The Insurance Marketplace

This section begins with an overview of marketing distribution systems. It then focuses on producers, describing in detail their licensing and education requirements, duties and authorities, and code of ethics. This section also explores the different types and qualifications of insurers. Finally, you will read about market conduct regulations for underwriting, sales, ratemaking, and claims handling. Pay close attention to regulations regarding unfair trade practices and fair claims settlement practices.

TERMS TO KNOW

Appointment — the authority given by an insurer to an agent to transact insurance on the insurer's behalf
Cease and desist — to stop or discontinue
Coercion — forceful act or threat aimed to influence a person to act against his or her will
Commission — payment to the agent by the insurance company for placing insurance, usually a percentage of the policy premium
Commissioner — the head of the State Department of Insurance
Exempt — not subject to an obligation
Inducement — an offer that attempts to influence the other party
Injunction — a court issued order to stop committing an act or violation
Insolvent — unable to meet financial obligations
Restitution — restoration to the original condition or repayment
Surplus lines insurance — insurance that is not available from admitted insurers

A. Distribution Systems

Educational Objective:

I.C.1. Be able to identify different distribution systems that include, but are not limited to, the following:

a. Agency
b. Direct response

1. Agency

A **producer** is a legal entity, either human or corporate, that acts on behalf of, or in the place of, its **principal.** In insurance, the producer is the agent, and the principal is the insurer.

An insurance agent must first establish a licensing relationship with the state or states within which the agent wishes to conduct business. This requires meeting educational standards and passing required tests for the type of insurance which will be sold. This licensing relationship is separate from, and can exist without, any agent/insurer relationship being established.

The **independent agent** has contracts with more than one insurer and, ideally, is then in an enhanced position to offer clients a wide range of product options. When the time to renew a policy comes, the independent agent is said to **own the renewal** or **own the expiration.** This means that the independent agent can move the client to a different insurer for the renewal. This would best be done only if it is to the client's advantage. An ethical challenge facing the independent agent is to avoid moving clients simply to generate new or higher commissions.

The **exclusive** or **captive** or **career agent** chooses to have a contract with one company. An agent may choose to do this when he or she finds the insurer's products to be of extraordinary quality and applicability and feels no need to have other insurer relationships. An agent might also make this choice because the insurer only allows its products to be sold through its own, exclusive agents.

Exclusivity, depending on the viewer, can appear to be a positive or a negative. Positively, the agent can represent a product that would otherwise be unavailable to the client. Negatively, the agent is not able to search throughout the industry for a product which will be more to the client's advantage.

2. Direct Response

Mass marketing of insurance products through mail solicitations, print media advertisements, or television and radio are referred to as **direct response** marketing. The policies provided are generally low in benefits and low in premiums.

The term "direct response" refers to the necessity of the potential client to take the initiative and respond to the advertisement through a telephone or mail contact with the insurer as directed in the ad.

B. Producers

1. Legal Relationships

Educational Objective:

I.C2.1. Be able to understand the general rules of agency as they apply to an agent, broker, and insurance company:

a. The responsibilities and duties of each
b. The effect of the types of authority an agent may exercise (express, implied, apparent)

A producer is an individual licensed to sell, solicit, or negotiate insurance contracts on behalf of the **principal (insurer)**. The producer is considered an agent of the insurer. The **law of agency** defines the relationship between the principal and the producer: the acts of the agent within the scope of authority are deemed to be the acts of the insurer.

In this relationship, it is a given that

- An agent represents the insurer, not the insured;
- Any knowledge of the agent is presumed to be knowledge of the insurer;
- If the agent is working within the conditions of the agent's contract, the insurer is fully responsible; and
- When the insured submits payment to the agent, it is the same as submitting a payment to the insurer.

The agent is responsible for accurately completing applications for insurance, submitting the application to the insurer for underwriting, and delivering the policy to the policyowner.

Know This! Insurance agents represent the *insurer* (principal). "Who is your pal? The principal!"

Insurer as Principal

In applying the law of agency, the insurer is the **principal**. The acts of an agent or producer who is acting within the scope of their authority are the acts of the insurer.

Producer and Insurer Relationship

An agent (or producer) will always be deemed to represent the insurer, not the insured. With regards to an insurance contract, any knowledge of the agent is presumed to be knowledge of the insurer. **If the agent is working within the conditions of their contract, the company is fully responsible.**

The **agent** is responsible to the insurer when completing applications for insurance, submitting the application to the insurer for underwriting, and when issued, delivering the policy to the policyowner and explaining the contract. In addition, if the insured submits payment to the agent, it is the same as submitting a payment to the insurer.

Responsibilities to the Applicant and Insured

Although the agents act for the insurer, they are legally obligated to treat applicants and insureds in an ethical manner. Because an agent handles the funds of the insured and the insurer, the agent has a **fiduciary responsibility**. A *fiduciary* is someone in a position of trust. More specifically, it is illegal for insurance producers to commingle premiums collected from the applicants with their own personal funds.

Authority and Powers of Producers

The agency contract details the authority an agent has within his/her company. Contractually, only those actions that the agent is authorized to perform can bind

the principal (insurer). In reality, an agent's authority is much broader. There are 3 types of agent authority: express, implied, and apparent.

Express

Express authority is the authority a principal intends to grant to an agent by means of the agent's contract. It is the authority that is written in the contract.

Implied

Implied authority is authority that is **not expressed or written into the contract, but which the agent is assumed to have in order to transact the business** of insurance for the principal. Implied authority is incidental to and derives from express authority since not every single detail of an agent's authority can be spelled out in the written contract.

Example:

If the agency contract does not specifically authorize the agent to collect premiums and remit them to the insurer, but the agent routinely does so in the process of solicitation and delivery of policies, the agent has the implied authority to collect and remit premiums.

Apparent

Apparent authority (also known as *perceived* authority) is the appearance or the assumption of authority based on the actions, words, or deeds of the principal or because of circumstances the principal created. *For example,* if an agent uses insurer's stationery when soliciting coverage, an applicant may believe that the agent is authorized to transact insurance on behalf of the insurer.

Definition of "Transact"

Educational Objective:

I.C2.4. Be able to identify the Code definition of *transact* and why the definition is important (CIC 35, 1621-24, 1631, 1633).

a. Know that the CIC prohibits certain acts by unlicensed persons (CIC 1631)
b. Know the penalties for such prohibited acts (CIC 1633)

When a person performs any of the following actions, they are **transacting insurance:**

- Solicitation of insurance;
- Negotiations preliminary to the execution of a contract;
- The actual execution of a contract; and/or
- Any transactions that later result from the operation of the contract.

With the exception of certain persons who receive non-commission compensation from their employer for these actions, any other person who

receives compensation for “transacting insurance” must be licensed as an agent or broker. It is a **misdemeanor** to transact insurance without a license. The maximum penalty for **transacting insurance without a valid license is a fine of up to $50,000** or imprisonment in a county jail for up to 1 year, or both.

The California Insurance Code defines a variety of specific **licenses** which may be issued to qualified persons:

- Property and casualty;
- Life;
- Accident and health or sickness;
- Personal lines; and
- Surplus lines.

An **insurance agent** in this state means a person authorized to transact all classes of insurance on behalf of an admitted insurer **other than life, disability, or health insurance**.

Life agents in California are authorized to transact **insurance on human lives** including the following benefits:

- Endowments;
- Annuities;
- Death or dismemberment by accident; and
- Disability income.

Accident and health or sickness agents may transact the following types of insurance:

- Sickness;
- Bodily injury;
- Accidental death;
- Disability income; and
- 24-hour coverage.

A **property and casualty** licensee (former fire and casualty licensee) may be authorized to transact any of the following coverages:

- Automobile insurance;
- Personal watercraft;
- Residential property (including earthquake and flood);
- Inland marine insurance; and
- Umbrella or excess liability insurance.

A **personal lines agent** may transact only personal automobile, inland marine for personal property, residential property, and umbrella or excess liability lines of insurance.

A **limited lines automobile insurance agent** is authorized to transact auto insurance, including automobile liability coverage, physical damage coverage, and collision coverage.

A **surplus line broker** is authorized to transact insurance with a nonadmitted insurer only if a specific class of insurance cannot be obtained from admitted insurers (after proof of a diligent search).

Regardless of the type of license held, with the exception of a surplus line broker, agents or brokers may not advertise or transact insurance on behalf of a nonadmitted insurer or aid a nonadmitted insurer in any way to transact insurance in California.

2. Types of Licensees

Educational Objective:

I.C2.6. Be able to identify the difference between the terms *agent* and *broker* with respect to their relationship with insurers and with their insured. Know the definitions and licensing requirements for the following:

a. Insurance agent
b. Life licensee
c. Insurance broker
d. Life settlement broker

Agent vs. Brokers

Agents legally represent the insurer, not their clients. In other words, all of an agent's actions are considered to be made on behalf of the insurer, not the insured. With brokers, however, this is reversed. **Brokers legally represent their clients**, not insurance companies. They negotiate contracts of insurance on their clients' behalf.

The broker represents, and is expected to act in the best interests of the client, not those of the insurance company. Although a broker could receive compensation from an insurance company for a transaction, typically the broker receives a fee for his or her services directly from the client. It could be unethical for a broker to accept both a fee from the client and a commission from the insurer.

Insurance Agents and Insurance Brokers

Insurance agent in this state means a person authorized to transact all classes of insurance on behalf of an admitted insurer *other than life, disability, or health insurance.* The term **insurance broker** refers to a licensee who, for compensation and on behalf of a person *other than an insurer,* transacts insurance *other than life, disability, or accident and health*. Note that there is **no such license** as "life broker" or "health broker." However, a person can be life licensed (as an independent), acting in a broker's capacity.

A **life licensee** is a person authorized to act as a life agent on behalf of a life insurer or a disability insurer to transact life insurance, accident and health insurance, or a combination of life and accident and health insurance.

Educational Objective:

I.C2.3. Be able to define the following:

a. Life agent (CIC 1626(a)(1))
b. Accident and health agent (CIC 1626(a)(2))
c. Life and disability insurance analyst (CIC 32.5, 1831-1849)
d. Certified insurance agent (CCR 6800)

Life Agents (CIC 1622)

Life agents in California are authorized to transact **insurance on human lives** including the following benefits:

- Endowments;
- Annuities;
- Death or dismemberment by accident;
- Disability income.

Accident and Health Agent

Accident and health agents may transact the following types of insurance:

- Sickness;
- Bodily injury;
- Accidental death;
- Disability income;
- 24-hour coverage.

Life and Disability Analysts

Educational Objective:

I.C2.21. Concerning a Life and Disability Insurance Analyst license, be able to identify the requirements and prohibitions for charging fees (CIC1848)

A **life and disability analyst** is any person who receives a fee or other compensation from any person or source other than an insurance company for the purpose of advising or offering to advise an insured, beneficiary, or other person who has an interest in a life or disability insurance contract about their rights, benefits, or any other aspect of the contract. Under California law, a life and disability analyst must be properly licensed.

To be licensed as a life and disability insurance analyst, a person must be a state resident, be knowledgeable and competent on the subject of insurance, and be of good business and general reputation. The candidate must take a prelicensing examination no more than **12 months** prior to applying for this license.

An organization may also hold a license to act as a life and disability insurance analyst, as long as it has an eligible natural person named under an organizational license.

Licensing Requirements

The following are eligibility requirements for life and disability analysts:

- Be a resident of the state of California;
- Pass the examination within 12 months of the license issue;
- Be of good business and general reputation;
- Have a thorough knowledge of life and disability insurance;
- Not be associated with any business that has failed in its fiduciary responsibility toward any other person;
- Not attempt to avoid or prevent the operation of insurance laws by virtue of being licensed; and
- Not be an employee of an insurance company.

In addition to these requirements, prior to applying for a life and disability insurance analyst license, a person must have been **licensed as a life and accident and health insurance agent for at least 5 years.**

Requirements and Prohibitions for Charging Fees (CIC 1848)

Life and disability analysts are not permitted to charge a fee for any services they provide unless they have a signed, written agreement with the party being charged, including a statement of the charge or basis on which charges will be made. They are not permitted to receive a fee from a client for any service which is customarily associated with soliciting or transacting insurance, or for which the analyst is receiving any form of compensation from an insurance company.

The written agreement must disclose the services to be provided and that the same information and services may be available without charge directly from the insurance company. If the analyst is also licensed as a life agent, the agreement must inform the client of this, and that commissions are received from the sale of insurance products.

Life Agent vs. Life Analyst

A primary difference between a life agent and a life analyst is how each receives payment: an **analyst** is not paid a commission by an insurer either directly or indirectly for any insurance transacted by an analyst. An **agent**, on the other hand, acts on behalf of an insurer and received commission for insurance transactions.

Another distinction between the two is that an analyst's primary goal is advising an insured, beneficiary, or other person about their rights, benefits, or any other aspect of the insurance contract. An agent transacts insurance business and creates binding contracts.

Certified Insurance Agent

A **Certified Insurance Agent** is an agent certified by the Exchange to transact in the individual and Small Business Health Options Program (SHOP) Exchanges. Under the health reform law in California, **Covered California is the state's Health Benefit Exchange**. Certified Insurance Agents assist enrollees with completing the application, tracking their process, help evaluate individuals' health care needs and budget considerations to recommend a plan that works best for each enrollee, and provide additional help on an ongoing basis, among other services.

A Certified Insurance Agent must be a natural person who holds a valid license to transact in accident and health insurance, and is in good standing. Currently, Certified Insurance Agents must be **recertified every 5 years**.

Life Settlement Brokers

The term **life settlement** refers to any financial transaction in which the owner of a life insurance policy sells a policy that is no longer needed to a third party for some form of compensation, usually cash. While *viatical settlements* are still used for persons who are terminally ill, most states regulate policies that are sold to a third party for compensation under the term *Life Settlements.*

In life settlements, the seller (the policyowner) could have a life expectancy of more than one year. Policyowners may choose to sell their policies because they feel they no longer need their coverage, or the premium costs have grown too high to justify continuation of the policy.

Definitions

The term **Business of Life Settlement** refers to **any** activity relating to the solicitation and sale of a life settlement contract to a third party who has no insurable interest in the insured.

The term **owner** refers to the owner of the policy who may seek to enter into a life settlement contract. The term does not include an insurance provider, a qualified institutional buyer, a financing entity, a special purpose entity, or a related provider trust.

Insured is the person covered under the policy that is considered for sale in a life settlement contract.

Qualified Institutional Buyer is one that owns and invests at least $100 million in securities and is allowed by the SEC to trade in unregistered securities. A life settlement provider may sell, or in some other manner approved by the Superintendent, transfer ownership of a settled policy to a qualified institutional buyer or other investment entity approved by the Superintendent.

Life Expectancy is an important concept in life settlement contracts. It refers to a calculation based on the average number of months the insured is projected to live due to medical history and mortality factors (an arithmetic mean).

Life Settlement Contract establishes the terms under which the life settlement provider will pay compensation to the policyowner, in return for the absolute assignment, transfer, sale, or release of any portion of any of the following:

- The death benefit;
- Policy ownership;
- Any beneficial interest; or
- Interest in a trust or any other entity that owns the policy.

A life settlement contract also includes a premium finance loan that is made on or before the date of issuance of the policy if one or more of the following conditions

apply:

- The loan proceeds are not used solely to pay premiums for the policy;
- The owner receives a guarantee of the future life settlement value of the policy; and
- The owner agrees to sell the policy in the event of a default.

The following **would not constitute** a life settlement contract:

- A policy loan issued by a life insurance company;
- A loan made by a bank or a lender;
- A collateral assignment of a life insurance policy by the owner;
- An agreement between closely related parties (by blood or by law);
- A bone fide business succession arrangement;
- Employer-owned life insurance on key employees;
- An agreement between a service recipient and a service provider;
- Any other form specified by the Commissioner.

A **Life Settlement Broker** is a person who, for *compensation*, solicits, negotiates, or offers to negotiate a life settlement contract. Life settlement brokers represent only the policyowners, and have a fiduciary duty to the owners to act according to their instructions and in their best interest.

This does not include a licensed life settlement provider or its representative, an attorney, an accountant, or a financial planner. This category includes persons who would not receive a commission upon completion of a life settlement contract, but charge a fee for their services, whether or not ownership of the policy is transferred.

Life Settlement Producer is a person licensed as a resident or nonresident insurance agent who is qualified to transact life settlements.

Financing Entity includes any accredited investor who provides funds for the purchase of one or more life settlement contracts and who has an agreement in writing to do so.

Financing Transaction takes place when a licensed settlement provider obtains funds from the financing entity.

Broker License Requirements

Before a person can act as a life settlement broker in this state, he or she must be properly licensed. The following are the required qualifications for a licensee:

- Complete required prelicensing education (15-hour training course);
- Pass the licensing exam;
- Submit an application to the Commissioner on the approved form;
- Pay any required fees (currently, a 1-year license fee is $136); and
- Be determined competent and trustworthy.

If an individual has been licensed as a **life agent for at least a year**, he or she may act as a life settlement broker; however, they must notify the California Department of Insurance within 10 days of transacting life settlements. In lieu of a broker's license, life agents will be required to pay the notification fee of $136 dollars, and renew that notification biennially, at the time of life license renewal.

Licensed **viatical settlement brokers** or providers will be considered to have met the licensing requirements for life settlement brokers or providers.

Solicitors

Educational Objective:

I.C2.7 Be able to recognize:

a. The difference between the authority of an agent and a solicitor
b. That there is no such license as "life solicitor" or "accident and health solicitor" (CIC1704(d))
c. That an insurance solicitor is a natural person employed to aid an insurance agent or insurance broker in transacting insurance other than life, disability, or health (CIC 1624)

An **insurance solicitor** is a **natural person** employed to assist a property and casualty producer acting as an insurance agent or insurance broker in transacting insurance **other than life, disability, or health**. In this state an insurance solicitor is not eligible to act as an insurance agent or broker at the same time. A person authorized to act as either an insurance agent or broker is not eligible at the same time to act as an insurance solicitor.

A solicitor may make prospecting telephone calls, set appointments, even offer quotes, or take applications for insurance other than life insurance. A solicitor may be employed by more than one insurance producer at a time. A notice of appointment appointing a solicitor may be filed by a second or subsequent property and casualty insurance producer. In order to perform the duties of an insurance solicitor, the Insurance Code requires that a person hold an insurance solicitor's license.

There is no such license as "life solicitor" or "accident and health solicitor."

California Producer License Types and License Qualifications Update

The California Department of Insurance's (CDI) has recently completed conversions of specific producer license qualifications and producer license types to provide uniformity with standards in the National Association of Insurance Commissioners Producer Licensing Model Act (PLMA). Producer licensing conversions do not affect the authority, scope, or subject area of the line of insurance. In accordance with the PMLA standards, the following previous individual and business entity license types became inactive on May 23, 2022, and the "new" license types were added to the license record:

License Type Prior to 5/23/22	New License Type
Resident Insurance Producer	Insurance Producer
Nonresident Insurance Producer	Insurance Producer

Resident Personal Lines Broker-Agent Insurance Producer
Resident Personal Lines Broker-Agency

Nonresident Personal Lines Broker-Agent Insurance
Nonresident Personal Lines Broker- Producer
Agency

In addition, the license records will now list the following "new" individual and business entity license qualification:

License Qualifications Prior to 5/23/22	New License Qualifications
Life-Only	Life
Accident and Health	Accident and Health or Sickness
Variable Contracts	Variable Life and Variable Annuity
Rental Car	Car Rental
Property Broker-Agent	Property
Casualty Broker-Agent	Casualty
Personal Lines Broker-Agent	Personal Lines
Travel Agent	Travel
Registered Administrator	Administrator

3. Administrator

Although administrators must meet the same general qualifications, as well as pay the same license fees as life agents, they are not licensed as agents. **Administrators** are persons who perform life and health insurance-related services such as collecting premiums from, or settling claims on behalf of, insurers and insureds. Often known as **Third Party Administrators,** these persons must meet all the basic requirements of a life agent and have a written agreement with the insurer specifying their responsibilities and compensation arrangements (if any) with the insurer.

Administrators must also hold a **certificate of registration** from the Commissioner of Insurance. Payments from insureds to administrators are considered as having been received by the insurer, but payments from insurers to administrators are not considered received by an insured until the payment has actually been delivered to the insured by the administrator.

The Insurance Code identifies specific individuals who may perform duties similar to administrators, but who are not considered administrators. They are the following:

- An employer acting on behalf of employees;
- A union on behalf of its members;
- An insurer in connection with its contracts of insurance;
- A life agent exclusively selling life or disability insurance;
- A creditor on behalf of its debtors and their debts;
- A trust, its trustees, or its employees in the performance of their duties;
- Trusts, trustees, or employees of IRC 501(c) organizations, or custodians or agents of custodial accounts defined by IRC 401(f);
- A bank, credit union, or financial institution;
- Credit card companies collecting premiums from cardholders, but not involved in settling or adjusting claims;
- Attorneys who adjust or settle claims, but do not collect charges or premiums for life or disability insurance;
- Licensed adjusters in the course of their duties;
- A nonprofit agricultural association (i.e., a "Grange," or a "Farm Bureau"); and
- Managed Health Care provider organizations (HMOs, PPOs, etc.) or their employees.

4. Continuing Education Requirements

Educational Objectives:

I.C2.19 (Life). Be able to identify the continuing education requirements for:

a. An individual licensed as a life agent (CIC 1749.3-1749.33)
b. A life agent who sells annuity products to individual consumers.

Know that the total hours of CE required for the life agent are not increased by the above.

I.C2.18 (Accident and Health). Be able to identify the continuing education requirements for an individual licensed as an accident and health agent (CIC 1749.3-1749.33)

Continuing education rules are established to protect the public by maintaining high standards of professional competence in the insurance industry, and to maintain and improve the insurance skills and knowledge of licensed producers. The State of California has implemented prelicensing and continuing education requirements for initial applicants and license renewals that apply equally to life producers, accident and health or sickness producers, property insurance producers and casualty insurance producers (formerly fire and casualty broker-agents).

Any licensee must complete **24 hours** of continuing education (CE), including **3 hours of ethics**, per each 2-year license renewal term for the type of license held. This regulation applies to the following licenses:

- Life;
- Accident and health or sickness;
- Property;
- Casualty; and
- Personal lines.

These hours can be completed at any time before the license renewal date. The CE courses and programs must be approved by the Commissioner.

If an agent holds 2 types of licenses (e.g., life and property/casualty), the agent may satisfy CE requirement by completing CE for any of the license types held.

It may not be practical to complete precisely the minimum number of CE units during a license period. While it is not possible to renew a license without the required number of credits, those credits in excess of the required number will be carried over into the next licensing period; they are not “lost.”

Note, however, that only those hours that were completed during the second year of the licensing period may be carried over. The number of hours that can be carried over cannot exceed the number of hours that are required to renew the license.

Continuing education is available in a variety of settings. Courses are available with a live instructor, known as a “contact” setting, via mail order as a “self-study” course, and even by computer over the Internet, also a “self-study” method. Agents should be certain, however, that the courses they pay for are approved by the Department of Insurance for California continuing education. A student may gain valuable knowledge by taking any course, but only approved courses will satisfy license renewal requirements.

Life Agent (CIC 1749.3)

Life insurance producers, accident and health or sickness insurance producers, or property and casualty insurance producers may only receive credit for CE courses approved for their respective licenses. Agents who hold licenses in more than one line of authority must satisfy the continuing education requirements by completion of the approved courses or programs of instruction for any of the license types.

Licensees who have been in good standing for 30 continuous years in this state and who are 70 years of age or older are not required to comply with the requirements for continuing education.

Agents Selling Annuity Products

Every life agent who sells annuities to individual consumers is required to complete **8 hours** of training prior to soliciting sales of annuity contracts. Every 2 years thereafter, agents are required to complete **4 hours** of training, which are part of the overall CE requirement. The training must be approved by the Commissioner and must consist of topics related to annuities, California law, regulations, and requirements related to annuities, prohibited sales practices, and unfair trade practices.

Note that the total number of CE hours required for the life agent is not increased by this requirement.

Agent Writing Long-Term Care Insurance (CIC 10234.93)

Educational Objective:

I.C2.20. Be able to describe the differences between benefits provided under an accelerated death benefit rider for chronic illness and benefits under long-term care insurance.

Know that long-term care training is **required** if an agent is transacting accelerated death benefit provisions or riders that require the provision of *personal care services* to the chronically ill insureds. LTC training is **not required** when an agent is transacting accelerated death benefit provisions or riders that do not require any provision of *personal care services* to an insured.

The required training is **8 hours** of training in each of the **first four 12-months periods** beginning from the date of original license issuance, and **8 hours** of training prior to each license renewal thereafter.

Insurer's Responsibility

Insurers are required to ensure that agents offering, marketing, or selling accelerated death benefits on their behalf are able to describe the differences between benefits provided under an accelerated death benefit and benefits provided under long-term care insurance. Life producers must be able to communicate the following:

- The differences between the benefits afforded to an insured through an accelerated death benefit and a long-term care insurance policy or rider;
- The differences between benefit eligibility criteria;
- Whether an elimination period applies to either an accelerated death benefit or long-term care insurance and a description of the elimination period;
- The benefits under the accelerated death benefit or long-term care insurance if benefits are never needed;
- The benefits under the accelerated death benefit or long-term insurance if benefits are needed;
- Restrictions on benefit amounts;
- Tax treatment of benefits; and
- Income and death benefit considerations.

Agents Writing California Partnership Coverage

Accident and health agents who intend to sell **California Partnership for Long-Term Care (CPLTC)** insurance must also satisfy the continuing education requirement for those courses. These agents are required to complete one specifically designated long-term care training course, and one specifically designated 8-hour California Partnership for Long-Term Care classroom course. Once the initial training requirement has been met, the agents are required to complete an 8-hour classroom CE course on the Partnership every 2-year licensing period.

Life agents may be authorized to solicit long-term care riders to a life insurance policy after meeting the proper training requirements.

Note that the total number of CE hours required for the accident and health or sickness agent is **not increased** by CE requirement for LTC or CPLTC.

5. Prohibited Actions

Educational Objective:

I.C2.4. Be able to identify the California Insurance Code definition of transact and why the definition is important (CIC 35, 1631, 1633):

a. Know that the Code prohibits certain acts by unlicensed persons (CIC 1631)
b. Know the penalty for such prohibited acts (CIC 1633)

No person may perform the activities of an insurance agent or broker without holding the appropriate valid licenses described in the Insurance Code. This includes soliciting, negotiating, and executing contracts of insurance.

As a result, any person who acts, offers to act, or assumes to act in any manner that would require a license, but does not hold a valid license, is guilty of a **misdemeanor**. A misdemeanor conviction in California can result in imprisonment in the county jail for up to 1 year, a fine of up to $50,000, or both.

6. Written Consent in Regard to Interstate Commerce

Educational Objective:

I.C2.5. Written consent regarding persons engaged in the business of insurance whose activities affect interstate commerce (prohibited persons in insurance):

a. Be able to identify what conduct is prohibited and identify what civil and criminal penalties apply *(Title 18 United States Code Sections 1033 and 1034).*

It is considered **unlawful insurance fraud** for any person engaged in the business of insurance to willfully, with the intent to deceive, make any oral or written statement that contains either false statements or omissions of material fact. This includes information and statements made on an application for insurance, renewal of a policy, claims for payment or benefits, premiums paid, and financial condition of an insurer.

Anyone engaged in the business of insurance whose activities affect interstate commerce, and who knowingly makes false material statements may be fined, imprisoned for up to 10 years or both. If the activity jeopardized the security of the accompanied insurer, the sentence may be extended up to **15 years**. Anyone acting as an officer, director, agent or other insurance employee that is caught embezzling funds faces the aforementioned fines and imprisonment. However, if

the embezzlement was in an amount that is **less than $5,000**, prison time may be reduced to 1 year.

Federal law makes it illegal for any individual convicted of a crime involving dishonesty, breach of trust or a violation of the **Violent Crime Control and Law Enforcement Act of 1994** to work in the business of insurance affecting interstate commerce without receiving written consent from an insurance regulatory official (Director of Insurance, Commissioner of Insurance, etc.) — known as a **1033 waiver**. The consent from the official must specify that it is granted for the purpose of 18 U.S.C. 1033. Anyone convicted of a felony involving dishonesty or breach of trust, who also engages in the business of insurance, will be fined, imprisoned for up to 5 years or both.

Any person who engages in conduct that is in violation of Section 1033 may be subject to a civil penalty of **not more than $50,000** for each violation or the amount of compensation the person received as a result of the prohibited conduct, whichever is greater.

Section 1034: Civil Penalties and Injunctions

According to Section 1034: Civil Penalties and Injunctions for Violations of Section 1033, the **Attorney General** may bring a civil action in the appropriate United States district court against any person who engages in conduct constituting an offense under section 1033 and, upon proof of such conduct, the person will be subject to a civil penalty of not more than $50,000 for each violation, or the amount of compensation which the person received or offered for the prohibited conduct, whichever amount is greater.

If the Attorney General has reason to believe that a person is engaged in conduct constituting an offense under section 1033, the Attorney General may petition an appropriate United States district court for an order prohibiting that person from engaging in such conduct. The court may issue an order prohibiting that person from engaging in such conduct if the court finds that the conduct constitutes such an offense.

7. Errors and Omissions

Educational Objective:

I.C2.8. Regarding insurance agent's errors & omissions insurance, be able to identify:

a. The types of coverages available
b. The types of losses commonly covered and not covered
c. The need for the coverage

An insurance agent or broker may wish to obtain professional liability insurance to protect against financial losses that could occur due to the agent's negligent acts or actions. This is known as **errors and omissions (E&O)** liability insurance.

Types of Coverage

Errors and Omissions insurance is written for professionals (such as insurance producers) to provide protection resulting from actions charging that the professional failed to render reasonable duties or services. While some professional liability insurance coverage is written with a limit of liability on an occurrence basis and the insurance company is required to obtain the insured's consent for any out-of-court settlement, the modern trend is to provide coverage on a claims-made basis and to delete previous requirements for consent of the insured for out-of-court settlements.

Errors and omissions liability contracts are renewable annually and are usually written with “per claim” deductibles of at least $500 or $1,000, and have either a “limit per claim” or “limit for all claims during the policy period” provision that describes the contract’s maximum benefit.

Types of Losses

The following are examples of acts or omissions that could lead to professional liability claims:

- An agent unintentionally records an answer incorrectly on an application for insurance, concealing the client’s actual response to a question regarding qualifying information. Upon investigation of a claim, the insurer discovers the correct information and lawfully rejects the claim and voids the contract on the basis of the incorrect answers in the application, refunding premiums paid. The E&O policy would pay for the actual claim losses of the agent’s client.
- The agent fails to disclose material information about a contract of insurance, such as deductibles, coinsurance, copayments, surrender charges, premium increases, or principal exclusions. Actual demonstrated damages incurred by the agent’s client could be covered by the E&O policy.
- The agent tells a client, “I guess I made a mistake,” in calculating the original premium quotation when, in fact, the increased premium was due to the client’s substandard rating. If an insured later discovers the misrepresentation and decides to cancel the contract, an E&O policy could pay the difference between the actual premiums paid and what the client was originally quoted by the agent as the periodic premium, from the date of the client’s discovery of the error.
- The agent leads a client to believe that projected investment results in a variable contract, or that the sales illustration for a contract with non-guaranteed interest, are guaranteed elements of the contract. Actual client losses could be paid for by an E&O policy.
- The agent accepts a check from a client, representing an unscheduled deposit to the cash account in a variable or flexible premium policy, and fails to send it to the insurer on a timely basis. Actual investment or interest losses could be restored by an E&O policy.

Losses Not Covered

Errors and Omissions insurance does not offer any protection for liabilities that result from a person's criminal acts, such as fiduciary crimes, unfair business or trade practices, or material misrepresentations which result in financial loss or damages to a client.

It must be understood that if any of the previously named liability claims arise out of a criminal conviction, or result in a criminal conviction, the E&O policy will not pay the claim, and the agent or broker will remain personally liable for the client's damages.

Need for Coverage

Because of the risk of injuring a person as a result of the advice or services rendered (an error) or not rendered (an omission) to that person, E&O insurance is a necessity.

At any time during the sales process, there can be a misunderstanding or misrepresentation that could lead to legal action being taken by the insured. Agents should "document, document, document"— interviews, phone conversations, requests for information, etc. The sales interview and the policy delivery are the most common time for E&O situations to occur.

8. Prohibited Acts Regarding Nonadmitted Insurers

A *nonadmitted* insurer is one which has not met the requirements, either by choice or by failure, to legally have its representatives physically present in order to conduct business in California. Such an insurer can be represented within the borders of California by specially licensed individuals, called “surplus lines brokers.” A valid Certificate of Authority must first be secured from the department of insurance prior to conducting business in California.

Surplus lines brokers are of value to the residents of California: they help the residents purchase types of property and casualty insurance that are not available from an admitted insurer.

The following acts are **misdemeanors** except when performed by a surplus line broker:

- Acting as an agent for a nonadmitted insurer in the transaction of insurance;
- Advertising a nonadmitted insurer in any way;
- In any way aiding a nonadmitted insurer to transact insurance.

In addition to any penalty given for committing a misdemeanor, a person violating any provision of this section will be fined $500, along with a $100 fine for each month or part of a month during which the person continues the violation.

New legislation was recently passed to streamline the surplus line broker licensing laws, and the following changes were included. All individuals must hold an individual surplus line broker license. Applicants for such a license must already be licensed to transact fire (property) and casualty insurance.

Additionally, the application and renewal fee for a surplus lines broker is $700. This fee allows for a **2-year** license term.

The fee for a licensed surplus line broker organization to endorse a licensed individual line broker is $24. When terminating such a broker, the CDI must be notified (which is also a $24 fee).

Surplus Line brokers transacting insurance on behalf of a licensed surplus line broker organization will not be required to file a bond. However, all other surplus line brokers must file a $50,000 surplus line broker bond.

9. Prohibitions of Free Insurance

To protect the integrity of the insurance industry in California, the state has adopted the philosophy that insurance is a product of sufficient importance and that it should be paid for by the insured because of its intrinsic value. To this end, it is **illegal** for any insurance licensee to offer **free insurance** as an incentive to conduct some other type of business.

If any insurer, agent, broker or solicitor willfully violates this provision, the Insurance Commissioner may suspend or revoke that person's certificate or license or other authority to do business for a period not exceeding 1 year.

The following are *exceptions* to the free insurance prohibition:

- Insurance provided in connection with newspaper subscriptions;
- The purchase of credit union shares;
- Insurance to guarantee the performance of a product and reimburse a customer for losses resulting from such product's failure;
- Title, life, or disability insurance which will pay off a debt in case a debtor becomes disabled or dies;
- Services provided by an attorney; and
- The services of a motor club (AAA, for example) in regard to towing, emergency roadside service, bail bond service, DMV transactions or other normal motor club services that are not defined as the transaction of insurance.

10. Appointment Regulations

Educational Objective:

I.C2.15. Be able to identify the importance and the scope of the Code regarding:

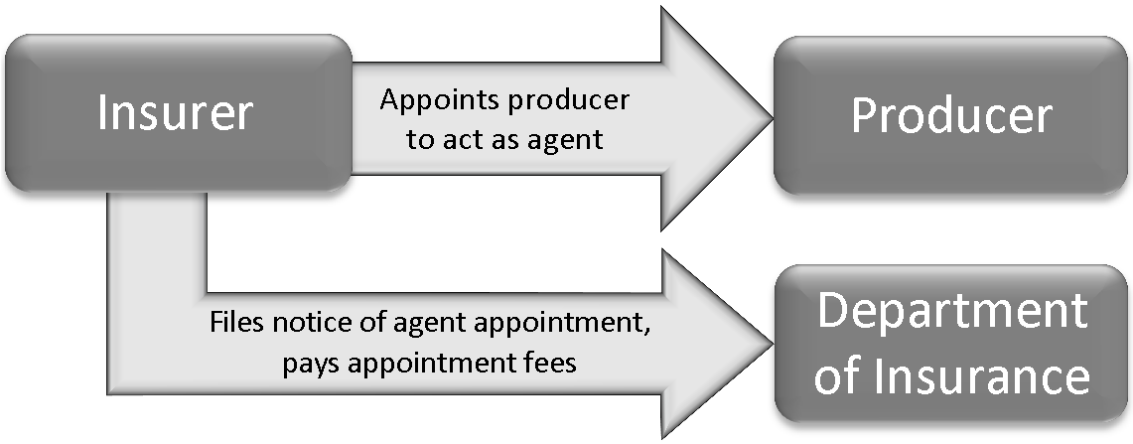
a. The filing of a notice of appointment to transact Life insurance *(CIC 1704 & 1705)*
b. An inactive license *(CIC 1704(b))*
c. Cancellation of a license by the licensee in the licensee's possession or in the employer's possession *(CIC 1708)*

An insurance agent or producer cannot legally act as an agent of an insurer unless they become an **appointed agent** of that insurer. An insurance producer who does not act as an agent of an authorized insurer does not need to become appointed.

In order to validate and legitimatize the agency relationship and the insurance contract, the insurer must submit a notice of appointment within **14 days** to the Commissioner. The licensee will be legal to conduct business, and the insurer will become responsible for the acts of the licensee, as of the date the appointment is signed by the insurer.

An appointment will cease, and the licensee will become unable to conduct business for the insurer when any of the following conditions exist:

- The licensee loses the license; or
- The licensee is terminated and/or loses their appointment with an insurer.



Life Insurance

Upon signing and submitting an appointment for an original license, an insurer is inherently confirming to the Department of Insurance that the applicant has a good reputation and is worthy to be issued the license. This includes confirmation that the applicant has sufficient experience or education or will soon (within 30 days) receive sufficient education to meet the requirements of the license. All of this is true for the entity and each of its natural persons if the applicant is a business entity.

When a licensed business entity adds a person to its license, the declarations discussed above are presumed to have been made about that person.

A life or accident and health agent is allowed to present a coverage proposal to a client for an insurer with whom the agent is not appointed. If the proposal results in an application to the insurer and a policy is issued, which the insurer is under no obligation to do, it is assumed that the insurer is appointing the agent. **Within 14 days**, the insurer must file the notice of appointment with the Department. All payments from the client in regard to such a policy must be made payable to the insurer. The following are exceptions to this rule:

- An unappointed agent may not present a proposal or accept an application for an insurer which uses only “career” agents, agents which exclusively represent only a single company or group of companies; and
- The insurer requires that it be the first insurer to whom its agents present policy applications.

Disability Insurance

A person licensed as a property and casualty insurance producer, a life insurance producer, or an accident and health or sickness insurance producer may transact disability insurance on behalf of any insurer authorized to transact disability insurance if the producer has filed a **notice of appointment** for the purpose of transacting disability insurance. The authority to transact disability insurance becomes effective the day the notice of appointment is signed by the insurer. This authority will apply to transactions occurring after that date and for the purpose of determining the insurer's liability for acts of appointed agents.

Inactive License

When a licensee has no active appointments, he or she does not lose his or her license. The insurance license is the result of a relationship the licensee has with the Department of Insurance, and a lack of appointments does not change that relationship. A licensee with no appointments has a license which is designated as **inactive**. Upon being appointed by any insurer, the license becomes *active* again.

Cancellation of a License by the Licensee

Licensees may surrender their license for cancellation at any time. If the license is in the possession of the licensee, the licensee may surrender the license by delivering it to the Commissioner. If the license is in the possession of the insurer or the licensee's employer, the licensee may still surrender the license by delivering a written notice of surrender to the Commissioner.

Acting as an Agent without Appointment (CIC 1704.5)

A licensed life or accident and health agent who is not specifically appointed for a particular insurer may not solicit insurance to a prospective client with that insurer or pass on an application for insurance to that insurer if the insurer requires that all its agents represent only that insurer.

If an insurer does not specifically require all of its agents to be appointed, then any licensed agent may present a proposal for insurance to a potential client on behalf of an insurer for which the agent is not specifically appointed and may also give an application for insurance to that insurer. If an insurance policy is issued, the insurer is considered to have authorized the agent to act on its behalf, and the insurer is responsible for all actions of the agent that relate to the application and policy as if the agent had been properly appointed for the insurer. The insurer must forward to the Commissioner a **notice of appointment** of the agent as the insurer's agent within **14 days** after the agent submitted the insurance application. An insurer is not obligated to accept an application for underwriting from a life agent.

Some insurers employ **exclusive/captive/career** agents and will not allow any other agents to sell their products. The Insurance stipulates that licensed agents not contracted with such companies are not allowed to present insurance applications to those companies. However, if an insurer does not require that all agents be appointed by them in order to sell their products, an agent is allowed to represent that company to a client and to receive an application for insurance with that company. All payments by the client must be made payable to the insurer, not to the agent. If the insurer does not accept the application, no agency appointment exists. However, the insurer, by issuing a policy in response to such an application, is deemed to have thereby appointed that agent. The insurer must then notify the Commissioner of that appointment within **2 weeks** of receiving the application.

11. Miscellaneous Code Requirements and Specifications

Educational Objective:

I.C2.11. Be able to identify the Code requirements for the following:

a. An agency name, use of name (CIC 1724.5, 1726, and 1729.5)
b. Change of address (CIC 1729)
c. Filing license renewal application (CIC 1720)
d. Printing license number on documents (CIC 1725.5)

Agency Name, Use of Name (CIC 1724.5, 1729.5)

California state regulation has no ability to limit a human being's right to use his/her actual name to conduct the business of insurance. Regulators of insurance have a responsibility to ensure that California's residents not be misled by the name or names attached to a licensed entity.

Every licensee, individual and corporate, must reveal to the Insurance Commissioner the real name of the legal person as well as all fictitious ("DBA") names which are intended for use. To prevent confusing the insurance consumer, the Commissioner may deny the use of a name for any of the following reasons:

- The name would interfere with the business of another or is too similar to the name of another;
- The name would mislead the consumer in any way;
- The name gives the impression that the licensee is authorized to conduct a type of business which it cannot legally conduct;
- Though the terms "Chartered Property and Casualty Underwriter" and "Chartered Life Underwriter" are commonly used by those who have earned those designations, it is not acceptable to use the term "underwriter" in such a way as to give the impression that the licensee is authorized to act as such. The term "underwriter" can be used in the name of an organization of insurance producers who are individually licensed; or
- The licensee is already using 2 approved names. The exception to this is a licensee who acquires ownership of another licensee, in which case the use of a maximum of 2 names for each such entity is allowed.

Based on the requirement listed above, a name may be disapproved if it uses one or more of the following, or similarly misleading, words or phrases: *advisor, analyst (unless the licensee holds or is applying for a Life and Disability Analyst License), assurance company*, *department, government, investment, national, state, trust, or underwriter*, among others. Similarly, a name maybe disapproved if it improperly uses any of the following words: *affordable, cash, cheap, discount, elder, expert, legal, protection, secure, and specialist*, among others.

Licensees are prohibited from using a true or fictitious name upon the disapproval of the Commissioner. If the Commissioner determines that there are facts in mitigation in connection with the continued use of the name, the Commissioner may permit its use for a specified reasonable period of time. The permission must be in writing.

If a broker or agent has a contract to provide service for a corporation which holds an insurance license in its own name, or is a stockholder in a licensed corporation, or is a member of an incorporated agency, that broker or agent may use the name of such organization in printed materials as long as the broker or agent clearly identifies the relationship. The following are acceptable relationship identifiers:

- "Representing _____;"
- "A stockholder of _____;"

- "Placing business through _____;" and
- "Using services of _____."

Any licensed agent or broker who advertises insurance **online** (online direct sales) and transacts insurance in this state must identify the following information, even if the agent or broker is not responsible for maintaining his or her internet presence:

- The licensee's name as filed and approved by the Commissioner;
- The licensee's state of domicile and principal place of business;
- The licensee's California insurance license number; and
- The word "insurance."

Any person who conducts the following online is deemed to be transacting insurance in this state:

- Provides insurance premium quotes to California residents;
- Accepts applications from California residents; and/or
- Communicates with California residents regarding terms of an insurance agreement.

Fictitious Names

All licensees, from individuals to organizations, must file with the Commissioner their true names and any fictitious names under which they are conducting business. They must also notify the Commissioner if any of the names are changed or discontinued. The Commissioner has the right to approve and disapprove names.

Licensees may not use more than two names, real or fictitious. When licensees purchase or inherit a business, two additional names may be used for that business.

Change of Address (CIC 1729)

All licensees, on their initial license application, must provide their residence, business, and mailing addresses. It is the responsibility of the licensee to notify the Commissioner **immediately** of any changes in the *e-mail, residence, principal business, or mailing addresses* though the use of an electronic service approved by the Commissioner.

Reporting Administrative Actions and Criminal Convictions

According to the CIC 1729.2, all licensees and applicants for licenses must report any **administrative actions or criminal convictions**, and background changes to the California Department of Insurance Producer Licensing Bureau **within 30 days** of the final disposition of the matter. Background information that must be reported includes the following:

- Misdemeanor or felony convictions;
- Filing of felony criminal charges against the licensee in state or federal court;
- Administrative actions regarding an occupational license;
- Personal or organizational bankruptcy filing; or
- Any financial breach or misappropriation.

Licensees and applicants are required to submit supporting documents, such as a statement regarding the background change, certified court documents, administrative documents, or any other related documents.

To report this information to the Department, licensees may use the background change disclosure form available at www.insurance.ca.gov, Producer Background Information, under Agents & Brokers. Background changes may also be submitted electronically to the National Insurance Producer Registry (NIPR) by selecting "Reporting of Actions" under "Attachments Warehouse."

Filing License Renewal Application (CIC 1720)

Insurance licenses in this state must be renewed every **2 years.** If a licensee delays completing the renewal requirements and finds himself or herself near the license expiration date, the licensee can continue to conduct business for **60 days** past that expiration date if the licensee completes all requirements and submits the license renewal fee no later than the expiration date.

Printing License Number on Documents (CIC 1725.5)

In order to facilitate a potential client's investigation of a producer, each producer must place his/her license number on all printed materials placed before the public, including business cards, proposals, and all print advertisements in California.

To ensure that the number is not minimized and would not be missed by a prospective insurance purchaser, the license number must be printed *at least as large as the smallest address or telephone number on the same document*. For licensees with more than one license, a single license number will suffice. Solicitors must use the license number of their employer.

A first offense will be punished by a fine of $200, a second by a fine of $500, and a third by a fine of $1,000. However, a separate penalty cannot be imposed for each piece of illegal material used. There is a process for explaining violations, and the Commissioner has the option to consider extenuating circumstances and relieve the licensee of the penalty.

The one exception to the license number requirement is motor club (A.A.A., etc.) advertisements which include insurance in a general list of services provided without giving details regarding the insurance products.

Record Maintenance

Educational Objective:

I.C2.12. Be able to identify the records an insurer and agents must maintain (CIC 10508-10508.5)

One of the challenges facing new agents and brokers is to accept the responsibility to obtain and maintain accurate, legible records which can be available within 30 days after a request to the insurer from the Department of

Insurance. Each admitted insurer must maintain certain records pertaining to the activities of its life, life and disability, and disability agents for a period of **5 years.** Life, life and disability, and disability insurance agents must also maintain all applicable records at their principal place of business for a minimum of 5 years. The records must be maintained in orderly manner and be available for Commissioner's review at all times.

The records may be in the form of originals, copies, or electronic data-processing records and must include the following:

- Name of insured;
- Name of insurer;
- Policy number;
- Date insurance is effective and any date it ceases to be effective;
- Renewals;
- Coverage changes;
- All information regarding binders;
- Proposals, including comparisons with existing coverage;
- Copy of the application or other request for insurance;
- All correspondence or other written records which describe the transaction, except printed materials in general usage;
- All correspondence regarding cessation of coverage; and
- Legally required outline of coverage or disclosure statement.

The following records must be kept regarding policies, premium payments and commissions:

- The original policy application;
- Amount of premiums received by the insurer;
- Production records showing policies sold by each agent;
- Itemization of the premium received;
- All written communications send by the insurer or its agents to a prospect, applicant or insured; and
- A copy of outline of coverage or disclosure statements.

Life Insurance Policy Illustrations

Educational Objective:

I.C2.13. Be able to identify the requirements applicable to an insurer for life insurance policy illustrations (CIC 10509.950-10509.965)

The following laws are intended to ensure that illustrations do not mislead purchasers of life insurance and to make illustrations more understandable by providing formats and standards to be followed when illustrations are used, and specifying the disclosures that are required in connection with illustrations.

As often as possible, insurers should eliminate the use of footnotes and caveats and define terms used in the illustration in language that is understandable by a typical person.

Each insurer must notify the Commissioner at the time of filing whether a policy is to be marketed with or without an illustration.

If the insurer identifies a policy form as one to be marketed **without an illustration**, any use of an illustration for any policy using that form prior to the first policy anniversary is prohibited. If a policy form is to be marketed **with an illustration**, the insurer must prepare and deliver a basic illustration.

An illustration used in the sale of a life insurance policy must be clearly labeled "life insurance illustration," and include (but not be limited to) the following information:

- Name of insurer;
- Name and business address of producer or insurer's authorized representative, if any;
- Name, age and sex of proposed insured, except where a composite illustration is permitted;
- Underwriting or rating classification upon which the illustration is based;
- Generic name of the policy, the company product name, if different, and form number.
- Initial death benefit;
- Dividend option election or application of nonguaranteed elements, if applicable.

Educational Objective:

I.C2.14. Be able to identify the Code specifications regarding producer application investigation, denial of applications, and suspension or revocation of license (CIC 1666, 1668-1669, 1738)

Producer Application Investigation

The Commissioner is obligated to the consumers of California to assure that all insurance licensees are qualified in regard to their knowledge and character. To this end, the Commissioner is authorized to require the provision of any information or documents necessary to make such a determination. After the investigation is complete, the applicant may be authorized to conduct business.

Alterations on Disability Application

Educational Objective:

I.C2.24. Be able to identifythe alterations an agent may make to an applicant's written disability application (CIC 10382).

No alteration of any written application for a disability policy can be made by any person other than the applicant without the applicant's written consent. However, the insurer may make insertions for administrative purposes only, as long as they are not pertaining to the applicant. Making any other alteration without the consent of the applicant is considered a **misdemeanor**. Note that if the agent alters the application, the insurer will be the liable party.

Denial of Applications

There are many possible causes given in the Insurance Code for denying an insurance license. Keep in mind that these causes apply to legal “persons” which include individuals and business entities such as agencies and corporations. Licensure can be denied if the applicant is found unqualified or if licensing the applicant would be against the public’s best interest.

An applicant's license **could be denied** if the applicant has committed any of the following:

- Has no intention of selling the insurance permitted by the license;
- Does not have a good business reputation;
- Lacks integrity;
- Was denied or lost another state license within the past 5 years for a reason which would also cause an insurance license to be denied;
- Wants the license to avoid the consequences of insurance law;
- Has lied on his/her application;
- Previously acted dishonestly in business;
- Exposed the public to loss as a result of incompetence or lack of trustworthiness;
- Lied about an insurance policy;
- Has either not done something required by, or has done something forbidden by the Insurance Code;
- Has been convicted of (not charged with) any felony or a misdemeanor violation of insurance law;
- Has helped someone else commit a crime which would make that other person lose or be denied a license;
- Has allowed an employee to violate the Insurance Code;
- Has acted as a licensed person prior to issuing of a license;
- Has submitted a fraudulent educational certificate; or
- Does not qualify for a license on a permanent basis or is denied issue within 1 year of application or issuance.

The applicant may be **denied a license** without the right to a hearing if the applicant has a history of any of the following conditions:

- Felony convictions;
- Misdemeanor violations of insurance law;
- Denial of an insurance license within the past 5 years; or
- Insurance license suspension or revocation within the past 5 years.

Note that any person **caught willfully cheating** on the licensing examination will be barred from taking any license examination and from holding an active license for a period of **5 years**.

In regards to what may constitute a *conviction*: any applicant for licensure in the state of California will be considered convicted of a misdemeanor or felony if he or she was found guilty or convicted after entering a plea of "nolo contendere," or "no contest."

It is important to remember that **all convictions**, at *any time* in an applicant's past, must be disclosed on the license application. This also applies to convictions for which the charges were later dismissed or expunged, or for which a person was placed on probation or received a suspended sentence. If an applicant fails to **disclose** all convictions, the application for a producer license will be denied (CIC 1729.2).

Suspension or Revocation of License

A permanent license may be revoked for any of the reasons given for which a license could be denied. A hearing would not be allowed if one of the four conditions mentioned above exists.

Termination of a License, Dissolving Partnerships

A licensee can surrender their insurance license at any time, either by returning the license to the Commissioner or, if not in possession of the license, sending a notice of resignation.

An insurance license automatically terminates when the licensee dies. If the licensee is an organization, the license will terminate if its partnership, association or corporation is dissolved. Also, a partnership will lose its license if it changes the persons serving as partners. When new partners join, a partnership can continue its license if it files notice within 30 days with the Department and the changes are approved.

When any of the above organizations cease, they may continue to conduct business under another name if the same people remain involved and the necessary paperwork is completed within **30 days**.

Internet Advertisements

A California agent or broker who advertises his or her services over the internet, regardless of whether the agent/broker created the ad or someone created it on his or her behalf, must include all of the following information in the ad:

- His or her name as it appears on the insurance license, as well as any fictitious name approved by the Commissioner;
- The state of his or her domicile and principal place of business; and
- His or her license number.

A person is deemed to be transacting insurance when the person advertises on the Internet, regardless of whether the agent or broker maintains the Internet presence or if it is maintained on his or her behalf, and does any of the following:

- Provides an insurance premium quote to a California resident;
- Accepts an application for coverage from a California resident; or
- Communicates with a California resident regarding one or more terms of an agreement to provide insurance or an insurance policy.

Duty to Disclose Effective Date of Coverage

When an applicant or insured applies for an insurance policy or pays the initial premium, a producer must **disclose the effective date of coverage** (if known), or the circumstances under which coverage will be effective as soon as specific conditions are met. This regulation applies only to coverage for personal lines of insurance.

12. Fiduciary

Educational Objective:

I.C2.17. Be able to identify and apply the definition of the term "fiduciary" and producer fiduciary duties described in the Code (CIC 1733-1735)

The term *fiduciary* describes both the responsibility inherent in handling another person's financial affairs, and the individual with such responsibility. Insurance licensees commonly act as a conduit, receiving and transferring funds from client to insurer, and, eventually, from insurer to client. Any person who diverts or appropriates fiduciary funds to his or her own use is guilty of **theft** and punishable for theft as provided by law.

If fiduciary funds are received by a licensed producer, he or she must ensure the following:

- Remit and return premiums received to the insurer (minus commissions due); and
- Maintain fiduciary funds at all times in a trustee bank account separate from any other accounts, in the amount at least equal to the premium and return premiums received by the producer and unpaid to the person entitled to those funds.

13. Ethics

You should be able to **identify and apply** the meaning of the following:

- Place the customer's interest first;
- Know your job and continue to increase your level of competence;
- Identify the customer's needs and recommend products and services that meet those needs;
- Accurately and truthfully represent products and services;
- Use simple language (avoid jargon) that insurance consumers (laypersons) can understand;
- Stay in touch with customers and conduct periodic coverage reviews;
- Protect your confidential relationship with your client, including protecting the privacy of customer information using physical and electronic safeguards;
- Keep informed of and obey all insurance laws and regulations; and
- Avoid unfair or inaccurate remarks about the competition.

Note that the California Insurance Code (CIC) and the California Code of Regulations identify many unethical and/or illegal practices. It is impossible, however, to write legislation for every possible unethical act.

An agent's role in the insurance industry is one of great responsibility toward others. The Insurance Code articulates in many different ways the legal and ethical aspects of the client-agent relationship. Fiduciary responsibilities are very high on the list — the contact an agent has with the money or premiums of insureds, or the advice and recommendations given to others which have implications for their money or financial security.

An insurance agent must practice and demonstrate the highest level of ethics, integrity, and morals. Failures or lapses in any of these areas can result in great financial harm to others. Misrepresentation, twisting, concealment, diverting client money to personal use, commingling client money with general business funds (even if there was no bad intent), and other practices are ethical, integrity, and moral issues and are prohibited in various ways by the Code. Failing to answer, or giving an intentional wrong answer to questions that insureds or prospects ask

is also an ethical problem, because it can lead a client to make a choice that might not be in their best interest. Unethical conduct can lead to suspension or loss of license, monetary penalties, and even time in jail or prison.

Agents must make recommendations to clients based on the clients' best interests. For an agent to recommend products or services to a person that he or she would not recommend for himself or herself in the same circumstances is an ethical dilemma. This is often described as conflict of interest. The normal conduct of business, especially in the insurance industry, can present agents with many opportunities for conflicts of interest.

Agents are typically paid on a commission basis. Commissions are usually calculated on the basis of annual premium submitted, even though the client may have paid just the first monthly installment with their application. For an agent, then, the higher the premium collected, the higher their commission check. If the higher premium, and the higher commission, is the result of an inappropriate recommendation for the client, that is a conflict of interest and an unethical act.

The opportunity an agent may have to represent multiple insurers can be in the best interest of the client, but it can also lead to conflicts of interest, especially if a decision to place business with a particular company is made on the basis of which company is offering the best “perk” to its agents. Incentives such as commission bonuses, trips or cruises, computers, or other sales-based contests all present opportunities to do what’s right for the agent, but not what’s right for the client.

Ethics demands that the other person and his or her family are of primary importance. An agent who demonstrates the highest respect for others will have the most successful career. Agents who neglect this respect for others may have success initially, but they rarely have long-term success. The responsibility for ethical behavior is squarely on the agent.

Special Ethical Concerns Regarding Senior Citizens

Educational Objective:

I.C2.24. Be able to identify special ethical concerns that may occur when you are dealing with senior citizens (CIC 785 - 789.10)

Seniors are among the least likely to report financial crimes or abuses against them because they might be embarrassed at having “been taken,” or because they do not wish to appear to be losing the ability to manage their lives or personal finances.

Unethical agents have been caught selling multiple, duplicative policies to seniors, proposing one type of insurance policy or annuity contract but delivering another *(bait and switch),* and misleading senior consumers into believing that an annuity product is actually a long-term care contract (or vice-versa).

The California Insurance Code has established rules and regulations for insurers, brokers, and agents who engage in insurance transactions with individuals who are **65 years of age or older**. All insurers, agents and brokers who solicit insurance to insureds age 65 or older, owe those insureds a **duty of honesty, good faith and fair dealing.**

Any **advertisement** or other device designed to produce leads based on a response from a potential insured that is directed towards persons 65 years of age or older must prominently disclose that an agent may contact the applicant. In addition, an agent who makes contact with a person as a result of acquiring that person's name from a lead generating device must disclose that fact in the initial contact with the person.

An insurance broker or agent may not participate in, be associated with, or employ any party that participates in, or is associated with, the origination of a **reverse mortgage**, unless the insurance agent or broker maintains procedural safeguards designed to ensure that the agent or broker transacting insurance **has no direct financial incentive to refer** the policyholder or prospective policyholder to a reverse mortgage lender.

Individuals transacting insurance may not receive compensation, commission, or direct incentive for providing reverse mortgage borrowers with a noncasualty insurance product that is connected to or a result of the reverse mortgage.

An agent or broker may still offer title insurance, hazard, flood, or other peril insurance, or other similar products that are customary and normal under a reverse mortgage loan.

In addition, insurance agents or brokers may not participate in, be associated with, or employ any party that participates in, or is associated with, obtaining **veterans benefits for a senior**, unless procedural safeguards are in place to ensure that the agent or broker transacting insurance has no direct financial incentive to refer the policyholder, or prospective policyholder, to any veterans benefits program offered through the government.

Unless an agent is licensed as an attorney, the agent is prohibited from delivering to a person age 65 or older a **living trust** or **other legal document**, other than an insurance contract or other insurance product document, if a purpose of the delivery is to sell an insurance product.

It is also prohibited for any insurance agent who is licensed as an attorney to deliver to a person age 65 or older, a living trust or other legal document, other than an insurance contract or other insurance product document, unless the insurance agent complies with the disclosure requirements for attorneys who provide financial services.

All group life insurance policies offered for sale to individuals age 65 or older in California must provide an **examination period of 30 days** after the receipt of the policy for purposes of review of the contract. If the policyholder chooses to cancel the policy and returns it for cancellation, by mail or other delivery method, within the 30-day examination period, will be void from the beginning, and the

policyholder will be entitled to a full return of policy premium (no later than within 30 days of the policy return).

Finally, a person who meets with a senior **in the senior's home** regarding the sale of life insurance or annuity products is required to deliver a **notice in writing** to the senior **no less than 24 hours and no more than 14 days prior** to that individual's initial meeting in the senior's home. If the senior has an existing insurance relationship with an agent and requests a meeting with the agent in the senior's home the same day, a notice must be delivered to the senior prior to the meeting. The notice must be a stand-alone document, with the appropriate information inserted and without any attachments. It must be written in 16-point bold type and include all of the relevant information, such as the agent's full name, license number, mailing address and telephone number, as well as the required disclosure for the purpose of the visit.

C. Insurers

Insurance is available from both private companies and the government. The major difference between government and private insurance is that the government programs are funded with taxes and serve national and state social purposes, while private policies are funded by premiums.

Private insurance companies can be classified in a variety of ways:

- Ownership;
- Authority to transact business;
- Location (domicile);
- Marketing and distribution systems; or
- Rating (financial strength).

As you read about different classifications of insurers, keep in mind that these categories are not mutually exclusive, and the same company can be described based on where it is located and allowed to transact the business of insurance, who owns it, and what type of agents it appoints.

Educational Objectives:

I.C3.1. Be able to differentiate between:

a. Admitted and nonadmitted insurers (CIC 24-25)
b. Domestic, foreign and alien insurers (CIC 26-27, 1580)
c. Regulation of an admitted insurer and nonadmitted insurer, and the potential consequences for consumers (CIC 24, 25, 1760-1780)

I.C3.2. Be able to identify the penalty for unlawfully acting as an agent for a nonadmitted insurer without (CIC 703)

1. Admitted vs. Nonadmitted

Before insurers may transact business in a specific state, they must apply for and be granted a license or **Certificate of Authority** from the state department of

insurance and meet any financial (capital and surplus) requirements set by the state. Insurers who meet the state's financial requirements and are approved to transact business in the state are considered **authorized or admitted** into the state as a legal insurer. Those insurers who have not been approved to do business in the state are considered **unauthorized or nonadmitted**. Most states have laws that prohibit unauthorized insurers from conducting business in the state, except through licensed excess and surplus lines brokers.

Know This! Insurers must obtain a Certificate of Authority prior to transacting business in this state.

Transaction of insurance business in this state without a certificate of authority is considered a **public offense punishable** by:

- Imprisonment according to the Penal Code; or
- Imprisonment in a county jail for up to 1 year; or
- Fine up $100,000; or
- Both that fine and imprisonment.

Regulation of Admitted and Nonadmitted Insurers

The Insurance Code provisions limit the insurance that may be placed with nonadmitted insurers to the following:

- Reinsurance of the liability of an admitted insurer;
- Insurance against perils of navigation, transit, transportation, or other shipowner property, or marine insurance needs;
- Aircraft or spacecraft insurance; and
- Insurance on property or operations of railroads in interstate commerce.

These types of insurance may be placed with a nonadmitted insurer only through a special lines surplus lines broker.

Placing insurance in violation of these regulations is considered a **misdemeanor.**

Penalty for Unlawfully Acting as an Agent of a Nonadmitted Insurer

Except when performed by a surplus line broker, the following acts are considered **misdemeanors** in California:

- Acting as agent for a nonadmitted insurer;
- Advertising in any form of a nonadmitted insurer; and
- In any other manner aiding a nonadmitted insurer to transact insurance business.

In addition to any penalty provided for commission of misdemeanors, a person violating any provision of this section of the Insurance Code will be fined **$500**, along with **$100 for each month** or fraction thereof during which he or she continues the violation.

These rules do not apply to advertising authorized for surplus line insurers.

2. Domestic, Foreign, and Alien

Insurance companies are classified according to the **location of incorporation** (domicile). Regardless of where an insurance company is incorporated, it must

obtain a Certificate of Authority before transacting insurance within the state.

Know This! A *domicile* refers to the location where an insurer is incorporated, not necessarily where the insurer conducts business.

A **domestic** insurer is an insurance company that is incorporated in this state. In most cases, the company's home office is in the state in which it was formed — the company's domicile. *For instance,* a company chartered in Pennsylvania would be considered a Pennsylvania domestic company.

A **foreign** insurer is an insurance company that is incorporated in another state, the District of Columbia, or a territorial possession. Currently, the United States has 5 major U.S. territories: American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands.

For example, a company chartered in California would be a foreign insurer within the state of New York. A company chartered in Puerto Rico will be foreign in any U.S. state.

An **alien** insurer is an insurance company that is incorporated outside the United States.

3. Mutual, Stock, and Fraternal Insurers

Educational Objective:

I.C3.6. Be able to differentiate between mutual, stock and fraternal insurers, and understand the concepts of earned surplus and divisible surplus as policyholder dividends and as shareholder dividends

The following are the most common types of ownership.

Stock companies are owned by the stockholders who provide the capital necessary to establish and operate the insurance company and who share in any profits or losses. Officers are elected by the stockholders and manage stock insurance companies. Traditionally, stock companies issue **nonparticipating** policies, in which policyowners do not share in profits or losses.

A nonparticipating (stock) policy does not pay dividends to policyowners; however, **taxable dividends are paid to stockholders**. The dividends are not guaranteed as they are based on company profit.

Mutual companies are owned by the policyowners and issue **participating** policies. With participating policies, policyowners are entitled to dividends, which, in the case of mutual companies, are a return of excess premiums and are, therefore, **nontaxable**. Dividends are generated when the premiums and the earnings combined exceed the actual costs of providing coverage, creating a surplus. **Dividends are not guaranteed.**

De-mutualization is the process in which a mutual insurer becomes a stock company.

A **fraternal benefit society** is an organization formed to provide insurance benefits for members of an affiliated lodge, religious organization, or fraternal organization with a representative form of government. Fraternals sell only to their members and are considered charitable institutions, and *not insurers.* They are not subject to all of the regulations that apply to the insurers that offer coverage to the public at large.

In most states, fraternal benefit societies are permitted to issue life insurance (including endowments), health insurance (including medical and disability), and annuities. They do not issue property or liability policies.

Earned Surplus and Policy Dividends

As defined by the California Insurance Code 1152, "**Earned surplus** is unassigned funds, as required to be reported on the insurer's annual statement." Stock insurance company's dividends are paid from its earned surplus; however, the dividends cannot be declared out of earned surplus derived merely from the net appreciation in the value of assets not yet realized. It can only be returned to the stockholders once it has been earned and is not needed for expenses, reserves, liabilities, etc.

Policy dividends are the underwriting income of mutual insurance companies. They are not income or profit; they are refunds. Dividends are paid to the company's policyholders. They are also not guaranteed, since a company's expenses can never be fully anticipated. Some dividend options allow the purchase of additional insurance.

4. Operating Divisions

Educational Objective:

I.C3.3. Be able to identify the functions of the following major operating divisions of insurers: *marketing, sales, underwriting, claims, and actuarial*

Insurance companies operate with many different departments and divisions. Among them are four principal departments responsible for the major functions: Marketing or Sales, Underwriting, Claims, and Actuarial. These departments each have a specific purpose within the structure of an insurer, and each can have an impact, positive or negative, on the profitability of the company.

Marketing and Sales

The **marketing department** is responsible for advertising, promoting, and distributing an insurer's products to the public. This department also sells the products, trains the producers, and develops any materials related to the marketing process. Agents are field representatives of the marketing department, responsible for putting the company's products and services in the hands of clients. Monitoring compliance with the various laws relating to the conduct of agents and the transacting of contracts may also be handled within the marketing department. The marketing department is also responsible for watching

consumer trends and then researching and developing or modifying products and services to meet the needs or demands of the marketplace.

Underwriting

The **underwriting department** is responsible for receiving applications for insurance and then evaluating them according to established guidelines. Applications are either approved or declined. Those that are declined do not meet the company's guidelines, but not all approved applicants are equal either. Many present risks that, although the company is willing to insure them, are greater than average risks the company expects to insure, and will be classified as **substandard**. There will also be some applicants whose risks are more favorable than average, and those will be classified as **preferred**.

The underwriting department's main objective is to prevent **adverse selection**, which is an imbalance of risks or the selection of poor risks: too many substandard compared to preferred and standard risks. If the underwriting department approves too many poor risks, the statistical predictions of the actuaries may not hold up, and the company will not have the level of profit it expected, or could even suffer a loss.

Claims

The **claims department** is responsible for receiving claim requests, evaluating them in light of the actual contract, paying those claims which are covered by the terms of the contract, and rejecting those which are not. The claims department may employ or contract with adjusters or other investigators to assist in the evaluation of claims, or to seek evidence of false or fraudulent claims. If the claims department does not settle claims promptly or fairly, or makes payments for claims that are not actually covered by the contract, the profitability of the company can be affected.

Actuarial

The **actuarial department** is where the science of statistics is put into practice. Insurance company actuaries are persons who study mortality and morbidity statistics, the nature of claims and actual claims experience, even factoring in the potential for fraudulent claims and the financial impact of those claims, including investigating fraudulent claims and payments. The actuaries must also account for the ordinary expenses of doing business, including the payment of claims, as well as make a conservative estimate of earnings from invested reserves (premiums received by the company but not currently needed to pay expenses). After all the analyses and calculations have been made, the actuaries publish the rates that must be charged for each line of business the company insures, with the intent of achieving profitability.

5. Insurer's Qualifications

Educational Objective:

I.C3.5. Know that any person, association, organization, partnership, business trust, limited liability company or corporation capable of

making a contract may be an insurer (CIC 19 and 150)

According to California Insurance Code 150, any person capable of making a contract may be an insurer, subject to the Code restrictions. In order to become an admitted insurer (legally entitled to transact insurance in this state), there are many financial, technical, and legal qualifications that a company must meet. The Code regulation is in place to prevent unqualified persons from offering insurance to the public.

The term *person* is used in the law to refer to any entity which is legally capable of performing legal acts, such as making contracts, on its own behalf. In California, a person may, therefore, be either a natural person **at least age 18** who is legally competent, or any of the following entities:

- Association;
- Organization;
- Partnership;
- Business trust;
- Limited liability company; or
- Corporation.

Any person may be an insurer by meeting the following guidelines of the California Insurance Code:

- Submitting all forms, products, premiums, and advertising for approval prior to use;
- Using only licensed agents and brokers;
- Using acceptable D.B.A. ("Doing Business As") names; and
- Maintaining required financial reserves.

6. Primary Insurer in Reinsurance

Educational Objective:

I.C3.4. Be able to identify that a primary insurer (i.e., ceding company) is the insurance company which transfers some or all of its loss exposure to another insurer in a reinsurance transaction

Reinsurance is insurance purchased by a primary insurer to protect itself against the catastrophe of a comparatively large single loss or a large number of small losses caused by a single occurrence. The reinsurance contract is between two parties.

1. **Reinsurer:** the company that, in consideration of the premium paid, assumes a part of the risk over an amount retained by the primary insurer, known as the **net line.**
2. **Primary insurer:** the insurer covering losses on a first dollar basis (sometimes subject to a deductible), who issues the policy over which reinsurance is purchased. In the reinsurance contract, the primary insurer may also be called the **ceding company.**

The contract between the reinsurer and the primary insurer is called a **treaty.** There are two types of reinsurance treaties:

1. **Automatic treaty:** The reinsurer agrees, in advance, to accept a portion of the gross line of the primary company's risks that meet the reinsurer's underwriting rules.
2. **Facultative treaty:** Each risk is considered individually by both parties. A risk is submitted to the reinsurer for acceptance or rejection. If the risk is accepted, the primary insurer may accept or reject the rates and terms of the offer.

When a reinsurance company reinsures risks with other reinsurance companies, this is known as **retrocession.**

7. Insolvent Insurers

Educational Objective:

I.C4.4. Be able to define an insolvent insurer (CIC 985), and know the following:

a. The definition of *paid-in capital* (CIC 36 and 985)
b. That it is a misdemeanor to refuse to deliver any books, records, or assets to the Commissioner once a seizure order has been executed in an insolvency proceeding (CIC 1013)

Insolvency means either of the following:

- Any impairment of minimum paid-in capital required of an insurer by the provisions of the Insurance Code for the class, or classes, of insurance that it transacts anywhere; or
- An inability of the insurer to meet its financial obligations when they are due.

Even if the insurer is able to provide for all its liabilities and for reinsurance of all outstanding risks, it cannot escape the condition of insolvency unless it has additional assets equivalent to the aggregate paid-in capital as established by the state regulation.

Paid-in Capital

Paid-in capital or **capital paid-in** means the following:

- In the case of a **foreign mutual insurer** not issuing or having outstanding capital stock, the value of its assets in excess of the sum of its liabilities for losses reported, expenses, taxes, and all other indebtedness and reinsurance of outstanding risks as provided by law. Foreign mutual insurers cannot be admitted unless their paid-in capital is composed of available cash assets amounting to at least $200,000.
- In the case of a **foreign joint stock and mutual insurer**, its paid-in capital may be computed by the insurer according the Insurance Code provisions for foreign mutual insurers.
- In the case of **all other insurers**, the lower of the following amounts:
    - The value of its assets in excess of the sum of its liabilities for losses reported, expenses, taxes, and all other indebtedness and reinsurance of outstanding risks as provided by law; or
    - The aggregate par value of its issued shares of stock.

For the purpose of computing paid-in capital or capital paid-in, shares of stock are not taken as liabilities.

Refusal to Issue Information

Whenever it appears to the Commissioner that irreparable loss and injury to the property and business of a person has occurred or may occur unless the Commissioner takes action, the Commissioner, without notice and before applying to the court for any order, can take possession of the property, business, books, records, and accounts of the person and the person's office. The Commissioner can continue to retain possession after receiving a court order.

Any person against whom a seizure order has been issued and who refuses to deliver pertinent books, records, or assets will be guilty of a **misdemeanor** and could be punishable by a maximum fine of $1,000, imprisonment for no longer than 1 year, or both.

D. Market Regulation - General

Educational Objective:

I.C4.1. Be able to identify:

a. The California Insurance Code (CIC) and how it may be changed
b. The California Code of Regulations (CCR Title 10, Chapter 5) and how it may be changed
c. How the Insurance Commissioner is selected, the terms of office, and the responsibilities of the position (CIC 12900 and 12921)

1. California Insurance Code

The **California Insurance Code (CIC)** is the primary body of laws established by the state legislature, which regulates the business of insurance in California. The present form of the Code, as amended, was enacted in 1935, as a restatement and expansion of previously established law. It is a dynamic, fluid device, constantly being reviewed, amended, added to, and even having outdated sections repealed, all consistent with current issues and practices in the marketplace.

How the Code May be Changed

In order to change the Insurance Code in any way, **legislative** action is required. A bill amending or repealing an existing section or desiring to add something new is introduced into either the Assembly or the Senate, where it undergoes a variety of committee hearings and revisions before it is presented to the full body for a vote. If approved, it goes to the other body for the same sort of process. If more changes are made before the bill is approved, it must be returned to the first body for re-approval. Once approved by both houses, the bill goes to the Governor for approval or veto, or it may also become law without action, positive or negative, by the Governor.

Definitions
Shall and May (CIC 16)

Certain concepts or terms have special relevance to insurance, but they do not have different legal interpretations in insurance law than elsewhere. *For example*, the words **shall** and **may** always have the same implications, whether they appear in the Insurance Code or any other law.

Shall is a word that compels action; it normally indicates that a specific action or response is mandatory. Where the Code states that a person "shall" or "shall not" do something, there is usually no room for misunderstanding what that means. The word **may**, on the other hand, is normally a word of options or permission; it leaves room to act or not act and still remain in compliance with the law. However, the Code leaves open the possibility that, in context, even the word **may** could be interpreted the same as the word **shall**.

Person (CIC 19)

Even the word **person** is expansive. A *person* does not simply mean a living, breathing human being – a natural person. *Person* also refers to associations, organizations, partnerships, trusts, limited liability companies, and even corporations – all are non-natural persons. Whether natural or non-natural, all persons are distinguished by their ability to contract, sue, or be sued. Non-natural persons simply have to designate a natural person to represent them or act as their agent.

2. California Code of Regulations

The **California Code of Regulations (CCR)**, also known as the California **Administrative Code**, is the set of regulations issued by the Department of Insurance that identifies the standards for the Insurance Code, and how it is to be administered. The CCR contains the regulations that have been issued by the Insurance Commissioner for clarification and administration of the Insurance Code.

3. The Commissioner

Selection of Commissioner

The Commissioner of Insurance is an **elected** officer in California. The Commissioner may be elected to serve not more than **two consecutive 4-year terms**.

The Commissioner is expected to be a person knowledgeable in the business of insurance, but cannot be an active agent, officer, director, or employee of an insurance company. If a licensed person is elected Commissioner, he or she must surrender his/her license within 10 days of taking office. At the conclusion of his/her term of office, he/she may have his/her license reinstated for the balance of his/her license term without penalties or fees.

Responsibilities

The Commissioner of Insurance has **no power or authority to write or change the law** but **has the authority to enforce the law**. The Commissioner's duty is to issue regulations which establish how the Department of Insurance intends to interpret and enforce the law. The regulations proposed by the Commissioner must

undergo a public hearing process to determine their fairness or applicability before they may actually go into effect.

The Commissioner has the responsibility to oversee the California Department of Insurance (CDI) and direct all of the CDI's affairs and staff.

The Commissioner can appoint persons to act on the Commissioner's behalf. These representatives can negotiate settlements with agents or insurers who have violated the Insurance Code. However, it is the Commissioner's responsibility to make the final approval of a sanction.

The Commissioner is responsible for a procedure to investigate complaints and respond to inquiries and, when warranted, to bring enforcement actions against insurers. The system for managing complaints must include the following:

- A toll-free number published in telephone books throughout the state, dedicated to the handling of complaints and inquiries;
- Public service announcements to inform consumers of the toll-free telephone number and how to register a complaint or make an inquiry to the department;
- A simple, standardized complaint form designed to assure that complaints will be properly registered and tracked;
- Retention of records on complaints for at least 3 years; and
- Guidelines to disseminate complaint and enforcement information to the public that includes license status, number and type of complaints filed within the last calendar year, number and type of violations found, and enforcement actions taken. Also included is the ratio of complaints received to total policies in force, or premium dollars paid in a given line, or both.

The Commissioner's duty is to provide to the insurer a description of any complaint against the insurer that the Commissioner received and deemed to be justified at least **30 days** prior to public release of a report summarizing the information required. This description includes the name of the complainant, the date it was filed, a description of facts and a statement of the DOI's rationale for determining whether the complaint is valid.

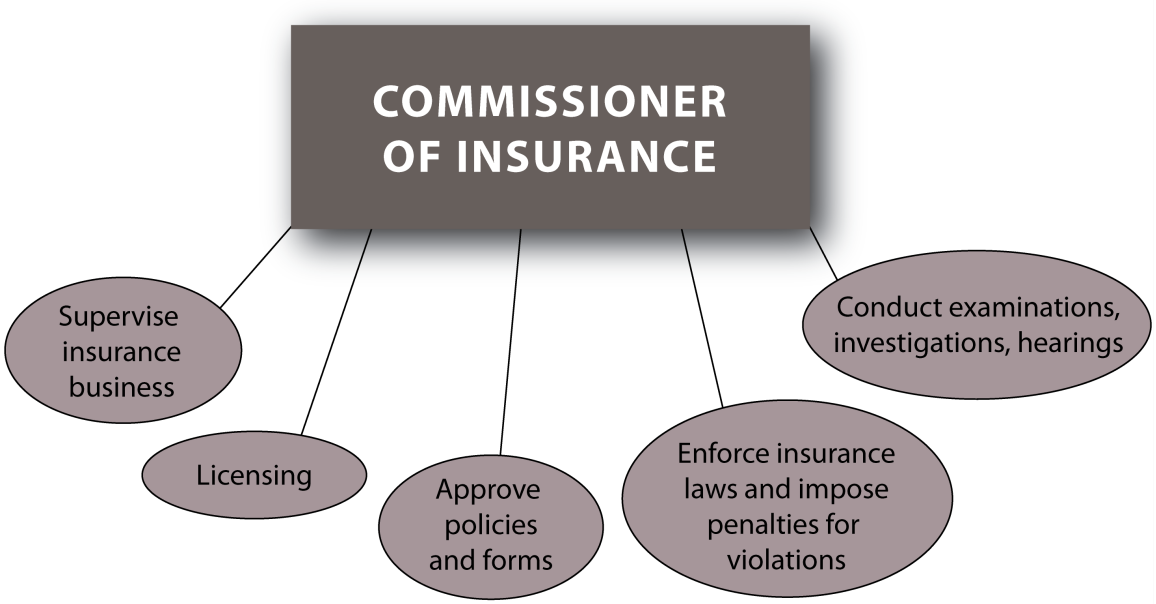
The Commissioner must prepare a written report, to be made available by the DOI to
interested individuals upon written request, that details complaint and enforcement information on individual insurers in accordance with the CIC. The report must be made available by mail, telephone, internet and email.

All public records of the Department and the Commissioner must be available for inspection and copying.

The Commissioner receives complaints and inquiries, investigate complaints, prosecute insurers according to guidelines determined by the CIC, and must respond to complaints and inquiries concerning alleged misconduct. The Commissioner must notify the complainant of receipt within **10 working days**. The complainant will be notified of final order within 30 days of judgment.

The Commissioner has the authority to issue a **cease and desist order** against any person acting as an insurance agent or broker without being licensed, and against any person transacting insurance without having been issued a certificate of authority. The Commissioner may issue a cease and desist order without holding a

hearing prior to issuance of the order, and may also impose a fine of up to $5,000 for each day the order is violated. A person to whom a cease and desist order is issued may request a hearing by filing a request with the Commissioner within 7 days after service of the order.



Educational Objective:

I.C4.3. Be able to identify the privacy protection provisions of the following acts:

a. The Gramm-Leach-Bliley Act (GLBA)/California Financial Information Privacy Act (CFC 4050 - 4060)
b. Insurance information and Privacy Protection Act regarding practices, prohibitions and penalties (CIC 791 - 791.26)

4. Gramm-Leach-Bliley Act (GLBA)

The Gramm-Leach-Bliley Act stipulates that in general, an insurance company may not disclose nonpublic personal information to a nonaffiliated third party except for the following reasons:

- The insurance company clearly and conspicuously discloses to the consumer in writing that information may be disclosed to a third party;
- The consumer is given the opportunity, before the time that information is initially disclosed, to direct that information not be disclosed to the third party; or
- The consumer is given an explanation of how the consumer can exercise a nondisclosure option.

The Gramm-Leach-Bliley Act requires **2 disclosures** to a customer (a consumer who has an ongoing financial relationship with a financial institution):

1. When the customer relationship is established (i.e., a policy is purchased); and
2. Before disclosing protected information.

The customer must also receive an annual privacy disclosure, and have the right to opt out, or choose not to have their private information shared with other parties.

5. California Financial Information Privacy Act

The **California Financial Information Privacy Act**, in effect since July 1, 2004, was enacted to provide consumers the ability to control how consumer nonpublic personal information is shared or sold to third-party financial institutions. The act is designed to provide greater privacy protections than those under the federal Gramm-Leach-Bliley Act (GLBA).

The act restricts financial profiling of consumers and makes consumers aware of their rights through a clearly written and easy-to-understand notice, which provide the consumer the ability to opt-in or opt-out of sharing nonpublic personal information.

Nonpublic personal information refers to personally identifiable information collected by a financial institution by way of the consumer providing it, a transaction between the institution and consumer, or other means.

Personally identifiable information includes:

- Information on an application to obtain loans, credit cards, or other financial products or services;
- Account balance information, payment history, credit or debit card purchase information;
- Information from previous and current financial institutions used by a consumer;
- Financial information collected through internet cookies or web servers; and
- Information on a consumer report.

An authorized privacy notice must include the following:

- A form, statement, or writing that is separate from other documents;
- A title reading "*IMPORTANT PRIVACY CHOICES FOR CONSUMERS*;"
- The consumer's signature and date;
- A disclosure that the consumer is consenting to the release of personally identifiable information to a nonaffiliated third party;
- A disclosure that consent will remain in effect unless revoked or modified by the consumer;
- A procedure for the consumer to revoke consent; and
- A statement that the financial institution will maintain the notice and the consumer may receive a copy if requested.

A financial institution is not required to obtain a consumer's consent if nonpublic personal information is shared with its wholly owned financial institution subsidiaries.

If a financial institution is found to be in violation of the California Financial Information Privacy Act, the institution may be fined up to **$2,500** per violation of one consumer's information being released, or **$500,000** for multiple consumers.

6. Insurance Information and Privacy Protection Act

Practices

Section 791 of the Insurance Code is concerned with access to, or collection and distribution of, a person's private or privileged information which may be necessary to obtain in connection with an application for insurance. The law is sensitive to a consumer's desire to keep certain information private, but it also recognizes that in the absence of that information, an insurer might approve a person for insurance that it could lawfully decline coverage to if it knew that same information.

Section 791 tries to strike a balance of fairness for both applicants and insurers in the process of gathering and using information. The law is intended to apply to natural persons who are residents of the state and are seeking life or disability insurance. It also applies to any person seeking property or casualty insurance for policies that will be issued or delivered in this state.

The information necessary for proper underwriting may be both personal and highly sensitive in nature. Because of this, there is great potential for harm to an individual if their personal information is disclosed to others who have no legitimate reason for receiving it. How, and from whom, that information is obtained, collected, held, and when or how it will or may be disseminated to others must be disclosed in advance to applicants for insurance.

In some cases, insurers may decide to conduct an investigative consumer report in connection with an application. An investigative consumer report goes beyond simply gathering information from the credit reporting bureaus or the Medical Information Bureau (MIB). It can include interviews with applicants, their relatives, employers, or neighbors, or any other person who may have personal or other information about the person's character, general reputation, personal characteristics, and lifestyle. The Insurance Code allows people to request that they be interviewed personally. It also requires that the person must be given a copy of the report upon request and provides them with a mechanism to protest and request correction of inaccurate information about them. The person has a right to know to whom the information has been given and those who were the source or sources of information about them.

In the event of an "adverse underwriting decision," which could mean being declined, rated, or in any way deemed less than a standard risk, or even being issued coverage by a company other than the one the applicant originally intended to apply for coverage, the person must be given the reason for the decision. That information must be given to them in writing, or the person must be advised that they may request in writing the reason for the action be furnished to them.

If the information is medically-related, and supplied by a medical care institution or medical professional, it must be disclosed, upon request, to the individual directly or to a medical professional of that person's choosing who is licensed to treat the person for the condition to which the information relates. If the information is related to a person's mental health, it may only be disclosed with the consent of the professional who is responsible for the treatment related to that information.

Prohibitions

The Insurance Code also describes how information about a person's past adverse underwriting decisions may not be used as the basis of a new underwriting decision, unless it is received directly from the insurer or agent who made the adverse decision. Simply being declined or rated for insurance in the past, or having insurance provided by a residual carrier (one other than the original company to which the application for coverage was submitted) is insufficient for declining or rating a person for new insurance.

Additionally, applications for insurance which contain questions that are not designed to gather information about the applicant but are designed for marketing or research purposes must be clearly identified as such. Marketing or research questions could include those designed to reveal a person's shopping habits, for example, but they could actually reveal other *privileged information* that the insurer or agent has no reason to need or possess. These questions do not need to be answered, and a decision not to answer such questions cannot be used as the basis for an adverse underwriting decision.

Pretext Interviews

Under most circumstances, insurance institutions, agents, and insurance-support organizations are not allowed to use **pretext interviews** to obtain information that relates to an insurance transaction.

A **pretext interview** is conducted when any person, in an attempt to gain information about another natural person, does one or more of any of the following:

- Pretends to be someone he or she is not;
- Pretends to represent someone he or she is not actually representing;
- Misrepresents the purpose of the interview; or
- Refuses to identify himself or herself upon request.

Pretext interviews are prohibited during any phase of the transaction process of insurance. This includes information gathering during underwriting. Obviously, the use of a pretext interview could reveal information that is privileged and would not normally be available to the insurer or agent. It could result in an **adverse underwriting decision**. However, in the investigation of a claim, particularly when fraud is suspected, as an investigative technique, pretext interviews are permitted.

It is further required that the reason of the interview must be to investigate a claim where there is a reasonable basis for suspecting criminal activity, fraud, material misrepresentation, or material nondisclosure in connection with a claim.

Penalties

Section 791 also details under what circumstances and how the Commissioner may examine insurers, agents, and others engaged in the information gathering processes, and how they maintain or distribute the information obtained. There are a variety of penalties which can be applied to the various violations that could be committed. The following are some of the penalties:

- Suspension or loss of license; and

- Civil fines for violating cease and desist orders of up to $10,000 for each violation; or
- Up to $50,000 if the violations are found to be committed with a frequency indicating they are a general business practice.

Insurers or agents can also be liable for civil damages and legal fees that arise for the unlawful collection or distribution of personal, private, or privileged information about a person that causes him/her harm. Certain acts could also violate other criminal laws and subject a person to prosecution, resulting in fines or imprisonment.

7. Other Privacy Protection Provisions

Cal-GLBA

The California Financial Information Privacy Act provides standards for financial institutions regarding sharing or selling of nonpublic personal information about consumers. California Legislature, known as **Cal-GLBA**, provides greater privacy protection to consumers than the federal Gramm-Leach-Bliley Act. Cal-GLBA outlines consumer privacy choices and rights, and allows California consumers to have greater control over the disclosure of nonpublic personal information.

As defined by the California Financial Code, *nonpublic personal information* means any financial information that is

- Provided by a consumer to a financial institution;
- Obtained as a result from a transaction with the consumer; or
- Obtained by a financial institution by any other means.

HIPAA

Under the **Privacy Rule** for HIPAA (Health Insurance Portability and Accountability Act), protected information includes all "*individually identifiable health information*" held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper or oral. This is called **protected health information (PHI).**

Individually identifiable health information including demographic data that relates to past, present or future physical or mental health or condition, or payment information that could easily identify the individual.

A covered entity must obtain the individual's written authorization to disclose information that is not for treatment, payment, or health care operations.

8. Conservation Proceedings

Educational Objective:

I.C4.5. Be able to identify the scope and correct application of the conservation proceedings described in the Code (CIC 1011, 1013, 1016)

Insurance companies are specifically exempted under federal bankruptcy laws, which means that any **liquidation** of an insolvent insurer is strictly a matter for the state to pursue. To accomplish this, California has adopted the **Uniform Insurers Rehabilitation Act**. This Act describes the steps that the Commissioner must take when attempting to either rehabilitate an **insolvent** or **delinquent** insurer to sound financial condition or liquidate an insurer that cannot be rehabilitated. The Code also describes the mandatory action the superior court is required to take when the Commissioner presents a petition for either a **conservation** or **liquidation** order.

Each year, on or before March 1, every insurer doing business in California is required to report its financial condition to the Commissioner. At that time, or at any other time, if an insurer's legal reserve funds are less than the minimum required by law, the company is **impaired** in its ability to pay claims, and is technically **insolvent**. The Commissioner has authority under the Code to take control of the insurance company, and the superior court *must* grant the Commissioner's petition for conservation. There is no long, drawn-out legal battle – the insurer has no power to prevent the act of conservation.

The court order gives the Commissioner absolute control over the assets and operations of the company. The Commissioners first responsibility is to attempt to rehabilitate the company, if at all possible. Initially, all new business transactions are terminated. Existing and new claims are paid, and ways to return the company to solvency are explored. If it becomes clear that there is no possibility of rehabilitating the company, the Commissioner's final move will be to liquidate the company, selling assets to continue to pay claims, and if all claims have been satisfied, any remaining assets will be used to satisfy the claims of other creditors.

If the company cannot pay any or all of its claims, the two Guarantee Associations in California are prepared to pay a portion of the claims, depending on the type of policy. If either or both of the Guarantee Associations have paid claims due to the inability of the company to pay, they become creditors of the company and can seek repayment through the liquidation process.

In a conservation or liquidation effort, the Commissioner also has the power to sue officers, directors, or others who may bear responsibility for the company's condition, including managing general agents, auditors and accountants, or actuaries in order to add to the "estate" of the company in order to pay claims of insureds or creditors. Even the industry rating companies have been held responsible for their published inaccuracies!

Additionally, in a liquidation, other parties not normally associated with the claims-paying responsibility of the company may have their assets seized. If the insolvent insurer was a substantial owner of another business or partnership, those assets may be taken to satisfy the obligations of the insurer, regardless of whether that business was involved in the business of insurance.

When the Commissioner is engaged in liquidating an insurer, there is a legal requirement to publish the notice of liquidation for 4 consecutive weeks, and, in most cases, to also mail notices to known potential claimants against the estate of the company. Once the notices have been published or mailed, claimants have

no more than 6 months to file their claims. The Insurance Code establishes the priority of claims, and only when the claims of a class or group have been fully satisfied will the next in order be entitled to pursue their claims.

9. Discontinuance and Replacement of Group Life or Group Disability Insurance

Educational Objective:

I.C4.8. Be able to identify the requirements for discontinuance of group life insurance (CIC 10128.1 - 10128.4)

Educational Objective:

I.C4.9. (Health) Be able to identify the requirements for discontinuance of GroupDisability Insurance (CIC 10128.1 - 10128.4).

When persons are covered under group life or disability insurance policies, there are provisions in the Insurance Code to protect them in the event the coverage is being discontinued, or they are no longer eligible to be covered by the policy. These provisions are discussed in the Code as **discontinuance**, **extension of benefits**, and **replacement coverage**.

The term **discontinuance** is described as the termination of a plan of insurance between the insurer and the entire group of employees. It does not refer to the termination of benefits with regard to an individual employee whose employment is terminated or whose eligibility under the group plan has been affected because of a reduction of work hours or other qualifying factor.

Extension of benefits provisions have been established to protect covered persons, employees, or dependents, who are **totally disabled** prior to the discontinuance or termination of their group insurance, while they remain totally disabled. The Insurance Code provides for up to 12 months of continued coverage for disability and health care claims beyond the termination of the preceding policy, as long as the person remains totally disabled.

If an existing group policy is being replaced by a new group policy, the new policy **is required** to accept all the insured covered under the previous policy. However, the insurer is not required to take over existing claims. In this case, a person who is totally disabled at the time of replacement must have his/her continuing claim paid for by the former insurer if the new insurer elects not to cover pre-existing claims. However, it is possible for a replacing insurer to agree to accept all covered persons and their existing claims.

In this case, a continuing claim does not have to be covered longer than 12 months following the date of replacement, since this is the same amount of time a former insurer would have been required to provide coverage under the “discontinuance” provision. But all new claims unrelated to the person’s total disability would have to be covered by the new policy. This concept is also known as **no loss, no gain.** The covered person would not be entitled to receive more or less benefits than

the preceding insurer would have been required to provide. The person must be treated the same as any other covered employee with respect to new claims.

Additionally, in the event replacement coverage does not actually become effective at the same time as the former policy ends, all persons who were covered as of the date of discontinuance, or who would have become eligible for coverage except for the discontinuance, must be covered by the new policy, without exception, only if the new policy takes effect within 60 days of the date of discontinuance.

A replacement policy taking effect more than 60 days following discontinuance of a previous policy and any group policy which includes a life insurance benefit and allows conversion to an individual plan of insurance if eligibility is lost, must also permit conversion to an individual policy at the conclusion of the extension of benefits period. This would permit a person to have a continuous period of total disability covered without the payment of further premiums for up to 12 months, and then allow the covered person, even if still totally disabled, to convert the group coverage to individual coverage without proof of insurability.

10. Notice by Mail

Since there is always the possibility that a party to a policy may attempt to avoid responsibility under the policy by falsely claiming that he or she sent a notice or that the other party never sent an important notice, the law explains what is considered to be sufficient proof of mailing.

If the notice had postage applied and was put in the hands of the U.S. Postal Service with the last known address of the recipient on it, then an affidavit by the sender, stating such facts, is proof of the mailing. Any notice provided by electronic transmission must be treated as if mailed or given for the purposes of any provision of the Insurance Code. A valid electronic signature will be sufficient for any provision of law requiring a written signature.

A licensee must acquire an insured's **consent to opt in to receiving records electronically**. Additionally, a licensee must disclose to the insureds that they may opt out of electronic transmission at any time, a description of the records the insured will receive, a process to change or correct an insured's email address, and the licensee's contact information.

The insurance company must **retain a copy of the confirmation** and electronic signature, when either is required, with the policy information so that they are retrievable upon request by the Department of Insurance while the policy is in force and for **5 years** thereafter.

Upon the request of the insured, a licensee must provide at least one free printed copy of records on an annual basis.

If required to transmit a record by return receipt, a licensee may demonstrate actual delivery by:

- Having the recipient acknowledge the receipt;
- Have the record posted in the licensee's secure website; or

- Have the record transmitted to the named insured through an secured application.

If a record is not delivered directly to the insured's email, a licensee must either contact the insured to confirm his or her email address or resend the record by regular mail within **5 business days**.

11. California Life and Health Insurance Guarantee Association

Educational Objective:

I.C4.6. Be able to identify the purpose and scope of the CIC concerning the California Life and Health Insurance Guarantee Association (CLHIGA) (CIC 1067.02(a)1 & (b)1):

a. Basic coverages and exclusions of CLHIGA (CIC 1067 - 1067.18)

The **California Life and Health Insurance Guarantee Association (CLHIGA)** exists to pay claims of insureds or beneficiaries when an insurer is **insolvent** or **impaired**. The Association provides coverage for the following:

- Most contracts of life and health insurance and annuities;
- Persons who are state residents, and in special circumstances, who are nonresidents; and
- Structured settlement annuities.

The Association is **liable**, at most, for the lesser of the following benefits:

- 80% of the contractual obligations of the insurer if it had not become insolvent;
- $100,000 in total net cash surrender and net cash withdrawal values for life insurance;
- $250,000 in net cash surrender and net cash withdrawals values for deferred annuity contracts; or
- $300,000 for all benefits including cash values, with respect to any one life.

In no event would the Association be obligated to cover more than an aggregate of $300,000 in benefits with respect to any one life. With respect to a single owner of multiple nongroup policies of life insurance (usually found in business insurance or similar circumstances), the Association is not liable for more than $5,000,000 in benefits, regardless of the number of policies and contracts.

For health insurance claims, the CLHIGA is obligated to pay the *lesser* of the actual covered claims of an insured, but not more than $200,000 in health insurance benefits, adjusted for inflation based on increases or decreases in the health care component of the Consumer Price Index (CPI) from January 1, 1991, to the actual date of insolvency. Health insurance claims **do not** include the following:

- Accidental death or dismemberment;
- Credit disability, disability income or indemnity;
- Workers compensation; or
- Long-term care.

CLHIGA is composed of all insurers who lawfully do business in the state. It assesses members according to the lines of business it transacts, and maintains 2 separate accounts:

1. Life insurance and annuity account, which includes 2 subaccounts (the life insurance account and the annuity account); and
2. Health insurance.

Based on a formula established by the Association's board of directors, insurers pay a maximum of 1% of their annual premiums, as reported to the Commissioner in their annual financial reports, in each of these lines of business for the future payment of claims.

In the event there are insufficient funds in any account to pay the obligations of the Association, member insurers can be assessed an additional amount, in proportion to their total premiums, necessary to fund the claims against the Association. Additionally, for health insurance, these additional assessments on insurers can be recovered by passing the cost on to current policyholders "over a reasonable length of time" as a premium surcharge.

The following are not covered by the California Life and Health Insurance Guarantee Association:

- Any portion of a policy not guaranteed by the insurer, or under which the risk is borne by the policyholder;
- Any policy of reinsurance, unless assumption certificates have been issued;
- Any portion of a policy to the extent that the rate of interest on which it is based exceeds a rate of interest determined by subtracting six percentage points from Moody's Corporate Bond Yield Average or Moody's Corporate Bond Yield Average;
- Guaranteed investment contracts, guaranteed interest contracts, funding agreements, deposit administration contracts, and all other unallocated annuity contracts;
- A person who is a payee, or beneficiary, of a contract owner resident of this state, if the payee, or beneficiary, is afforded coverage by the association of another state;
- Any plan of an employer or association to provide benefits to its members to the extent that the program is self-funded or uninsured;
- Any portion of a policy to the extent that it provides dividends or experience rating credits, or provides that any fees or allowances be paid to any person;
- Any annuity issued through a charitable organization not primarily involved in the business of insurance; or
- Any policy or contract issued at a time when the member insurer was not licensed or did not have a certificate of authority.

12. Unfair Trade Practices

Educational Objective:

I.C4.2. Be able to identify the correct application of the Unfair Practices article, including its prohibitions and penalties (CIC 790 - 790.10):

a. Know that only the Commissioner may enforce the provisions of the Unfair Practices Act

b. Know that the Commissioner may conduct hearings to identify additional unfair acts or practices and determine their enforcement

Subsequent to passage of the McCarran-Ferguson Act in 1945, affirming the role of state regulation of insurance, California adopted regulations pertaining to “unfair practices.” Section 790 of the Code, together with its subparts, contain the several different practices that the Code has specifically identified as unfair, as well as the penalties and other regulations related to unfair practices. The Code is also clear that any other undefined act or practice which the Commissioner determines to be unfair to consumers or unfair to insurers, even though it is not mentioned in particular, may still be a violation of the Code.

General Prohibitions

Many of the most common or prevalent practices which are problems include things such as misrepresentations in sales illustrations or advertised policy terms, or in the financial condition of an insurer, including its reserves, policy titles which could mislead a person into believing that the contract performs differently, or other misrepresentations which could lead a person to lapse, forfeit, or surrender a policy. Additionally, acts such as filing false financial documents, unfairly discriminating against classes of insureds, or simply making false statements which should be known as untrue by using "reasonable care" are identified as unfair practices.

Unfair claims settlement practices include the following:

- Misrepresenting facts or provisions of policy coverage;
- Failure to determine within a reasonable amount of time following submission of proof of loss forms whether or not a claim is payable;
- Not making a fair and equitable settlement of a claim after the insurer’s liability has been made clear;
- Compelling insureds to sue the insurer in order to obtain a judgment to enforce a claim by offering substantially less than the insured receives following a trial, only to collect an amount the same or nearly the same as the insured hoped to receive;
- Advertising insurance that the insurer will not sell; and
- Providing untrue or deceptive information about a person or entity engaged in insurance.

Also included in this subpart are other offenses, such as the following:

- An insurer attempting to appeal arbitration awards in an effort to get the insured to accept a settlement or compromise for less than the arbitration award;
- Requiring insureds to submit preliminary claim reports followed later by a request to submit essentially the same information in order to either deny or accept a claim;
- Advising an insured not to retain or seek an attorney;
- Delaying payment in regard to hospital, medical, or surgical claims for persons with AIDS or HIV, for more than 60 days after filing a claim for the purpose of attempting to invoke a pre-existing condition exclusion
- Filing false financial statements;
- Unfair discrimination;
- Advertising membership in the State's Guarantee Association; and
- Boycott, coercion, intimidation.

Specific Unfair Trade Practices Defined

False Advertising

Advertising covers a wide scope of communication, from publishing an ad in a newspaper or magazine, to broadcasting a commercial on television or the Internet. Advertisements cannot include any untrue, deceptive, or misleading statements that apply to the business of insurance or anyone who conducts it. The violation of this rule is called **false advertising.**

It is prohibited to advertise or circulate any materials that are untrue, deceptive, or misleading. False or deceptive advertising specifically includes **misrepresenting** any of the following:

- Terms, benefits, conditions, or advantages of any insurance policy;
- Any dividends to be received from the policy, or previously paid out;
- Financial condition of any person or the insurance company; or
- The true purpose of an assignment or loan against a policy.

Representing an insurance policy as a share of stock, or using names or titles that may misrepresent the true nature of a policy also will be considered false advertising. In addition, a person or an entity cannot use a name that deceptively suggests it is an insurer.

Misrepresentation

It is illegal to issue, publish, or circulate any illustration or sales material that is false, misleading, or deceptive as to policy benefits or terms, or the payment of dividends. This also refers to verbal statements. Committing this illegal act is called **misrepresentation**.

Rebating

Rebating is defined as any inducement offered to the insured in the sale of insurance products that is not specified in the policy. Both the offer and acceptance of a rebate are illegal. Rebates may include, but are not limited to, the following:

- Rebates of premiums payable on the policy;
- Special favors or services;
- Advantages in the dividends or other benefits; and
- Stocks, bonds, securities, and their dividends or profits.

Twisting

Twisting is a misrepresentation, or incomplete or fraudulent comparison of insurance policies that persuades an insured/owner, to their detriment, to cancel, lapse, switch policies, or take out a policy **with another insurer**. Twisting is prohibited.

Unfair Discrimination

Discrimination in rates, premiums, or policy benefits for persons within the **same class** or with the same life expectancy is illegal. No discrimination may be made on the basis of an individual's marital status, race, national origin, gender identity,

sexual orientation, creed, or ancestry unless the distinction is made for a business purpose or required by law.

Defamation

Defamation occurs when an oral or written statement is made that is intended to injure a person engaged in the insurance business. This also applies to statements that are **maliciously critical** of the *financial condition* of any person or a company.

Boycott, Coercion and Intimidation

It is illegal to be involved in any activity of **boycott, coercion, or intimidation** that is intended to restrict fair trade or to create a monopoly. This would include unfair behavior that influences not only clients, but competing agents and brokers.

Coercion is to require, as a condition to a loan, that the applicant purchase insurance from a specific insurer.

Penalties

Whenever the Commissioner has reason to believe that a person has been engaged or is engaging in any unfair trade practices, the Commissioner must issue a cease and desist order to show cause, the person's liability, and the notice of a hearing, which must be at least **30 days** from the date of the order. At the hearing, if the charges are found to be justified, the Commissioner may issue a penalty.

The **civil penalties** which may be assessed for violations of unfair trade practices are $5,000 for each act in violation of the Code, whether intentional or not. However, if the act or practice is determined to be a willful violation or a general business practice, the penalty increases to a maximum of $10,000 per violation. In addition to this, the Commissioner may also take action against the license of a person found to have been engaged in any unfair practice.

If the Commissioner has reason to believe that a person has **violated a cease and desist order** after the order has become final, the Commissioner may, after a hearing at which it is determined that the violation was committed, order that person to pay a sum not to exceed $5,000 which may be recovered in a civil action. If the violation is found to be willful, the amount of the penalty may be a sum not to exceed $55,000. These fines are in addition to civil penalties for violation of insurance code ($5,000 for each act) and intentional violation of insurance code ($10,000 for each act).

13. Unfairly Discriminatory Practices

Educational Objective:

I.C4.9. Be able to identify discriminatory practices prohibited by the California Insurance Code (CIC 10140-10145)

In insurance, there are two types of discrimination. **Fair discrimination** occurs when an insurer's underwriting department finds information which indicates an increase of risk which can be verified through actuarial (statistical) proof. When that insurer then decides to limit coverage or other policy benefits, increase premiums or refuse coverage for that client (discriminate), it is appropriate for them to do so and the law allows it.

Unfair discrimination is morally unacceptable and illegal. One step in enabling insurers to avoid unfair discrimination is to place insureds and applicants in classifications based on actuarially acceptable guidelines. Such classifications upon which risk and insurability can be based will naturally vary with the specific type of coverage. Generally, they may include the following:

- Gender;
- Age;
- Tobacco use;
- Height/weight ratio;
- Geographic location; or
- Profession and avocations (hobbies).

A combination of these may be used, but only if statistics prove that the classification increases the risk for a claim on the specific type of insurance being considered.

For example, it would not be acceptable to charge life insurance clients a higher premium based on their ZIP code since their geographic location, as long as it is within the United States, does not increase their risk of death. It would, however, be acceptable to charge the same clients a higher or lower premium for health insurance if the costs of health care in their ZIP code are higher or lower than the average. For this reason, it is common for insurers to apply a **rating factor** to raise or lower a health insurance premium based solely on ZIP code.

Once a client's actuarial classifications have been determined, that client must be treated the same as all other clients within the same classifications. The person may not be provided with different policy benefits or charged a different premium than everyone else in those classifications.

The specific classifications which **cannot** exist include the following:

- Race;
- Color;
- Religion;
- National origin;
- Ancestry;
- Sexual orientation; and
- Physical and mental impairments which do not increase risk or vision impairment, including blindness.

Classifying people according to these would be unfair as these characteristics have no effect on the client's risk. It is forbidden for insurers or their representatives to acquire, request or share such information. It is acceptable to ask an applicant for their place of birth, if that information is used only for identification purposes.

In regard to sexual orientation, it would be a blatant violation for an insurer to ask an applicant any question regarding the subject. However, it has been noticed that, while an insurer won't ask a direct question, it may attempt to reach a conclusion concerning sexual orientation through analysis of other factors in the applicant's life and then adjust benefits or premium based on a presumption of an increased risk of AIDS. Therefore, insurers cannot use the following to attempt to make a judgment about sexual orientation:

- Marital status;
- Living arrangement;
- Jobs;
- Gender;
- Beneficiary;
- ZIP code or any other geographic classification; or
- Any combination of these.

It is therefore necessary, if an insurer is concerned about the risk of claims resulting from AIDS and desires to test for HIV, to test everyone under the same guidelines.

If an insured who has a condition which is expected to cause death within 1 year requests an experimental treatment and is refused by their insurer, the insurer must provide the following:

- The specific medical and scientific reasons for the denial and specific references to pertinent policy provisions upon which the denial is based;
- A description of the alternative medical procedures or treatments covered by the policy, if any; and
- A description of the appeal/review process within 30 days or 5 days if delaying treatment would be detrimental.

Insurers that provide life or health insurance are not allowed to do anything which affects the coverage or premium of anyone because the insurer suspects that the person may become a victim of **domestic violence**, even if the person has been a victim in the past. Underwriters are, however, allowed to take into consideration an actual medical condition that does exist, as long as they don't consider whether the condition was caused by domestic violence. Intentional acts of the insured can still result in loss of benefits.

Domestic violence is defined by Section 6211 of the California Family Code as abuse perpetrated against any of the following:

- A spouse or former spouse;
- A cohabitant or former cohabitant;
- A person with whom the respondent is having or has had dating or engagement relationship;
- A person with whom the respondent has had a child, where the presumption applies that the male parent is the father of the child of the female parent under the Uniform Parentage Act;
- A child of a party or a child who is the subject of an action under the Uniform Parentage Act, where the presumption applies that the male parent is the father of the child to be protected; or
- Any other person related by blood or affinity within the second degree.

Medical policies must include coverage for diagnosing and treating severe mental illness for all insureds and serious emotional disturbances of a child just as they do

any other condition. This then excludes insurers from providing coverage for such conditions any specific-coverage policy, such as accident only, dental, etc.

Penalties

In addition to any other remedy permitted by law, the Commissioner has the administrative authority to assess penalties against life or disability insurers for violations of the Insurance Code section on discriminatory practices. The penalties for the insurer for **unfair discrimination** violations are as follows:

- 1st violation — **$2,500;**
- Subsequent violations — **$5,000 each;**
- Violations so frequent as to indicate they are a general business practice of that insurer — **$15,000 - $100,000 per violation.**

Any person who **negligently discloses results of a genetic test** for an unauthorized third party will be assessed a civil penalty of up to $1,000, plus court costs, payable to the subject of the test. Any willful violations will be subject to a civil penalty between $1,000 and $5,000, plus court costs.

If the subject suffers any economic, bodily or emotional harm, the violation becomes a **misdemeanor** punishable by a fine up to $10,000. Each unauthorized disclosure is considered a separate violation. If a person decides to share that information with the public, the fine and damages could be in the hundreds of thousands of dollars.

14. Fraud

Educational Objective:

I.C4.7. Be able to identify the scope and correct application of the False and Fraudulent Claims article of the California Insurance Code (CIC 1871 and 1871.4):

a. Efforts to combat fraud
b. That if an insured signs a fraudulent claim form, the insured may be guilty of perjury

Common Circumstances

Insurance fraud is a significant problem for insurance companies and insureds alike. Premiums for most forms of insurance have risen in recent years because of the increasing number of fraudulent claims that are being presented to insurers for payment. The most common forms of insurance fraud include claims in the following areas:

- Staged automobile accidents;
- Fraudulent healthcare billings (including HMO and Medi-Cal);
- False and/or inflated property loss claims;
- Phony Workers Compensation claims;
- Fraudulent denial of Workers Compensation benefits;
- Arson for profit;

- Fake life insurance claims; and
- Workers Compensation premium fraud by employers.

Efforts to Combat Fraud (CIC 1872, 1874.6, 1875.8, 1875.14, 1875.20, 1877.3b1)

Federal, state, and local law enforcement officials work together, aided by insurance companies and industry support organizations to combat all forms of insurance fraud. The California Department of Insurance has created **the Fraud Division** to enforce the provisions of the Penal Code and to administer the fraud reporting provisions. *(CIC 1872)*

Among other agencies and systems put in place to help combat fraud is the **Arson Information Reporting System** that allows for cooperation between insurers, law enforcement agencies, fire investigating agencies, and district attorneys. This system allows all parties to deposit arson case information in a common data base within the Department of Justice. *(CIC 1875.8)*

To prevent auto insurance related fraud, every insurer must report covered private passenger vehicles involved in theft, including the vehicle identification number and any other pertinent information, to the National Automobile Theft Bureau or a similar central organization engaged in automobile loss prevention approved by the Commissioner. Prior to the payment of theft losses, insurer must comply with verification procedures according to the regulations adopted by the Commissioner. *(CIC 1874.6)*

Insurance companies, agents and brokers also have a legal responsibility to report suspected fraud. Whenever an insurer or licensed rating organization knows or reasonably believes that it knows the identify of a person or entity that has committed a fraudulent act relating to a workers compensation insurance claim or policy, they insurer must notify the local district attorney's office and the Fraud Division of the Department of Insurance, and may notify any other authorized governmental agency of that suspected fraud and provide any additional information. *(CIC 1877.3)*

The Commissioner may license an organization as an **Insurance Claims Analysis Bureau** if is a nonprofit corporation organized for the purposes of fraud prevention with at least 2 years of relevant experience. An Insurance Claims Analysis Bureau is required to perform the following functions:

- Collect and compile information and data from members concerning insurance claims;
- Disseminate claims-related information to members for the purpose of preventing and suppressing insurance fraud;
- Promote training and education related to investigation, suppression, and prosecution of insurance fraud; and
- Provide to the Commissioner (without fee or charge) all state data and information contained in the records of the Bureau to further prevent and prosecute insurance fraud.

Every insurer admitted to do business in this state must provide for the continuous operation of a **unit or division to investigate** possible fraudulent claims by insureds or by persons making claims for services or repairs against policies held by insureds *(CIC 1875.20)*.

Insurers, agents, and brokers have legal immunity from civil suits claiming libel or slander that might result from giving statements, filing reports, or furnishing any other information, as long as the information is offered *"in good faith and without malice."*

Steps a Licensed Agent Should Take When Fraud is Suspected

An agent or broker who, before placing an insurance application with an insurer, reasonably suspects or knows that a fraudulent application is being made must **submit the information on an electronic form to the Fraud Division, within 60 days** after the determination by the agent of a potential fraudulent application.

All data fields within the Fraud Division's Consumer Fraud Reporting Portal electronic form must be completed accurately, to the best of the agent or broker's ability. An agent or broker cannot submit a fraud referral anonymously. The Fraud Division will review each report and undertake further investigation it deems necessary and proper to determine the validity of the allegations.

If an agent or broker reasonably suspects or knows that fraud has been perpetrated after an insurance application has been placed with an insurer must **report that information directly to the insurer's special investigative unit**.

Fraudulent Claim Forms

If a claimant signs a fraudulent claim form, the claimant may be found guilty of **perjury**.

False and Fraudulent Claims Article

Chapter 12 of the Insurance Code is devoted exclusively to the **Insurance Fraud Prevention Act**. The Insurance Code describes the basic responsibilities that the Insurance Commissioner, law enforcement agencies, insurers, agents, brokers, and others have when "confronting aggressively the problem of insurance fraud in this state."

State insurance claim forms are required to carry a notice informing claimants of their liability in the event of a fraudulent claim. The notice now reads: "*For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison."*

Every person who **commits insurance fraud** may be punished as follows:

- Imprisonment in the county jail for 1 year, or in the state prison, for up to 5 years;
- Fine up to $150,000 or double the value of the fraud, whichever is greater; or
- Both imprisonment and fine.

The court will determine the amount of restitution, and where the restitution must be paid. A person convicted may be charged for the costs of investigation at the discretion of the court.

A person who commits insurance fraud and who has a prior felony conviction will receive a **2-year enhancement** for each prior conviction in addition to the

sentence provided.

E. Fair Claims Settlement Practices Regulations

1. Definitions

Educational Objective:

I.C5.1. Be able to identify definitions of the following terms:

a. Claimant (CCR Title 10, 2695.2(c))
b. Notice of legal action (CCR Title 10, 2695.2 (o))
c. Proof of claim (CCR Title 10, 2695.2(s))

A **claimant** is any person who asserts a right of recovery under a surety bond, an attorney, any person authorized by operation of law to represent the claimant, or any of the following persons properly designated by the claimant:

- Insurance adjuster;
- Public adjuster; or
- Any member of the claimant's family.

A **notice of legal action** is one that is commenced against the insurer with respect to a claim, or notice of action against the insured received by the insurer, or notice of action against the principal under a bond. This includes any arbitration proceeding.

A **proof of claim** is any documentation in the claimant's possession submitted to the insurer which provides evidence of the claim and supports the magnitude or the amount of the claimed loss.

2. File and Record Documentation

The Commissioner reserves the right to examine every licensee's claim files, including all documents, notes and work papers (including copies of all correspondence). The files should be in such detail that events and the dates of events can be reconstructed; and the licensee's actions can be determined.

Insurers must do the following:

- Maintain claim records that are accessible, legible and retrievable;
- Record the dates the licensee received, processed and transmitted or mailed relevant documents in the file; and
- Maintain hard copy files. If the files aren't hard copies, they must be in a format that is accessible, legible and capable of being duplicated to hard copy.

If the licensee cannot construct complete records, he or she must document for the Commissioner the inability or difficulty to obtain data due to catastrophic losses or other unusual circumstances.

In this case, the licensee must submit to the Commissioner a plan for file and record documentation to be used while the circumstances that keep the licensee from compiling a complete record persist.

3. Duties upon Receipt of Communications

Upon receiving any inquiry from the Department of Insurance concerning a claim, the licensee must respond within **21 calendar days**. The response must address all issues raised by the Department of Insurance in its inquiry.

Upon receiving any communication from a claimant (regarding a claim) that reasonably suggests that a response is expected, every licensee must furnish the claimant with a complete response within **15 days**.

A designation of claimant must be in writing, signed and dated by the claimant, and must indicate that the designated person is authorized to handle the claim. All designations must be transmitted to the insurer and will be valid from the date of execution until the claim is settled or the designation is revoked. A designation may be revoked by a writing transmitted to the insurer, signed and dated by the claimant, indicating that the designation is to be revoked and what the effective date of the revocation will be.

Upon receiving notice of claim, every licensee must immediately transmit a notice of claim to the insurer. The licensee's duty to transmit the information will be satisfied when the licensee complies with pertinent written instructions received from the insurer.

Upon receiving notice of claim, every insurer must do the following (unless the notice of claim received is a notice of legal action) within **15 days**:

- Acknowledge receipt of the notice to the claimant unless payment is made within that period of time. If the acknowledgement is not in writing, a notation of acknowledgement must be made in the insurer's claim file and dated. Failure of an insurance agent or to promptly transmit notice of claim to the insurer will be imputed to the insurer;
- Provide to the claimant necessary forms, instructions, and reasonable assistance. This includes specifying the information that the claimant must provide for proof of claim; and
- Begin any necessary investigation of the claim.

4. Standards for Prompt, Fair and Equitable Settlements (CA Ed. Obj. I.C5.4.)

Insurers cannot discriminate in their claims settlements practices based on a claimant’s age, race, gender, income, religion, language, sexual orientation, ancestry, national origin, or physical disability, or the territory of the property or person insured.

Once the claim is received, insurers must either accept or deny it within **40 calendar days**. The amounts accepted or denied must be clearly documented unless the claim has been denied in its entirety. (The time frame doesn’t apply to claims arising from disability insurance and disability income insurance policies, or to automobile repair bills arising from policies of automobile collision and comprehensive insurance.)

If an insurer rejects a first party claim, that must be done in writing and state the basis for the rejection. Insurers are protected from disclosing information that

could alert a claimant that a claim is being investigated as a suspected fraudulent claim.

Written notification must include a statement that a claimant may have a claim reviewed by the California Department of Insurance if he or she suspects the claim has been wrongfully denied or rejected. The notice will include the address and telephone number of the unit of the Department which reviews claims practices.

If an insurer needs more time to determine if a claim should be accepted or denied, the insurer must, within the 40-day acceptance period, notify the claimant in writing of the need for more time and any additional information the insurer requires and any continuing reasons for the insurer's inability to make a determination. Thereafter, the written notice must be provided every 30 calendar days until a determination is made or notice of legal action is served.

An insurer cannot attempt to settle a claim by making a settlement offer that is unreasonably low. Upon acceptance of the claim, insurers are required to provide payment within **30 days.**

F. Chapter Recap

This chapter focused on state-specific regulations for insurers and producers. Let's first recap some of the important requirements and processes.

STATE REGULATIONS	
Regulations	• *California Insurance Code:* the primary body of laws established by the state legislature that regulates the business of insurance • *California Code of Regulations:* Administrative Code that identifies the standards for the Insurance Code and how it is to be administered
Commissioner of Insurance	• Elected for 4 years (maximum 2 consecutive terms) • Regulates the internal affairs of the Department of Insurance • Does not write laws • Examines all authorized insurers
Insurance Guaranty Association	• Protects policyowners, insureds, and beneficiaries against insolvent insurers • All admitted insurers must be members of the Association • Unfair trade practice: stating that the insurer's policies are guaranteed by the existence of the Association
LICENSING REQUIREMENTS	
Licensing Process	• Pass examination and meet prelicensing education requirements • Submit application and fees • Be a state resident • Be of good character
Types of Licenses	• Insurance agent: represents the insurer • Insurance broker: transacts insurance on behalf of the insured • Life and disability analyst: receives a fee from a source other than insurance company; advises regarding insurance

Maintenance and Duration	• Must be renewed every 2 years
	• Continuing education - must be completed every reporting period (24 hours, including 3 hours of ethics)
	• Report changes in name and address immediately
	• Report administrative actions within 30 days
	• License is not required if a person does not receive commissions
	• Inactive license: no active appointments
	• Disciplinary actions:
	  ◦ Cease and desist order
	  ◦ Denial, suspension, revocation or refusal to renew
	  ◦ Monetary fines

Producer Regulation	• Must be licensed in the line of authority for which the agent transacts insurance • Must be appointed by insurer to transact on the insurer's behalf • Maintain records of transactions for 5 years • Avoid unfair trade practices
TYPES OF INSURERS	
Domicile	• *Domestic* - home office is incorporated or chartered in the same state where policies are being sold • *Foreign* - home office is located in a different state than the one where policies are being sold • *Alien* - home office is chartered in any country other than the United States; considered an alien insurer in ALL U.S. states and territories

Ownership	• *Stock:*
	  ◦ Owned and controlled by stockholders
	  ◦ Nonparticipating policies
	• *Mutual:*
	  ◦ Owned and controlled by its policyowners
	  ◦ Sell ONLY participating policies
	• *Fraternal Benefit Society:*
	  ◦ Not an insurer
	  ◦ Operates as a corporation, society or association
	  ◦ Is for the benefit of its members and beneficiaries
	  ◦ Not for profit; lodge system

Admitted/Authorized	• Licensed and authorized to transact business in this state • Must obtain a Certificate of Authority

G. Ethics

This section will recap some of the most important points regarding insurance producer ethics. The information will provide you with a greater understanding of ethical principles and practices, and is part of the required ethics education. However, the information presented in this section will not appear on the state exam.

1. Ethics: Principles and Practices

The purpose of this part of the course is to provide the foundation of knowledge and understanding that an individual needs to function ethically in his or her role as an insurance professional. We'll focus on the social, professional, and legal aspects of ethics.

It seems that in many news reports that a person reads or listens to these days, some insurance company or insurance agent is receiving negative publicity as a result of bad professional judgment or poor ethical conduct. Bad news usually

attracts far more attention than that paid to the legions of insurance agents who perform their daily sales and service tasks in a thoughtful, fair, and ethical manner. Their exemplary work will be discussed in detail.

As you will discover, ethics can be studied on two levels:

1. **Philosophically**, where a code of personal ethics helps you gain personal and professional satisfaction; and
2. **Practically**, where a code of personal ethics helps you avoid controversy and misunderstandings, which increases your personal efficiency as an agent.

Ethics Defined

Ethics is a derivative of the Greek word *ethikos,* meaning "moral" and *ethos,* meaning "character." By textbook definition, ethics is "a branch of philosophy that deals with the values of human life in a coherent, systematic, and scientific manner." The Oxford English Dictionary defines ethics as "the department of study concerned with the principles of human duty" and the "rules of conduct recognized in certain associations or departments of human life."

You won't find universal agreement among philosophers as to what, exactly, is ethically right. Immanuel Kant, a German philosopher, believed what is right is based on pure reason. On the other hand, Jeremy Bentham, early 19th-century British philosopher, believed *right* to be that which will produce the greatest good. Religious philosophers, like St. Thomas Aquinas, say that *right* is determined by the will of God, and *wrong* is anything contrary to God's will.

For the purpose of our work, we will use Albert Schweitzer's definition of ethics:

Ethics is the name we give to our concern for good behavior. We feel an obligation to consider not only our own personal well-being but also that of others and of human society as a whole.

Dr. Schweitzer, who was a French medical missionary and philosopher, applied this idea of "duty beyond the group" to all humanity. He believes that the ultimate goal of ethics is the fullest measure of justice for all. If we were to distill the philosophy of Dr. Schweitzer into three words, they would be "regard for others."

Avoiding Conflicts of Interest

Ethically, an insurance agent who has signed an exclusive contract with his or her insurer cannot serve two principals at the same time. As a "captive" agent, he or she owes a singular loyalty to that insurer. It would be unethical for that agent to represent two insurance companies selling the same policies. In addition, an agent has the ethical obligation to inform his or her company about any other related services that he or she provides and receives payment for. An agent who does part-time preparation and filing, for example, or who serves as a consultant to a local business, should inform his or her company of this activity. The insurer can then determine if there is a **conflict of interest**.

Independent agents also face this issue when they attempt to serve their clients while being contracted to an insurer. Conflicts can be avoided if independent agents follow these guidelines for dual agency:

- The agent represents the insurance company when insurance is being applied for and when it is in the process of being underwritten, in recordkeeping, and in claim settlement or other insurer-related activities.
- The agent "represents" his or her client only during the process of helping the client select the insurance plan best suited to the client's needs.

2. Ethics for Insurance Agents

Consider these questions:

Is it ethical for an insurance agent to use for a prospect list the names of individuals who registered for a new home in a supermarket drawing?

Is it ethical for an insurance agent to call himself or herself a financial planner or an estate planning specialist without the proper training, experience, or qualifications?

Is it ethical for an insurance agent to show a prospect a policy illustration without explaining the difference between guaranteed and nonguaranteed benefits?

Of course, the answer to all of these questions is "**NO**." None of these situations shows proper ethical behavior by an insurance agent. No matter how extreme these examples might seem, they represent ethical responsibilities that an insurance agent is expected to fulfill. An agent's four primary ethical responsibilities are to the following:

- Insurer;
- Policyowners;
- General public; and
- State.

Each of these areas will be discussed in detail in the following sections, but let's take a brief look at them now.

Ethical Responsibilities to the Insurer

The duties of an insurance agent to his or her insurer are established by the concept of agency. This concept is tangibly represented by the agency contract, which both parties agree to and sign. Within the scope of that contract, the insurance agent owes to his or her insurer the duties of honesty, good faith, and loyalty. He or she also is obligated to reveal to the insurer all material facts concerning the agency.

In carrying out his or her duties, the insurance agent is the direct representative of the insurer. An insurance agent's day-to-day activities are a direct reflection on the insurer's image within the community. Should the agent behave unethically, everyone in that community is given to believe that the insurer is also unethical.

Ethical Responsibilities to Policyowners

The professional agent can meet his or her ethical responsibilities to an insured policyowner by filling needs and providing quality service. Service is a primary function of the insurance industry. The way that service is provided often

determines the agent's future, since clients are a good source for future sales and references.

In addition to quality service, the agent also owes the policyowner the same degree of loyalty that he or she provides to the insurer. The agent is also charged with the ethical responsibilities of full disclosure, confidentiality, timely submission of all applications, and prompt policy delivery.

Selling to Needs

Before an individual becomes a policyowner, he or she is a prospect. The transition from prospect to policyowner, and ultimately from policyowner to client, comes about when an agent follows two basic rules: **sell to needs** and **service the sale**.

In doing so, the agent will also live up to the ethical duties that he or she has to policyowners.

An insurance agent has one principal reason for calling on a prospect: to offer a product or service that will benefit the prospect in some way. An agent must sell the kinds of policies that will best fit the prospect's needs and in amounts that he or she can afford to pay. No one profits – not the insurer, not the agent, and especially not the policyowner – if an individual is coerced or misled into buying too much insurance or purchasing coverage that doesn't suit specific needs.

Fortunately, most agents recognize that selling to fit needs is the best approach to the products and services that they represent. They know that specific types of insurance policies are designed to meet specific needs and that matching policies to needs produces the maximum effect, to the benefit of the policyowner. They also know that needs selling involves problem analysis, action planning, product recommendation, and plan implementation. This requires two important commitments on the agent's part:

- A commitment to obtain and maintain the knowledge and skills necessary to carry out those tasks; and
- A commitment to educating the prospect or client about the products and plans that may be implemented.

Service the Sale

Selling to needs is only part of what an agent must do to meet the ethical responsibilities that he or she owes to a policyholder. Service during and after the sale is just as important. Quality and productivity experts such as W. Edwards Deming and Joseph M. Juran see service as a process in which the customer's wants and needs are anticipated and then satisfied. Most companies today are committed to giving their customers quality service.

In fact, the quality of a company's level of service is perceived as the most important single factor affecting a business unit's performance in the long run. Since 1972, the Strategic Planning Institute (SPI) of Cambridge, Massachusetts, has collected data to determine what corporate strategies influence performance. SPIs studies consistently show that successful companies stress quality service over their competitors.

Service Begins with the Application

In securing coverage for your client, your main responsibility as an agent is to act reasonably under the circumstances. This means that you must also adhere to your ethical responsibilities to the insurer and see that the prospect completes the application accurately and completely.

At this point, your primary responsibility is to the insurer because you are acting as its agent during the application process. Remember that the insurer is relying upon you for full disclosure of all pertinent information regarding the applicant. However, you also have an ethical responsibility to educate your prospective insured to make sure that he or she fully understands the nature of the application process, including educating them about the following:

- Why the information is required;
- How it will be evaluated;
- The need for accuracy and honesty in answering all questions; and
- The meaning of terms such as “waiver of premium,” “automatic premium loan,” “nonforfeiture options,” and “conditional receipt.”

Confidentiality

In the course of qualifying a prospect, completing a financial questionnaire, analyzing needs, or working on an estate or business plan, insurance agents are privy to a client's personal and financial information. Ethics require that the agent respect the sensitive nature of this information and keep it confidential. Personal information about a client should never be released without proper approval from the client.

Commitment to Knowledge and Skills

The relationship between the professional insurance agent and the policyowner is usually built upon the policyowner's trust in the agent's knowledge and skills. The policyowner must rely on the agent to provide informed options and trusts that the recommendations for insurance are in the client's best interest.

An agent thus has an obligation to ensure that this trust is justified. This means that an agent has the ethical responsibility to obtain the necessary knowledge and skills needed to evaluate and service the insurance needs of clients. Indeed, the term "professional" implies knowledge and skill. If the agent feels that he or she is not properly trained to perform the needed service, then another professional should be called in to assist.

An agent must also keep his or her base of knowledge and skills current. To this end, the agent must be committed to a program of continuing education. He or she must also stay informed of the latest developments affecting a client's interests. In recent years, there has been an increasing trend toward insurance professionalism. Agents should be competent professionals with a high degree of technical knowledge so that they can match a prospect's need with the appropriate solution.

Commitment to Educating the Prospect or Client

Client's trust must be earned, nurtured, and constantly reinforced. The agent who remembers this basic rule is the agent who communicates to his or her client the reasons why a particular insurance policy or program is being recommended and how it will serve the client.

Individuals who understand what a particular insurance plan or policy will do for them are more likely to buy, more likely to be satisfied with their insurance, and more likely to keep their business on the books. This communication and education continues long after the particular policy or program is sold and becomes part of the overall insurance program designed for that client. As noted earlier, the professional agent has established his or her client's insurance program based on needs. These needs should be reviewed annually, supported by explanation and communication of the programs put in place to meet those needs.

Ethical Responsibilities to the Public

The insurance agent has more control over the public's attitude toward insurance than sales representatives for most other consumer products. This is because the insurance agent initiates contact with a prospect, determines a prospect's need for insurance, recommends a certain product or solution, makes the sales presentation, and finally develops a long-term relationship with after-sale service. In many cases, the prospect has little or no direct contact with the insurance company.

Because this special relationship involves a great deal of contract between the consumer and agent (and because the public generally understands very little about insurance), public perceptions of the industry itself are based on how well or how poorly an agent does his or her job. Thus, the professional insurance agent has two main ethical responsibilities to the public:

- To inform the public about insurance with the highest level of professional integrity; and
- To strive for an equally high level of professionalism in all public contacts in order to maintain a strong, positive image of the industry.

Ethical Responsibilities to the State

The responsibility to regulate the insurance industry is shared by the federal and state governments. However, the states carry the burden of regulating insurance affairs, including the ethical conduct of licensed insurance agents. In some states, the regulation of ethical conduct falls under the category of "marketing practices," while other states refer to it in the context of "unfair trade practices."

Whatever it is called, all states have established a code of ethical standards for insurance agents by defining through laws and regulations what an agent can and cannot do. Although these laws differ from state to state, there are enough similarities to discuss them in general terms. This will be the subject of the next section, in which ethical standards for financial planning and the Investment Advisers Act will also be discussed.

Ethical issues are attracting increasing attention in the business of life insurance. While most states have adopted "Unfair Trade Practices," which defines practices that constitute unfair methods of competition or unfair or deceptive acts or

practices, the products offered by life insurance agents have become very complicated. An agent's explanation of the link between their advantages and disadvantages, as well as his/her suggestion of a specific product may determine the financial situation of a client for years.

Also, the complexity of the products makes adequate regulation of insurance companies and their producers extremely difficult. Assessing an agent's activities may be hard, even with detailed regulation. It is impossible to include every possible unethical action in the law; therefore, it is possible for an action to be unethical, even if it is not designated as illegal under the Insurance Code. For these reasons and others, it is necessary in today's climate that producers assume the responsibility for being knowledgeable with regard to the products that they sell and refrain from improper solicitations. No misrepresentation of any kind should be made to an insured or to an insurance company.

Underwriting Process
Keeping the Applicant Informed

The underwriting process for an insurance application can be time-consuming. Most insurance companies strive to complete the process within a 21-day period, assuming that there are no delays. Delays can occur whenever an underwriter needs additional information from the applicant and relays that request through the agent, or when a counteroffer, different policy, or different rate is made to the applicant (again through the agent).

An agent's ethical responsibilities to his or her client during the underwriting process center around promptness and policy delivery.

Promptness

An insurance agent needs to ensure that there are no unnecessary delays in the underwriting process. This does not mean that the agent has to rush from an applicant's home to the nearest post office to mail an application. It does, however, mean checking the application for accuracy and giving careful thought to it before the application is actually submitted. Many underwriting delays occur simply because the application is not complete or is not clear.

Applications should be submitted as soon as possible. The time frame will vary, of course, depending on the plan of insurance and the complexity of the case. An agent must take these factors into account to act in an efficient manner. If it appears that the underwriting process may take longer than anticipated, the agent should notify the applicant of the delay.

Policy Delivery

Most policies are issued as applied for. In such cases, the agent owes his or her new policyowner prompt delivery of the policy and a review of its features and benefits. Not only does this help solidify the sale, it also represents a step toward making the policyowner a lasting client.

On the other hand, some policies will be rated or rejected. When this happens, the agent has two responsibilities:

1. To personally review the rating or rejection. *Was it medical? Was there an unfavorable medical report? Was something overlooked or not made known to the underwriter? Should additional information be submitted? Is the rating or rejection proper? Should the application be reconsidered?* In any event, the agent should have as much information as possible and be able to explain the rating or rejection to the applicant.
2. Assuming that the rating or rejection was valid, to notify the applicant promptly. To withhold this information is a breach of ethics and could actually harm the applicant and his or her family.

3. Avoiding Unethical Practices

Deceptive Use of Advertising Material

There are two indisputable facts about insurance and the buying public:

1. The average insurance buyer knows very little about insurance and relies on the advice and recommendations of the insurance agent; and
2. By the time a consumer finds that a particular policy does not meet his or her needs or does not live up to the agent's promises, it may be too late to purchase another policy.

The potential for deceptive advertising or promotion by companies and agents alike is significant, and the consequences to the consumer can be quite grave. Accordingly, all states have enacted laws regulating insurance advertising. The basis for many of these state statutes is the NAIC's model Unfair Trade Practices Act, which expressly cites false advertising as an unfair trade practice and prohibits it. In this context, the term "advertising" is quite broad. It includes print and radio material, descriptive literature, sales aids, slide shows, prepared group talks, brochures, sales illustrations, policy illustrations, and TV commercials – in short, almost any kind of communication or presentation used to promote the sale of an insurance policy.

The purpose of the NAIC model act is to established guidelines to ensure that insurance companies and their agents promote their products properly and accurately, without exaggerating the benefits or minimizing the drawbacks. *For example*, the act forbids any misrepresentations of the benefits, terms, conditions, or features of any insurance policy, including dividends. The act also bars any misrepresentation of an insurer's financial condition or its legal reserve system, and it prohibits names or titles of insurance that do not represent their true character.

Some states have enacted regulations that separately address life insurance and health insurance advertising. Life insurance advertising, for instance, cannot use the terms *investment, saving*s, or *profit* in a misleading way. Health insurance advertising must disclose provisions regarding renewability, cancellability, termination, or modification of benefits.

Generally speaking, the burden of complying with state insurance advertising law rests on insurance companies because most advertisements or promotional pieces, regardless of the writer or presenter, are considered to be the responsibility of the insurer whose policies are being advertised. In practice, most of the advertising and sales literature that an agent uses is prepared by the insurer under the careful eye of its legal staff. For an agent, then, the ethical issue

isn't necessarily the material itself but instead how the material is used and the deceptive sales presentation that may result.

Deceptive Sales Presentations

Deceptive sales presentations have probably generated more complaints of unethical agent behavior than any other activity. In addition to the life insurance CEOs in the United States, concern over this activity is shared by the National Association of Life Underwriters (NALU) and the American Society of CLU & ChFC, as well as by the Independent Insurance Agents of America. The topic has also been addressed by the U.S. Congress in committees studying insurance company activity.

What constitutes a deceptive sale? Any presentation that gives a prospect or client the wrong impression about any aspect of an insurance policy or plan is deceptive. Any presentation that does not provide complete disclosure to a prospect or client is deceptive. Any presentation that includes misleading or inconclusive product comparisons is deceptive. Even if the deception is unintentional, the agent has done the consumer a great disservice.

Deceptive sales presentations can be blatant. For example, a comparison of a term policy and a whole life policy based only on premium rates is obviously misleading and incomplete. Yet, deception does not have to be so apparent to be unethical. What about describing a personal life insurance policy as a "tax shelter" but failing to mention that premiums are not deductible and that surrendered cash values may be subject to tax? What about recommending a certain kind of health policy without explaining the conditions under which it could be canceled or the premiums increased? While any of these ploys might help make the sale, they are all misleading and unethical.

Policy Illustrations

Of all the companies surrounding the marketing and the sales of life insurance, none resonate so loudly as those over the use and misuse of policy illustrations. As insurance policies changed over the years, with the emphasis on the growth, return, and investment aspects of permanent plans; the "unbundling" of a policy's accumulation and protection elements; and the flexibility of premium payments, insurers, and agents discovered that one of the best ways to demonstrate the complex mechanics of a policy was through the use of the computerized policy illustration.

Unfortunately, these illustrations have also been used to "predict" a policy's potential and its future performance based on assumptions that may or may not be realized. Vanishing premiums, huge cash values, in-force lifetime benefits – all of these things have been extolled to sell a life insurance policy, without the explanation that they are based on nonguaranteed numbers projected into the future. What did not accompany these illustrations was an understanding on the part of the consumer that the values they were being shown would materialize only if the underlying assumptions came true.

Along with the changing dimensions and features of today's life insurance products comes a subtle shift in risk back to the buyer. The more flexible the

policy, the more aggressive the assumptions and the more sensitive the product will be to changes in mortality, expense, and interest rates. However, this fact has been buried, ignored, or glossed over intentionally and unintentionally in too many sales presentations. Current and illustrative values have been spotlighted, and guaranteed values have been pushed backstage. In many sales situations, the policy illustration became the focus of the presentation (i.e., the illustration became the product).

The consequences of illustration-based selling became apparent in the early 1990s. Individuals who purchased life insurance policies in the mid-1980s (when interest rates were high) with the expectation that they would pay premiums for only seven or eight years found out that their policy's accumulated values were sufficient to "vanish" but were charged against the policy's value. Others who bought plans with the idea that premiums of a few hundred dollars a year would produce values of a million dollars by the time they were ready to retire discovered that they were far from their goals.

The experiences described above gave momentum to the charge that the misuse of policy illustrations has created a "crisis" situation in the insurance industry. Consumer groups, politicians, and journalists have declared that life insurance buyers are being misled by many in the insurance industry who abuse the use of policy illustrations and don't distinguish between values and benefits that are guaranteed and those that are not. For some agents and some companies, the allegations have led to lawsuits.

The problems associated with policy illustrations have compelled the industry to respond. Insurance companies are redesigning their disclosures to promote better understanding by consumers as to policy pricing, company and product performance, and illustration assumptions. They're instructing their agents to show illustrations based on a variety of assumptions, not merely those in which current assumptions prevail against the guarantees. However, perhaps the most significant initiatives, given their combined impact and reach, come from the NAIC and the American Society of CLU & ChFC. The NAIC has draft model legislation on policy illustrations, and the American Society has developed an illustration questionnaire to help agents understand the assumption that is used to designed and create sales illustrations.

Attitude toward Competition

Agents should avoid criticizing other agents; such activity is detrimental to everyone in the business. Any criticism of other company's policies should be avoided. An incomplete comparison is misleading and harmful to the public, and it can even result in the revocation of the license of the guilty party.

If you are asked to evaluate an insurance company's reputation, you should refer your questioners to one of the widely respected insurance company rating systems. These evaluate each insurance company's financial status and look at reserves, underwriting, investments, and management and rate the companies accordingly. Some of the most widely known and respected are AM Best Company, Standards and Poor's, and Weiss Rating, Inc.

In addition, some situations, such as the handling of death claims or a national disaster, call for insurance professionals to lay aside all thoughts of competition and join hands to provide the best possible service for the people involved.

4. Ethics vs. Values

Ethics is the rightness of what you do. **Values** are what you believe in, what you hold important.

Values that represent how an individual should behave are considered to be moral values, such as respect, honesty, fairness, and responsibility. Statements around how these values are applied are sometimes called moral or ethical principles.

Many people do not realize the connection between values and ethics. They live each day without recognizing the cumulative impact of their individual actions. Leading an ethical life requires that we establish our values carefully and then work every day to live up to those values.

Core Ethical Principles

We build a more principled life with the small choices that we make each day. If we are to lead more ethical lives, we must all develop the ability to recognize ethical considerations. We must all become better at recognizing these opportunities to elevate our existence.

These core ethical values can serve as a tool to identify ethical considerations. Whenever honesty, integrity, promise-keeping, fidelity, loyalty, fairness, caring, compassion, respect for others, and personal responsibility come into play, it always involves the consideration of ethics.

Ethical decision-making is a process of evaluating and choosing among alternatives. The goal is to eliminate unethical options and select the best ethical alternative. To consistently make ethical decisions, one must accomplish two fundamental things:

1. Evaluate alternative courses of conduct on the basis of core ethical principles; and
2. Choose the action that best advances those principles.

There are many definitions of ethics, but it is generally accepted that any definition would include the following core ethical values and the long-term commitment to their implementation:

1. **Honesty:** Is truthful, straightforward, sincere, and candid. It is not deceptive, tricky, or misleading.
2. **Integrity:** Is honorable. It has courage of conviction; it stands up for beliefs and puts principle over expediency. It is not hypocritical, weak, or dishonorable.
3. **Promise-keeping:** Always strives to keep commitments.
4. **Fidelity/Loyalty:** Commits to being reliable and dependable.
5. **Fairness:** Strives to be equitable, open, just, and unprejudiced. It does not discriminate on an improper basis. It is not arbitrary or self-serving.
6. **Caring/Compassion:** Is considerate, kind, sharing, and charitable. It is not selfish, manipulative, or controlling.
7. **Respects for Others:** Respects freedom, dignity, and rights of others.

8. **Personal Responsibility:** Considers consequences and accepts responsibility for actions and inaction. It doesn't shift blame or make excuses.

Rationalization as a Tool

There are a variety of reasons why we do not take the actions necessary to earn the high ethical ratings that we give ourselves. To make ourselves more comfortable with our actions, we often revert to rationalizations. Have you ever heard yourself say any of the following?

1. "I'm simply fighting fire with fire."
2. "If it is legal, it must be okay."
3. "I was just doing it for you."
4. "We all do it; it's just how you play the game."
5. "If it doesn't hurt anyone, it's okay."
6. "It's necessary to get the order."
7. "Business is business. I'll be as ethical as the competition allows."
8. "I deserve it: I have it coming."

Rationalizations make it easier to live with ourselves when we do the things that we want to do, rather than the things that we know we should be doing.

The Bottom Line

History is made and lives are changed not by those who follow the crowd, but by those who are prepared to take the ultimate risk and stand up for what is right.

It is always a challenge to do the right thing in a competitive environment. But each time we make a decision to stand for what is right, even if it costs us something, we reinforce our own moral character and influence others.

We do not develop that ability overnight. It is developed in small steps as we do the right thing each day. Unfortunately, many of us do not even recognize the opportunities that exist.

There are four basic principles of a highly ethical individual:

1. The individual is at ease when interacting with diverse customers.
2. The individual is obsessed with fairness. The individual's ground rules emphasize that the other persons interests count as much as his/her own.
3. The individual assumes personal responsibility for his/her actions, and he/she is responsible for himself/herself first and then to his/her organization.
4. The individual sees his/her activities in terms of purpose. This method of viewing an individual's activities is highly valued by the members of the industry or organization. Purpose ties the individual to the organization – and the organization to the environment.

The following are characteristics of a highly ethical organization or industry:

1. There exists a clear vision and picture of integrity throughout the industry.
2. The vision is owned and embodied by top management in the industry, over time.
3. The reward system is aligned with the vision of integrity.
4. Policies and practices of the industry are aligned with the vision – no mixed messages.
5. It is understood that every significant decision has ethical value dimensions.
6. Everyone in the industry is expected to work through conflicting value perspectives.

The Benefit of Applying Ethics

Ethical standards support individual growth: Attention to ethics in the industry helps an agent to face realities, both good and bad, in the industry and within himself. In this regard, an agent may feel full of confidence and can admit and deal with whatever comes his way.

Ethics programs are a form of insurance; they help to ensure that policies and practices are legal and can stand the test of public or shareholder scrutiny. There is an increasing number of lawsuits in regard to the effects of products and services on the consumer. Attention to ethics ensures highly ethical policies and procedures in the workplace. Analysts believe that it is far better to incur the cost of mechanisms to ensure ethical practices now, rather than to incur the costs of litigation later.

Ethical standards help to avoid criminal acts of omission and can lower fines: Ethics standards, such as an insurance agent's code of ethics, tend to detect ethical issues and violations early on, so they can be addressed. In some cases, when an organization is aware of an actual or potential violation and does not report it to the appropriate authorities, it can be considered a criminal act.

Ethical guidelines adopted on an industry-wide basis potentially decrease fines if an organization or individual has clearly made an effort to operate ethically.

Ethical standards help to manage values: Ethics programs identify preferred values and ensure that the individual's behavior is aligned with those values. This effort includes recording the values, developing policies and procedures to align behavior with preferred standards, and then training personnel about the policies and procedures. Ethical standards are highly useful for managing strategies, such as expanding market shares, reducing costs, and managing diversity.

Ethical standards promote a strong public image: Attention to ethics is also a strong public relations tool. Admittedly, managing ethics should not be done primarily to enhance public relations. But the fact that an organization regularly gives attention to ethics can portray a strong, positive image to the public. People see those organizations as valuing people more than profit, as striving to operate with the utmost integrity and honor. Aligning behavior with values is critical to effective marketing and public relations programs.

Here's the bottom line: Applying ethical standards legitimizes managerial actions, strengthens the coherence and balance of the industry, improves trust in the relationship between individuals and groups, and supports greater consistency in the standards and qualities of products.