

Many drivers have been rewarded with lower premiums because of their high insurance scores. Nevertheless, the use of credit as an underwriting factor has pitted insurance companies against many consumer advocates.

Those opposed to insurance scoring question what a person's credit has to do with their ability to operate a vehicle safely. Is it fair when a scoring system forces a driver with bad credit but no accidents to pay more for auto insurance than someone with one accident and a positive credit history? And what about people who have bad credit due in large part to a job loss, or a person who has a thin credit history due to a general preference for cash and living within one's means? Are these people less deserving of affordable auto insurance than the rest of us?

The use of credit-based underwriting has also led to accusations of indirect discrimination. Though insurance scoring is not supposed to take a person's race, ethnicity or income into account, studies have shown that racial and ethnic minorities and low-income people are disproportionately likely to have lower insurance scores.

Congress has considered bills from time to time that would put major restrictions or an outright ban on credit-based underwriting in the insurance industry, and nearly every state has implemented limits of its own. For example, California generally prohibits auto insurers from using credit as a factor when underwriting or pricing coverage. In many other states, insurance scores

are allowed but cannot be used as the sole reason for raising premiums or rejecting an applicant. Questions about what is specifically permissible on a state level ought to be answered by an expert in your community.

### Gender

In states where insurers can use gender to set auto insurance rates, pricing tends to favor women. Numbers reported in the Journal of Insurance Regulation show that despite a nearly equal amount of drivers, men cause slightly more accidents than women and are responsible for nearly three-fourths of auto fatalities.

### Marital Status

Though there does not appear to be much difference among women, a young married man is likely to have less accidents than a young single man and, therefore, will often pay less for auto insurance. If he is married with children, he may represent an even better risk. However, not every state allows insurers to use marital status as a factor in determining rates or offering coverage.

### Other Factors

We've touched on some of the most common pieces of information that can influence a driver's auto insurance costs, but there are many more that an insurer might consider. Like the factors we have already mentioned, some of them are within the driver's control and some are not.

Depending on the insurer, answers to the following questions might influence a driver's premiums:

- Does the person usually drive during rush hour or late at night?
- Has the insurer lost a lot of money recently because of fraud committed by consumers?
- Is the insurer losing money because of increases in the cost of medical care or car repairs?
- What is the driver's occupation? (Some companies have been known to charge less if a driver has a white-collar job.)
- What is the driver's education level? (At some companies, drivers will be viewed more favorably if they've had a lot of schooling.)
- Is there evidence to suggest that the driver has operated a vehicle without insurance? (Some companies might be less inclined to insure someone who had insurance in the past, cancelled it and is reapplying for coverage after a significant gap in time. However, this practice is illegal in some states.)

## After an Accident

Being in an auto accident can be inconvenient to say the least. Besides the possible anger and physical pain that might be caused by a collision, affected drivers might be extremely concerned about how they will get their vehicle fixed and whether they will end up being involved in a lawsuit.

Drivers who are already aware of what to do after an accident are likely to experience less stress when one actually occurs. With this in mind, you may find it helpful to review what services an insurer owes to a policyholder after a loss and what a policyholder owes to an insurer.

### Transportation Expenses

If drivers are in an accident and are unharmed, their most immediate problem might be how to get around while their vehicle is being repaired. If their car sustained significant damage, they might be facing several weeks of taking buses and trains or using a rental car.

These unexpected travel expenses can add up, and you may wonder who is responsible for paying them. If another driver caused the accident, the at-fault driver's insurance should pick up

the costs of the alternative transportation. But what if the accident wasn't someone else's fault? Or what if the victim doesn't want to bother with the other driver's insurer and just wants expenses to be covered quickly?

Drivers who are in either of those situations might be covered if they purchased collision coverage or comprehensive coverage for their vehicle. If they have comprehensive coverage and their car is stolen, their insurer will give them a limited amount of money for temporary transportation expenses. To be eligible for this benefit, the damaged vehicle must be unavailable for at least two full days.

If a car is unavailable because of property damage, the owner's insurer might provide a limited amount of transportation coverage after a 24-hour waiting period. To be eligible for this benefit, the owner must have the proper kind of property insurance and must pay an additional premium.

**Towing and Labor Charges**

We noted earlier that auto insurance does not cover losses associated with wear and tear. That's generally true, but a very minor degree of coverage can be added for an extra charge.

If drivers are willing to pay more money, their insurance company will cover them for emergency roadside assistance, even if their vehicle simply won't start. This additional insurance will pay for towing a car to a repair shop. The cost of labor is covered, too, but since this only applies to work done at the site of the emergency, coverage will probably be limited to relatively simple tasks like changing a tire.

In some cases, insurance claims for roadside assistance will be treated in the same way as liability claims or property damage claims and could impact a driver's eligibility for affordable insurance at a later date. To avoid this problem or to see what similar coverage options might be available, consumers might consider contacting a motor club.

**Duties of the Insured**

When drivers are in a car accident, there are certain things they must do in order to be reimbursed by their insurer. There are also several things that, required or not, should be done in order to get their claim paid quickly.

Of course, safety comes first. If an accident results in bodily injury, someone at the scene should call for help. If there are no injuries, state laws might still require that the police be notified. For their losses to be covered, drivers must call the police if their car has been stolen or if they have been the victim of a hit-and-run accident.

After calling for emergency assistance, drivers should do what they can to prevent further damage to their vehicle. If possible, damaged autos should be moved away from traffic so that an even bigger accident does not occur.

While waiting for police assistance, drivers can start taking important notes. Names should be obtained from all drivers, passengers and other witnesses. Insurance information should be shared among the group, and each party should verify the make and model of any damaged vehicles. When law enforcement arrives, drivers should explain the situation and inquire about obtaining a copy of the police report.

After everyone's safety has been secured and all information has been exchanged, policyholders should make contact with their insurance company. Upon learning of the accident, the insurer will assign a claims adjuster, who will usually contact the insured in a matter of days.

If the accident is likely to involve a liability claim, drivers must cooperate with the insurer so that a fair settlement can be reached in a timely manner. If drivers receive notice that they are being sued, or if they intend to pursue a suit against someone else, copies of all legal notices must be

sent to the insurance company. If drivers incur expenses or miss work as a result of helping their insurer with a liability dispute, reimbursements will be provided by the insurer up to certain dollar limits.

If a claim involves the medical payments portion of a policy, the insurer can force the injured party to be examined by a physician of its own choosing at its own expense. The insurer may also request access to the party's medical records.

If drivers want property damage covered by their insurer, they should hold off on doing repairs until a claims adjuster has examined the vehicle. After inspecting the damage, the appraiser will calculate a possible settlement amount, which the vehicle's owner can either accept or decline. According to the Insurance Information Institute, insurers cannot force a driver to have repairs done by a particular garage or body shop, but they can require drivers to obtain multiple estimates of repair costs.

If a policyholder and a claims adjuster cannot agree on a settlement for property damage, the insurer and the insured can go through the arbitration process. Each party will hire an appraiser at its own expense, and if the two appraisers cannot agree on a settlement, an impartial arbitrator will be asked to resolve the dispute.

### The Impact of Other Insurance

If multiple insurance policies or other forms of compensation can be applied to the same loss, it can be difficult to determine who pays and in what amount. As usual, much will depend on policy language and state law.

If a policyholder is involved in an accident while driving someone else's car, the vehicle owner's insurer usually pays first. If the owner's insurance is not enough to cover the entire loss, the driver's policy will make up the difference.

From a compensation standpoint, accidents involving the insured's car and multiple policies are usually more complicated. If a driver has multiple policies that could be used to cover the same loss, the amount paid to the insured under each policy will be based on the relationship between each policy's dollar limit and the cumulative dollar limit for all applicable policies.

For example, pretend Pete is in an accident and is sued for $50,000. If Pete has an auto policy with a $100,000 liability limit and another liability policy that could cover the same loss up to $200,000, his auto insurance company might add the two dollar limits together for a total of $300,000. By dividing its own liability limit ($100,000) by the total liability limit ($300,000), the insurer would get an answer of one-third. Based on those calculations, Pete's auto policy might cover one-third of $50,000 and leave the rest to be covered by his other insurance. As a practical matter, many non-auto insurers avoid this issue by specifically excluding auto liability from their coverage forms.

### Stacking

If drivers insure multiple vehicles under the same policy, some states will allow them to combine the benefit limits for each vehicle and apply the total to a single accident. This option, known as "stacking" can require an additional premium and is most commonly offered as part of a driver's uninsured and underinsured motorists coverage.

Imagine that Sue owns two vehicles and covers them under the same policy with a $100,000 limit for uninsured motorists coverage. If Sue is hit in either car by an uninsured driver and her losses exceed $100,000, she could multiply $100,000 by two and be covered for as much as $200,000. Most states, though, either forbid or have put limits on stacking, and an insurer might still refuse to offer it as an option even where it is allowed by law.

## Auto Insurance Laws

By itself, a driver's license does not allow people to buy a car and take it out on the road. Vehicle owners must abide by local auto insurance laws before they drive.

Since auto insurance laws are different in every state and can be replaced with new legislation, this is not the place for specific, up-to-date information about a particular state's requirements. We can, however, make some general comments about what these laws demand from drivers and how they impact the public.

### Compulsory Insurance Laws

Nearly every state has "compulsory" auto insurance laws. Under these laws, anyone who owns a car must be covered by a minimum amount of insurance. Proof of this insurance usually must be given before a vehicle can be registered.

At the very least, a compulsory insurance law requires drivers to be covered by a minimum amount of liability insurance. As you might recall from our discussion of split-limit policies, a state might have three different minimum liability amounts:

- One amount for all bodily injuries sustained by one person.
- One amount for all bodily injuries sustained in a single accident, regardless of the number of people.
- One amount for all property damage that occurs in a single accident, regardless of the number of people.

If a state has three separate limits for liability, drivers must comply with all of them. Depending on where they live, drivers might not be required to purchase other forms of auto insurance, such as medical payments coverage, uninsured motorists coverage or collision coverage for their own vehicle.

Compulsory auto insurance laws were created to make it easier for accident victims to be compensated for their losses, but they do not guarantee that innocent people will receive all the money they deserve. Obviously, someone who only purchases the minimum amount of liability coverage might not have enough to compensate someone following a major accident.

It's also inevitable that some drivers will either ignore compulsory laws altogether by not registering their vehicles or attempt to sidestep state requirements by cancelling coverage soon after registration is complete. Some states have tried to crack down on these uninsured drivers by requiring auto insurers to report former policyholders who have canceled or failed to renew their coverage.

### Financial Responsibility Laws

States without compulsory insurance laws still have a "financial responsibility law" that must be obeyed. In fact, although not all financial responsibility laws are compulsory insurance laws, all compulsory insurance laws are financial responsibility laws.

In regard to driving, financial responsibility laws basically say that if drivers cause an accident, they must prove that they can compensate any victims up to a certain dollar amount. To comply with these laws, a driver might purchase insurance, post a bond or make some other kind of deposit. If someone is in an accident and cannot demonstrate an ability to compensate people for their losses, the state can take the person's driving privileges away.

## Tort vs. No-Fault

The kind of insurance drivers need to obtain will depend partially on whether their state has tort insurance laws or no-fault insurance laws. Up to now, the information provided in this course has assumed that a driver is from a tort state. No-fault states take a different attitude toward liability insurance, so coverage in these parts of the country is different in some significant ways.

### *Tort States*

Most states use a tort system for auto insurance. Under a tort system, drivers receive limited or no compensation after an auto accident unless they can prove another person was at fault. If an accident victim suffers bodily injury or property damage, the at-fault driver's liability insurance will cover the losses. Accident victims can also collect compensation from the at-fault driver for non-economic losses, such as pain and suffering.

Tort systems make it more likely that the cost of an accident will be the responsibility of the person who caused the damage, but they do not always make it easy for victims to receive insurance benefits quickly and in full. If victims do not have medical payments coverage or property damage coverage for their own car (or if their losses exceed their benefit limits for such coverage), they might have to deal with the at-fault driver's insurance company, and they may have to take the at-fault driver to court. Both of those endeavors can involve a lot of stress and a lot of time. Some critics of tort systems have also argued that a lack of limits on rewards for pain and suffering is at least partially responsible for the high cost of liability insurance.

### *No-Fault States*

Drivers in roughly one-third of the country are governed by a "no-fault" insurance system. Under no-fault laws, losses that drivers sustain as a result of bodily injury are handled by their own insurance company even if an accident is caused by another person. In exchange for the supposed simplicity of having to deal only with their own insurer, drivers give up a significant portion of their right to sue the at-fault individual.

Drivers in a no-fault state are usually required to purchase "personal injury protection" (PIP). PIP is very similar to the medical payments coverage in other personal auto policies, but in addition to reimbursing the insured for medical expenses, it can also help people recoup lost income, funeral costs and other extra expenses that are linked to an accident.

In no-fault states, any losses that relate to an injury will first be covered by the injured person's PIP. If the injured person did not cause the accident and losses exceed his or her PIP dollar limit, the other driver's liability insurance might make up the difference. Compensation for non-economic damages, such as pain and suffering, is often prohibited. As in tort states, compensation for property damage is usually provided to victims by the at-fault driver's insurer.

Drivers in no-fault states are only allowed to sue another driver for pain and suffering if the consequences of an accident are serious. Within the context of insurance, the consequences of an accident are considered to be serious if they exceed a statutory threshold.

Depending on state law, a statutory threshold may be either monetary or verbal. With a monetary threshold in place, drivers can sue for pain and suffering if their injuries cost them more than a particular dollar amount. If a state has a verbal threshold, the actual size of people's medical bills aren't important, but they can sue when the severity of their injuries is at least equal to the severity described in an applicable insurance law. For example, under a verbal threshold, a driver (or a driver's estate) might be allowed to sue for pain and suffering whenever an accident results in death, permanent disfigurement or long-term disability.

A few states are considered “choice” states because they let drivers choose between no-fault coverage and traditional tort coverage. In places where this option is available, drivers who opt for no-fault coverage tend to pay lower premiums.

The fact that there are three basic kinds of auto insurance systems in the United States suggests that neither tort systems nor no-fault systems are perfect. When several states passed no-fault insurance legislation in the 1970s, regulators assumed that such measures would cut down on lawsuits and reduce the waiting time for victims to receive benefits. No-fault systems, though, have not always been effective in reducing costs for consumers, and some critics argue that they force good drivers to subsidize bad ones. Concerns about cost were at least one reason why many states that had enacted no-fault laws in the 1970s eventually switched back to a tort system.

Keep in mind that each no-fault state has its own specific features and that requirements can change over time. If you receive auto-related questions from someone in a no-fault state, you may want to research current laws and requirements in the person’s area.

## Coverage in Other States and Other Countries

Considering all the different variations on auto insurance requirements in the United States, drivers might wonder what happens to their coverage when they travel across state lines. If they at least have the minimum amount of auto insurance in their own state, they can journey from coast to coast without much anxiety.

As a vehicle travels into another state, the owner’s coverage automatically adjusts, insuring the driver for at least the minimum required amount in that other state. It doesn’t even matter if drivers live in a tort state and get into an accident in a no-fault state. They can operate their car anywhere in the nation and still be in compliance with the law.

Insurance for vehicles that are driven in foreign countries is a different story. A personal auto policy usually only pertains to accidents that occur in the United States, Canada or one of those countries’ territories. It often does not even protect U.S. drivers who cross the border into Mexico.

Travelers who go overseas can obtain coverage from a rental company in another country. They might also have some protection from their credit card company. Either way, it is very important to secure adequate insurance. If a driver is in an accident outside of the United States and Canada and does not have insurance, local authorities may be able to detain the person until the matter is settled.

### Helping High-Risk Drivers and the Uninsurable

Since auto insurance is mandatory for drivers in just about every corner of the country, insurance professionals are guaranteed to come in contact with applicants who are not good risks. These people might be inexperienced behind the wheel, have a poor driving record or display any one of many characteristics that make high premiums necessary. Depending on a company’s underwriting guidelines, an application from a high-risk driver might even be turned down.

Despite their unattractiveness from a business perspective, high-risk drivers still deserve quality service from auto insurance experts. For many of those drivers, that service might include being told what can be done to lower their high insurance costs. For others, it might involve receiving some advice about what to do when insurance has been denied, cancelled or not renewed. We’ll conclude this portion of our course with some general guidance regarding these consumers.

## Dealing With High Premiums

In order to manage risks and keep costs manageable for reliably safe motorists, auto insurance companies must price coverage in a way that makes some drivers pay more than others. However, consumers who are unhappy with the size of their auto premiums are not entirely

powerless in the matter. If they want to save money, they can adjust their coverage or take steps that make them seem less likely to get into major accidents.

This section contains a number of cost-conscious strategies, many of which have already been mentioned in our course. Keep in mind, though, that some of these tips reduce the benefits that are available to policyholders after an accident. Before agreeing to a reduction in coverage as a way of reducing costs, drivers should be made to understand the possible consequences of their decision. As always, the cheapest option is not always the best option.

Drivers who are mainly concerned about price may want to consider taking some of the actions listed below:

- Purchase auto insurance from the same company that insures their home, their health or their lives.
- Take a defensive driving course.
- Tell the insurer if they only drive a few thousand miles or less each year.
- Elect to pay for coverage in a lump sum rather than in monthly installments.
- Opt for a vehicle with excellent safety features.
- Install an anti-theft device in their vehicle.
- Increase deductibles.
- Let the insurer know if they take a carpool to work.
- If they have multiple vehicles, insure them all under the same policy.
- Drop comprehensive and collision coverage for vehicles with a low actual cash value.
- Drop medical payments coverage if they and their passengers have adequate health insurance.
- Exclude high-risk members of the household from their policy.
- If they are parents and plan on covering a son or daughter, cover all family members under the same policy rather than through a separate policy.
- Improve their credit score, and check for errors in their credit reports.

**Dealing With Cancellations and Non-Renewals**

Auto insurance policies tend to cover drivers for six months or a year, but coverage can end at any time if the policyholder or the insurer cancels it.

Consumers don't need a reason to cancel their auto insurance. They merely need to give the insurer notice of the cancellation. This can be done by sending the insurer a written statement that indicates the exact date when coverage should end. It can also be accomplished by sending the policy back to the insurance company.

Requirements for cancellation are stricter when the insurer is the one ending the relationship. In most cases, an insurer cannot cancel a person's auto insurance unless at least one of the following statements is true:

- The person failed to pay premiums.
- The person is no longer allowed to operate a vehicle.
- The person misrepresented important facts to the insurance company.

If an insurer plans on cancelling someone's auto insurance, the person must receive notice of the cancellation before coverage actually ends. The amount of required notice will depend on state law.

Proper notice is also required if the insurance company chooses not to renew someone's auto insurance. In this scenario, coverage will not be interrupted during the current policy period but will stop once the policy period ends. Depending on the circumstances, non-renewal may occur if a driver makes too many insurance claims, violates a major rule of the road or is responsible for a serious accident. In general, an insurance company's ability to non-renew someone's coverage is broader than its ability to cancel that coverage.

Drivers who are faced with cancellation or non-renewal should try to secure replacement coverage as soon as possible. If they cancel their insurance and go without coverage for a significant length of time, they might encounter pricing problems when they reapply for coverage in the future. And, of course, if they continue to drive without any insurance, they could be breaking the law.

### The Residual Auto Insurance Market

If a state makes auto insurance mandatory, it must ensure that everyone with a valid driver's license has an opportunity to purchase minimum coverage. Each state has a "residual market," which provides insurance to high-risk drivers who are denied coverage from an insurance company.

Many states operate some form of "assigned-risk program." In an assigned-risk program, all auto insurers in the state are required to cover a certain portion of high-risk drivers. The number of high-risk drivers who must be covered by a particular insurer will generally be proportionate to that company's market share. A large insurer will usually be responsible for covering more high-risk drivers than a small insurer.

A few states have dealt with high-risk drivers by covering them through "joint underwriting associations." A joint underwriting association consists of several insurance companies. When a driver suffers an insured loss, all of the members are financially responsible for covering a portion of it. The size of an insurer's portion will depend on how much business the company does in the state. (Again, large insurers will contribute more than small insurers.) However, only a few members will be held responsible for actually dealing with consumers and doing all the administrative work involved with issuing policies and handling claims.

Instead of being part of an assigned-risk program or joint underwriting association, an insurer might cover high-risk drivers through a reinsurance pool. When an insurer is part of a reinsurance pool, it generally cannot deny insurance to an applicant. It can, however, require that all other insurers in the state share a portion of the presented risk. After a loss, a driver contacts his or her own insurer, and each pool member must fund a portion of the benefits.

Since it's meant for high-risk drivers, insurance from the residual market is very expensive. The market exists to make insurance accessible, not to make it affordable. Drivers who find themselves in it will want to improve their driving record so that they can eventually obtain cheaper, more comprehensive coverage in the regular market.

### Conclusion

Though car owners generally know they must purchase auto insurance, they are probably not aware of all the different ways it can help them manage the risks of the road. By studying and explaining the contents of a typical auto policy, you can get people to think about more than minimum legal requirements. You might even make it possible for your customers to recover from the inevitable accident with a limited amount of loss and stress.

BOOKMARKEDUCATION

# CALIFORNIA INSURANCE CE

**Satisfy your entire CE requirement.**
**Discount packages are available.**

**Choose a package**
**and SAVE!**

Don't Delay, Enroll Today

**Online:**

BookmarkEducation.com

**Phone:**

(800) 716-4113