Chapter One

GENERAL INSURANCE

LEARNING OBJECTIVES

Upon the completion of this chapter, you will be able to:

1. Recognize definitions of general insurance and insurance law terminology
2. Identify basic insurance concepts and principles
3. Identify the characteristics of insurers
4. Recognize the role of insurance producers
5. Recall the elements of legal contracts and interpretations affecting contracts
6. Define Insurable interest

OVERVIEW

This chapter is designed to acquaint the student with the fundamentals of the insurance industry as a whole, as well as to go over the foundational concepts that constitute the basis of insurance, regardless of the state in which a student is licensed.

1.1 The World of Insurance

The insurance industry consists of companies, agencies, producers, and organizations that provide information and support to the private firms and persons who buy insurance.

Private Firms and Persons

- **Insurance companies (known as Insurers or Carriers)** manufacture and sell insurance coverage in the form of insurance policies or contracts of insurance.
- **Insurance Agencies** are captive or independent organizations that recruit, contract with, train, and support insurance producers.
- **Insurance Producers** are licensed individuals representing and appointed by an insurance company when transacting insurance business.
- **An Insured** is the person or entity that is covered by the Insurer, which covers losses due to loss of life, health, property, or liability.
- **An Owner** is not necessarily the insured under the policy but is responsible for paying the policy's premium and has various rights as specified in the contract.

Trade and Regulatory Associations

The National Association of Insurance Commissioners (NAIC) consists of all state and territorial insurance commissioners or regulators. It provides resources, research, legislative and regulatory recommendations and interpretations for state insurance regulators. It also promotes uniformity among states. Members may accept or reject recommendations. The NAIC has no legal authority to enact or enforce insurance laws.
**Federal Insurance Office (FIO)** was established by the Dodd-Frank Wall Street Reform and Consumer Protection Act. This office monitors the insurance industry and identifies issues and gaps in the state regulation of insurers. It also monitors access to affordable insurance by traditionally underserved communities and consumers, minorities, and low- and moderate-income persons. The FIO is not a regulator or supervisor. Insurance is primarily regulated by the individual states. Insurance producer and company trade associations also exist to provide education, support, networking and lobbying for insurance companies and producers.

**Insurance Regulation at the State Level**
The insurance industry is regulated primarily at the state level. The legislative branch writes and passes state insurance laws, or statutes, to protect the insuring public. The judicial branch is responsible for interpreting and determining the constitutionality of the statutes. The role of a state’s executive branch is to enforce the existing statutes that have been put in place. The Commissioner, Director, or Superintendent of Insurance is typically appointed (or in some jurisdictions elected) by the Governor, and the Commissioner has the power to issue rules and regulations to help enforce these statutes.

**Insurance Regulation at the Federal Level**
In the aftermath of the Supreme Court decision in U.S. vs South-Eastern Underwriters (1944), the McCarran-Ferguson Act of 1945 established that the federal government will not regulate the business of insurance in areas which the states have historically had the authority to do so (such as producer and company licensing) unless the states fail to cooperate. Congress created federal agencies to provide regulatory oversight impacting insurance practices.

**Private vs. Government Insurers**
Most insurance is written through private insurers. However, there are instances where governmental-based insurers step in to offer an insurance alternative when private insurers are unable to provide protection, usually related to the catastrophic nature of the risk, capacity to handle the risk, and lack of desire to engage in a line of insurance where experience to evaluate necessary premium intake to offset potential loss is lacking.

### 1.2 Types of Insurers – Insurance Companies or Carriers

**Stock Insurance Company**
A stock company is owned by **stockholders** or shareholders. Directors and officers, which are elected by stockholders, put in place a management team to carry out the company’s mission.

Stockholders may receive taxable corporate dividends as a share of the company’s profit when and if declared by the Directors. However, dividends are not guaranteed. Traditionally, stock insurers issue Non-Participating policies, meaning that the policyholder is not entitled to receive any dividends.

**Mutual Insurance Company**
A mutual company is owned by **policyholders** (who may be referred to as members). A Board of Trustees or Directors is elected by policyholders. The directors and officers put in place a management team to carry out the company’s mission. Policyholders may receive non-taxable dividends as a return of any divisible surplus when and if declared by the directors.
Traditionally, mutual insurers issue Participating policies, meaning that policyholders are entitled to receive any dividends. The dividends represent the favorable experience of the company and result from excess investment earnings, favorable mortality, and expense savings. Dividends can be paid in cash, used to reduce premiums, left to accumulate at interest, and used to purchase paid-up additional insurance. Dividends are not guaranteed.

**Reciprocal Insurance Company**

A reciprocal insurance company is a group-owned insurer whose main activity is risk sharing. A reciprocal insurer is unincorporated, and is formed by individuals, firms, and business corporations that exchange insurance on one another. Each member is known as a subscriber, and each subscriber assumes a part of the risk of all other subscribers.

If premiums collected are insufficient to pay losses, an assessment of additional premium can be made. The exchange of insurance is affected through an Attorney-In-Fact, who is not required to be insurance licensed.

**Lloyd's of London**

Lloyd’s of London is not an insurance company, but consists of groups of underwriters called Syndicates, each of which specializes in insuring a particular type of risk. Lloyd’s provides a meeting place and clerical services for syndicate members who actually transact the business of insurance.

Members are individually liable for each risk they assume, and coverage provided is underwritten by a syndicate manager such as an attorney-in-fact or individual proprietor.

**Fraternal Benefit Societies**

Fraternal benefit societies are primarily social organizations that engage in charitable and benevolent activities that can provide life and health insurance to their members. Membership typically consists of members of a given faith, lodge, order, or society. They are usually organized on a non-profit basis, and fraternal insurance producers represent the fraternal insurer and sell insurance to fraternal members.

**Risk Retention Groups (RRG)**

Risk Retention Groups are group-owned insurers that primarily assume and spread the liability-related risks of its members. They are owned by their policyholders, and are licensed in at least one state. However, they may insure members of the group in other states.

Groups must be made up of a large number of homogeneous or similar units. Membership is limited to risks with similar liability exposures such as theme parks, go-cart tracks, or water slides. They must have sufficient liquid assets to meet loss obligations. Each member assumes a portion of the risks insured.

**Self-Insurers**

Self-insurers assume all of the financial risk faced without transferring that risk to an insurer. Rather than paying premiums to a third party the self-insurer sets aside funds in an amount equal to or greater than the expected losses. If the losses are less than what is reserved to pay claims, it is a gain, otherwise, losses in excess of the reserve will require additional funding perhaps from on-going operation revenues.

This is generally an option only for large companies who may limit their risk by only self-insuring up to a certain dollar amount of risk and then acquiring insurance for dollar amounts in excess of that amount.
Retention Question 1

A ____________ insurance company is owned by its policyholders.

a. Stock  
b. Reciprocal  
c. Fraternal Benefits Society  
d. Mutual

1.3 Fundamentals of Insurers

Residual Markets

Residual markets are a last resort private coverage source for businesses and individuals who have been rejected by the voluntary insurance market. Coverage is typically written as Workers' Compensation, personal auto liability or property insurance on real property.

- **A Joint Underwriting Association or Joint Reinsurance Pool** – Requires insurers writing specific coverage lines in a given state to assume their share of profits/losses of the total voluntary market premiums written in that state.
- **Risk Sharing Plan** – Insurers agree to apportion among themselves those risks that are unable to obtain insurance through normal channels.

Reinsurance Companies

Reinsurance companies are insurance companies that operate to accept all or a portion of the financial risk of loss from the primary (or “ceding”) insurance company. The risk of loss is shared with one or more insurance companies. All contractual obligations are on the original (primary) company and consumers have no direct contact with reinsurance companies.

Reinsurance is what makes insurance affordable. No single insurance company is exposed to 100% of the losses it insures. When claims are paid by the insurer to the consumer, the actual source of the funds may come from both the insurer and their reinsurer but the consumer will not know how much came from each.

Types of Reinsurance Agreements

- **Treaty** – Reinsurance agreement that automatically accepts all new risks presented by the ceding insurer (the company seeking or requesting the reinsurance from the reinsurer).
- **Facultative** – Reinsurance agreement that allows the reinsurance company an opportunity to reject coverage for individual risks, or price them higher due to their substandard (higher risk) nature.

Financial Rating Services

Independent financial rating services evaluate and rate the claims paying ability and financial stability of insurance companies. These firms assign letter ratings that indicate the financial strength of each company which may be based on both public and nonpublic data.

The higher the rating the opinion is that the insurer has a higher likelihood of the ability to pay claims. The lower the rating, the opinion is that the insurer is less likely of being able to pay claims. The ratings are made available to the public, though insurers may purchase reprints of their ratings for use as marketing tools.

Producers are responsible for placing business with insurers that are financially sound. Examples of rating services include: A.M. Best Company, Standard & Poor’s, Moody’s Investment Services, Weiss Insurance Rating, and Fitch Ratings.
Retention Question 2

_If an insurance company wants to transfer all or part of the risk it has accepted, it would buy which of the following types of insurance?_

a. Residual  
b. Reinsurance  
c. Reciprocal  
d. Insurer

### 1.4 Insurer Domicile and Admittance

**Domicile** – Refers to the jurisdiction (i.e., state or country) where an insurer is formed or incorporated.

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<th>Domestic Insurer</th>
<th>Foreign Insurer</th>
<th>Alien Insurer</th>
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<tr>
<td>An insurer organized under the laws of this state, whether or not it is admitted to do business in this state.</td>
<td>An insurer organized under the laws of any other state, possession, territory, or the District of Columbia of the United States, whether or not it is admitted to do business in this state.</td>
<td>An insurer organized under the laws of any jurisdiction outside the United States, whether or not it is admitted to do business in this state.</td>
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<tr>
<td><strong>Example:</strong> An insurer incorporated in New York is considered domestic to New York.</td>
<td><strong>Example:</strong> An insurer incorporated in New York is considered foreign to Kansas.</td>
<td><strong>Example:</strong> An insurer incorporated in Ontario, Canada, is considered alien to New York.</td>
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</table>

**Admitted vs. Non-admitted** – Refers to whether or not an insurer is approved or authorized to write business in this State.

- The domicile does not impact whether an insurer may be admitted to do business in this state.
- An **Admitted (Authorized) insurer** is authorized by this State’s Commissioner of Insurance to do business in this State and has received a **Certificate of Authority** to do business in this State.
- A **Non-admitted (Unauthorized) insurer** has either applied for authorization to do business in this State and was declined or they have not applied. They are not authorized to transact insurance in this State.
- Excess lines insurance can be placed through non-admitted carriers.

**Surplus Lines Insurance** finds coverage when insurance cannot be obtained from admitted insurers. However, it cannot be utilized solely to receive lower cost coverage than would be available from an admitted carrier.

- Each State regulates the procurement of Surplus Lines insurance in its State.
- Can be placed through non-admitted carriers. Non-admitted business must be transacted through a Surplus Lines Broker or Producer.
Retention Question 3

Which of the following is an insurance company that is organized under the laws of another state within the United States?

a. Domestic
b. Alien
c. Foreign
d. Authorized

1.5 Insurer Management and Distribution

Management

- **Executives** – Oversee the operation of the business.
- **Actuarial Department** – Gather and interpret statistical information used in rate making. An actuary determines the probability of loss and sets premium rates.
- **Underwriting Department** – Responsible for the selection of risks (persons or property) to insure and rating that determines policy premiums.
- **Marketing/Sales Department** – Responsible for advertising and selling.
- **Claims Department** – Assists the policyholder, insured, or beneficiary in the event of a loss and processes, and pays the amount of the claim in a timely manner, based upon the contractual provisions and the amount insured.

Distribution Models

- **Exclusive or Captive Agency System** – Deals with the insured through an exclusive or captive agent.
  - Agent represents solely one company or group of companies having common ownership
  - Insurer retains ownership rights to the business written by the agent
  - The agent is an employee or a commissioned independent contractor
  - Insurer may or may not provide office and agency support services

- **Direct Writing System**
  - Producer or Agent is an employee of the insurer
  - Insurer owns the accounts
  - The agent may be paid a salary, salary + bonus, or commission

- **Independent Agency**
  - An agent or agency that enters into selling agreements with more than one insurer. It may represent an unlimited number of insurers.
  - Agency retains ownership of the business written.
  - An independent contractor that is paid a commission and covers the cost of agency operations.

- **Career Agency System** – Agents are recruited, trained and supervised by either a managing employee or General Agent who is contracted with the insurance company.

- **Personal Producing General Agent**
  - Does not recruit career agents.
  - Sells insurance for carriers it is contracted with and maintains its own office and staff.
Direct Mail or Direct Response Company
- Insurers who sell insurance policies directly to the public with licensed employees or contractors.
- A marketing system utilizing mass media, such as direct mail, newspapers, magazines, radio, television, internet, web sites, call centers and vending machines.

Mass Marketing
- Used to target a specific type of insurance to a large group of individuals, such as the American Association of Retired People (AARP).
- Insurer may benefit by reductions in marketing costs and underwriting expenses may be lower when offering coverage to a limited population. Mass marketing uses the direct response or direct mail method to reach its targeted audience.
- Associations may receive some financial benefit from allowing an insurer to market directly to its membership.

Retention Question 4
Which insurance company department accepts the insurance risk?
- a. Executive
- b. Actuarial
- c. Claims
- d. Underwriting

1.6 Insurance Agents and Producers

Law of Agency – The relationship of a person (called the agent or producer) who acts on behalf of another person, company, or government, known as the principal. The principal is responsible for the acts of the agent, and the agent’s acts bind the principal. An act of an agent is the act of the principal.

Insurer (principal) – The Insurer is the source of authority from which the producer must abide. The Insurer appoints the producer to act on its behalf in transacting the business of insurance. It is responsible for all acts of its producers when a producer is acting within the scope of his/her authority. A producer may be personally liable when his/her actions exceed the authority of his/her contract.

Producer (agent) – A person or agency appointed by an insurance company to represent it and to sell policies on its behalf. A producer acts with one or more of the following three types of authority:

- **Express** – Authority that is written into the producer’s contract. An example would be the producer’s binding authority if written in the contract. A producer’s contract may also express what the producer may not do, such as creating his/her own advertisements.
- **Implied** – Authority the public assumes the producer has. An example would be the business activities of providing quotes, completing applications and accepting premiums on behalf of the insurer.
- **Apparent** – Authority created when the producer exceeds the authority expressed in the agency contract. This occurs when the insurer takes no action to counter the public impression that such authority exists. An example would be the producer’s issuance of a binder when, in fact, the producer has not been granted such authority.
Producer’s Responsibilities to the Insurer:

- Fiduciary duty to the insurer in all respects. A fiduciary is a legal or ethical relationship of trust between two or more parties. Typically, a fiduciary prudently takes care of money for another person especially when handling premiums for insurance policies or applications.
- Must keep premiums in a trust account separate from other funds and forward to insurer promptly (no commingling).
- Must report any material facts that may affect underwriting.
- Responsible for soliciting, negotiating, selling, and cancelling the insurance policies with the insurer.
- Duty to only recommend the purchase of suitable policies.

Producer’s Responsibilities to Insurance Applicant or Insured:

- Forward premiums to insurer on a timely basis.
- Seek and gain knowledge of the applicant’s insurance needs.
- Review and evaluate the applicant’s current insurance coverage, limits, and risks.
- Serve the best interests of the applicant or insured, although producers represent the insurer.
- Recommend coverage that best protects the insured from possible loss and NOT the most profitable coverage from the perspective of the producer.
- Life and health producers do not issue contracts or binders for life or disability insurance, and should not imply that coverage is in effect simply because a person submits an application and payment for the first premium.

Broker – A licensed individual who negotiates insurance contracts with insurers on behalf of the applicant. A broker represents the applicant or insured’s interests, not the insurer, and does not have legal authority to bind the insurer. Broker licenses are not applicable in all states.

Retention Question 5

Which of the following individuals represents the insurance company when selling an insurance policy?

a. Producer
b. Broker
c. Adjuster
d. Insurer

Retention Question 6

Which of the following type of authority does the public assume an agent has when quoting insurance?

a. Authorized
b. Express
c. Implied
d. Apparent

Retention Question 7

A producer has each of the following responsibilities to the Insurer, EXCEPT:

a. A fiduciary duty
b. Forwarding premiums to the insurer on a timely basis
c. Reporting material facts that may affect underwriting
d. A duty to recommend only high premium policies
CHAPTER ONE

1.7 Federal Regulations

Fair Credit Reporting Act (15 USC 1681–1681d)

The Fair Credit Reporting Act protects consumer privacy and protects the public from overly intrusive information collection practices. It ensures data collected is confidential, accurate, relevant, and used for a proper and specific purpose.

When an application is taken, it must inform the applicant a credit report (from a consumer reporting agency) can be obtained. The purpose of this is to determine the financial and moral status of an applicant (for variety of purposes such as employment screening, insurance underwriting or loan approvals). An applicant has the right to review the report.

- **Applicant Challenge** – Credit reporting agency must reinvestigate within 6 months if applicant challenges accuracy.
- **Inaccuracies** – Agency must forward to applicant inaccurate information given out within previous 2 years.
- **Disallowed Information** – Report must not include lawsuits over 7 years old or bankruptcies more than 10 years old.
- **Disclosure upon Request** – Consumer reporting agencies must provide the information on file if requested.
- **Limited Access to Information** – A consumer reporting agency may not provide a credit report to any party that lacks a permissible purpose, such as the evaluation of an application for a loan, credit, service, or employment. Permissible purposes also include several business and legal uses.
- **Investigation of Disputed Information** – If a consumer’s file contains inaccurate information, the agency must promptly investigate the matter with the source that provided the information. If the investigation fails to resolve the dispute, a statement may be added to the credit file explaining the matter.
- **Correct or Delete Inaccurate Information** – A consumer reporting agency must correct or, if necessary, delete from a credit file the information that is found to be inaccurate or can no longer be verified. The consumer reporting agency is not required to remove accurate data from a file unless it is outdated. Adverse information that is more than 7 years old (10 years for bankruptcies) must be removed from the file.

USA PATRIOT Act and Anti Money Laundering (AML)

With the increase of drug trafficking and acts of terrorism, the desire and demand for laundered money has also increased. As of May 2006, insurance companies have been required to provide anti-money laundering training to their producers. Brokers as well as agents are required to undergo training as insurance products are now being used to give legitimate appearance to money financed by and for illegal activities.

These new requirements and standards were necessitated by the USA PATRIOT Act. This act specified which financial institutions would be required to institute AML training programs including insurance companies. The act specified which insurance products require anti-money laundering training and how to respond to suspected laundering activity. It also helped expand the definition of money laundering to include the money’s ultimate purpose as well as its origin. The insurance products being used are mostly single premium permanent life insurance and annuity products, as they generate cash value.
There are several “red flags” agents are trained to recognize, one in particular is a client buying a policy simply to hide or move illegal money. Practices that are outside the norm for life insurance transactions include:

- Paying for an entire policy up front with cash.
- Early cancellation of the policy, regardless of cancellation fees (surrender charges).
- The heavy use of third parties for policy transactions.
- Strong reliance on wire or electronic fund transfers to foreign accounts.

Agents/brokers are required to report any activity they believe or even have reason to suspect is an effort to launder money. Depending upon a producer’s involvement in the transaction, failure to comply can result in dismissal and civil or possibly even criminal prosecution.

**Fraud and False Statements (Fraudulent Insurance Act)**

Fraud always involves a false statement and deceit; it can be either a criminal or civil crime. Federal laws prohibit the commission of fraud. In 2001, the NAIC adopted model legislation for the prevention and enforcement of insurance fraud. Subsequently, each of the states enacted its own Fraudulent Insurance Act.

A fraudulent act involves a misstatement of material fact by a person who knows or believes that statement to be false. The statement is made to another person who relies on its accuracy to make a decision or to act and is subsequently harmed by relying on the deliberately false statement. State fraudulent insurance acts do not modify the privacy of any individual; they protect producers, brokers, and insurers in the event fraudulent information is provided by consumers.

Insurance applications and claim forms must contain a disclosure about how false statements and fraud will be treated by the insurer. A sample warning is, “Any person who knowingly presents false or fraudulent information on an insurance application or claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.”

If a person engaged in the business of insurance whose activities affect interstate commerce willfully embezzles, misappropriates funds/property, knowingly and with the intent to deceive makes a false material statement or purposely overstates the security of an insurer, the following penalties apply:

- A fine of no more than $50,000, imprisonment for up to 10 years, or both
- If the violation jeopardized the safety and soundness of an insurer and was a significant cause of the insurer being placed in conservation, rehabilitation, or liquidation by an appropriate court, imprisonment can be for up to 15 years
- If the amount embezzled or misappropriated does not exceed $5,000, violators will be fined up to $50,000 or imprisoned for up to 1 year, or both

If a person uses threats, force or attempts to impede/obstruct the administration of the law during any proceeding involving the business of insurance before any insurance regulatory official, he/she will be fined up to $50,000 or imprisoned up to 10 years, or both.

Any individual who has been convicted of a felony involving dishonesty or a breach of trust, who then willfully engages or permits an individual to engage in the business of insurance, and whose activities affect interstate commerce, will be fined up to $50,000 or imprisoned up to 5 years, or both.
Gramm-Leach-Bliley Act (the Financial Services Modernization Act of 1999)

This repealed parts of the Glass-Steagall Act of 1933 to allow the merger of banks, securities companies, and insurance companies. It also established the Financial Privacy Rule and Safeguards Rule for the protection of consumers’ privacy.

The Financial Privacy rule requires “financial institutions,” which include insurers, to provide each consumer with a privacy notice at the time the consumer relationship is established and annually thereafter. In insurance, the consumer relationship is created when the policy is issued to the client. Application information remains confidential and cannot be used for other purposes without prior notice to the consumer.

The privacy notice must explain:

- The information collected about the consumer
- Where that information is shared
- How that information is used
- How that information is protected

The notice must also identify the consumer’s right to opt out of the information being shared with unaffiliated parties pursuant to the provisions of the Fair Credit Reporting Act.

Should the financial institutions privacy policy change at any point in time, the consumer must be notified again for acceptance. Each time the privacy notice is re-established, the consumer has the right to opt out again.

Violent Crime Control and Law Enforcement Act of 1994 (18 USC 1033, 1034)

The largest crime bill in U.S. history expands funding to federal agencies such as the FBI, DEA, and INS and includes provisions that address (among other topics) domestic abuse and firearms, gang crimes, immigration, registration of sexually violent offenders, victims of crime, and fraud.

The Act made it a felony for a person to engage in the business of insurance after being convicted of a state or federal felony crime involving dishonesty or breach of trust. Violations include willfully embezzling money, knowingly making false entries in any book, report or statement of the business, threatening or impeding proper administration of the law in any proceeding involving the business of insurance.

- Dishonesty refers to misrepresentation, untruthfulness, falsification.
- Breach of Trust is based on fiduciary relationship of parties and the wrongful acts violating the relationship.
- Penalties – Fines and possible prison time.

Insurance license applicants and producers:

- Applicants who have been convicted of a felony must apply for Consent to Work (1033 Waiver) in the business of insurance—prior to applying for an insurance license.
- Producers must apply for consent in their resident state.
- Officers and employees must apply for consent in the state where their home office is located.
- Prohibited persons (convicted felons) must apply for consent in order to discover if they are permitted or prohibited from the insurance business.
- Reciprocity – If consent is granted by any state, other states must allow the applicant to work in their states as well.
- Consent Withdrawal – If conditions of consent are not continually met, the consent may be withdrawn.
Retention Question 8

*A federal regulation called the ____________ protects consumer privacy.*

a. Consolidated Omnibus Budget Reconciliation Act
b. Fraudulent Insurance Act
c. Privacy Protection Act
d. Fair Credit Reporting Act

1.8 Risk Management

**Risk** – A condition where the chance, likelihood, probability or potential for a loss exists.

**Management**

- The determination of what types of protection are required to meet an insured’s needs. Risk may be manageable, but it cannot be eliminated.
- A survey of the insured’s operations, health, and risk exposures that could give rise to losses, including the identification of hazardous conditions or situations that could be reduced or eliminated to prevent losses.
- Assessment of potential loss frequency and severity.
- Physical inspections, applications or medical exams used in underwriting may help to manage or raise awareness of a risk.
- Health insurance providers may offer insureds “wellness” programs at low or no cost for weight loss, smoking reduction, stress, or medical conditions such as diabetes as a means of reducing the company’s future claims exposure.

**Types of Risk**

- **Speculative Risk** – Situations where there is a chance for loss, gain, or neither loss nor gain to occur. Examples of speculative risk include gambling, investing, starting a new business. Speculative risk cannot be insured.
- **Pure Risk** – Situations where there is no chance for gain; the only outcome is for nothing to occur or for a loss to occur. Pure risk is the only risk that can be insured. Examples include the possibility of:
  - Damage to property caused by a fire or other natural disaster.
  - Financial loss as a result of injury, illness, or death.

**Loss** – Reduction, decrease, or disappearance of value. A loss is the basis of a claim under the terms of an insurance policy.

**Peril** – The cause or source of a loss (fire, windstorm, embezzlement, disease, death).

**Hazard** – A specific condition that increases the probability, likelihood, or severity of a loss from a peril.
### Three Types of Hazard

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<thead>
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<th>Physical Hazard</th>
<th>Moral Hazard</th>
<th>Morale Hazard</th>
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<tr>
<td>A physical condition that increases the likelihood or probability of loss. Physical hazards may be seen, heard, felt, tasted, or smelled. <strong>Example:</strong> Flammable material stored near a furnace.</td>
<td>Dishonest tendencies that increase the probability of a loss; certain characteristics and behaviors of people. Moral hazards most closely related to some form of lying, cheating, or stealing. <strong>Example:</strong> An insured burns down his/her own house to collect the insurance payout.</td>
<td>An attitude of indifference toward the risk of loss that increases the probability of a loss occurring. <strong>Example:</strong> Driving too fast for conditions, not wearing a seat belt, ignoring stop signs at familiar intersections, smoking, failure to take medications that could control a medical condition, are all morale hazards.</td>
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**Loss Exposure** – The condition of being at risk of loss. Simply by existing, property and people are subject to many different risks. To an insurance company, each insured person or their covered property represents the risk of loss and the value of each potential claim is a known loss exposure.

**Adverse Selection** – An imbalance created when risks that are hard to insure (more prone to losses than the average (standard) risk) are the only risks seeking insurance within a specific marketplace. For example, only those living in earthquake-prone areas seek to buy earthquake insurance or those in the poorest of health seeking to acquire life or health insurance. High risks exposures tend to seek or continue insurance at a higher participation rate than the average risk exposures do.

**Managing Risk** – Analyzing exposures that create risk and designing programs to minimize the possibility of a loss. Ways of managing risk:

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<td>■ Investments by a large number of people may be pooled by use of a corporation or partnership.</td>
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<td>■ Pooling or spreading the risk among a large number of persons or entities.</td>
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<tr>
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<td>■ Transferring the risk from one party to another, such as from a consumer to an insurance company.</td>
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<td>■ Transfer the uncertainty of loss via a contract.</td>
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<td>■ Elimination of the risk.</td>
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<td>■ Avoid the activity that gives rise to the chance of loss.</td>
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<td>■ After potential areas of hazards have been identified, it may be found that some exposure to risk can be eliminated, but it is impossible to avoid all risk.</td>
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<td>■ A risk may be avoided by not accepting or entering into the event which has hazards. This method has severe limitations because such a choice is not always possible, or if possible, it may require giving up some important advantages.</td>
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<td>■ Minimizing the chance of loss, but not preventing the risk. For example, sprinkler systems, burglar alarms, pollution controls and safety guards on machinery, taking medications, having preventive medical care.</td>
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<td>■ Assume the responsibility for loss.</td>
<td></td>
</tr>
<tr>
<td>■ Self-insure the entire loss or a portion of the loss. Choosing deductibles is a method of risk retention.</td>
<td></td>
</tr>
<tr>
<td>■ It may be economically practical for an insured to not insure each exposure to loss and, instead insure only those risks that threaten financial stability or security.</td>
<td></td>
</tr>
</tbody>
</table>
Insurable risks must include:

- Large number of **homogeneous** units or groups with the same perils.
  - **Law of Large Numbers** – As the number of units in a group increases, the more likely it is to predict a particular outcome.
  - Auto insurance losses are the easiest type of insurance loss to predict precisely because the number of units insured is so great.
- The chance of loss must be **calculable**. A statistical expectation of loss is used by insurers to calculate premiums.
- The loss must be **measurable** (definite and verifiable in terms of amount, cause, place and time).
- The premiums must be affordable.
- From the perspective of the insured, the loss must be **accidental** in nature.
- Catastrophic perils are not covered; examples include war, nuclear hazard and illegal operations.

Retention Question 9

**Dishonest tendencies that increase the probability of loss are what types of hazard?**

- a. Physical
- b. Moral
- c. Emotional
- d. Legal

Retention Question 10

**Each of the following must be included in an insurable risk, EXCEPT:**

- a. Calculable chance of loss
- b. Excluded catastrophic perils
- c. Large group with dissimilar members
- d. Accidental losses

### 1.9 Insurance Concepts

**The Insurance Contract**

- A legal contract purchased to indemnify the insured against a loss, damage, or liability arising from an unexpected event.
- The exchange of a relatively small and definite expense for the risk of loss that, if it occurs, may be large or small.
- A contract designed to transfer risk from the insured to the insurer.

**Principal of Indemnity**

- Insured is intended to be restored to the same financial or economic condition that existed prior to the loss, depending on the amount and type of insurance purchased.
- Insured should not profit from an insurance transaction, but be made “whole again.”
**Insurability** – The ability of an applicant to meet an insurer’s underwriting requirements.

**Underwriting** – The process of selecting, classifying, and rating a risk for the purpose of issuing or not issuing insurance coverage.

**Insurable Events** – Any event, past or present, which may cause loss or damage, or create legal liability on the part of an insured.

**Insurable Interest**

- **All Policies**
  - Insurable interest must exist in every enforceable insurance contract.
  - Requires the potential for an insured to suffer financial or economic hardship in the event of a loss, as well as a valid legal purpose for the contract.

- **Life & Health Policies**
  - Insurable interest must exist at the time of application, but not at time of loss.
  - Coverage is determined based on the possibility of an economic or financial loss due to an accident, sickness, or death of the insured.
  - The amount of insurance that may be purchased varies based on the type of coverage. Each person has an unlimited insurable interest in his/her own life, but this does not prevent an insurance company from limiting the amount of life insurance it makes available to any person. The insurer does not want to over insure as this may increase the likelihood of a claim.

- **Property**
  - While it is unlikely an insurer will issue a policy if there is no insurable interest at the time of application, insurable interest must specifically exist at the time of the loss.
  - Property ownership (or mortgage or lien) is evidence of insurable interest.

- **Casualty**
  - Insurable interest must exist at the time of the loss, but need not be continuous.
  - Insurable interest usually results from property or contract rights and potential legal liability.

**Retention Question 11**

*Which principle of insurance restores the insured to the same economic condition that existed before the loss?*

a. Indemnity  
b. Insurability  
c. Adhesion  
d. Underwriting
### General Terms

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contract Law</td>
<td>Pertains to the formation and enforcement of contracts.</td>
</tr>
<tr>
<td>Tort Law</td>
<td>Torts are civil wrongs; they’re not crimes or breaches of contract. They result in injuries or harm that constitute the basis of a claim by a third party.</td>
</tr>
<tr>
<td>Hold Harmless Agreement</td>
<td>A contractual agreement that transfers the liability of one party to another party; it is used by landlords, contractors, and others as a way to avoid or reduce risk.</td>
</tr>
<tr>
<td>Reasonable Expectations</td>
<td>What a reasonable and prudent policy owner would expect; the reasonable expectations of policyowners are honored by the Courts although the strict terms of the policy may not support these expectations.</td>
</tr>
</tbody>
</table>

### Four Elements of a Legal Contract

A contract is an agreement between two or more parties in which there is a promise to do something in return for a valuable benefit known as consideration. The parties to each agreement are subject to the specific terms of that agreement, which govern the way its provisions are carried out.

In the formation and enforcement of any legal contract, 4 necessary elements must have existed at the time the contract was executed between the parties. They are:

1. **Competent Parties**
   - All parties to a contract (i.e., Insurer and Insured must have legal capacity to enter into a contract).
   - Those without legal capacity include:
     - **Minors** – The insurer may be held responsible for its obligations. However, in most cases a minor cannot enter into a contract. Exceptions do exist, such as for the purchase of auto insurance.
     - The mentally incompetent or incapacitated.
     - Persons under influence of drugs or alcohol.

2. **Legal Purpose**
   - All parties to a contract must enter it for a legal purpose; public policy cannot be violated by a legal contract.
   - All parties to a contract must enter it in good faith.

3. **Agreement** – One party must make and communicate an offer to the other party and the second party must accept that offer. Without an offer, there is nothing to accept, and without acceptance of an offer, there can be no agreement. Offer, acceptance, or agreement can represent this element.
   - **Offer** – The offer made to enter into an insurance contract is most commonly an application, accompanied by an initial premium, and submitted by the applicant.
   - **Acceptance** – The acceptance of an offer to provide an insurance contract takes place when the insurance company agrees to issue the insurance applied for, after receiving an initial premium and complete application. If the applicant is insurable, but only under less favorable terms, the insurer may make a counteroffer. In such cases, the insured has been determined to be acceptable to the insurance company but a policy will not be in force until the applicant pays a higher premium and/or accepts any conditions imposed on the coverage (such as reduced benefits).
4. Consideration

- Something of value is exchanged by each of the parties to the contract; the exchange of money (first premium only) for a promise (the guarantees within the contract).

- The consideration made by the applicant is the information on the application and the initial premium payment. If an application is not accompanied by the initial premium, no offer has been made in the technical sense, since the consideration given is incomplete. If the insurer still offers a policy based on the application (notice the policy is now an offer), then acceptance is given when the initial premium is paid. At that point, consideration is complete, and the policy is in force.

- The consideration provided by the insurer is its promise to pay for covered losses—the contract itself.

**Insurance Contract Terms**

These terms are commonly used when describing insurance contracts:

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indemnity Contract</td>
<td>Pays a specified dollar amount as stated in the contract up to the amount of the actual loss. These contracts are considered reimbursement plans.</td>
</tr>
<tr>
<td>Parol Evidence Rule</td>
<td>A written contract may not be altered without the written consent of both parties.</td>
</tr>
<tr>
<td>Valued contract</td>
<td>A contract that pays a specified amount regardless of the actual loss. A life insurance contract is an example of a valued contract. It has a face value that provides a death benefit in the event of a loss.</td>
</tr>
<tr>
<td>Subrogation</td>
<td>Occurs when a claim is paid by the insurer who has the contract and the right to take legal action against a negligent third party who may have caused the loss. Life policies have no right of subrogation.</td>
</tr>
</tbody>
</table>

**Characteristics of an Insurance Contract**

**Contract of Adhesion** – One party writes the contract, without input from the other party. One party (insurer) prepares the contract and presents it to the other party (applicant) on a "take-it-or-leave-it" basis, without negotiation. Any doubt or ambiguity found in the document is construed in favor of the party that did not write it (insured).

**Aleatory Contract** – The exchange of value is unequal. Insured’s premium payment is less than the potential benefit to be received in the event of a loss. The insurer’s payment in the event of a loss may be much greater, or much less (e.g., $0 in the event a loss doesn’t occur), than the insured’s premium payment.

**Personal Contract** – A contract between the insurance company and an individual. Personal contract are specific to the person insured at the time the contract is formed. The owner and insured cannot be changed without consent of the insurance company. A property and casualty insurance contract is personal since it cannot be assigned. Life insurance is NOT a personal contract. The policy can be assigned—or a new owner may be named as long as the insurer is notified of the change.

**Unilateral Contract** – Only one party is legally bound to the contractual obligations after the premium is paid to the insurer. Only the insurer makes a promise of future performance, and only the insurer can be charged with breach of contract. The policyowner can cancel the policy at any time and for any reason. The policyowner is not required to continue paying future premiums.
**Conditional Contract** – Both parties must perform certain duties and follow rules of conduct to make the contract enforceable. The insurer must pay claims if the insured has complied with all the policy’s terms and conditions. Without premiums being paid on time and in full the insurer is not obligated to pay the claim if the policy lapses.

**Legal Interpretations Affecting Contracts**

**Principal of Indemnity** – The insured is restored to the same financial or economic condition that existed prior to the loss, depending on the amount and type of insurance purchased. The insured should not profit from an insurance transaction.

**Utmost Good Faith** – Both parties bargain in good faith when forming and entering into the contract. The two parties rely upon the statements and promises of the other and assume no attempt to conceal or deceive has been made.

**Representations** – Statements made by the applicant on the application are considered representations and not warranties. The representations are statements that are believed to be true to the best of the knowledge and belief of the applicant/insured at the time of application.

- **Material vs. Immaterial Representations** – Statements that impact the acceptance of an insurable risk—whether involving the rating of an acceptable risk, or the decision as to whether to accept or decline a risk—are considered to be material. Immaterial representations do not affect the acceptance or rating of the risk.

**Misrepresentations** – A false statement contained in the application; usually does not void coverage or the policy, if it is immaterial. If material to the issuance of coverage, meaning the insurer would not have issued a policy had the misrepresentation not been made, or premiums charged would have been higher, or coverage limited, coverage does not apply. A material misrepresentation may void the policy.

**Warranties** – Statements in the application or stipulations in the policy that are guaranteed true in all respects. If warranties are later discovered untrue or breached (past, present or future), coverage (and sometimes the contract) is voided.

**Concealment** – The willful holding back or secretion of material facts pertinent to the issuance of insurance (or a claim). Concealment may result in denial of coverage and may void the policy.

**Fraud** – Intentional deception of the truth in order to induce another to part with something of value or to surrender a legal right. Contains 5 elements:

- False statement, made intentionally and that pertains to a material fact
- Disregard for the victim
- Victim believes the false statement
- Victim makes a decision and/or acts based on the belief in, or reliance upon, the false statement.
- The victim’s decision and/or action results in harm.

**Waiver** – Voluntary surrender of a known right, claim or privilege; An example would be an insurer’s failure to obtain an answer to an unanswered question in its application for insurance prior to issuing the policy. Such a failure waives the insurer’s right to contest a claim based on the information it could reasonably have obtained. It may also be in cases in which the insurer accepts an overdue premium that keeps the policy in force.

**Estoppel** – Judicial denial of a contractual right based on prior actions contrary to what the contract requires.
Example

An insurer who routinely does not require an application for reinstatement cannot contest a claim because an application was not submitted even though it is a requirement stated in the reinstatement provision in its contracts. In the law, there are several different forms of estoppel. If the insurer waives its rights, it cannot later then assert those rights.

Retention Question 12

Each of the following is an element of a legal contract, EXCEPT:

a. Consideration
b. Legal Purpose
c. Agreement
d. Indemnity

Retention Question 13

A warranty is defined as which of the following?

a. Intentional misrepresentation on the application
b. Statement in the application that is guaranteed to be true
c. A false statement in the application
d. What a reasonable and prudent buyer can expect

1.11 Insurer Underwriting

Underwriter

The underwriter’s primary responsibilities include the selection of risks by determining insurability. Insurable interest is also established at that time. The underwriter also determines the classification, or type of risk, and premium rating if a risk is accepted by the insurer.

Underwriting protects the insurer against adverse selection and risks that are more likely than average to suffer losses. The goal is to select risks that fall into the normal range of expected losses. The field underwriter is the producer.

Underwriting Factors

■ Age
■ Gender
■ Tobacco use
■ Medical history and preexisting conditions
■ Hazardous hobbies and occupations

Premium Assumptions

An adequate premium must be charged for the risk based on the same factors used in evaluating the risk. Premium rates are considered inadequate when they do not cover projected losses and expenses. Rates must not be excessive or unfairly discriminatory.

■ Rate – The dollar amount charged for a particular unit of insurance, such as $5 per $1,000 of insurance.
■ Premium – The total cost for the amount of insurance purchased.

$50,000 of coverage = $5 rate x 50 (per $1,000 of insurance) for a $250 premium.
Retention Question 14

Each of the following is a factor considered by an underwriter, EXCEPT:

a. Age
b. Marital status
c. Gender
d. Hazardous occupation

CHAPTER ONE — LIGHTNING FACTS

1. The State Commissioner, Supervisor, or Director of Insurance is the chief insurance regulator and has the power to issue rules and regulations to enforce state insurance statutes. 1.1
2. A stock insurance company issues non-participating policies and is owned by stockholders who may receive taxable corporate dividends as a share of the company’s profit. 1.2
3. A mutual insurance company issues participating policies and is owned by the policyholders who may receive non-taxable dividends as a return of any divisible surplus. 1.2
4. Reinsurance is the transfer of risk between insurance companies. The reinsurer assumes some or all of the risk of the ceding, or primary, insurance company. 1.3
5. Domicile refers to the state in which an insurer incorporated. A domestic insurer is organized under the laws of the resident state, a foreign insurer is organized under the laws of another state within the United States, and an alien insurer is organized under the laws of a country outside the U.S. 1.4
6. An admitted insurer is authorized to do insurance business in the state and is issued a Certificate of Authority by the state’s Department of Insurance. 1.4
7. The underwriting department of an insurance company is responsible for the selection of risks (persons and property) to insure and determines the rate to be charged for the amount of coverage to be issued. 1.5
8. Under the Direct Writing System, an agent/producer can be the employee of an insurance company that owns the agent’s book of business. Under the Independent Agency, a producer is an independent agent that enters into selling agreements with more than one insurance company. They are appointed by more than one insurer. Independent agent retains ownership of their books of business. 1.5
9. The Law of Agency is a relationship where a Principal authorizes an Agent to act on its behalf in the business of insurance. An act of the agent is an act of the agent’s principal. 1.6
10. Express authority is written into the producer’s agency contract; implied authority is that which the public assumes the agent possesses; and apparent authority is created when the agent exceeds express authority and the insurer accepts the agent’s actions. 1.6
11. The Fair Credit Reporting Act (FCRA) protects consumer privacy by ensuring that any data collected by an insurer remains confidential, and is accurate, relevant, and used for a proper and specific purpose. 1.7
12. A risk is the condition where the chance, probability or potential for a loss exists. 1.8
13. A peril is the cause or source of a loss. 1.8
14. A hazard increases the probability of a loss. The 3 types of hazards are physical, moral, and morale. 1.8
15. The principle of indemnity means that the insured should not profit from a loss. Instead, it restores the insured to the same financial or economic condition that existed prior to the loss. 1.9
16. Insurable interest in property and casualty insurance must exist at the time of the loss but for life insurance, it must exist only at the time of application and policy issuance. 1.9

17. The insurance contract is one of adhesion; one party (the insurer) prepares the contract and presents it to the second party (the insured), who must accept it on a "take-it-or-leave-it" basis. 1.10

18. The underwriting factors used to determine premium include age, gender, tobacco use, medical history, hazardous hobbies and hazardous occupations. 1.11