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**INSURANCE TRAINING  
INSTITUTE, INC.**

## History of Insurance

NEW YORK INSURANCE LICENSEE  
CONTINUING EDUCATION COURSES



***INSURANCE TRAINING INSTITUTE***

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Licensed by the New York State Insurance Department

As a Continuing Education Provider – NYPO 100210

The Insurance Training Institute (**ITI**) is an approved provider of Continuing Education Courses for all New York State Insurance Department licensees required by the Insurance Law to complete biennial education to renew their licenses. **ITI** provides classes at over 20 locations and will provide classes at your own facility. We follow all guidelines and procedures required by the NYS Education and Insurance Departments.

**ITI** provides its clients with competitive tuition and offers a broad range of up-to-date courses to meet their needs along with the best-trained and qualified instructors. **ITI** provides you and your employees the insurance training that you deserve in this rapidly changing market. For over 18 years, our Director, Robert Secovnie, worked with many of you in his capacity as an employee of the Executive Branch of the NYS Insurance Department, (assigned to the Licensing Bureau). Bob worked with other states' Insurance Departments, the ASI Insurance Testing Company regarding legislative and law changes, state examination materials, insurance course approvals, and has worked with many agencies regarding licensing questions and problems over the years.

**ITI's** goal is to meet your needs in training and consulting as a professional organization committed to improve the operation and image of the insurance industry. Our Continuing Education classes will qualify your agents and brokers for their license renewals. All classes will be held either at our locations or at your office for your convenience. All classes held at your office will meet the requirements of the NYS Insurance Department. **ITI** Courses will also meet the reciprocity requirements of most other states for your Non-Resident Licenses.

Thank you for your time and consideration;

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## History of Insurance

### Outline

Section / Title
<i>History of Insurance</i>
Introduction
Chapter 1 - History of Insurance
(Section 1.1)
General History
(Section 1.2)
Other forms of Ancient Insurance
(Section 1.3)
Property Casualty – From Marine to Fire
(Section 1.4)
General History Review
Chapter 2 – Homeowners Insurance
(Section 2.1)
Standard Homeowners Insurance Policy
(Section 2.2)
Modern Homeowners Policy
(Section 2.3)
National Flood Insurance Program (NFIP)
(Section 2.4)
Fire / Homeowners Insurance Review
Chapter 3 – Auto Insurance Coverages
(Section 3.1)
Auto Insurance
(Section 3.2)
SUM Coverage & No-Fault
Section 3.3
Assigned Risk Auto Plan
Section 3.4
Supplemental Spousal Liability Insurance
(Section 3.5)
Auto Insurance Review
Chapter 4 – Commercial Coverages
(Section 4.1)
Commercial Insurance Excess Markets

(Section 4.2)
Risk Retention Groups, Purchasing Groups and Trusts
(Section 4.3)
Commercial Property and Commercial General Liability Policy
(Section 4.4)
Commercial Coverage Review
Chapter 5 - Adjusting
(Section 5.1)
Claims and Adjusting
(Section 5.2)
Claims Settlement Review
Chapter 6 – Life Insurance
(Section 6.1)
Life Insurance History in America
(Section 6.2)
Annuities
(Section 6.3)
Pensions
(Section 6.4a)
Regulation 60
(Section 6.4b)
(Section 6.4c)
(Section 6.4d)
(Section 6.5)
Life Insurance Review
Chapter 7 – Health Insurance
(Section 7.1)
Healthcare
(Section 7.2)
HMO Act 1973
(Section 7.3)
The Patient Protection and Affordable Care ACT of 2010
(Section 7.4)
Health Insurance Review
Chapter 8 – Federal and State Programs
(Section 8.1)

Social Security, Medicare and Medicaid
(Section 8.2)
Social Security Medicare & Medicaid Review
Chapter 9 Workers Compensation & Disability
(Section 9.1)
Workers Compensation & Disability
(Section 9.2)
New York State Insurance Fund
(Section 9.3)
Wage Replacement (Cash) Benefits
(Section 9.4)
Disability Insurance
(Section 9.4)
Workers Compensation & Disability Review
Chapter 10 – Development of Regulations
(Section 10.1)
Regulation of the Insurance Industry
(Section 10.2)
Modern Era Federal Regulations
(Section 10.3)
Principles Based Regulation Modern Era Federal Regulations
(Section 10.4)
Regulation Review
Chapter 11 – Best Practices
Best Practices
(Section 11 a)
(Section 11 b)
(Section 11 c)
(Section 11 d)
(Section 11 e)
Chapter 12 – Regulatory Process
(Section 12.1)
Legislative Process
(Section 12.2)
Senate Bill - S7814

(Section 12.2b)
(Section 12.3a)
Senate Bill S7661
(Section 12.3b)
(Section 12.4)
Circular Letters
(Section 12.5)
Unlicensed and Support Staff Guidelines
(Section 12.6)
Waiver of Pre-Licensing Criteria
Chapter 13 - Fraud
(Section 13.1) Ancient Insurance Fraud
(Section 13.2) Insurance Fraud Organizations
(Section 13.3) NY Insurance Fraud Bureau
(Section 13.4) Insurance Scams
(Section 13.5) Types of Fraud
(Section 13.5a) Auto
(Section 13.5b) Medical
(Section 13.6) FBI
Section 13.7 Fraud Review
Chapter 14
(Section 14)
Disciplinary Actions
<i>Glossary</i>

## History of Insurance

### **Introduction**

The Insurance Training Institute (ITI) has been a leader in providing continuing education to insurance professionals in New York State since 1996. Our courses are designed to provide students with an updated view of multiple insurance disciplines to improve the individual competency as well as overall professionalism of our industry.

The History of Insurance course, like all ITI programs, is a “Bridge” course providing 15 hours of New York Department of Financial Service (NYDFS) approved continuing education credit hours for all insurance license holders. Although a significant number of students are licensed for Property and Casualty (P&C) as well as Life, Accident and Health (LA), ITI is committed to the belief that all insurance license holders should have a working understanding of all major insurance disciplines. For example, Life, Accident and Health producers should be aware of the medical coverage elements of auto insurance policies while P&C producers will benefit with an understanding of Life insurance principles.

History of Insurance is organized to be informational and we hope pleasing for students to read. The text will prepare students for our proprietary monitored exam which is offered at more than 25 locations across New York State.

The course examines the history of specific product lines as far back in history as possible to establish the foundation on which our industry currently sits. Readers will note the repeating theme of insurers working to expand their product offering as commercial enterprise, although discrimination in underwriting is consistently exercised limiting the reach of product distribution. The text attempts to explain the need or desire within communities which leads to the introduction of products, whether voluntarily, through government intervention, or a combination of both.

Readers will note that while History of Insurance takes an approach to teaching of looking significantly to the past, the text fully examines current state of the insurance industry. Each product line investigated is followed from its inception, or earliest historical record, through to its current state. The text includes review of current rules and regulations, descriptions of modern product lines, currently accepted underwriting principles, ethical guidelines for licensees and much more.

In writing this course, certain texts were invaluable as references, including “The Origin and Early History of Insurance” by CF Trenery, originally published in 1911 and “A treatise on the Law of Benefit Societies and Life Insurance” Third Edition by Frederick H. Bacon published 1904. These works provide a flavor of antiquity which modern writing struggles to match.

As stated, the goal of the course is to make every student a more well-rounded insurance professional.

### **History of Insurance**

#### Chapter 1

##### (Section 1.1)

### **General History**

All discussion of history is bound by documentation that can be used repeatedly as a reference source. That documentation may be written word or symbol, oral narrative or physical reference. History does not necessarily limit the possibility or probability of acts or thoughts existing in the past. History merely is a limit on our knowledge to a specific point in the past. It is with that understanding that we do not talk of the invention of insurance, but rather its earliest documentation and subsequent innovations, which have been recorded by one means or another.

Credit is given to Chinese merchants as far back as 3000 BC for their risk management practices of dividing cargo

among several vessels to reduce their losses should a vessel with cargo fail to complete its voyage. While not a classic form of **bottomry**, (*Bottomry is generally a pledge of the boat – from its keel or bottom up, against a particular debt.*) partly because there is no evidence of **contract**, (*a promise to perform in exchange for compensation*) **indemnification** or **third party** involvement with the shippers dating to this time in China, it is a close cousin. This Chinese practice was simply sound business, although it was lacking a guarantee to restore to the merchant or financier the value of contents lost.

**Bottomry**, a term referenced throughout this text, can be defined in more than one way. The most accepted definition relates to the situation where a ship requires repair while in port in order complete its journey and the Captain takes a loan with pledge of payment secured against default by the ship itself. Another aspect of bottomry is a venture at a voyages start wherein a loan is made to fund an expedition with payment in the form of interest collected only upon the completion of the voyage. **Respondentia**, a term commonly used with bottomry, applies the same principles to the cargo, rather than the ship itself.

The establishment of law governing loss in written form is credited to Hammurabi and dates back to at least 1750 BC. **Hammurabi's Code** contains 282 clauses which gave guidance on the judgement over matters ranging from infidelity to the right of an accused to be presumed innocent until proven guilty. Included in the Code also are directions regarding the responsibility for loss due to natural occurrences.

#### Code #48

If any one owe a debt for a loan, and a storm prostrates the grain, or the harvest fail, or the grain does not grow for lack of water; in that year he need not give his creditor any grain, he washes his debt-tablet in water and pays no rent for this year.

Codes 100 through 107 deal with loan rates of interest and contracts for trading purposes. In this context the rate of interest was tied to the risk of the contract venture and the length of time anticipated for completion. The codes deal specifically with the safe arrival of goods and protections against specific losses incurred.

#### Code # 100

... interest for the money, as much as he has received, he shall give a note therefor, and on the day, when they settle, pay to the merchant.

#### Code # 101

If there are no mercantile arrangements in the place whither he went, he shall leave the entire amount of money which he received with the broker to give to the merchant.

#### Code # 102

If a merchant entrust money to an agent (broker) for some investment, and the broker suffer a loss in the place to which he goes, he shall make good the capital to the merchant.

#### Code # 103

If, while on the journey, an enemy take away from him anything that he had, the broker shall swear by God and be free of obligation.

#### Code # 104

If a merchant give an agent corn, wool, oil, or any other goods to transport, the agent shall give a receipt for the amount, and compensate the merchant therefor. Then he shall obtain a receipt form the merchant for the money that he gives the merchant.



Stele with Law Code of Hammurabi

Hammurabi is portrayed receiving the laws directly from Shamash the sun god.

Code # 105

If the agent is careless, and does not take a receipt for the money which he gave the merchant, he can not consider the unreceipted money as his own.

Code # 106

If the agent accept money from the merchant, but have a quarrel with the merchant (denying the receipt), then shall the merchant swear before God and witnesses that he has given this money to the agent, and the agent shall pay him three times the sum

Code # 107

If the merchant cheat the agent, in that as the latter has returned to him all that had been given him, but the merchant denies the receipt of what had been returned to him, then shall this agent convict the merchant before God and the judges, and if he still deny receiving what the agent had given him shall pay six times the sum to the agent.

Hammurabi's Code also established a pay scale for medical services in codes 215 – 223, however there is no **indemnification** (refund of payment to the patient) mentioned.

The ancient history of Hammurabi's Babylon leads historians to assume that the early practice of Bottomry was introduced to the Phoenecians, Chinese, Indians, Greeks and subsequently to the Romans. The development of trade throughout centuries refined the contract practice. The Jewish Isqa, Bysentine Chreokoinonia and Muslin Qirad preceded the Italian “Commenda” contract introduced during the middle ages (950 – 1350 AD), which resembles forms used in modern Western cultures today.

The early Italian **Commenda** contract involves an investing party and a traveling party or agent. The contract specified the equity between parties, their investment and payoff upon completion. The contract placed requirements upon the traveling party to actively seek completion of the agreement, assigning a fiduciary responsibility to their investing partners. The Commenda is thought to be the initial western contract to hold the traveling party harmless of liability for losses during their voyages resulting from weather or piracy. The contract still provided no indemnification to either party.

## (Section 1.2)

### **Other forms of Ancient Insurance**

Trade over land and over sea led to the development of the Commenda, however other forms of insurance were developing simultaneously in organic fashion. In great cultures and small communities, the mortality of man has never been a reality that could be escaped. For the obvious reasons of public health, various religious beliefs and even individual vanity, the burial of dead members in a community has been a social responsibility and a burden. In most situations, as is the case today, surviving family also faced challenges from the loss of productivity and profit from the deceased, which in and of itself could be an additional burden on the communities.

A form of insurance equally ancient to bottomry developed to bury the dead and provide for their remaining family members, forming into **Benefit Societies** during the height of Greek society and later developing into **Guilds** during European Middle Ages. While little is known about early contract forms of death and burial insurance, it is clear that the business of paying regular premium in anticipation of inevitable demise was somewhat common. As with the spread of bottomry, the idea of life insurance spread from one culture to another over centuries. The common thread always being a small incremental monetary contribution (**premium**) in exchange for a guaranteed payment upon one's death to pay the expense of burial and possibly to provide economic relief for remaining family.

From Hammurabi's Code, to the Italian “Commenda” and various documents in the Middle Ages, contracts for insurance were in use, in one form or another. Enforcement of contracts was carried out, generally speaking, in local Courts of one form or another. Local Lords, Kings or prominent members of a community presided over matters between arguing parties until more formal courts were established. Law enforcement in Europe grew to be more

uniform with the introduction of the Sheriff, or Shire Reeve, who enforced rules in a Shire or County somewhere around the 9<sup>th</sup> Century.

Many regions in the known world had established common rules specific to maritime trade, since that was the predominant form of commerce. The Hanseatic League, a grouping of Baltic Sea States, adhered to the **Laws of Wisby**, also referred to as the Wisby Sea Laws. The Laws of Wisby are based closely on the **Laws of Oleron**, which date to 1152-1160. The Laws of Oleron, which were used in the European world, namely between France, England and their neighboring Countries, were based on **Lex Rhodia** which dates to **1000 BC**. Rhodes, an island south of Greece, was a major Mediterranean port and marketplace. While no copy of “Lex Rhodia” is known to exist, it is referred to in “Book 2, Title 7 of the Roman law text, *Opinions of Julius Paulus circa 235.*” (duhaime.org)

These maritime laws established many rules which are still adhered to today, from care for crew that took ill while away from their home port, to fraud in the course of a contract. The laws also laid the framework of responsibility for cargo and its loss under various circumstances. For example, if a ship were threatened with capsize due to weather; it was accepted and expected for the crew to lighten the load by tossing merchandise overboard to save the ship, with no responsibility for the loss held to the captain or crew, but for the loss to be shared equitably by the merchants and financiers. The practice is known as **Jettison**, remains a part of many insurance contracts today and the **duty to protect** is found in today’s homeowners insurance policies.

### **ISO 1999 HO 3**

#### **Section 1 – Conditions**

In case of a loss to covered property, we have no duty to provide coverage under this policy if the failure to comply with the following duties is prejudicial to us. These duties must be performed either by you an “insured” seeking coverage, or a representative of either:

- B-4. Protect the property from further damage. If repairs to the property are required, you must:*
  - a. Make reasonable and necessary repairs to protect the property; and*
  - b. Keep an accurate record of repair expenses...*

(Note: A standard policy stipulates that the insured must file a **proof of loss statement**)

While the existence of a set of laws covering maritime trade offered a level of security to merchants and mariners, enforcement was left to the local Lord, Mayor, Sheriff or community leader, such as a high ranking Guildsman, in the locality of the complaint. Documents of court proceedings and enforcement rulings in Europe exist dating to at least 1318. (Columbia Law Review - Early History of Insurance, pg 7)

The regulation of trade, and in turn insurance, began to take modern form in England with the grant of Royal Charters beginning in the 13<sup>th</sup> Century.

A Royal Charter is a way of incorporating a body that is turning it from a collection of individuals into a single legal entity. A body incorporated by Royal Charter has all the powers of a natural person, including the power to sue and be sued in its own right.

<http://privycouncil.independent.gov.uk/>

Insurance, prior to the 17<sup>th</sup> Century, is accepted to be exclusive to maritime trade. While it may be commonly held that Lloyd’s Coffee House in London is the birthplace of modern insurance; written contracts of assurance existed for centuries and likely longer in many countries. In London, and later France, there were processes to record contracts of insurance.

Walter Overbury. Registrar of Assurances in the City of London in 1628  
([genuki.org.uk/big/wal/cgn/membersparl](http://genuki.org.uk/big/wal/cgn/membersparl))

An edict, December, 1657, creating offices of notary-register of insurances at each of the seats of Admiralty in the kingdom, with exclusive privilege of receiving and passing all maritime instruments,

policies of insurance, bills of lading, charter parties, contracts of affreightment and maritime loan, and of registering bills of lading under private signature. (Emerigon, Treatise of Insurances 1783)

Little to no reference to the maintenance of individual health can be found prior to the modern era. The forms of insurance for an individual injured but not dead were generally “**Accident**” policies and not “**Health**” policies as there was little science in the way of medicine, which could improve failing health. Ancient medicine was limited in most cultures by rule against the dissection of a human corpse, leaving surgical exploration to later ages. While many cultures identified numerous maladies commonly suffered, few developed successful remedies.

Among the earliest reliable forms of treatment through medicine was the understanding of anti-pyretic (fever) properties of willow bark, which ultimately led to the development of modern day Aspirin. Willow bark preparations were documented in the Ebers Papyrus dating to 1500 BC. The benefits of willow bark were also noted by Hippocrates in 460 BC and remained in common use throughout the world as a remedy to fever and other ailments. Aspirin, according to the Pharmaceutical Journal, (9/26/2014) was “one of the first drugs to come into common usage”. Acetylsalicylic acid, a refined concoction based on willow bark preparations used for millennia, was named **Aspirin** by Bayer Pharmaceuticals in 1899.

The science of medicine develops in a post-medieval era with a number of inventions, which allowed great new exploration. While there is some controversy, Roger Bacon is given credit by many for the invention of spectacles in 1249. Benjamin Franklin is credited with Bi-focals. However, it is Zacharius Janssen who invented the microscope in 1590 who opened a new world for science. Anton van Leeuwenhoek discovered blood cells with a microscope in 1670 and observed bacteria in 1683. It was not until 1857 that Louis Pasteur identified germs as a cause of disease. Joseph Lister developed the use of antiseptic surgical methods in 1867.

Florence Nightingale, “The Lady with the Lamp”, brought cleanliness to wartime hospitals during the Crimean War when she led a troop of nurses in 1854. Separating beds by a minimum of three feet, removing horses from the hospital basement and providing improved ventilation are credited with reducing mortality rates drastically.

Health insurance was practiced in Europe by numerous **friendly societies** and **trade guilds** for hundreds of years. In 1816, the rapid growth of industrialized life in England resulted in the formation of the Generous Society of Insurance – a mutual organization for protection against disability and to provide for maintenance and education of the children of the insured. In 1820 the General Benefit Company was organized, and in 1829 the Clergy Mutual Assurance Society, an organization composed of the clergy of the United Church of England and Ireland. Over the past 200 years, various societies and companies have been formed for the purpose of transacting health insurance as a business.

The post medieval era also brought property insurance into a new age. Population growth and urbanization led to larger buildings, with higher values, built closer together. Containment of loss by fire also became more difficult. The burning of London, which started on September 2, 1666, took 13,000 houses when it consumed 430 acres in the city built largely of timber frame construction. Many buildings were torn down or blown up during the fire to create fire breaks and prevent further spread of the destruction. Needless to say, the baker on Pudding Lane where the fire started, did not have a good day.

While other countries had Chartered Companies involved with maritime trade, it is England that we need to focus on from this point forward to understand the development of modern insurance. London was becoming an international trade center. Their merchants, like others in the known world, were profiting from the trade, mainly textiles, and in search of new markets, shorter trade routes and the avoidance of piracy or capture by foreign countries which were at war or in disagreement with their own country.

Mercer (Merchant) Guilds, in many cities began to form new **Merchant Adventurer Companies** in the 16<sup>th</sup> Century. These early companies, while Chartered, were still generally of “partnership form.” As the potential for profit grew, greater sums were invested, leading to the introduction of **Joint Stock Companies**.

“the joint-stock company, in which investors can contribute variable sums of money to fund the venture. In doing so they become joint holders of the trading stock of the company, with a right to share in any profits in proportion to the size of their holding.”

*[www.historyworld.net/wrldhis/PlainTextHistories.asp](http://www.historyworld.net/wrldhis/PlainTextHistories.asp)*

The First **joint stock companies** in England was the Muscovy Company (1555), later re-chartered as the Russia Company. Others include The [East India Company](#) was established in 1600 as a [joint-stock company](#) with a monopoly of the trade to and from the East Indies ([www.britannica.com/topic/chartered-company](http://www.britannica.com/topic/chartered-company)). Of more significant importance to the United States is the chartering of the **Virginia Company** in 1606, followed by the **Massachusetts Bay** and **Providence Companies** in 1629, which furthered settlement of the British Colonies in America.

As an established practice in the 17<sup>th</sup> Century, insurance for merchant voyages were generally secured through wealthy individuals or small groups. The coffee house of **Edward Lloyd** in the 1680's became a home for insurance transactions. **Lloyd's of London** has never been an actual insurance company but has remained a "**marketplace**" for customers to find insurance for their ventures.

England's first fire insurance company was started in 1681 by Nicholas Barber and 11 associates, which was called Insurance Office for Houses. The first insurance company in an American Colony was formed in Charleston, South Carolina in 1732. This "**friendly society**" failed with the Charleston fire of 1741. Benjamin Franklin organized the **Philadelphia Contributorship for the Insurance of Houses from Loss by Fire** in 1759. Mr. Franklin's company continues to operate today.

### (Section 1.3)

#### Property Casualty – From Marine to Fire

The modern insurance industry has its roots firmly set in the marine commerce business. The Colonies of North America were built largely as a result of European merchant's willingness to back voyages of exploration and development. The concepts of insurance proved to be sound business practice for all parties; merchants, captain and ship owner, and insurers. The business of insurance in North America has very early roots as well with the earliest evidence dating to at least 1721.

The first forms of insurance in this country were marine. In 1682, as we are informed from records, vessels engaged in trade between England and the colonies, were insured against the perils of the sea, and as early as 1721, an advertisement appeared in the American Weekly Mercury announcing that John Copson, of High Street, Philadelphia, would open an office for insurance on "vessels, goods and merchandise." For quite a long period the insurance business of the colonies continued to be marine; part of it being written by agents of English companies, and the remainder being issued in American ports. In 1762, at the London Coffee House, at the southwest corner of High and Front Streets William Bradford, announced that they would underwrite risks in general, and before the close of the century a considerable number of offices had been established.

*Historical Study of Fire Insurance in the United States. F.C. Oviatt 1905*

Insurance expanded its reach following the Great Fire of London in 1666. The Pudding Lane bakery fire grew and destroyed 75 percent of the buildings in the city. The inferno was stopped by the Thames River on one side and the British Navy who took down buildings to create a firebreak, or an empty space, where the fire could be controlled.



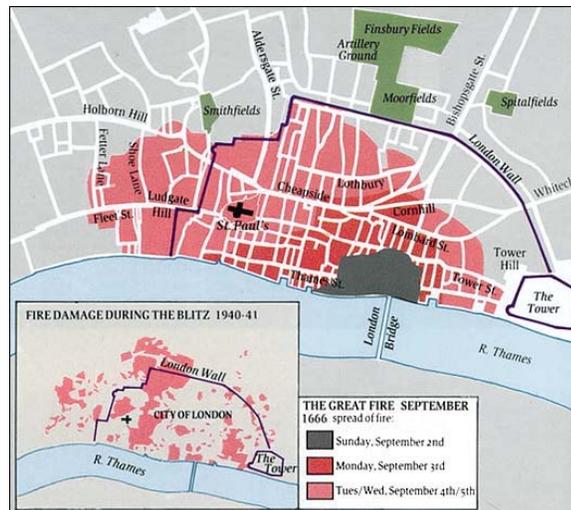
Lieve Verschuer. *The Great Fire of London, 1666*. Museum of Fine Arts, Budapest.

#### *The Great Fire of London, 1666*

*The Great Fire of London began on the night of September 2, 1666, as a small fire on Pudding Lane, in the bakeshop of Thomas Farynor, baker to King Charles II. At one o'clock in the morning, a servant woke to find the house aflame, and the baker and his family escaped, but a fear-struck maid perished in the blaze.*

*At this time, most London houses were of wood and pitch construction, dangerously flammable, and it did not take long for the fire to expand. The fire leapt to the hay and feed piles on the yard of the Star Inn at Fish Street Hill, and spread to the Inn. The strong wind that blew that night sent sparks that next ignited the Church of St. Margaret, and then spread to Thames Street, with its riverside warehouses and wharves filled with food for the flames: hemp, oil, tallow, hay, timber, coal and spirits along with other combustibles. The citizen firefighting brigades had little success in containing the fire with their buckets of water from the river. By eight o'clock in the morning, the fire had spread halfway across London Bridge. The only thing that stopped the fire from spreading to Southwark, on the other side of the river, was the gap that had been caused by the fire of 1633.*

The standard procedure to stop a fire from spreading had always been to destroy the houses on the path of the flames, creating “fire-breaks”, to deprive a fire from fuel. Lord Mayor Bludworth, however, was hesitant, worrying about the cost of rebuilding. By the time a Royal command came down, carried by Samuel Pepys, the fire was too out of control to stop. The Trained Bands of London were called in to demolish houses by gunpowder, but often the rubble was too much to be cleared before the fire was at hand, and only eased the fire’s way onward. The fire blazed unchecked for another three days, until it halted near Temple Church. Then, it suddenly sprang to life again, continuing towards Westminster. The Duke of York (later King James II) had the presence of mind to order the Paper House demolished to create a fire break, and the fire finally died down.



[www.luminarium.org/encyclopedia/greatfire.htm](http://www.luminarium.org/encyclopedia/greatfire.htm)

The fire of 1666 led to the formation of fire insurance companies. The Insurance Office for Houses was formed in 1681 in London. The London model tied insurance companies to specific fire brigades which led to the distribution of “fire marks” which identified where the building was insured and which fire brigade would fight potential fires. The Sun Fire Office is the oldest property insurance company still operating and was founded in 1710.

Just as marine insurance had been introduced to the colonies, fire insurance followed soon after. The first fire insurance company was formed in Charles Town (Charleston) South Carolina in 1732. A fire on November 18, 1740 destroyed the city and bankrupted the company.

The Philadelphia Contributorship for the Insurance of Houses from Loss by Fire was formed by Benjamin Franklin in 1752. Franklin, well known for inventions and innovations, took a broader look at insurance and the cause of losses. Home construction to Franklin was one indicator of potential for loss of insured property with neighboring properties also being brought into consideration when determining eligibility for coverage and pricing. The presence of trees in front of a house also was a significant issue as they obstructed fire fighters. These underwriting values allowed the company to remain successful and it still operates today.

The growth of fire insurance companies was slow until after the Revolutionary War. The first record of an insurance company in New York dates to April 1787 and the Mutual Insurance Company, renamed in 1846 as Knickerbocker Fire. The original charter permitted the company to conduct Fire, Maritime and Life insurance. The New York Mutual Insurance Company soon met competition from the New York Insurance Company. In 1801, the Columbian Insurance Company of New York formed followed by Eagle Fire in 1806. Separate insurance for furniture and merchandise against fire was offered in 1794 by Sanford and Wallace in Hartford, CT.

Maritime trade continued to dominate economics and insurance as the 18<sup>th</sup> Century closed and our Nation recovered from the Revolutionary War.

*The early underwriting in Connecticut, as in other colonies, was generally of a personal or partnership character. It should be remembered that the country in the last decade of the eighteenth century, was poor. Its capital had been very largely exhausted by the Revolutionary struggle, and enterprises which had been prosperous had been completely disorganized, and during the whole period of the confederacy the uncertainty of the future paralyzed to a large extent the commercial life of the colonies.*  
Oviatt

The Hartford Fire Company, organized in 1810, is the oldest “**stock**” company in Connecticut. Their first policy was a **builder’s risk** of \$4000. (*Builder’s Risk insurance covers the construction phase of building. Upon completion, a building is covered by a property or fire policy.*)

*The year after the company organized, it began to plant agencies, but without any system. For instance, there was one agency at Canandaigua, N.Y.; another at Middlebury, T., and by 1820, an agency had been established at Cleveland, Ohio. As showing the relative importance of cities and towns, it should be noted that it was not until 1821 that an agency was established in New York City. The compensation was a sort of graded commission, determined by the importance of the town. Three of the agents were given 10 per cent on all premiums received exceeding \$1,000 for any one year, while in the early years some gratuities were voted by the directors to those who had rendered special services.*  
Oviatt

While the fire insurance business did continue to grow in the 18<sup>th</sup> Century, fire continued to pose catastrophic potential. New York City burned in September 1776 destroying 1/3 of lower Manhattan’s buildings between Broadway and the Hudson River (near Beaver Street and City Hall).

The City of New York burned again in 1835. This fire covered 17 city blocks. By this time, New York was a premier city for business and trade, due in part to the Erie Canal, which connected the world to the land west of the Appalachians.

The fire began on the evening of December 16, 1835 in a five-story warehouse at 25 Merchant Street, now known as Beaver Street, at the intersection of Hanover Square, Manhattan and Wall Street. As it spread, gale-force winds blowing from the northwest towards the East River spread the fire. At the time of the fire, major water sources including the East River were frozen solid in temperatures as low as -17°F. The conflagration was visible from Philadelphia, approximately 80 miles away. *Wikipedia*

In July 1845, another fire started in a whale oil and candle manufacture business and spread to consume 345 buildings. While significant, it shows the move to **fire resistant material**, brick and stone, was an important building practice. The Fire Department of the City of New York (FDNY) was still a volunteer organization. By 1845, the Croton Aqueduct provided water to Manhattan.



In 1853, 62 insurance companies reported to the New York State Comptroller. Most companies were local fire insurance companies. It is important to note that 100 years into the insurance business, standard forms for policies still were not in use. This created problems for courts in the settlement of claims as well as for consumers of both

business and personal coverage. Massachusetts was the first state to require a **standard fire policy** in 1880. New York followed in 1886. The New York form became the chosen model and was used by states without their own form.

*It was the nineteenth century viewpoint of most legal systems that a regime of free contract was the norm, i.e., that absent compelling reasons to the contrary, parties to contracts were to be free to negotiate about terms and to conclude agreements with any stipulations they might wish. Though freedom of contract is still regarded as an important value in the twentieth century, the public authority now intervenes frequently in the formation of contracts and places many restrictions on the freedom of parties to bargain as they will. Such restrictions have been imposed particularly for “**contract of adhesion**,” those agreements in which one of the parties has no choice other than to adhere to the terms dictated by the other party or reject the contract altogether. With its complicated terms defining and qualifying a contingency on which payment will be made, an insurance policy that is designed for mass sale to small policyholders is a classic example of a contract of adhesion.*

*The Fire Insurance Contract “It’s History and Interpretation” Rough Notes 1922.*

(Section 1.4)

**General History Review**

**Bottomry** is generally a pledge of the boat – from its keel or bottom up, against a particular debt.

**Benefit Societies, Friendly Societies and Guilds** provided early forms of health, life and burial insurance.

**Jettison** is the term for lightening the load by tossing merchandise overboard to save the ship.

**Duty to protect** is found in today's homeowners insurance policies and requires an insured to attempt to protect property from further loss.

**Aspirin** was developed by Bayer Pharmaceuticals in 1899 and is one of the first modern medicines used to improve a person's health.

**Merchant Adventurer Companies** in the 16<sup>th</sup> Century were the first to use **Joint Stock Company** form.

Benjamin Franklin organized the **Philadelphia Contributorship for the Insurance of Houses from Loss by Fire** in 1759

**Builder's Risk insurance** covers the construction phase of building. Upon completion, a building is covered by a property or fire policy. The Hartford Fire Company, organized in 1810, is the oldest "**stock**" company in Connecticut. Their first policy was a **builder's risk** of \$4000.

Massachusetts was the first state to require a **standard fire policy** in 1880. New York followed in 1886.

## Chapter 2

### (Section 2.1)

#### Standard Homeowners Insurance Policy

Several changes during the early 20<sup>th</sup> Century led to the development of a more concise form of fire coverage in 1943 known as the **New York Standard Fire Policy**, which was **165 lines** and was required by law in most states. The first page of the policy was the **Declarations page** that identified, among other items, the name of the insured and the location of the property. The Standard Fire Policy was a **single-line policy** covering loss by fire only.

1 **Concealment**, This entire policy shall be void if, whether  
2 fraud. before or after a loss, the insured has wil-  
3 fully concealed or misrepresented any ma-  
4 terial fact or circumstance concerning this insurance or the  
5 subject thereof, or the interest of the insured therein, or in case  
6 of any fraud or false swearing by the insured relating thereto.  
7 **Uninsurable** This policy shall not cover accounts, bills,  
8 and currency, deeds, evidences of debt, money or  
9 excepted property. securities; nor, unless specifically named  
10 hereon in writing, bullion or manuscripts.  
11 **Perils** not This Company shall not be liable for loss by  
12 included. fire or other perils insured against in this  
13 policy caused, directly or indirectly, by: (a)  
14 enemy attack by armed forces, including action taken by mili-  
15 tary, naval or air forces in resisting an actual or an immediately  
16 impending enemy attack; (b) invasion; (c) insurrection; (d)  
17 rebellion; (e) revolution; (f) civil war; (g) usurped power; (h)  
18 order of any civil authority except acts of destruction at the time  
19 of and for the purpose of preventing the spread of fire, provided  
20 that such fire did not originate from any of the perils excluded  
21 by this policy; (i) neglect of the insured to use all reasonable  
22 means to save and preserve the property at and after a loss, or  
23 when the property is endangered by fire in neighboring prem-  
24 ises; (j) nor shall this Company be liable for loss by theft.  
25 **Other Insurance**. Other insurance may be prohibited or the  
26 amount of insurance may be limited by en-  
27 dorsement attached hereto.  
28 **Conditions** suspending or restricting insurance. Unless other-  
29 wise provided in writing added hereto this Company shall not  
30 be liable for loss occurring  
31 (a) while the hazard is increased by any means within the con-  
32 trol or knowledge of the insured; or  
33 (b) while a described building, whether intended for occupancy  
34 by owner or tenant, is vacant or unoccupied beyond a period of  
35 sixty consecutive days; or  
36 (c) as a result of explosion or riot, unless fire ensue, and in  
37 that event for loss by fire only.  
38 **Other perils** Any other peril to be insured against or sub-  
39 ject of insurance to be covered in this policy  
40 shall be by endorsement in writing hereon or

41 added hereto.

42 **Added provisions.** The extent of the application of insurance  
43 under this policy and of the contribution to  
44 be made by this Company in case of loss, and any other pro-  
45 vision or agreement not inconsistent with the provisions of this  
46 policy, may be provided for in writing added hereto, but no pro-  
47 vision may be waived except such as by the terms of this policy  
48 is subject to change.

49 **Waiver** No permission affecting this insurance shall  
50 provisions. exist, or waiver of any provision be valid,  
51 unless granted herein or expressed in writing  
52 added hereto. No provision, stipulation or forfeiture shall be  
53 held to be waived by any requirement or proceeding on the part  
54 of this Company relating to appraisal or to any examination  
55 provided for herein.

56 **Cancellation** This policy shall be cancelled at any time  
57 of policy. at the request of the insured, in which case  
58 this Company shall, upon demand and sur-  
59 render of this policy, refund the excess of paid premium above  
60 the customary short rates for the expired time. This pol-  
61 icy may be cancelled at any time by this Company by giving  
62 to the insured a five days' written notice of cancellation with  
63 or without tender of the excess of paid premium above the pro  
64 rata premium for the expired time, which excess, if not ten-  
65 dered, shall be refunded on demand. Notice of cancellation shall  
66 state that said excess premium (if not tendered) will be re-  
67 funded on demand.

68 **Mortgagee** If loss hereunder is made payable, in whole  
69 interests and or in part, to a designated mortgagee not  
70 obligations. named herein as the insured, such interest in  
71 this policy may be cancelled by giving to such  
72 mortgagee a ten days' written notice of can-  
73 cellation.

74 If the insured fails to render proof of loss such mortgagee, upon  
75 notice, shall render proof of loss in the form herein specified  
76 within sixty (60) days thereafter and shall be subject to the pro-  
77 visions hereof relating to appraisal and time of payment and of  
78 bringing suit. If this Company shall claim that no liability ex-  
79 isted as to the mortgagor or owner, it shall, to the extent of pay-  
80 ment of loss to the mortgagee, be subrogated to all the mort-  
81 gagee's rights of recovery, but without impairing mortgagee's  
82 right to sue; or it may pay off the mortgage debt and require  
83 an assignment thereof and of the mortgage. Other provisions  
84 relating to the interests and obligations of such mortgagee may  
85 be added hereto by agreement in writing.

86 **Pro rata liability.** This Company shall not be liable for a greater  
87 proportion of any loss than the amount  
88 hereby insured shall bear to the whole insurance covering the  
89 property against the peril involved, whether collectible or not.

90 **Requirements** in The insured shall give immediate written  
91 case loss occurs. notice to this Company of any loss, protect  
92 the property from further damage, forthwith  
93 separate the damaged and undamaged personal property, put

94 it in the best possible order, furnish a complete inventory of  
95 the destroyed, damaged and undamaged property, showing in  
96 detail quantities, costs, actual cash value and amount of loss  
97 claimed; and within sixty days after the loss, unless such time  
98 is extended in writing by this Company, the insured shall render  
99 to this Company a proof of loss, signed and sworn to by the  
100 insured, stating the knowledge and belief of the insured as to  
101 the following: the time and origin of the loss, the interest of the  
102 insured and of all others in the property, the actual cash value of  
103 each item thereof and the amount of loss thereto, all encum-  
104 brances thereon, all other contracts of insurance, whether valid  
105 or not, covering any of said property, any changes in the title,  
106 use, occupation, location, possession or exposures of said prop-  
107 erty since the issuing of this policy, by whom and for what  
108 purpose any building herein described and the several parts  
109 thereof were occupied at the time of loss and whether or not it  
110 then stood on leased ground, and shall furnish a copy of all the  
111 descriptions and schedules in all policies and, if required, verified  
112 plans and specifications of any building, fixtures or machinery  
113 destroyed or damaged. The insured, as often as may be reason-  
114 ably required, shall exhibit to any person designated by this  
115 **Company** all that remains of any property herein described, and  
116 submit to examinations under oath by any person named by this  
117 Company, and subscribe the same; and, as often as may be  
118 reasonably required, shall produce for examination all books of  
119 account, bills, invoices and other vouchers, or certified copies  
120 thereof if originals be lost, at such reasonable time and place as  
121 may be designated by this Company or its representative, and  
122 shall permit extracts and copies thereof to be made.  
123 **Appraisal.** In case the insured and this Company shall  
124 fail to agree as to the actual cash value or  
125 the amount of loss, then, on the written demand of either, each  
126 shall select a competent and disinterested appraiser and notify  
127 the other of the appraiser selected within twenty days of such  
128 demand. The appraisers shall first select a competent and dis-  
129 interested umpire; and failing for fifteen days to agree upon  
130 such umpire, then, on request of the insured or this Company,  
131 such umpire shall be selected by a judge of a court of record in  
132 the state in which the property covered is located. The ap-  
133 praisers shall then appraise the loss, stating separately actual  
134 cash value and loss to each item; and, failing to agree, shall  
135 submit their differences, only, to the umpire. An award in writ-  
136 ing, so itemized, of any two when filed with this Company shall  
137 determine the amount of actual cash value and loss. Each  
138 appraiser shall be paid by the party selecting him and the ex-  
139 penses of appraisal and umpire shall be paid by the parties  
140 equally.  
141 **Company's** It shall be optional with this Company to  
142 options. take all, or any part, of the property at the  
143 agreed or appraised value, and also to re-  
144 pair, rebuild or replace the property destroyed or damaged with  
145 other of like kind and quality within a reasonable time, on giv-  
146 ing notice of its intention so to do within thirty days after the

147 receipt of the proof of loss herein required.  
148 **Abandonment.** There can be no abandonment to this Com-  
149 pany of any property.  
150 **When loss** The amount of loss for which this Company  
151 payable. may be liable shall be payable sixty days  
152 after proof of loss, as herein provided, is  
153 received by this Company and ascertainment of the loss is made  
154 either by agreement between the insured and this Company ex-  
155 pressed in writing or by the filing with this Company of an  
156 award as herein provided.  
157 **Suit.** No suit or action on this policy for the recov-  
158 ery of any claim shall be sustainable in any  
159 court of law or equity unless all the requirements of this policy  
160 shall have been complied with, and unless commenced within  
161 twenty-four months next after inception of the loss.  
162 **Subrogation.** This Company may require from the insured  
163 an assignment of all right of recovery against  
164 any party for loss to the extent that payment therefor is made  
165 by this Company.

(In the process of **subrogation**, the insurer pays its insured for a loss then assumes the insureds right of action against the responsible party for reimbursement.)

## (Section 2.2)

### **Modern Homeowners Policy**

**Personal liability** was a common additional endorsement to the standard fire policy. The 165 line fire policy was also frequently enhanced with an “**Extended Coverage**” (EC) endorsement. This endorsement added the following **perils**: windstorm, hail, explosion (except steam boilers), riot, civil commotion, aircraft, vehicles, and smoke.

The **Insurance Services Office (ISO)**, formed in April 1971, consolidated state, regional and national rating bureaus to provide statistical, actuarial, underwriting, claims and policy language information and advice to insurance regulators and companies. Originally formed as a not for profit, ISO is currently owned by Verisk Analytics. Beginning in 1976 a set of homeowner forms proposed by ISO were adopted for use in most states. Although regularly modified, they remain the current standard across the country. These new forms packaged several previously separated coverages into single policies with language intended to be clear and understood not only by courts but by consumers as well.

The 1976 ISO proposed forms are numbered **HO-0 through HO-8**. The most common form used is the **HO-3 Special Form for Homeowners**.

#### ***Types of Homeowners Policy Forms and Their Coverages***

There are several standard policies available and they contain a standardized numbering system throughout the United States, as follows:

**HO-1:** Basic Form for Homeowners.

**HO-2:** Basic Form for Homeowners with similar coverage available for mobile home owners.

**HO-3:** Special Form for Homeowners.

**HO-4:** Renters’ or Tenants’ Insurance.

**HO-5:** Comprehensive Form for Homeowners.

**HO-6:** Condominium Unit owners insurance.

(There is no HO-7 Form)

**HO-8:** Market Value or Older Home Form for Homeowners.

- The **obligations** assumed by the insurance company on a contract of insurance can be found in the **insuring agreement**.
- The **rights and duties** of the insured and insurer are found in the **conditions** of an insurance contract.
- The provision in a policy that pledges that **a condition exists** at some time in the future is known as a **warranty**.
- A **statement of fact**, in legal terms, is known as a **representation**.
- The penalty for making a **false claim is a misdemeanor**.
- A **temporary contract** of insurance is a **binder**.
- **The return of premium** as an **inducement** to obtain insurance **is known as a rebate**.

These homeowner forms have companion **Dwelling Policy (DP)** forms used for non-owner occupied properties, however, the coverages are different. The chart below compares the most common homeowners policy, **HO-3**, with a Dwelling Fire Policy **DP-3** used for many rental properties.

<b>Homeowners Policy</b>	<b>Dwelling &amp; Fire Policy</b>
<b>(HO-3)</b>	<b>(DP-3)</b>
The HO-3 has been the most common homeowner's policy for 60 years and is adequate for the majority of homeowners and their insurance needs. For owners who live there.	The DP-3 is for rental properties that the owner does not occupy. It covers the basics of the house (dwelling) other coverages are not automatic: speak to us about customizing protection to your needs.
<b>Coverage A. Dwelling.</b> The amount of money your policy will pay to rebuild your home if it is destroyed.	<b>Coverage A. Dwelling.</b> The amount of money your policy will pay to rebuild your home if it is destroyed.
<b>Coverage B. Other Structures.</b> 10% of coverage A is automatically included. The amount your policy will pay to rebuild structures such as sheds & garages.	<b>Other Structures.</b> Not automatic. Have a garage? Other outbuilding? Add optionally.
<b>Coverage C. Personal Property.</b> The amount you have to replace all of your "stuff" in the event of a loss.	<b>Personal Property</b> Generally not included. Tenants should have their own insurance. Landlords can optionally include personal property for appliances if furnished.

**Coverage D. Loss of Use.** The funds you will have to rent another place while your damaged home is fixed or rebuilt.

**Coverage D. Loss of Use or Fair Rental Value.** The funds you will have for the tenants to rent another place or stay at a hotel while your damaged house is fixed or rebuilt.

**Personal Property Replacement Cost.** Ensures you get the full price to fix or replace any lost personal items in a total loss.

**Replacement Cost** On personal property, generally not included.

**Coverage E. Personal Liability.** In the event that you become a defendant in a lawsuit, the insurance company will provide up to \$1 million in coverage.

**Coverage E. Personal Liability.** In the event that you become a defendant in a lawsuit, this can provide up to \$1 million in protection. Always important for rental properties. Not all DP-3 policies offer Personal Liability and we may have to place a separate Liability policy for this protection.

**Coverage E. Medical Payments to Others.** If someone falls and is injured on your property, the medical payments will be covered up to this amount.

**NOTE:** If you own a primary home and have a homeowner's policy, you may extend the liability to cover the rental (multi-family) property.

**Optional Coverages & Endorsements.** There are many additional coverage items you can add to your HO-3 such as sewer backup, personal jewelry, identity fraud coverage, business pursuits, etc.

**Optional Coverages & Endorsements.** Also available to meet your unique needs. Talk to an expert at Gordon to customize protection for your individual needs.

As described later in this text, workers compensation and automobile insurance have residual markets to provide statutory insurance when private markets are unavailable or unwilling to accept certain risks. A companion program exists for dwellings in the form of a **Fair Access to Insurance Requirements (FAIR)** plan. The **New York Property Insurance Underwriters Association (NYPIUA)** was established in 1968 partly in response to riots across the country in the prior years.

New York Property Insurance Underwriting Association began its full-time operation on October 28, 1968. The widespread riots of the previous year that had caused property damage brought attention to the fact that some owners of inner city properties had trouble purchasing fire insurance.

Representatives of the insurance business met with Washington officials to look for a way to provide adequate insurance protection in a climate dominated by civil unrest. They created a program in which the private companies would provide fire insurance to any insurable risk regardless of location. If this proved too demanding for the private sector, then—with the approval of the state legislatures—joint underwriting associations were to be formed to provide coverage.

***NYPIUA.com***

NYPIUA also administers the **Coastal Market Assistance Program**, referred to as **C-MAP**, for coastal property owners. The purpose of C-MAP is to assist homeowners living in New York's coastal areas obtain insurance for their homes. C-MAP covers certain properties in the Bronx, Brooklyn, Staten Island, Nassau, Queens, Suffolk, and Westchester. The program is for owner-occupied, one-to-four family dwellings, apartment units, or condominium units.

### **(Section 2.3)**

#### **National Flood Insurance Program (NFIP)**

An overflow of water onto normally dry land is what we call a flood. In New York State filed more flood insurance claims than any other state in 2012 and 2013, and was third in 2014. With 58,300 claims in 2013 and a total claim payout of \$3,767,370,000, All insurance producers should be familiar with the potential of flooding as well as the options for insuring flood zone properties.

Flood insurance is provided by the **National Flood Insurance Program (NFIP)**, created by Congress in 1968. Today, NFIP is administered by the Federal Insurance Mitigation Administration (FIMA), created with the Federal Emergency Management Agency by Congress in 1979.

In order to solicit, negotiate or sell flood insurance in New York, licensed resident insurance producers must comply with the minimum training requirements of section 207 of the Flood Insurance Reform Act of 2004.

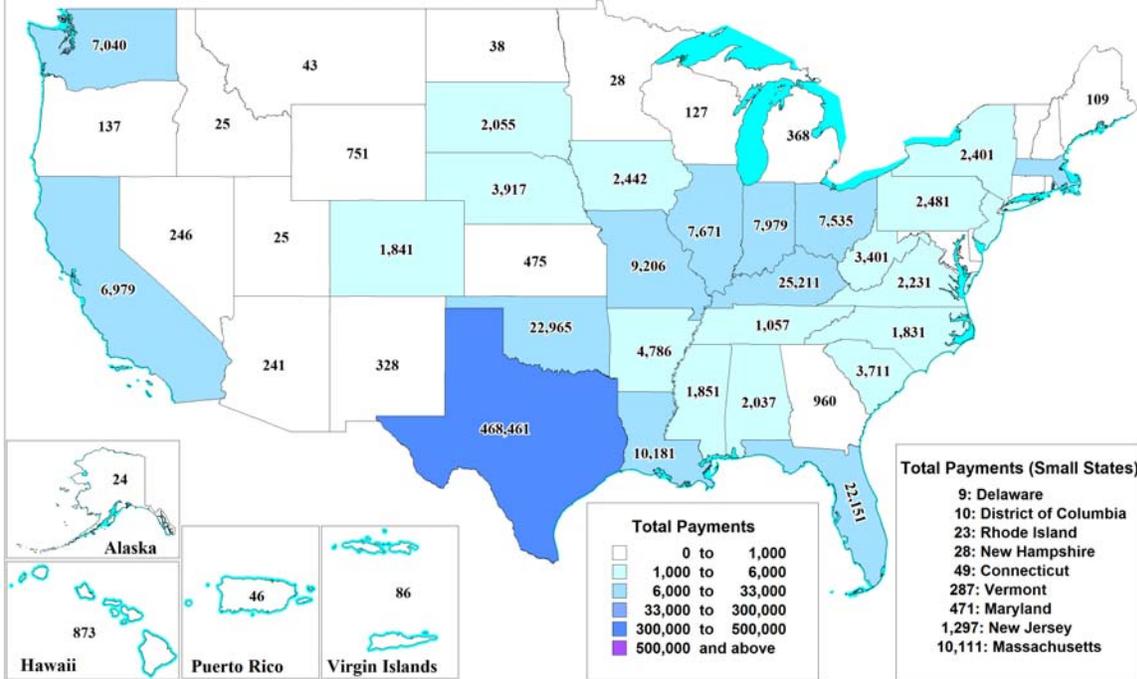
Claims from climate change are anticipated to increase as global temperatures continue to rise, in addition to losses related to coastal storms such as Hurricane Sandy.

P&C insurers are on the veritable “front line” of climate change risks, and there is compelling evidence that those risks are growing. Rising sea levels and more pronounced extreme weather events will mean increasingly damaging storm surges and flooding. Hurricane Sandy caused an unprecedented 14-foot storm surge, eclipsing the 10-foot record set in 1960, and resulted in more than 68 billion in total losses (over \$29 billion in insured losses) and 210 deaths. A tremendous amount of property (both insured and uninsured) is increasingly threatened by sea level rise. CoreLogic, a global property information and analytics provider, identified more than 6.5 million U.S. homes at risk of storm surge damage, with a total reconstruction value of nearly \$1.5 trillion in a July 2014 report.

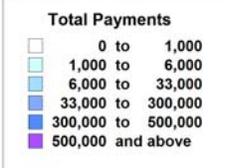
*Insurer Climate Risk Disclosure Survey Report & Scorecard: 2014 Finding & Recommendations – Ceres Insurance Program.*

# National Flood Insurance Program Total Claim Payments

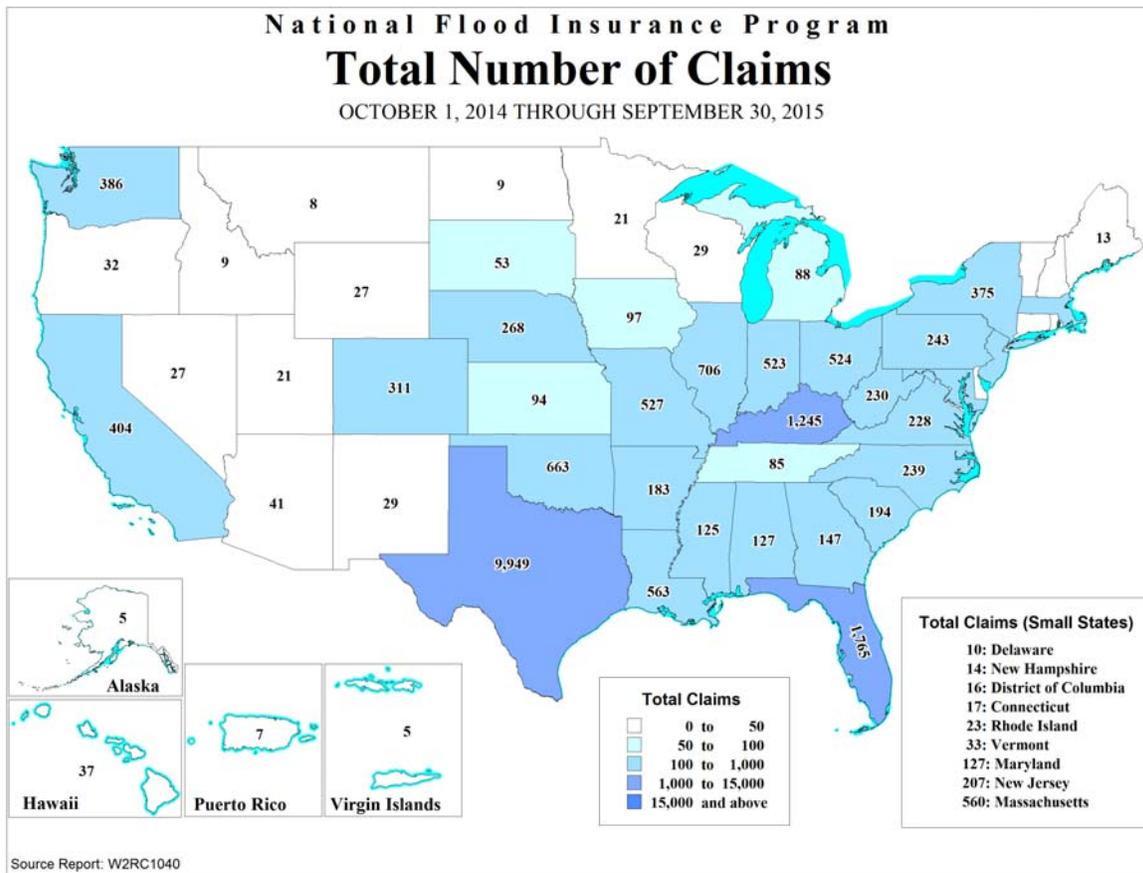
(THOUSANDS OF DOLLARS)  
OCTOBER 1, 2014 THROUGH SEPTEMBER 30, 2015



**Total Payments (Small States)**  
 9: Delaware  
 10: District of Columbia  
 23: Rhode Island  
 28: New Hampshire  
 49: Connecticut  
 287: Vermont  
 471: Maryland  
 1,297: New Jersey  
 10,111: Massachusetts



Source Report: W2RC1040



New York remains one of the higher Flood prone states. Recent results should not be considered as justification for opting out of the purchase of Flood Insurance. In 2012, New York over had \$531, 915,000 in Flood claims. Global weather patterns remain unpredictable and the National Flood Insurance Program provides the only insurance against this peril.

Additional information about flood insurance is available at [www.floodsmart.gov](http://www.floodsmart.gov).

Any conversation of standardization in the insurance world with respect to policies should also include a mention of **ACORD (Association for Cooperative Operations Research and Development)**, which was formed in 1970. From the ACORD #1, Property Loss Notice, and the 125 Commercial Insurance Application, to the 877 Disclosure of Intent to Obtain Consumer Report, the use of ACORD forms allows business to move from producer to carrier in a consistent and clearly understood manner.

**(Section 2.4)**

**Modern Fire / Homeowners Insurance Policy - Review**

**New York Standard Fire Policy**, which was **165 lines**, was required by law in most states.

**Personal liability** was a common additional endorsement to the standard fire policy

**Extended Coverage**” (EC) endorsement added the following **perils**: windstorm, hail, explosion (except steam boilers), riot, civil commotion, aircraft, vehicles, and smoke.

**Insurance Services Office (ISO)** provides statistical, actuarial, underwriting, claims and policy language information and advice to insurance regulators and companies

**ISO** developed standard homeowner forms **HO-0 through HO-8**. The most common form used is the **HO-3 - Special Form for Homeowners**.

**ACORD (Association for Cooperative Operations Research and Development)** produces forms which allow business to move from producer to carrier in a consistent and clearly understood manner

**Fair Access to Insurance Requirements (FAIR)** plan is an insurance **Market of Last Resort** for homeowners.

The **New York Property Insurance Underwriters Association (NYPIUA)** was established in 1968 partly in response to riots across the country in the prior years.

The **Coastal Market Assistance Program**, referred to as **C-MAP** assists homeowners of owner-occupied, one-to-four family dwellings, apartment units or condominium units in certain coastal area properties in the Bronx, Brooklyn, Staten Island, Nassau, Queens and Westchester, obtain insurance coverage for their homes.

Flood insurance is provided by the **National Flood Insurance Program (NFIP)**, created by Congress in 1968.

### Chapter 3

#### (Section 3.1)

#### Auto Insurance

The presence of 120,000 horses in New York City, wrote one 1908 authority for example, is “*an economic burden, an affront to cleanliness, and a terrible tax upon human life.*” The solution to the problem, agreed the critics, was the adoption of the “horseless carriage.” <http://www.banhdc.org/archives/ch-hist-19711000.html>

The automobile, or self-powered vehicle, has been around since 1672 when a Jesuit Missionary gave a steam-powered toy to the Chinese Emperor. The first train, powered by steam, operated in 1801. Electrical, hydrogen and diesel concepts were experimented with throughout the 19<sup>th</sup> Century. Karl Benz, however, was the first to patent an internal combustion engine vehicle in 1884. Within 15 years, Travelers Insurance Company would sell automobile liability policies to Gilbert Loomis of Westfield Mass in 1897, and Dr. Truman Martin of Buffalo, NY in February 1898.

Transportation overland was, to the greatest extent for everyone in the United States, by foot as the country became industrialized. Commerce was conducted by horse drawn carriage or wagon. The volume of waste and overall expense of maintaining a stable of horses to conduct business easily let to the wide acceptance of horseless carriages.

In 1905, according to the New York Transit museum, the Fifth Avenue Coach Company first used a gasoline powered motor coach and replaced all of its horses within 2 years. The American Review of Reviews reported in September 1910:

“it is estimated that there are more than 130,000 automobiles, besides some 35,000 motor trucks, delivery wagons etc., and 150,000 motor cycles and tricycles. Eight years ago the number of automobiles in the United States did not exceed 6000.” *Oldmagazinearticles.com*

To get to the origins of auto insurance, specifically compulsory auto insurance, we take a larger look at the state of the industry in the 1940’s, just before the compulsory requirement for auto coverage was enacted.

#### **THE MULTIPLE-LINE PRINCIPLE BY G. F. MICHELbacher (1955)**

“while New York does not control, absolutely, the practices of other states in this country for a reason which will be disclosed later, it does set the national pattern for the majority of insurers. Let us begin, therefore, by examining the New York Insurance Law as it existed in 1940 to ascertain the permissible scope of operations of an insurer organized to cultivate that area of the field of insurance not specifically reserved for life insurers. The New York Law, in 1940, (Section 46) specified the kinds of insurance which might be authorized for insurers of the type in which we are interested as follows:

1. Life
2. Annuities
3. Accident and health insurance
4. Fire insurance
5. Miscellaneous property insurance
6. Water damage insurance
7. Burglary and theft insurance
8. Glass insurance
9. Boiler and machinery insurance

10. Elevator insurance
11. Animal insurance
12. Collision insurance
13. Personal injury liability insurance
14. Property damage liability insurance
15. Workmen's compensation and employers' liability insurance
16. Fidelity and surety insurance
17. Credit insurance
19. Motor vehicle and aircraft insurance
20. Marine Insurance
21. Marine insurance Marine protection and indemnity insurance...

There were certain classes of insurance which both types of insurers might write. Both were permitted to write automobile and aircraft property damage liability and collision insurance although automobile and aircraft personal injury liability insurance was reserved to casualty and surety insurers and automobile and aircraft material damage insurance (covering damage to the insured motor vehicle or aircraft and its equipment) was reserved to fire and marine insurers.

At this time, 1940, lines of insurance were separated and **package policies** still were not in use. A homeowner, for example, would hold a fire policy to cover loss by fire, and a separate policy for liability. If an individual owned an automobile and had insurance, there would be separate policies for **liability** and **accident** or **collision coverage**.

The American System was based on the theory that these reserves could be better managed and supervised if a rigid separation was maintained as between the two types of insurers. **MICHELbacher**

At the turn of the 20<sup>th</sup> Century, there were no standards to follow with respect to motor vehicle insurance. New York first required vehicles to be registered in 1901 and have a license plate in 1903, however insurance was not required. Massachusetts adopted **compulsory insurance** in **1927**, requiring every vehicle to have insurance in force prior to registration and operation on its public roadways. It was not until 1929 that a **limited compulsory insurance regulation** was adopted in New York State. The limited compulsory insurance rule required an operator's license and all vehicle registrations to be suspended if they were convicted of any of the following:

1. reckless driving, where property damage or personal injury is involved;
2. speeding, where property damage or personal injury is involved;
3. unlicensed operation;
4. driving while intoxicated;
5. leaving the scene of an accident without stopping; or
6. any of the above offenses committed in another state.

Following an accident, or other violation, a driver would be required to provide "**proof of financial responsibility**" to restore operator privileges. An insurance policy minimum limit of \$5000 per individual, \$10,000 per accident and \$1000 for property damage (**5/10/1**) was required.

For 25 years, debate over requiring compulsory insurance took place in New York. Parties injured in an accident had little recourse to recover for their injuries from responsible, yet uninsured, vehicle operators. A suspension could last up to three years, regardless of payment to an injured party. Even in the case of death of a party, an uninsured operator found guilty could have their license and vehicle registration restored, with no payment to the injured parties.

A Joint Legislative Committee, formed to study the "Problem of Unsatisfied Judgement Fund and Compulsory Insurance", issued a report in 1954 addressing the significant problems in New York State. Significant opposition from insurance carriers as well as the New York State Bar Association persisted. Agreement was reached on **compulsory insurance** and the **Motor Vehicle Financial Security Act** was adopted in **1956**. **Minimum insurance requirements** were set at **\$10,000** per person, **\$20,000** per accident and **\$5,000** for property damage (**10/20/5**).

Prior to the compulsory requirement, financial responsibility minimum limits were **(5/10/1)**

Victims of uninsured operators continued to be uncompensated until 1959 when the **Motor Vehicle Accident Indemnification Corporation (MVAIC)** was established. MVAIC, a not-for-profit company, requires all insurance companies writing automobile insurance to maintain membership and support the organizations operations. The MVAIC continues to operate and maintains a website at **MVAIC.com** providing information to the public and the ability to file claims online.

New York State raised the minimum auto liability insurance limit in 1995 to \$25,000 per person, \$50,000 per accident and \$10,000 in property damage **(25/50/10)**.

## Section 3.2

### SUM Coverage

An important part of the compulsory insurance model is the inclusion of **un-insured** and **under-insured motorist coverage** to supplement the policy. Supplemental Uninsured/Underinsured Motorist Coverage (**SUM**) must meet the minimum state liability limit, current set at \$25,000 per person and \$50,000 per accident. Higher limits for SUM coverage can be purchased along with higher liability limits. However, SUM coverage cannot exceed liability coverage. It is recommended that SUM coverage match liability coverage. For example, a policy with \$100,000/\$300,000/\$50,000 in liability limits should have SUM coverage of \$100,000/\$300,000.

### No Fault

New York State enacted the “**Comprehensive Automobile Insurance Reparations Act**”, commonly known as **No-Fault Insurance**, in **1974**. No-Fault insurance in New York State is also referred to as **Personal Injury Protection (PIP)** coverage. All auto insurance policies in New York are required to provide \$50,000 in coverage. Insureds can purchase additional coverage, known as **Additional PIP, or APIP**, in the amount of \$50,000, bringing their total benefit to \$100,000.

**(An individual can be refused PIP benefits in New York while committing a felony.)**

The pros and cons of no-fault insurance were debated for several decades prior to its enactment and continue to be debated today. Those in favor of no-fault insurance laws point to the need to ensure medical coverage for all accident victims and the delays in providing compensation to injured parties experienced in the Tort process.

**Tort:** A body of rights, obligations, and remedies that is applied by courts in civil proceedings to provide relief for persons who have suffered harm from wrongful acts of others.

*Legal-dictionary.thefreedictionary.com/tort+law*

Initial opposition to no-fault insurance was predominantly voiced by Bar Associations; however results studied over time have added additional opponents including many insurers.

**Many insurers and consumer groups that once supported no-fault as a means of reducing rate increases no longer support it.**

*The U.S. Experience with No-Fault Automobile Insurance A Retrospective – Rand Institute for Civil Justice*

There are three main components in the common “no-fault” insurance program. These components together are intended to reduce overall costs and provide superior medical care to those suffering accident injuries.

- 1 A partial or total restriction on the right to sue other drivers for being at fault for automobile accidents
- 2 A restriction on recovering for pain and suffering or other noneconomic damages
- 3 Mandatory insurance so that the victim can recover his or her economic losses (including medical costs) from his or her own insurance company.

### ***Rand Institute for Civil Justice***

Under a **pure no-fault** system, there would be no need for an injured party to sue an at fault party, since their **injuries would be completely covered by their own insurer**. However, there are limitations on no-fault in the form of **monetary** and **verbal limits**, which if exceeded allow the injured party to seek additional compensation from at-fault parties. Monetary limits are used in several states. New York State has a **verbal limit, or description of injuries**, for personal injuries which must be met in order to sue an at-fault party. The New York State Bar Association describes the verbal limit or Serious Injury Threshold as follows:

#### ***Serious Injury Threshold***

Article 51 of the Insurance Law provides that a plaintiff in a personal injury action arising out of negligence in the use or operation of a motor vehicle must establish that he/she has incurred a basic economic loss exceeding \$50,000 or must establish that he/she has suffered "serious injury". Insurance Law § 5104(a), (b). Serious injury is defined as personal injury which results in one of the following :

- Death
- Dismemberment
- Significant disfigurement
- Fracture
- Loss of a fetus
- Permanent loss of use of a body organ, member, function or system
- Permanent consequential limitation of a body organ or member
- Significant limitation of use of a body function or system
- Medically determined injury or impairment of a non-permanent nature which prevents the injured person from performing substantially all of the material acts which constitute such person's usual and customary daily activities for not less than 90 days during the 180 days immediately following the occurrence of the injury or impairment.

*New York State Insurance Law §5102(d).*

#### ***No-Fault Regulation 68***

##### ***A Brief Legal History of No-Fault Regulation 68***

Department of Insurance Regulation 68, which implemented New York's No-Fault law, was first promulgated in 1974. A new revised Regulation 68 was filed August 2, 2001 with the Department of State and published in the State Register on August 22, 2001. By its terms, (new) Regulation 68 was to be effective as of September 1, 2001. The revised Regulation was divided into four different regulations that addressed four separate regulated aspects of the No-Fault reparations system (Prescribed Policy Endorsements, Rights and Liabilities of Self-Insurers, Claims for Personal Injury Protection Benefits and Arbitration).

On August 29, 2001, various plaintiffs filed a lawsuit in the New York State Supreme Court seeking a stay of enforcement of the revised regulation and challenging the authority of the Superintendent to promulgate the regulation. A temporary stay preventing the Department from implementing the revised regulation was issued on August 31, 2001.

Accordingly, from August 29, 2001 to April 4, 2002 (the period of the temporary stay) the prior version of Regulation 68 remained in effect, as modified by the emergency twenty-fourth amendment (which was filed and effective on September 18, 2001 and remained in effect on an emergency basis through April 4, 2002) and the emergency twenty-fifth amendment (which was filed and effective on December 31, 2001 and remained in effect on an emergency basis through April 4, 2002). These two amendments provided

essential reforms to the No-Fault arbitration process; some of which took effect immediately and others took effect on March 1, 2002.

On February 19, 2002, Supreme Court Justice William Wetzel issued a decision upholding the State Insurance Department's promulgation of the revised Regulation 68 and denying a request that it be overturned. On April 4, 2002, the Appellate Division, First Department, unanimously denied petitioners' motion seeking injunctive relief pending appeal of Justice Wetzel's decision upholding the Department's promulgation of revised Regulation 68 and also vacated the interim stay in effect against implementation of the revised regulation.

As a result of this decision, revised Regulation 68 (the Regulation as promulgated in August 2001 to be effective on September 1, 2001) was effective as of April 5, 2002.

On April 11, 2002 the Department promulgated, on an emergency basis, the First Amendment to Regulation No. 68-C (11 NYCRR 65) and the First Amendment to Regulation No. 68-D (11 NYCRR 65). These two emergency regulations amended the provisions of the revised Regulation 68 to conform it with the 25th Amendment to the old Regulation, and were finally adopted on April 5, 2003.

The Appellate Division, First Department, affirmed the decision of Acting Justice Wetzel, Matter of Medical Society of the State of New York, et al., Appellants, v. Gregory Serio, &c., et al, Respondents, N.Y. App. Div. 1st Dep't, Oct. 22, 2002). The Court of Appeals ultimately upheld the decision of the First Department and affirmed the promulgation of the revised amendment, 2003 N.Y. LEXIS 3314 ([Court of Appeals decision dated October 21, 2003 \(PDF format\)](#)).

The text of both the prior [\(old\) Regulation 68](#), as well as revised [\(new\) Regulation 68](#) and amendments thereto, No-Fault frequently asked questions concerning the effective date(s) of provisions in the revised regulation, and select opinions of the Department's Office of General Counsel applicable to No-Fault coverage may be found on the [No-Fault Central Links](#) page.  
[http://www.dfs.ny.gov/insurance/r68/r68\\_intro.htm](http://www.dfs.ny.gov/insurance/r68/r68_intro.htm)

Many states have repealed their no-fault laws to return to **tort systems**, Colorado being the most recent to do so in 2003, effective 2004.

The current New York State automobile insurance policy provides the following mandatory and voluntary coverages:

Coverage	Minimum Limit	Mandatory or Voluntary
Liability	25,000 / 50,000	M
Property Damage	10,000	M
PIP (No-Fault)	50,000	M
Additional PIP	50,000	V
OBEL	25,000	V
UM/SUM	25,000 / 50,000	M
Medical Payments	5,000	V
Comprehensive	Deductible Applies	V
Glass	Deductible Applies	V
Collision	Deductible Applies	V
Rental Reimbursement	Daily Limit	V

**First Party Benefits**, those paid to the insured, are provided by **Medical Payments Coverage**, under an automobile insurance policy and by their individual health insurance plan.

### Section 3.3

#### Assigned Risk Plan

New York State has held an insurance requirement, in one form or another, since 1929. Prior to 1954, individuals with a financial responsibility requirement were required to purchase insurance and since 1954, all vehicles are required to be insured prior to registration. Insurance companies however were not forced by law to directly offer policies to any or every individual. To provide coverage to **high-risk** individuals with statutorily required coverage, states adopted “**Assigned Risk Plans**” starting in 1938 with New Hampshire. New York adopted a Plan in 1941, effective January 1, 1942. Various options were debated, including “*pooling of premiums and losses on risks unable to insure through normal channels among all licensed carriers in the State.*” (*A HISTORY OF THE UNIFORM AUTOMOBILE ASSIGNED RISK PLAN - W.Elden Day*) It was agreed within the industry that the preferred method was a proportional distribution of risks to insurers writing automobile coverages.

Beginning in January 1942, the **New York Automobile Insurance Plan (NYAIP)** distributed “assigned risks” to carriers. Today, the management of the NYAIP is managed by **AIPSO**, the **Automobile Insurance Plan Service Office**.

Insurance producers with the authority to write automobile insurance may place business with the NYAIP; however, a **Producer Certification Course** must be completed and application to the NYAIP must first be approved. Applications are submitted online through **NYPASS.COM**.

In addition to risks for private passenger autos, the NYAIP accepts the following commercial risks:

- Trucks, Tractors, Trailers
- Public Transportation
- Garage Coverage
- Non-owned Coverage
- Miscellaneous Section
- Light Commercial Physical Damage

The NYAIP is governed by a 22 Member Governing Committee which is comprised of 12 company representatives and 10 producer representatives. The New York State Department of Financial Services approves rule and rate changes proposed by the NYAIP.

Producers submitting applications for coverage to the NYAIP are bound to the rules of the NYAIP, in addition to rules and regulations of NYDFS. Producers found to be in violation of Plan Rules may be brought before a Peer Review Panel to determine

Peer Review Panel members are appointed by NY Superintendent of Insurance to conduct hearings for adverse performance involving:

- Rate Evasion
- Premium Diversion
- Fraud reported by carriers or IFB
- Dishonored checks • Late applications
- Fraud reported by carriers or IFB
- Misused ID cards
- Performance Standard Violations
- Unbound MVRs Ordered through PASS
- Deficient applications
- Misused ID cards

- Misused electronic binding
- Misused electronic app
- Pattern of abuse

The Peer Review Panel may issue penalties for violation of NYAIP Rules. Those penalties may include:

- Conditioned Certification
- Suspended Certification
- Revoked Certification

The volume of applications for coverage in the NYAIP has dropped considerably since the peak in the early 1990's. In the 1999 Annual Report to the Legislature, the Department noted that in 1992, 17.1% of all automobiles were insured through the Plan, representing more than a million vehicles. Today, the number of vehicles insured annually through the NYAIP is approximately 30,000. Market segmentation, rate tiering and credit scoring are major contributing factors in the de-population of the Plan.

### **(Section 3.4)**

#### **Supplemental Spousal Liability Insurance**

While your automobile liability insurance policy provides coverage for every passenger in your vehicle injured in an accident caused by the driver's negligence, until recently it likely not provide any liability coverage when the injured passenger is your spouse. In 2002, the state legislature passed a law requiring insurers to offer their policyholders the opportunity to purchase supplemental spousal liability coverage beginning January 1, 2003. This insurance covers the liability of an insured because of the death of or injury to his or her spouse for the liability insurance limits provided under the policy. Initially, a policyowner was required to request this additional coverage from their insurer and pay an additional premium for it unless your company is providing this coverage at no charge. Today, many insurers automatically provide Spousal Liability coverage.

The doctrine of spousal immunity was based on the traditional religious belief that upon marriage, a man and a woman become one flesh. English common law incorporated this belief, proffering that a man and a woman become one legal entity upon marriage.<sup>1</sup> This legal entity was forged by the merging of the wife's identity into her husband's.<sup>2</sup> Consequently, wives could not enter into contracts or sue without the joinder of her husband.<sup>3</sup> In turn, the husband was liable for all of the wife's tortious acts.<sup>4</sup> Spouses were also not permitted to recover against one another in liability suits.<sup>5</sup> This spousal immunity was based on the single entity rationale. Since a husband and wife were one entity, they could not sue each other because an interspousal suit was the equivalent of a person suing himself.

[http://mdafny.com/index.aspx?TypeContent=CUSTOMPAGEARTICLE&custom\\_pages\\_articlesID=14731](http://mdafny.com/index.aspx?TypeContent=CUSTOMPAGEARTICLE&custom_pages_articlesID=14731)

Circular Letter No. 23 (2002)  
November 15, 2002

TO: ALL INSURERS AUTHORIZED TO WRITE MOTOR VEHICLE INSURANCE IN NEW YORK STATE; RATE SERVICE ORGANIZATIONS; AND INSURANCE PRODUCER ORGANIZATIONS

RE: SUPPLEMENTAL SPOUSAL LIABILITY INSURANCE

**STATUTORY REFERENCE: SECTION 3420(g) OF THE INSURANCE LAW, and REGULATION 35-A**

The purpose of this Circular Letter is to advise the insurance community of the recent enactment of Chapter 584 of the Laws of 2002, which amends Section 3420(g) of the Insurance Law to require motor vehicle liability insurers to offer supplemental spousal liability insurance to all policyholders, personal and commercial, in New York State who are covered under motor vehicle liability insurance policies that satisfy the requirements of Article 6 of the New York Vehicle and Traffic Law. Insurers must offer this coverage on all such motor vehicle policies issued or renewed that become effective on or after January 1, 2003.

The statute defines supplemental spousal liability insurance as coverage against the liability of an insured because of death of, or injury to, his or her spouse up to the liability insurance limits provided under the policy even where the injured spouse, to be entitled to recover, must prove the culpable conduct of the insured spouse. This coverage must be made available upon written request of the insured and payment of a reasonable premium.

In addition, the statute requires, for all policies issued or renewed to be effective on or after January 1, 2003, that insurers provide appropriate written notification of the availability of this coverage. The notification must be contained on the front of the premium notice in boldface type and include a concise statement that supplementary spousal coverage is available, an explanation of such coverage, and the premium for the coverage. Subsequently, this information must be provided in a notification to all insureds at least once a year. This subsequent notification must contain the information detailed above. Section 60-1.6(b)(5) of the recently promulgated Seventh amendment to Regulation 35-A (11 NYCRR 60-1) contains a sample notification.

In order to be in compliance with the statute, insurers are advised to submit, as soon as possible, policy forms affording this type of coverage to the Department for the Superintendent's review and approval. Although insurers are required to provide notice of this coverage to their insureds, the policy notices are not subject to filing with the Department, unless they are made part of a policy form, such as the declaration page. If an insurer uses a different notice from the one contained in the regulation, the notice must contain substantially all of the same information in a clear and readable manner.

Rates and rating rules associated with such coverage must also be filed with and approved by the Superintendent.

Insurers are encouraged to utilize the Speed-To-Market filing procedures for the required policy form filings. Information on the speed-to-market process can be obtained from the Department's website at [www.ins.state.ny.us](http://www.ins.state.ny.us).

Any questions and/or comments with respect to this matter may be directed to:

Mr. Howard Baida  
Associate Insurance Examiner  
New York State Insurance Department  
25 Beaver Street  
New York, New York 10004  
212-480-5597 or [hbaida@ins.state.ny.us](mailto:hbaida@ins.state.ny.us)

Very truly yours,

Mark Presser  
Assistant Deputy Superintendent and Chief Examiner  
Property Bureau

### **(Section 3.5)**

Auto Insurance Review

Massachusetts was first to adopt **Compulsory Insurance** in **1927**

Prior to 1956, New York State had a **limited compulsory insurance regulation**.

**Compulsory insurance** and the **Motor Vehicle Financial Security Act** was adopted in **1956**.

**Minimum insurance requirements** in 1954 were set at **\$10,000** per person, **\$20,000** per accident and **\$5,000** for property damage (**10/20/5**).

Victims of uninsured operators continued to be uncompensated until 1959 when the **Motor Vehicle Accident Indemnification Corporation (MVAIC)** was established.

**Supplemental Uninsured/Underinsured Motorist Coverage (SUM)** must meet the minimum state liability limit, current set at \$25,000 per person and \$50,000 per accident.

New York State raised the **minimum auto liability insurance limit** in 1995 to \$25,000 per person, \$50,000 per accident and \$10,000 in property damage (**25/50/10**).

No-Fault insurance in New York State is also referred to as **Personal Injury Protection (PIP)** coverage.

Insureds can purchase additional coverage, known as **Additional PIP, or APIP**

**First Party Benefits**, those paid to the insured

**New York Automobile Insurance Plan (NYAIP)** is managed by **AIPSO**, the **Automobile Insurance Plan Service Office**.

**Producer Certification Course** must be completed and application to the NYAIP must be approved.

**High-risk** individuals can find insurance in **Assigned Risk Plans**.

## Commercial Coverages

### Chapter 4

#### (Section 4.1)

#### Commercial Insurance Excess Markets

Too often in our industry, the role of an “insurance producer” is reduced to sales clerk whose primary purpose is to process a sale at the request of a customer. Seldom are the nuances of agency and broker relationships explained to insurance consumers.

While fiduciary responsibility is not specifically referenced in New York State Insurance Law, the common practice guidelines provide a strong framework for insurance producers to follow:

*A **fiduciary** is expected to be extremely loyal to the person they owe the duty (the "principal")*

New York State Law, section 2101, provides the following definition of insurance agent and Broker:

**"insurance agent"** means any authorized or acknowledged agent of an insurer... who acts as such in the solicitation of, negotiation for, or sale of, an insurance, health maintenance organization or annuity contract.

**"insurance broker"** means any person, firm, association or corporation who or which for any compensation, commission or other thing of value acts or aids in any manner in soliciting, negotiating or selling, any insurance or annuity contract or in placing risks or taking out insurance, on behalf of an insured other than himself, herself or itself or on behalf of any licensed insurance broker.

A layman explanation of Fiduciary Responsibility for insurance producers can be reduced to the following statements:

An **insurance agent** is the direct representative of the insurance carrier, with the ability to bind coverage directly.

An **insurance broker** is the direct representative of the insurance consumer, assuming the responsibility of securing the best insurance coverage available to the broker.

These distinctions can have significant impact on the ability of an insurance producers' ability provide timely policy service to their client.

Changing economic cycles often have an impact on the availability of products from insurance companies, or markets, as their willingness to accept insurance risks is, to certain degrees, dependent of market conditions. Loss experience and competition between insurers also have impact upon product availability and price. Specific State Laws and Regulations may also have an impact on the willingness of carriers to accept risks and the limitations that are placed on coverage, if it is made available.

Insurance agents are directly limited in their ability to secure coverage by their relationships with carriers, while brokers have an ability to look to alternative markets on their customers' behalf. Insurance brokers should understand the important distinction between Admitted and Non-Admitted insurance companies when placing business.

An **admitted insurance company** is one that has applied for authority to conduct business within a state. In addition, it will comply with all of the dictates of that state including maintaining sufficient reserves, subjecting itself to tax laws, and abiding by the mandates of that state's Insurance Department

regulations. That state will issue an official accreditation - known as a Certificate of Authority – to the admitted insurance company.

A ***non-admitted insurance company*** must comply with the basic operating mandates of the state in which it does business, but does not seek Certification of Authority. It may want to solicit only certain classes of business but does not want to comply with the regulations of the state relating to maintaining reserves, residency, and tax regulations of the state.

Both admitted and non-admitted carriers are authorized to conduct business in a state. The terms authorized and unauthorized can be confusing. Both can conduct business in the state. The term unauthorized means that the insurance carrier possesses no authorized Certificate of Authority and thereby has not fully subjected itself to the full regulatory authority of the state.

An admitted insurance company, or Standard Market, offers the highest level of security to insurance consumer. The willingness of the admitted market to comply with state regulations provides the regulatory agency with an ability to intercede on behalf of the consumer in disputes between the parties.

### **Excess and Surplus Market**

When an admitted market is unavailable to an insurance producer, only a broker may pursue a non-admitted market, or Excess and Surplus Lines market. Lloyds of London is Excess and Surplus business and is regulated in New York State by the **Excess Lines Association of New York, ELANY**. Specific regulations are in place covering the placement of every individual account.

Most important of these regulations is the requirement for a “Total Cost Form” disclosure to be presented to the consumer. The Total Cost Form itemizes the individual charges to be paid, including policy premium, separate tax charges, policy fees and inspection fees.

**NOTICE OF EXCESS LINE PLACEMENT**

**Date:**

Consistent with the requirements of New York Insurance Law and Regulation 41 \_\_\_\_\_ is hereby advised that after a diligent effort to place the required insurance with companies authorized in New York to write coverages of the kind requested, all or a portion of the required coverages have been placed by \_\_\_\_\_ with insurers not authorized to do an insurance business in New York and which are not subject to supervision by this State. Policies issued by such unauthorized insurers may not be subject to all of the regulations of the Superintendent of Insurance pertaining to policy forms. In the event of insolvency of the unauthorized insurers, losses will not be covered by any New York State Insolvency Fund.

**TOTAL COST FORM**

In consideration of your placing my insurance as described in the policy referenced below, I agree to pay the total cost below which includes all premiums, inspection charges(\*\*) and a service fee that includes taxes, stamping fees, and (if indicated) a fee(\*\*) for compensation in addition to commissions received, and other expenses(\*\*).

I further understand and agree that all fees, inspection charges and other expenses denoted by (\*\*) are fully earned from the inception date of the policy and are non-refundable regardless of whether said policy is cancelled. Any policy changes which generate additional premium are subject to additional tax and stamping fee charges. \*Where a portion of the risk is located outside the state of New York, taxes and stamping fees are only charged against the premium allocated to the New York portion of the risk.

Re: Policy No. Insurer

Policy Premium \$

New York Allocated Premium (where applicable) \$

Service Fee Charges:

Excess Line Tax (3.60%) (\*) \$

Stamping Fee (\*) \$

Broker Fee (\*\*) \$

Inspection Fee (\*\*) \$

Other Expenses (specify)(\*\*) \_\_\_\_\_ \$ \_\_\_\_\_

Total Policy Cost \$

\_\_\_\_\_  
(Signature of Insured)

**STATE OF NEW YORK  
INSURANCE DEPARTMENT  
ONE COMMERCE PLAZA  
ALBANY, NEW YORK 12257**

The Office of General Counsel issued the following opinion on March 13, 2006 representing the position of the New York State Insurance Department.

**RE: Excess Line Placement.**

**Question Presented:**

If an excess line broker has obtained a quote from a authorized insurer for a liability policy that contains a defense within limits offset provision and a quote from an eligible excess line insurer for a liability policy with unlimited defense outside the liability limit, may the excess line broker place the policy with the excess line insurer if the excess line broker has also received three declinations from other authorized insurers?

**Conclusion:**

Yes, an excess line broker that has obtained a quote from a authorized insurer for a liability policy that contains a defense within limits offset provision and a quote from an eligible excess line insurer for a liability policy with unlimited defense outside the liability limit, may place the policy with the excess line insurer where the excess line broker has also received three declinations from other authorized insurers.

**Facts:**

No facts were provided. The inquirer requested further clarification of Opinion of General Counsel No. 05-12-14 (December 19, 2005) and has asked a question that is different from the question analyzed in that opinion.

**Analysis:**

An excess line broker placing business with an unauthorized insurer must comply with the provisions of N.Y. Ins. Law § 2118 (McKinney Supp. 2005) and N.Y. Comp. R. & Regs. tit. 11 Part 27 (Regulation 41) which require, inter alia, that a diligent effort be made to procure insurance from an authorized insurer and permit placement with an unauthorized insurer only when coverage can not be procured from the authorized insurer market and only to the extent it is in excess of any insurance available in the authorized market.

N.Y. Ins. Law § 2118(b)(3)(A) (McKinney Supp. 2005) provides, in relevant part, as follows:

The submission of insurance documents to the excess line association shall be accompanied by a statement subscribed to, and affirmed by, the licensee or sublicensee as true under the penalties of perjury that, *after diligent effort, the full amount of insurance required could not be procured, from authorized insurers*, each of which is authorized to write insurance of the kind requested and which the licensee has reason to believe might consider writing the type of coverage or class of insurance involved, and further showing *that the amount of insurance procured from an unauthorized insurer is only the excess over the amount procurable from an authorized insurer . . .* (emphasis added).

N.Y. Ins. Law § 2118(b)(4) (McKinney Supp. 2005) provides, in relevant part, as follows:

The number of declinations constituting diligent effort in regard to placement of coverage with authorized insurers for purposes of paragraph three of this subsection shall be three . . .

In Opinion of General Counsel No. 91-25 (NILS March 7, 1991), the Department stated, in relevant part, as follows:

Where the policy provides a broad range of coverages, such as a special multi-peril policy, the package policy may be placed with an unauthorized insurer if the coverages cannot be placed separately or as a package with an authorized insurer . . . or if the coverages not available from an authorized insurer . . . cannot be placed separately in the unauthorized market.

There are three caveats. First, the components must have some appropriate relationship to each other. One cannot tie some exotic risk to an unrelated commonplace exposure to obtain coverage in the unauthorized market. Second, the additional coverage must be material, covering a substantial, and not illusory exposure. Third, the coverages offered by the unauthorized insurer must not be illegal and must comply with appropriate statutory and regulatory requirements.

The exception described in Opinion of General Counsel No. 91-25 (NILS March 7, 1991) is clearly applicable to the circumstances that the inquirer described in his question where the broker was unable to procure a liability policy with unlimited defense costs coverage since the defense cost coverage is not permitted as a separate policy in either the authorized or excess line markets. All other things being equal, the coverage available in the unauthorized market providing for unlimited defense costs outside the liability limit of the policy would provide the insured with more coverage than the policy available in the authorized market that contains a defense within limits offset provision and is, therefore, superior coverage.

Thus, an excess line broker that has obtained a quote from a authorized insurer for a liability policy that contains a defense within limits offset provision and a quote from an eligible excess line insurer for a liability policy with unlimited defense outside the liability limit, may place the policy with the excess line insurer where the excess line broker has also received three declinations from other authorized insurers.

For further information you may contact Assistant Counsel Brenda M. Gibbs at the Albany Office.

#### **(Section 4.2)**

#### **Risk Retention Groups, Purchasing Groups and Trusts**

In addition to traditional markets authorized for a class of business, specifically designed insurance companies have also been established that differ from standard admitted or non-admitted carriers.

#### **Risk Retention Groups**

Risk Retention Groups (RRG) are federally authorized under the Liability Risk Retention Act of 1986 (which specifically preempts contrary state laws) to assume liability exposure for a particular class or group. RRGs must be licensed under the laws of at least one state, maintain a minimum premium volume, and subject itself to the regulations of the state in which it conducts business. As of November 2006, 238 RRGs were operating nationwide.

#### **Purchasing Groups**

**Purchasing Groups** are also federally authorized under the Liability Risk Retention Act of 1986 (which specifically preempts contrary state laws). Unlike Risk Retention Groups, Purchasing Groups do not provide individual customers with their own specific policy, but provide coverage under a single policy issued to a homogenous group. Typically, an insurance customer will join an association or other professional entity prior to gaining access to a purchasing group.

## Group Self Insured Trusts

In New York State, an alternative mechanism for workers compensation, exist through Group Self-Insured Trusts. **Group Self-Insured Trusts** are homogenous to specific industry classes and made up of member companies. Members contribute premiums to provide coverage to employees of member companies and agree to cover any shortfall when they assume, at time of application, joint and several liability. Membership in a Trust does not terminate upon an individual's exit from that trust. Members may be assessed additional premiums for losses incurred during their membership at any future date and can be held both jointly and individually liable for claims of fellow trust members.

Insurance producers should note that The New York Workers' Compensation Board Group Self-Insured Trusts Summary of Funding Status, dated October 22, 2004 indicated that 26 of the 64 New York trusts listed in the report were deemed under-funded. Placement of risks in a Self-Insured Trust should be done with full disclosure of the potential future liability to the prospective member.

## ISO Form vs. Carrier Specific Forms

**Insurance Services Office, Inc., (ISO)** an independent organization providing support to the insurance industry since 1971, has developed standard forms for different classes of business from homeowners and private passenger auto to commercial property and liability. Due to the complexity of developing insurance policies, many carriers opt to utilize the widely accepted standard ISO form.

ISO forms undergo constant review and updates are periodically published. Insurance producers should be careful to refer to the specific issue date of the form used by the issuing carrier, as updates may not necessarily have yet been introduced.

The numbering given the forms and endorsements offered by ISO for the Business owners Program (BOP) is very specific in its meaning. The sequence uses 10 digits:

- The first two digits are letters that represent the line of insurance, such as BP for Business owners policy forms or IL for Interline forms.
- The next two digits represent the category of insurance outlined in further detail below.
- The next two digits are the item or form number within the category.
- The last four digits represent the edition date month and year of the form. For simplicity, and because edition dates change frequently, this analysis does not include this information.

Many carriers continue to issue policies with proprietary language. Proprietary forms may enable a carrier to provide coverage specifically tailored to an underwriting philosophy or customer need.

### (Section 4.3)

## Commercial Property and Commercial General Liability Policy

As with a personal lines homeowners policy, the commercial property policy covers buildings and structures and business personal property. Extensions of coverage may be automatically included by a carrier or offered through an endorsement. Also paralleling the personal lines policy coverage for buildings, commercial property coverage is offered in basic, broad and special coverage forms.

**Basic Form Coverage** - protects your business against these perils (cause of loss):

- Fire, plus extended coverage, consisting of:
  - Lightning
  - Explosion
  - Windstorm or hail
  - Smoke

- Aircraft or vehicles
- Riot or civil commotion
- Vandalism
- Sprinkler leakage
- Sinkhole collapse
- Volcanic action

**Broad Form Coverage** - includes basic fire and extended coverages listed above plus:

- Breakage of glass
- Falling objects
- Weight of snow, ice or sleet
- Water damage (accidental discharge as a direct result of broken water system)

**Special Form Coverage** - includes basic form, plus broad form coverage plus:

- This form covers any other loss, unless the peril is specifically excluded, such as flood, earthquake, war, nuclear accident, etc. Check your policy for a complete listing of perils excluded.

Where the commercial property coverage policy differs from personal lines is in the **co-insurance** on the property covered. Co-insurance on commercial property is not the agreement that carriers will share a loss on a specific risk, as it typically is understood with our health insurance policies or with reinsurance arrangements between carriers. Co-insurance on commercial property is the agreement that property is insured to value as stated in the policy. Failure of the insured to maintain insurance to current value can result in reduced responsibility on the part of the carrier to pay following a loss. Using an accepted property valuation method becomes increasingly important when insuring commercial property for full, or near full replacement value.

Insurance of commercial property typically is written with either Actual Cash Value or Stated Value on a building or with Coinsurance between 80% and 100%.

**Consider the following:**

Acme Manufacturing insures a building with 80% co-insurance and a value of \$100,000. The policy has a deductible of \$1000.

- The property sustains a \$50,000 loss
- ACME assumes that their contribution will be their \$1000 deductible and the Carrier will contribute \$49,000.
- The insurance producer assumes that ACME will be responsible for their \$1000 deductible plus 20% of the remaining \$49,000, or an additional \$9,800.
- The Carrier, following investigation, determines the property value, prior to loss, to have been \$200,000. The Carrier determines it's obligation as follows:

Current Value of	X	Coinsurance	=	Obligation
\$200,000	X	80%	=	\$160,000
Actual Coverage	X	Current Value	=	Responsibility
\$100,000	X	\$200,000	=	50%
Loss	X	Responsibility Less Deductible	=	Contribution

The Carrier contribution to the loss is \$24,000 and ACME's contribution is \$26,000.

## **Equipment Breakdown Coverage**

Equipment breakdown coverage is included in many commercial property packages, however, specific care should be given to review the extent of coverage and the needs of individual clients. Higher limit needs of manufacturing clients or other industrial businesses may require additional limits or special property coverage.

## **Business Income Interruption**

Business income interruption provides reimbursement for actual loss of income, typically for up to 12 months. Coverage may reimburse for down time and extra expenses incurred to restore business operations, such as renting equipment or securing other operation space.

## **Business Personal Property**

Business personal property includes property that you own that is used in your business and property of others that is in your **care, custody or control**. Business personal property may also cover Improvements or Betterments made to a building you occupy, Leased property which you may be required to insure and exterior building glass, if you are a tenant.

## **Liability Protection**

A **Commercial General Liability (CGL)** Policy provides coverage for the insured in the event a third party suffers an injury because of business activities of the insured. An insured's liability may be for Bodily Injury (BI), Personal Injury (PI), Advertising Injury (AI) or Property Damage (PD). Also covered under the liability section of the policy are Medical Expenses incurred for bodily injury caused by an accident regardless of negligence on the part of the insured and the obligation for the insurer to provide a defense of its policy holder against all valid suits.

CGL policies are typically written on an Occurrence Basis covering incidents that happen within the coverage period. Claims Made policies may be available covering past acts of the insured that were not reported prior to the coverage period.

The CGL policy is comprehensive in nature, covering all hazards within the scope of the insuring agreement that are not otherwise excluded. Producers should be aware that items excluded under the CGL may be as important as what is covered.

## **Premises and Operations**

- Premises coverage exists when there is ownership or occupancy or property. Businesses entertaining customers at their location have premises exposure.
- Operations coverage exists when activity in addition to occupancy exists. Carpenters working at a customers property have operations exposure.

## **Products and Completed Operations**

- Products hazards exist with the manufacturer or sale of a product.
- Completed Operations is a hazard the remains after a job is completed.

## **Advertising Injury**

- Coverage for libel or slander, invasion of privacy, misappropriation of advertising ideas or style of doing business and infringement of copyright, title or slogan in the course of advertising.

## **Fire Legal Liability**

- Provides coverage to property leased or rented to the insured.

## **Medical Payments**

- Medical payments for persons other than the named insureds for Bodily Injury suffered on the premises, even though the insured was not negligent. The difference between Medical Payments and Premises

Liability is negligence. You do not need to be held negligent for the insurance company to pay a medical claim.

### **Professional Liability**

- Commercial General Liability policies generally exclude coverage for claims arising from the rendering or the failure to render professional services. Most professional exposures are more appropriately covered by a Professional Liability or Errors and Omissions policy

### **Commercial Package Policy**

Like the standard Homeowners Policy, the **Commercial Package Policy (CPP)** combines Property and General Liability insurance products into one package. The CPP provides flexibility for carriers to cover a wide range of risks in one form and is generally used for larger commercial risks and those requiring an individual combination of coverages.

### **Business Owners Policy (BOP)**

Like the Commercial Package Policy (CGL), the **Business Owners Policy (BOP)** also combines Commercial Property and General Liability insurance coverages into one convenient package. The BOP is used by carriers to expedite the underwriting and sales processes of smaller, homogenous risks. Sole proprietors, small contractors or small mercantile risks may be written on BOP forms, since each risk requires the same basic coverage and poses the same class of risk to the carrier.

A BOP covers building and contents. It will also pay to repair or replace your business property, including the items below, if they are damaged by fire or other covered loss in a building that you either, own or rent.

- Inventory, equipment, stock (perishable included)
- Furniture and fixtures
- Computers
- Phone equipment
- A/C system
- Refrigeration system
- Building glass
- Money or securities on the premises or money or securities that are physically transferred to a bank
- Personal belongings at the business site
- Equipment leased or rented for business use
- Business signs
- Valuable records that have been damaged or destroyed
- Property belonging to someone else that is accidentally damaged

### **From what types of third party actions will my Business Owners Policy (BOP) protect me?**

- Some accounts receivable may be insured if you are unable to collect outstanding balances as a result of lost or damaged account records.
- You will be protected against customers who pay with counterfeit money orders or currency.
- Your business' property will be protected while it is away from the principal business location, such as during an order delivery.
- You will be protected against business income interruption. A BOP would cover your business if something happens that causes a suspension of your business activities, such as a third party strike and/or if your business was forced to close down for an extended period of time.

## Commercial Umbrella

The **commercial umbrella**, or **excess liability** policy provides coverage in addition to the limits of an insured's BOP or Commercial General Liability policy. The umbrella increases the underlying policy limits and is secondary to the underlying policy. The umbrella can be primary in certain situations such as worldwide coverage and non-owned aircraft liability.

Principal features of most Umbrella policies typically consist of the following:

- World-wide coverage;
- Personal Injury coverage;
- Blanket Contractual Liability coverage for both written and oral contracts;
- Care, Custody and Control coverage;
- Non-owned Aircraft Liability;
- Watercraft Liability;
- Advertisers Liability;
- Liquor Law Liability;
- X. C. U. Liability; and
- Automatic coverage for additional insureds

When a loss is not covered by an underlying policy, a high Self Insured Retention typically applies. The SIR will often be from \$10,000 to \$25,000.

A common gap in umbrella coverage occurs in property or personal injury claims where non-owned autos used in the operations of an insured's partnership or joint venture are involved when the business has not been named as an additional insured on the auto policy. (Mr. Business owner uses his personal car but has not named the business as an additional insured on his personal policy and the business has no Hired Non-Owned coverage provision.)

Producers and customers should carefully compare underlying policies to the coverages in the umbrella. Gaps in coverage should be discussed with the umbrella policy underwriter.

Failure to maintain underlying coverage may enable the umbrella carrier to deny coverage.

### **Directors and Officers Coverage**

The directors and officers of a corporation or other business entity, whether publicly traded or privately held, hold highly visible positions of great fiduciary responsibility. **Directors & Officers (D&O) Liability Insurance** covers the litigation costs and damages resulting from such lawsuits. Generally designed to help protect both the assets of the company and the personal assets of the individual, D&O Insurance normally covers liabilities that arise when an individual or group acts in the capacity of a director or an officer of the firm.

## (Section 4.4)

### Commercial Coverage Review

A **fiduciary** is expected to be extremely loyal to the person they owe the duty (the "principal")

"**insurance agent**" means any authorized or acknowledged agent of an insurer... who acts as such in the solicitation of, negotiation for, or sale of, an insurance, health maintenance organization or annuity contract.

"**insurance broker**" means any person, firm, association or corporation who or which for any compensation, commission or other thing of value acts or aids in any manner in soliciting, negotiating or selling, any insurance or annuity contract or in placing risks or taking out insurance, on behalf of an insured other than himself, herself or itself or on behalf of any licensed insurance broker.

An **admitted insurance company** is one that has applied for authority to conduct business within a state. In addition, it will comply with all of the dictates of that state including maintaining sufficient reserves, subjecting itself to tax laws, and abiding by the mandates of that state's Insurance Department regulations. That state will issue an official accreditation - known as a Certificate of Authority – to the admitted insurance company.

A **non-admitted insurance company** must comply with the basic operating mandates of the state in which it does business, but does not seek Certification of Authority. It may want to solicit only certain classes of business but does not want to comply with the regulations of the state relating to maintaining reserves, residency, and tax regulations of the state.

The **Excess Lines Association of New York, (ELANY)** regulates non-admitted insurance business in New York State

**Risk Retention Groups (RRG)** are federally authorized under the Liability Risk Retention Act.

**Group Self-Insured Trusts** are an alternative mechanism for workers compensation.

A **Commercial General Liability (CGL)** Policy provides coverage for the insured in the event a third party suffers an injury because of business activities of the insured.

A **Commercial Package Policy (CPP)** combines Property and General Liability insurance products into one package.

A **Business Owners Policy (BOP)** also combines Commercial Property and General Liability insurance coverages into one convenient package for businesses of similar nature.

A **commercial umbrella, or excess liability** policy provides coverage in addition to the limits of an insured's BOP or Commercial General Liability policy.

**Directors & Officers (D&O) Liability Insurance** covers the litigation costs and damages for officers and directors of for profit and not for profit companies.

Adjusting

Chapter 5

**(Section 5.1)**

**Claims and Adjusting**

Since the first insurance policy was issued thousands of years ago, there has been a need to reach agreement between insurer and insured following an insured's loss. When disputes arise, the Court has been the arena of settlement as far back as the business of insurance can be documented. As the business of insurance modernized in the 19<sup>th</sup> and 20<sup>th</sup> centuries, the process of settling claims became a large part of the insurance industry with those arranging settlement of claims becoming known as **Adjusters**.

The insurance system of the 21<sup>st</sup> century has three types of adjusters that industry professionals should know; **Staff Adjusters, Independent Adjusters** and **Public Adjusters**. Staff and Independent adjusters work for insurers. Only Public Adjusters work exclusively on behalf of the insured. Independent adjusters can work for any insurance company as a freelance agent.

Most insurance consumers who suffer an insured loss will deal either directly with a staff adjuster who is employed solely by their insurance carrier, or sometimes with an Independent Adjuster hired by their carrier, to arrange for their claim to be settled. In most situations, the claim of loss reported will result with satisfactory settlement between the parties.

Consider the owner of an automobile with "full glass" coverage on their vehicle. If a stone from the road is picked up and hits their windshield, the insurer will pay the full cost of replacing the windshield, leaving the insured fully compensated for their loss.

In this scenario the carrier has paid for the review of the loss and worked with the insured to arrange for repair of all damage, completing the "adjusting" process. The claim most likely is processed by a Staff Adjuster.

In a more complex example, an insurer may hire an Independent Adjuster to evaluate a claim and arrange a settlement proposal with the insured.

A policy owner is involved in an auto accident while traveling in another state. With their insurance carrier not doing business in that state, a local Independent adjuster will be hired by the insurer to evaluate the damage and arrange a repair estimate.

Public adjusters are typically hired in situations where the extent of loss is significant or when the settlement proposed by the insurer is deemed by the insured to be less than their responsibility for the loss claimed.

A business owner suffers a loss due to a roof leakage. The leak damages inventory, building structure, telephone and computer system and causes a sustained work stoppage for employees as well as delays in product deliveries to customers.

The carrier will have a staff and/or independent adjuster work to evaluate the losses sustained. However, the client may choose to employ a Public Adjuster to expedite their claims, obtain a more satisfactory claim recovery, more quickly and completely restore their business operations, and insulate themselves from the stress of engaging in an adversarial process.

Public Adjusters are licensed to handle all claims of loss to property against an insured's insurance company, including contingent expenses, such as loss of use, business loss of income, and other expenses.

The Public Adjuster's main responsibilities are to:

- Evaluate existing insurance policies in order to determine what coverage may be applicable to a claim
- Research, detail, and substantiate damage to buildings and contents and any additional expenses
- Evaluate business interruption losses and extra expense claims for businesses
- Determine values for settling covered damages
- Prepare, document and support the claim on behalf of the insured
- Negotiate a settlement with the insurance company on behalf of an insured with the insured's consent.

There are a number of rules which public adjusters must adhere to in New York State that are of importance to insurance producers. Notable among them are the **prohibition from soliciting business between the hours of 6pm and 8am**. This prohibition extends to non-licensed individuals such as fire fighters and other emergency service providers. In addition, adjusters are prohibited from sharing commissions and fees with non-licensed individuals. Adjusters who are also employed or volunteer as fire fighters are required to adhere to the standards established and should refrain from distributing business cards or offering other types of referrals during these prohibited hours of solicitation.

In New York State, Public Adjusters in New York State **charge a percentage of the settlement**, with the percentage capped at **12.5%**, but subject to negotiation.

Public Adjusters and insureds enter into agreements in the form of **retainers**. **Regulation 10** requires retainer agreements to contain cancellation clauses which are clear and of minimum size (10 point font). Insureds have a **right to cancel retainer agreements within 3 days**, excluding Sundays, with no obligation to the Public Adjuster. Insureds can also cancel their retainer at any point in the claims process with responsibility for payment of services performed by the public adjuster up to that point in time.

The following "**Opinion**" from the Office of General Counsel illustrates a scenario wherein a public adjuster excluded or otherwise obscured the cancellation clause of a retainer agreement, thus violating Regulation 10.

***New York Department of Financial Services***

The Office of General Counsel issued the following opinion on December 22, 2003, representing the position of the New York State Insurance Department.

***Re: Public Adjuster Retainer Agreements and Regulation 10.***

**Questions Presented:**

1. Do the retainer agreements violate N.Y. Comp. Codes R. & Regs. tit. 11, §§ 25.1-25.13 (Regulation 10)?
2. If so, do these violations have the effect of rendering the agreements null and void?
3. Is there a private right of action under N.Y. Comp. Codes R. & Regs. tit. 11, §§ 25.1-25.13 (Regulation 10)?

**Conclusions:**

1. Yes, the retainer agreements violate N.Y. Comp. Codes R. & Regs. tit. 11, §§ 25.1-25.13 (Regulation 10).
2. The question of whether the retainer agreements are valid and enforceable, notwithstanding the violations of Regulation 10, is a question that would be more appropriately addressed by a court of competent jurisdiction.
3. While there may be no private right of action under Regulation 10, there is nothing in the New York Insurance Law that would prevent an individual from bringing an action under the retainer agreements themselves.

**Facts:**

The inquirer stated in his inquiry that his parents Mr. and Mrs. I owned premises located in Brooklyn, New York, which sustained a fire on December 25, 2000. Mr. PA, a New York State licensed public adjuster, entered into a retainer agreement with Mr. and Mrs. I to adjust certain claims relative to the property damage. Although Mrs. I is named in the retainer agreement, she did not sign the agreement. The agreement was signed solely by Mr. I. Pursuant to this retainer agreement, Mr. PA filed a claim with an insurer in regard to the fire loss. Mr. PA later made a separate claim for water damage, in case the insurer considered such damage separate and distinct from the fire. As per Mr. PA's request, Mr. I entered into another retainer agreement with Mr. PA in regard to the second claim. Mr. I subsequently submitted a claim for loss of rent without the assistance of Mr. PA.

In response to the claims, the insurer agreed to pay approximately half of the amounts submitted by Mr. PA. Many months passed and nothing was being done to settle the claims. Thereafter, in or around February 2002, after several calls from Mr. I and the inquirer, the insurer agreed to make partial payment on the policy for the undisputed amount of \$112,012.04, of which \$6,720.72 was paid to Mr. PA.

Mr. I did not believe that Mr. PA fully procured the settlement of the undisputed amount without the intervention of Mr. I and was thus not entitled to full compensation. Nor was he entitled to compensation on the loss of rent claim. Since the insurer would not provide payment any other way, Mr. I was required to request two separate checks. One check consisted of a 6% compensation to Mr. PA payable to Mr. and Mrs. I and Mr. PA. The second check was payable only to Mr. and Mrs. I for the balance of the claim.

In conjunction with the payment of the undisputed amount, the insurer demanded an appraisal of the property and refused to pay any additional amount on the claim until after the appraisal was completed. Problems occurred at the appraisal level in part because of Mr. PA's selection of an appraiser. Mr. I attempted to resolve the open issues without the help of Mr. PA. Many months passed with no action on either side.

In or around January 2003, Mr. I independently retained an attorney to file suit and settle the matter with the insurer. The attorney successfully obtained a settlement of the remainder of the claim, in the amount of \$53,500. Since Mr. PA is or was a client of the same law firm, he learned of the retention of counsel and submitted a letter asserting a lien on 6% of the proceeds obtained by the attorney. Like the insurer, the law firm refused to release the full amount of the funds to Mr. and Mrs. I unless a percentage of the proceeds was paid to Mr. PA. The inquirer provided a letter, with his inquiry, that was written by Mr. I which authorized the attorney to pay Mr. PA \$2,220, but noting that such payment was being made under protest.

**Analysis:**

**Question No. 1**

Section 25.9(b) of Regulation 10 provides that, "at the time the insured signs the compensation agreement, a completed form, in duplicate, captioned "Notice of Cancellation" shall be attached to the compensation agreement and easily detachable." This form must consist of, in not less than 10-point boldface type, substantively the information and statements contained in Form 2 contained in section 25.13(b) of Regulation 10.

Section 25.13(b) Form 2 provides, in pertinent part, as follows:

If you cancel, any payments made by you under the agreement and any negotiable instrument executed by you will be returned within ten business days following receipt by the public adjuster of your cancellation notice and any security interest arising out of the transaction will be cancelled. . . .

A review of the subject retainer agreements reveals that the public adjuster omitted the language required in Section 25.13(b) of Regulation 10 regarding the return of any payments made by the insured upon cancellation of the retainer agreement. In contrast, the retainer agreements provide that if the insured exercises his or her right to cancel the agreement within three business days of signing the agreement, the insured will be liable for expenses incurred during the three-day period. This language violates Section 25.10 of Regulation 10, which clearly states that the public adjuster shall not be entitled to any compensation for any services performed pursuant to a compensation agreement prior to its cancellation in accordance with Section 25.8 of the Regulation. Moreover, the agreement does not comply with the express requirement that the information on the Notice of Cancellation form appear in 10-point boldface type.

The inquirer should also be aware that Section 25.6(a) of Regulation 10 provides, in relevant part, as follows:

(a) A public adjuster may be compensated by an insured for or on account of services rendered to such insured by the public adjuster solely as provided for by a written compensation agreement obtained by the public adjuster which shall consist of substantively the same information and statements found in Form 1 in Section 25.13(a) of this Part.

Thus, a public adjuster may be compensated only in accordance with the terms of a retainer agreement that substantively contains the same information and statements as Form 1 of Section 25.13(a) of the Regulation. The subject retainer agreements include a statement assigning and authorizing direct

payment of the 6% fee to the public adjuster. This language violates Section 25.13 of Regulation 10, which does not provide for the inclusion of such an assignment and authorization in the retainer agreement.

Section 25.12 of Regulation 10 provides as follows:

When a claim is settled where the insured is represented by a public adjuster, upon the request of the insured, the insurer's check may be made payable to both the public adjuster and the insured or to the public adjuster named as payee, but not in excess of the amount of the public adjuster's fee, as indicated in the written compensation agreement signed by the insured and filed with the insurer. The balance of the proceeds shall be made payable to the insured or loss payee, or both, whichever is appropriate.

In accordance with this provision, upon the request of the insured, the insurer's check may be made payable to both the public adjuster and the insured or solely to the public adjuster. This provision was intended to give the insured the right to refuse to authorize payment of the adjuster's fee. Whether the insurer pressured Mr. I to authorize payment to the public adjuster and therefore acted inappropriately is a question of fact that can not be resolved in this opinion.

#### Question No. 2

While it is clear that the retainer agreements violate Regulation 10, the materiality of these violations and the question of whether the agreements remain valid and enforceable notwithstanding these violations, is a separate question that would be more appropriately addressed by a court of competent jurisdiction.

#### Question No. 3

The inquirer stated in his inquiry that, although he could not locate any case law that states whether there is a private right of action under Regulation 10, courts have held that there is no private right of action for consumer protection regulations. For example, courts have consistently held that there is no private right of action under N.Y. Ins. Law § 2601 (McKinney 2003), which deals with unfair claims settlement practices.

Typically, courts do not construe the Insurance Law as providing for a private right of action, in the absence of express language authorizing such enforcement. McKinnon v. International Fidelity Ins. Co., 182 Misc. 2d 517, 704 N.Y.S.2d 774 (Sup. Ct. New York County 1999); See, eg. Rocanova v. Equitable Life Assur. Society, 83 N.Y.2d 603, 634 N.E.2d 940, 612 N.Y.S.2d 339 (1994). There is nothing in Regulation 10 or the statutes enabling its promulgation that indicates that individuals have a private right of action to sue thereunder. However, the New York Insurance Law does not prevent an individual from bringing an action under a contract on the ground that it was illegally made.

Lastly, the inquiry and this opinion were referred to our Consumer Services Bureau for further investigation regarding the conduct of the insurer and public adjuster in this matter. The inquirer was directed to independently seek guidance from the appropriate licensing authorities regarding the conduct of the attorney.

For further information you may contact Senior Attorney Pascale Joasil at the New York City Office.

(Section 5.2)

**Claims and Adjusting Review**

**Staff** and **Independent Adjusters** work for insurers.

**Public Adjusters** work exclusively on behalf of the insured.

**Public Adjuster** responsibilities include:

- Evaluate existing insurance policies in order to determine what coverage may be applicable to a claim
- Research, detail, and substantiate damage to buildings and contents and any additional expenses
- Evaluate business interruption losses and extra expense claims for businesses
- Determine values for settling covered damages
- Prepare, document and support the claim on behalf of the insured
- Negotiate a settlement with the insurance company on behalf of an insured with the insured's consent.

In New York State, Public Adjusters in New York **charge a percentage of the settlement**, with the percentage capped at **12.5%**, but subject to negotiation.

Public adjusters are **prohibition from soliciting business between the hours of 6pm and 8am**.

## Life Insurance

### Chapter 6

#### (Section 6.1)

#### **Life Insurance History in America**

It has been shown that the earliest marine insurance policies contained provisions for life and accident insurance. Compensation to injured sailors or their family was understood as an important consideration in the dangerous business. This text also has shown other “**benefit societies**” and “**guilds**” providing death benefits for centuries, even millennia. The business of life insurance has slowly developed into the industry we know today.

The modern life insurance policy in America has direct lineage to Presbyterian Ministers in the early 1700’s. Records from the Presbyterian Ministers Fund show an organized effort in 1729 for the purpose of providing assistance to ministers and their families. In 1759 the success of the Fund led to the formation of **The Corporation for Relief of Poor and Distressed Presbyterian Ministers and of the Poor and Distressed Widows and Children of Presbyterian Ministers**. According to the Historical Society of Pennsylvania, this was the first Life Insurance company and among the first to “broach the idea of offering life insurance to all human beings” including women.

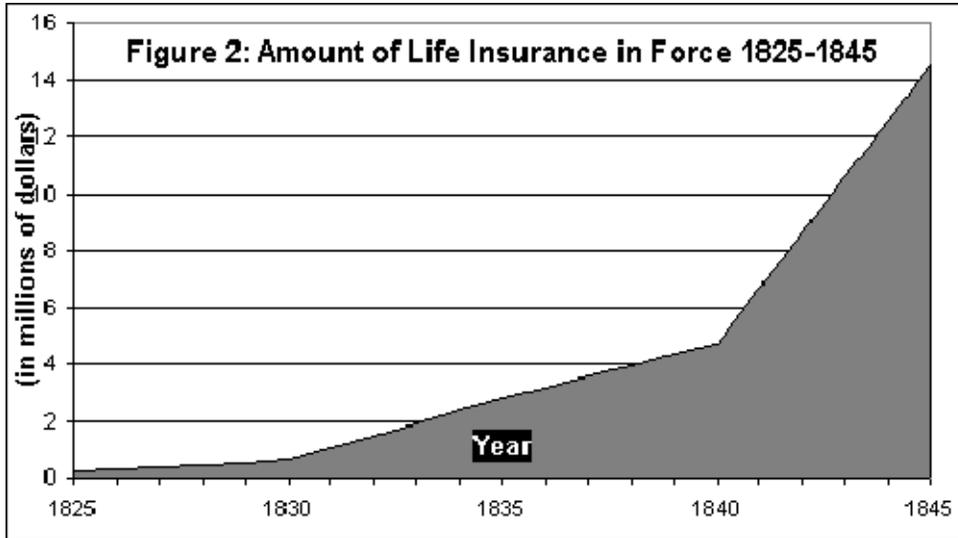
Life insurance was slow to grow in popularity during the early 19<sup>th</sup> Century. While none of the relatively few life insurance companies failed in the early part of the Century, no company saw strong growth either. Viviane Zelzar speculated that puritan views remained strong among the general public who viewed placing value on an individual’s death was tempting death.

“putting death on the market offended a system of values that upheld the sanctity of human life and its incommensurability”

Zelzar: Human Values and the Market: The Case of Life Insurance and Death in 19<sup>th</sup> Century America. (American Journal of Sociology Nov., 1978)

A number of factors, including urbanization, favorable legislative actions changes in marketing approaches helped to improve the distribution of life insurance in the 1830’s and 1840’s.

Despite this tentative start, the life insurance industry did make some significant strides beginning in the 1830s [Figure 2]. Life insurance in force (the total death benefit payable on all existing policies) grew steadily from about \$600,000 in 1830 to just under \$5 million a decade later, with New York Life and Trust policies accounting for more than half of this latter amount. Over the next five years insurance in force almost tripled to \$14.5 million before surging by 1850 to just under \$100 million of life insurance spread among 48 companies. The top three companies – the Mutual Life Insurance Company of New York (1842), the Mutual Benefit Life Insurance Company of New Jersey (1845), and the Connecticut Mutual Life Insurance Company (1846) – accounted for more than half of this amount.



Sharon Ann Murphy – [eh.net/encyclopedia/life-insurance-in-the-united-states-through-world-war-i/](http://eh.net/encyclopedia/life-insurance-in-the-united-states-through-world-war-i/)

Perhaps the most significant impediment to growth in sales of life insurance was the status of women under existing law. Women were prohibited from entering contracts on their own and were not considered to have an “**insurable interest**” in their husband’s life. (Insurable Interest is the provision that the insured be in a position to lose money at the time of a loss.) There was a movement to change this practice and legislatures began to view life insurance as a remedy to the destitution of widows and orphans. Chapter 80 of the New York Laws of 1840, *An Act in respect to insurance for lives for the benefit of married women*, gave the right to women to enter into a contract of life insurance on her husband with benefits paid without claim by his creditors or any other party. Other states soon followed and insurance companies saw rapid growth in sales.



Another significant development in the 1840's was the introduction of **mutual companies**. (A company owned and controlled by its policyholders. Mutual insurance companies issue participating policies.) The economy of the United States suffered a financial panic in 1837 following a period of economic growth and land speculation west of the original colonies. A Federal fiscal policy, instituted by outgoing President Andrew Jackson in 1836 known as Specie Circular, required new land purchases in western territories to be financed with gold or silver, rather than credit.

President Andrew Jackson's "hard" money policies, especially the 1836 Specie Circular that aimed to stabilize what Jacksonians saw as an out-of-control economy by requiring that all purchases of federal land be made with precious metal (i.e. "hard" money) rather than paper ("soft") money, only exacerbated the credit crunch.

*<http://millercenter.org/president/biography/vanburen-domestic-affairs>*

English banks, which were greatly invested into the United States, suffering their own domestic financial problems, increased interest rates on loans to US banks. The combination of these actions in turn caused domestic banks to tighten monetary policies. Businesses ran short on cash and as stock values decreased consumers lost faith in the traditional banking system as well as investment into stock companies. **Mutual companies**, with smaller initial capital requirements than stock companies, offered the average person a comfort in knowing that excess profit would be returned to them as **dividends**, not to stockholders.

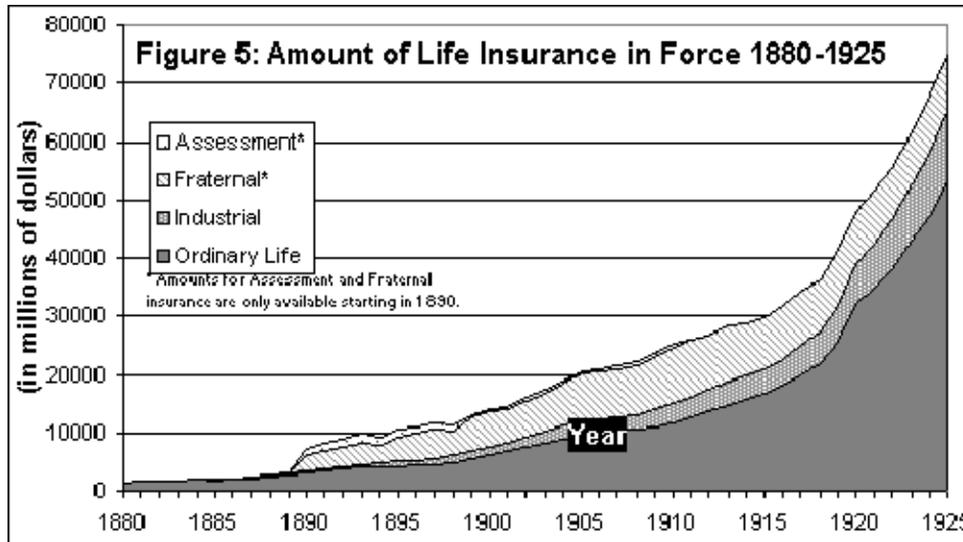
The Mutual Company concept was not enough on its own to create the drastic increase in life insurance sales, which occurred between 1840 and 1845. The sale of life insurance policies prior to 1840 had taken place primarily in the office of an attorney or banker, with little advertising or other promotion. The changing face of the workforce from family farm dominance to industrialized and urbanized economy brought in an era of advertising by pamphlet, magazine and door-to-door sales through soliciting agents.

Although life insurance sales increased in the 1840's, the industry saw irregular growth as regulation, the Civil War and economic instability continued for decades. Insurance companies entered the market and frequently lasted on a few years before folding. Companies continued to innovate in hopes of gaining customers and avoiding failure. Among the product introductions, which seemed to provide opportunities for growth were "**Industrial Life**" products. Industrial life policies had a low premium and relatively low benefit and were targeted to the laboring community. Although insurance companies in England sold industrial insurance, it was not until 1880 that Metropolitan introduced the first policies to the United States.

In 1879, MetLife President Joseph F. Knapp turned his attention to England, where "industrial" or "workingmen's" insurance programs were widely successful. American companies had not bothered to pursue industrial insurance up to that time because of the expense involved in building and sustaining an agency force to sell policies door to door and to make the weekly collection of five- or ten-cent premiums.  
[www.metlife.com](http://www.metlife.com)

**Note: (Industrial Life Insurance is no longer sold in New York State due to the low benefit provided, which generally was less than \$1000, and the small weekly or monthly premium. In addition, the premium cost was considered less beneficial than other life insurance products available.)**

The sales agents made weekly rounds to collect premiums, often earning a commission of 15% of total collected. The premium was referred to as a "debit" giving these agents the name "**debit agents**". The weekly rounds introduced agents to clients, their families and their neighborhoods and helped to build the insurance industry at the turn of the 19<sup>th</sup> Century.



Sharon Ann Murphy

**Group Life Insurance** was introduced by the **Equitable Life Assurance Society** in **1922** when they wrote a policy for the 125 employees of the **Pantosote Leather Company**. The policy did not require medical examinations nor did it require an application from each individual employee. Within a decade more than 29 companies would offer group life policies with “over a half billion dollars’ worth of life insurance in force”. (Murphy)

Following the World War II the American economy boomed and the demand for future security for family and retirement continued to grow. The multi-generational household that built the nation was quickly diminishing as agriculture mechanized and the family car allowed for the massive development of suburbs, further expanding the use of life insurance. Life insurance companies continued to develop new approaches to marketing, from fraternal and religious organizations, to door-to-door salesmen, and direct to the consumer over the internet in their effort to reach new customers. Insurers also modified their existing products to meet changing consumer demands.

All insurance companies can be classified either as **Participating** or **Non-Participating**.

Under a *Participating* Policy, the policyholder receives a portion of the earnings of the company in which he is insured. He shares in the divisible surplus of the company by means of an annual dividend in proportion to his policy’s contribution to that surplus. The amount of divisible surplus is subject to State regulation.

Under a *Nonparticipating* Policy, the policyholder does not share in the profits of the insurance company, i.e., the policyholder does not receive dividends. Nonparticipating Policies are issued with a guaranteed Premium Rate.

#### **Werbel Life Insurance Primer**

There have continued to be two major categories of life insurance, **Term** and **Whole Life/Permanent**, although countless variations on these two forms and insurance have been developed.

#### **Term**

Term Insurance is the simplest form of life insurance. It pays only if death occurs during the term of the policy, which is usually from one to 30 years. Most term policies have no other benefit provisions.

#### **Whole Life/Permanent**

Whole life or permanent insurance pays a death benefit whenever you die—even if you live to 100! There are three major types of whole life or permanent life insurance—traditional whole life, universal life, and variable universal life, and there are variations within each type.

<http://www.iii.org/article/what-are-principal-types-life-insurance>

In discussing life insurance, there are several concepts to understand, even with the most basic policies. While the general understanding of providing a benefit to surviving family may be common knowledge, life insurance policies may also be purchased by non-related individuals with no benefit paid to the insured's family, as is the case with a **Key Man** policy taken out by a business on the life of a valuable employee. The life of a child can also be covered with a **Juvenile life** policy or **Endowment** policy often used to save for a child's wedding or education.

Every policy has an **owner**, an **insured** and a **beneficiary**. In order for the policy to be valid, the contract must involve an **offer and acceptance** by two or more parties and there must be **consideration** or payment of premium.

**Beneficiary** – A person(s) or other entity designated to receive specified cash payment(s) in the event of the insured's death.

**Insurable Interest** – Relationship between the Beneficiary or Owner and the Insured, i.e., a blood relationship, marriage, or economic dependence.

**Policy Owner** - The person who has ownership rights in an insurance policy, usually the policyholder or insured.

Since the temptation to collect the proceeds from a life insurance policy, regulators hold the “**insurable interest**” provision to a high standard. Throughout history abuses of life policies have been well understood and documented. The once popular **Tontine** policy provided such sufficient incentive to hasten an insured's death that it is banned in most of the world today. The tontine is a scheme where a group of individuals invest into a fund with each subscriber's share surrendered to the pool upon their death, until single sole remains who inherits the pool.

Insurance Law § 3205 The statute defines “insurable interest,” and sets forth the standards for determining where an insurable interest exists. The statute provides, in relevant part, as follows:

(a) In this section:

(1) The term, "insurable interest" means:

(A) in the case of persons closely related by blood or by law, a substantial interest engendered by love and affection;

(B) in the case of other persons, a lawful and substantial economic interest in the continued life, health or bodily safety of the person insured, as distinguished from an interest which would arise only by, or would be enhanced in value by, the death, disablement or injury of the insured.

\* \* \* \*

(b) (1) Any person of lawful age may on his own initiative procure or effect a contract of insurance upon his own person for the benefit of any person, firm, association or corporation. Nothing herein shall be deemed to prohibit the immediate transfer or assignment of a contract so procured or effectuated.

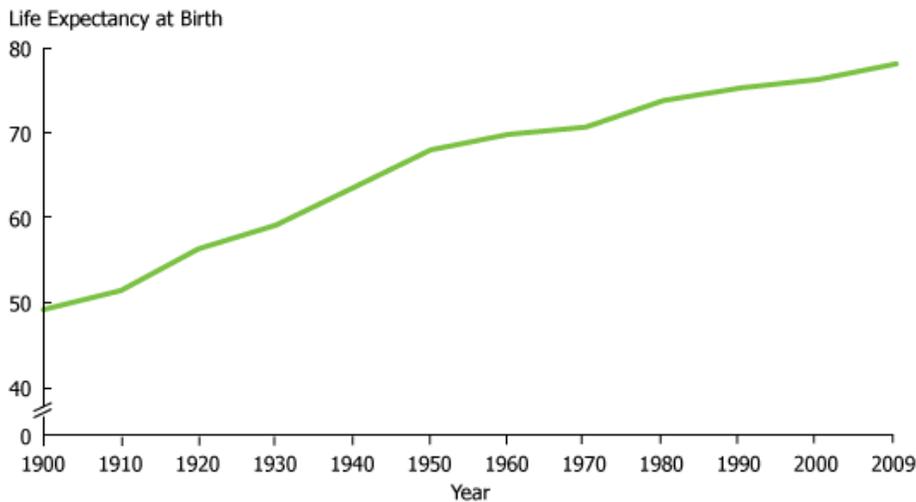
(2) No person shall procure or cause to be procured, directly or by assignment or otherwise any contract of insurance upon the person of another unless the benefits under such contract are payable to the person insured or his personal representatives, or to a person having, at the time when such contract is made, an insurable interest in the person insured.

(3) Notwithstanding the provisions of paragraphs one and two of this subsection, a Type B charitable, educational or religious corporation formed pursuant to paragraph (b) of section two hundred one of the not-for-profit corporation law, or its agent, may procure or cause to be procured, directly or by assignment or otherwise, a contract of life insurance upon the person of another and may designate itself or cause to have itself designated as the beneficiary of such contract.

## (Section 6.2)

### Annuities

Providing a guarantee of financial support to surviving family is the principal purpose of life insurance policies. Individuals make premium payments throughout their working life in anticipation of an ultimate end which we all face. The prospect of living beyond our working years however presents an entirely different set of challenges for individuals. Long life is not a new phenomenon, although life expectancy has continued to increase dramatically in the past 100 years.



National Center for Health Statistics, 2010

Throughout all recorded history we find examples of payment schemes to assist with living expense in late life or retirement. The payment of income in the form of an **annuity**, or a fixed sum annually clearly was used by wealthy members of society for millennia. CF Trenerry discusses the use of “annuity values known as Ulpian’s Table” dating to 225 AD in *The Origin and Early History of Insurance*. Annuities have stood out as specific financial vehicles, separate from life insurance and distinct from investments in property or other business interests.

We have before us the definition given by Sir Edward Coke (born 1552; died 1633). During his incumbency as Lord Chief Justice of the King's Bench, 1613-1620, he defined an annuity as "a yearly payment of a certain sum of money granted to another in fee, for life or years, charging the person of the grantor only." There are scores of definitions by our American courts which hark back to the one given by Coke.

*THE EARLY HISTORY OF THE ANNUITY BY EDWIN W. KOPF*

The **Tontine** was in and out of favor for centuries as well. More generalized and roundly supported were military pensions, in the form of an annuity, for soldiers and their families, also dating to the early Roman era and reintroduced during the Civil War. Annuities have been used in various forms since the Presbyterian Ministers.

During the Civil War, many annuities were awarded by the United States to military members in lieu of land ownership. The idea was supported by President Lincoln prior to his death as a method of assisting injured or disabled military personnel. After the Civil War, then President Grant rescinded many of these annuities on the grounds that the benefits far outweighed the contribution. A legal battle ensued and the Supreme Court heard the case a few years later and restored the benefits.

<http://www.annuity.com/the-glorious-history-of-annuities/>

1. At retirement, a variable annuity generates the annuitant monthly income for life.
2. Generally, the assets of a variable annuity separate account are invested primarily in common and preferred stock.
3. During a severe business recession variable annuity income is likely to decrease.

Today, annuities are **Fixed, Indexed** or **Variable**. A fixed annuity is a contract between the customer, or Annuitant, and an insurance company wherein the company agrees to pay the annuitant a specific rate of interest for a specific amount of time, known as accumulation phase, followed by periodic payments for a specified period of time. The annuitant can rely on an exact dollar amount for an exact timeframe. Indexed annuities provide accumulation based on investment performance, generally an index of investments such as the S&P 500, where growth may exceed that of a fixed annuity, although they likely will not be less than a minimum return regardless of the performance of the indexed investment. Variable annuities are more specifically tied to investments selected, typically mutual funds, and return to the annuitant is considered a higher risk than fixed or indexed products. Variable annuities and most indexed annuities are considered Securities, therefore their sales are regulated by the **Securities Exchange Commission (SEC)** requiring specific licensing.

Annuities have several payment options general categorized as **immediate** or **deferred**. An immediate annuity is typically **single purchase payment** which will generally begin making payments within 12 months of premium payment, usually a **lump sum payment**. The payout will typically be a fixed amount annuity and may likely be for a **fixed period**. Deferred annuities start several years after an initial premium payment is made. The length of time between first payment and the start of disbursements allows for a greater accumulation period and provides a higher likelihood of increased return.

The number of payments from an annuity can vary significantly for a single lump sum to a fixed period of 10 or 20 years or can extend for the lifetime of the annuitant. Some annuity payments end with the death of the annuitant while others provide for a defined benefit to be paid to a named beneficiary.

#### ***Information for Prospective Life/Accident & Health Insurance Agents***

Life/accident & health agent licenses are issued pursuant to Section 2103(a) of the Insurance Law authorizing agents to solicit the lines of life, variable annuities, accident & health and travel accident for those insurers from whom an appointment has been submitted to the Department after the license has been issued.

The term for agent licenses is up to **two years**.

- INDIVIDUALS/TBA - Effective Date of Issued License to ***Date of Birth Expiration***: If you were born in an even numbered year, your license will expire on your birthday in an even numbered year. If you were born in an odd numbered year, your license will expire on your birthday in an odd numbered year.
- ENTITIES - July 1 to June 30 of odd numbered years.

The fee for a resident license is **\$80.00** for an individual/tba, or \$80.00 for each sub licensee of a partnership, corporation or limited liability company for a license issued for a period greater than one year and \$40.00 if issued for one year or less. For non-residents, see fee list for information regarding reciprocity and fee amounts.

To become licensed as a life/accident & health agent, an applicant must submit:

Apply electronically online or submit fully completed **[Application for Life/Accident & Health Agent](#)**.

Documentation of having successfully completed a Department approved prelicensing education course totaling not less than 40 hours of instruction

- Documentation of having passed, within two years immediately preceding the date of the Department's receipt of the application, the examination(s) prescribed by the Superintendent for the lines of insurance for which the license is sought (an applicant for the variable annuities line must also be licensed for the life line and must submit proof of having passed NASD series 6, 7 or 63 - non-residents must be licensed in their home state for variable annuities).
- An approved appointment from a sponsoring insurance company
- An electronic payment or check payable to the Superintendent of Insurance for the license fee

Exceptions:

- A person holding a Chartered Life Underwriter or Chartered Underwriter Associate Designation need not complete the 40 hours of prelicensing education or Part 1 of the qualifying examination but must take only Part 2 of the examination.
- A person who was licensed to sell the same lines of insurance who does not apply for a license within two years following the date of termination of his license must demonstrate current competency by retaking the qualifying examination but need not retake the 40 hours of prelicensing education.
- A person licensed as a life broker or life consultant may apply for a life/accident & health agent license to sell the same lines of insurance without repeating the education and examination requirement for those lines of insurance.
- A non-resident applicant (one who has declared a state OTHER than New York as their Home State. Home State is where you maintain a principal place of residence or business AND are licensed in good standing for the lines of authority being applied for in the application) may submit an application, an approved appointment, a Certification from the Department of Financial Services of the home state in lieu of the education and examination documentation, and a check in the amount of the home state fee or the New York fee, whichever is greater. (See fee list for information regarding reciprocity and fee amounts.)

Insurance producers are also responsible for understanding various aspects of insurance law and regulation. Misrepresentation, twisting, commission sharing and acting as broker versus agent are terms that must be understood and policies which must be adhered to.

A producer (Agent of Broker) who makes false statements about an insurance company or another producer may be guilty of **misrepresentation**.

A **misrepresentation** is a false statement on an application for a policy.

An **Agent** represents a particular company. An agent may share commission only with other agents of the same company.

A **Broker** represents the buyer. A broker may share commission with any other licensed broker. A broker may be held personally liable to its client for not acting with reasonable care, skill and diligence to obtain effective coverage. A broker has a duty to obtain the coverage requested by their client. Brokers often perform a variety of additional services for their client, such as processing claims and payments.

### (Section 6.3)

#### Pensions

In addition to group life insurance provided through employers, **defined benefit** retirement plans gained significant standing as a method to gain and retain quality employees in both the public/government and private employment sectors during the mid-20<sup>th</sup> century. Pensions allow employees to retire with sufficient income to maintain a consistent lifestyle and could be expected as part of many employment packages until the 1970's.

The 20<sup>th</sup> century pension is a plan established and maintained by an employer for the benefit of their employees and beneficiaries with a primary purpose being the provision of **definite and determinable benefits** for the employee, usually for life, once they retire.

The first private pension plan in the United States was established by American Express in 1875. By 1900, there were only 12 private pension plans in the Country. An examination of statistics from the late 19<sup>th</sup> century provides some explanation to the lack of pensions and other retirement savings among the general population. **Life expectancy** for a male at birth in 1900 was just 47 years, according to the National Vital Statistics Report, Volume 50. In addition, those surviving to 65 could expect to live an additional 12 years. Those living into their 60's and beyond generally continued to work until their death or very near death.

As was true on the farm, the need for retirement plans among these early factory pioneers was limited. Life expectancy at the turn of the 20th century was approximately 49 years at birth and about 12 years for those age 60. Workers continued to work for as long as they were able. Employer provided retirement benefits were rare—in fact, employer benefits of any type were uncommon. Benefits that did exist took the form of benevolent associations of workers, providing a common pool of funds to assist those in need due to death or disability. Often workers in a given location or industry were immigrants from the same country; the benevolent associations were their means of sticking together and helping their fellow immigrants. Those who did leave the workforce, typically because they were no longer able to work, survived on the generosity of their friends and neighbors, their church, or similar charitable assistance.  
**William J. Wiatrowski: Changing retirement age: ups and downs**

The expansion of Pensions in the early 20<sup>th</sup> century can be attributed several different developments, including changes in Federal Tax policies and the overall successes of the American economy. Perhaps the most significant boost to pensions was the **tax deduction available to employers**.

1913 – Congress enacts the first federal income tax law.

1914 – Although there is no explicit provision about pensions in the 1913 income tax law, the IRS rules that pensions paid to retired employees are deductible, similar to wages, as ordinary and necessary business expenses.

1919 – Over 300 private pension plans exist, covering approximately 15 percent of the nation's wage and salary employees. The growth of pension coverage is attributed to employers' desire to attract workers, reduce labor turnover, and "more [humanely] remove older, less productive employees."

1921 – The Revenue Act of 1921 exempts trust income coming from stock bonus or profit sharing plans from an employee's current taxable income. It also provides that trust income is taxed at the time that it is distributed to an employee, to the extent that this income has exceeded the employee's own contributions. The Revenue Act of 1921 also established that a profit-sharing or stock bonus plan must be established for the exclusive benefit of "some or all" employees.

1926 – The Revenue Act of 1926 exempts trust income coming from pension plans from an employee's current taxable income. This act also established that pension plans must be established for the exclusive benefit of "some or all employees".

**A Timeline of the Evolution of Retirement in the United States – Georgetown University 2010**

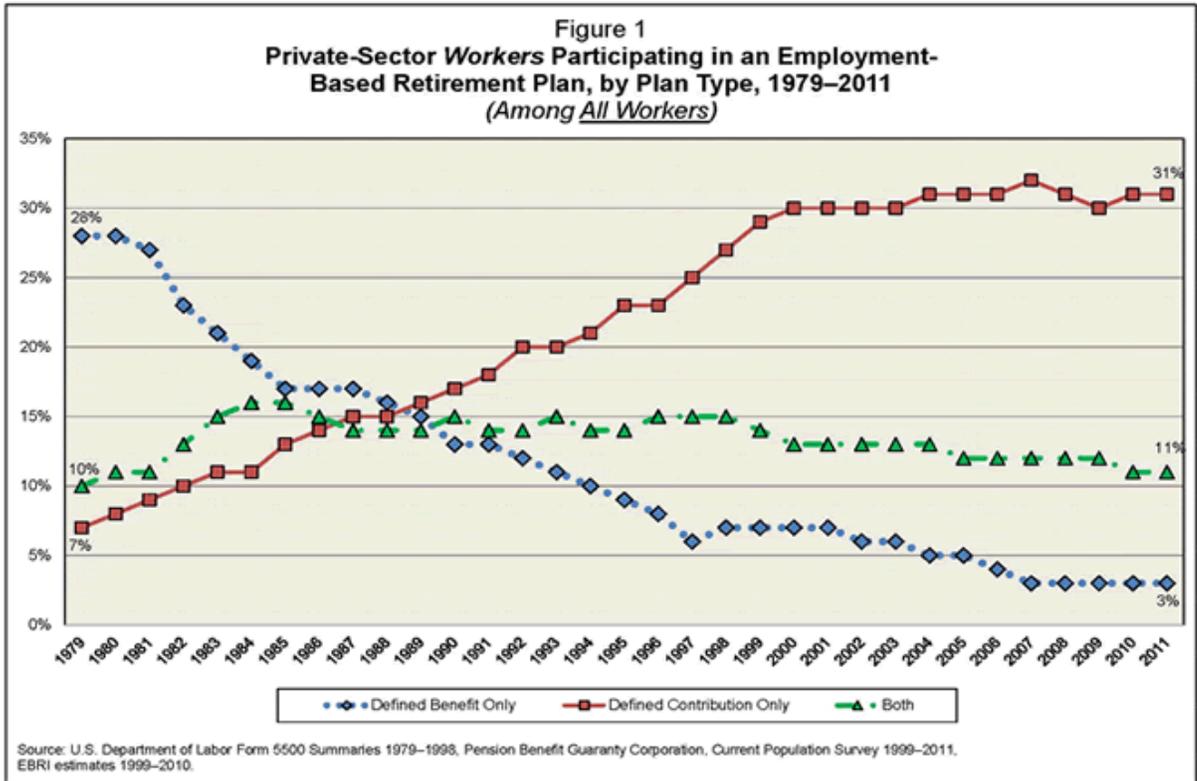
Through the 20<sup>th</sup> century, employers and employees became more educated with respect to tax policies and the **benefits of deferring tax on income until retirement**. Pension plans took full advantage of tax policies even as those policies evolved. **Qualified Pension Plans** are those that meet specific requirements of the Internal Revenue Service (IRS). In addition to being Qualified, pension plans may be **Defined Benefit Plans, Defined Contribution Plans, Target Benefit or Profit Sharing**.

- A. A Qualified Pension Plan is one that meets the requirements of the Internal Revenue Code. In nearly all cases, the plan has been submitted to, and approved by, the Internal Revenue Services. A Qualified Plan extends important tax advantages to both the employer and the plan participants.
- B. A defined Benefit Plan is a Pension Plan which provide predetermined benefits based on a formula. The benefit formula may be a flat benefit, a percentage of compensation or a unit benefit (years of service and percentage of compensation). The contribution to the plan is determined by actuarial calculations, and is an obligation of the Employer.
- C. A Defined Contribution Plan (sometimes referred to as Money Purchase Plan) provides for predetermined contributions (a flat dollar amount or a percentage of compensation). Pension benefits are based upon accumulation of monies and can only be estimated.
- D. A Target Benefit Plan is a Defined Contribution plan which has some of the features of a Defined Benefit plan. The primary one is that the amount of contributions is based on attaining a desired, certain benefit objective at retirement.
- E. Under a Profit Sharing Plan, an employer's profits (if any) are shared with participants. As a Qualified Plan, it enjoys most of the same tax advantages as a Pension Plan. Often, it has various purposes (in addition to retirement). Unlike Pension Plans, a Profit Sharing Plan may allow withdrawals prior to retirement. Since contributions are based on profits, the amount of benefits is far less certain for participants than in other Pension plans.

*Werbel*

Beginning in 1978 a new section **401 (k)** of the Internal Revenue Code provided for **Deferred Compensation Plans**. The 401k is a feature of a qualified profit sharing plan. A 401k allows employees as well as their employers to contribute part of their wages to individual accounts.

Since 1979, significant changes have occurred in the kind of employment-based retirement plan that workers participate in: Defined benefit plans have declined, while defined contribution plans have grown.



<https://www.ebri.org/publications/benfaq/index.cfm?fa=retfaq14>

**(Section 6.4a)**

**Regulation 60**

The Superintendent of the Department of Financial Services regulates the sale of life insurance products, including Annuities. Variable annuities are securities and are regulated by the Securities Exchange Commission (SEC). Fixed annuities are not securities and are not regulated by the SEC.

In New York State, a specific disclosure is required with the sale of life insurance and annuities. In 2015, the Department of Financial Services released the Third Revision of Regulation 60 which regulates the sale of life insurance and annuity products, including **disclosures when replacing a policy**. Agents and Brokers should review the update with their companies to ensure compliance with the most recent change.

**NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES THIRD AMENDMENT TO  
INSURANCE REGULATION 60**

**(11 NYCRR 51)**

**REPLACEMENT OF LIFE INSURANCE POLICIES AND ANNUITY CONTRACTS**

I, Benjamin M. Lawskey, Superintendent of Financial Services, do hereby promulgate the following Third Amendment to Part 51 of Title 11 of the Official Compilation of Codes, Rules and Regulations of the State of New York (Insurance Regulation 60) pursuant to the authority granted by Sections 202 and 302 of the Financial Services Law and Sections 301, 2123, 2403 and 4226 of the Insurance Law, to take effect 90 days after publication in the State Register, to read as follows:

**(MATTER IN BRACKETS IS DELETED; MATTER UNDERLINED IS NEW)**

**Section 51.1 Purposes.**

The purposes of this Part are to:

(a) [To] implement the New York Insurance Law [of New York] by regulating the acts and practices of insurers, insurance agents, insurance brokers and other licensees of the [Department of Financial Services] department with respect to the internal and external replacement of life insurance policies and annuity contracts[.]; and

(b) [To] protect the interest of the public by establishing minimum standards of conduct to be observed in the replacement or proposed replacement of life insurance policies and annuity contracts; by making available full and clear information on which an applicant for life insurance or annuities can make a decision in his or her own best interest; by reducing the opportunity for misrepresentation and incomplete comparison in replacement situations (commonly referred to as twisting); and by precluding unfair methods of competition and unfair practices.

**Section 51.2 Definitions.**

In this Part:

(a) [The term *replacement of a life insurance policy or an annuity contract* as used in this Part] Replacement of a life insurance policy or an annuity contract means, except as exempted in Section 51.3 of this Part, that new life insurance or new annuities are to be purchased and delivered or issued for delivery in New York and it is known to the department licensee that, as part of the transaction, existing life insurance policies or annuity contracts have been or are likely to be:

(1) lapsed, surrendered, partially surrendered, forfeited, assigned to the insurer replacing the life insurance policy or annuity contract, or otherwise terminated;

(2) changed or modified into paid-up insurance; continued as extended term insurance or under another form of nonforfeiture benefit; or otherwise reduced in value by the use of nonforfeiture benefits, dividend accumulations, dividend cash values or other cash values

(3) changed or modified so as to effect a reduction either in the amount of the existing life insurance or annuity benefit or in the period of time the existing life insurance or annuity benefit will continue in force;

(4) reissued with a reduction in amount such that any cash values are released, including all transactions wherein an amount of dividend accumulations or paid-up additions is to be released on one or more of the existing policies;

(5) assigned as collateral for a loan or made subject to borrowing or withdrawal of any portion of the loan value, including all transactions wherein any amount of dividend accumulations or paid-up additions is to be borrowed or withdrawn on one or more existing policies; or

(6) continued with a stoppage of premium payments or reduction in the amount of premium paid.

(b) [The term *sales material* as used in this Part] *Sales material* means any sales illustration prepared in accordance with Insurance Law section 3209 [of the Insurance Law] and any other policy or contract information used in the presentation to the applicant.

(c) [The terms *policy* and *contract* as used in this Part] *Policy or contract* shall include a certificate issued under a group policy or group contract.

### **Section 51.3 Exemptions.**

This Part shall not apply when:

(a) [The] the application for the new life insurance policy or new annuity contract is made to the same insurer that issued the existing life insurance policy or annuity contract [and a contractual conversion privilege is being exercised] or to any authorized life insurer in such insurer's holding company system, and the new life insurance policy or new annuity contract is being issued in accordance with the terms of a contractual conversion privilege in the existing life insurance policy or annuity contract or is being issued pursuant to a plan approved by the superintendent for the insurer to meet its obligations under Insurance Law section 3220(a)(6);

(b) [A] a policy change customarily granted by the insurer is being exercised, provided such change results in no additional surrender or expense charge or suicide or contestable restrictions, and only to the extent [such] that the change is approved by the [Superintendent of Financial Services] superintendent;

(c) [The] the new coverage is provided under:

(1) a group life insurance policy or group annuity contract, except when an insurance agent[,] or broker or insurer directly solicits the certificateholder for the new coverage and a portion of the premium or consideration is borne, directly or indirectly, by the certificateholder;

(2) an individual life insurance policy or individual annuity contract [whose] where the cost of the policy or contract is borne wholly by the applicant's employer or by an association of which the applicant is a member; or

(3) individual life insurance policies or individual annuity contracts covering employees of an employer, debtors of a creditor, or members of an association, that are distributed on a mass merchandising basis and administered by group-type methods, except when an insurance agent[,] or broker or insurer directly solicits the applicant for the new coverage and a portion of the premium or consideration is borne, directly or indirectly, by the applicant; or

(d) [The] the existing life insurance is a nonrenewable, nonconvertible term policy with five years or less to its expiration date.

**(Section 6.4b)**

**Section 51.4 Alternate procedures.**

[Procedures] An insurer may substitute procedures that are designed to meet the purposes of this Part, provided that:

(a) the procedures are approved in advance and determined by the [Superintendent of Financial Services] superintendent not to be detrimental to policyholders and contractholders[, may be substituted for this Part by an insurer where]; and

(b) (1) no sales agency force is used and the application is solicited and received by the insurer by mail or under other methods that are without insurance agent or broker involvement [. Any procedures approved by the Superintendent of Financial Services prior to the effective date of this Part must be resubmitted for approval.]; or

(2) the application is initially solicited by the insurer by mail or under other methods without insurance agent or broker involvement, and there is subsequent insurance agent or broker involvement limited to customer assistance or administrative support at the request of the customer, provided that an accurate and complete "Disclosure Statement" is signed by the insurance agent or broker and presented to the policy or contract holder in accordance with the provisions of this Part.

**Section 51.5 Duties of insurance agent and broker.**

Each insurance agent and broker shall:

(a) obtain with or as part of each application a completed "Definition of Replacement" in a form prescribed by the [Superintendent of Financial Services] superintendent and signed by the applicant and the agent or broker and leave a copy of such form with the applicant for [his or her] the applicant's records; and

(b) submit to the insurer along with each application a signed and completed "Definition of Replacement";

(c) where a replacement has occurred or is likely to occur:

(1) obtain with or as part of each application a list of all existing life insurance policies or annuity contracts proposed to be replaced;

(2) notify the insurer [whose] that issued the policy or contract that is being replaced and the insurer replacing the life insurance policy or annuity contract of the proposed replacement[.];

(3) [Submit] submit to the insurer [whose] that issued the policy or contract that is being replaced a list of all life insurance policies or annuity contracts proposed to be replaced, as well as the policy or contract number for such policies or contracts, together with the proper authorization from the applicant, and request the information necessary to complete the "Disclosure Statement" with respect to the life insurance policy or annuity contract proposed to be replaced. In the event that the insurer [whose] that issued the coverage that is being replaced fails to provide the information in the prescribed time, the agent or broker replacing the life insurance policy or annuity contract may use, and the insurer replacing the life insurance policy or annuity contract shall review and may accept, good faith approximations based on the information available;

[(3)] (4) present to the applicant, not later than at the time the applicant signs the application, the "IMPORTANT Notice Regarding Replacement or Change of Life Insurance Policies or Annuity Contracts" [and a completed "Disclosure Statement" signed by the agent or broker in the form prescribed by the Superintendent of Financial Services] and leave [copies] a copy of such [forms] form with the applicant for [his or her] the applicant's records;

[(4)] (5) have the applicant acknowledge that the “IMPORTANT Notice Regarding Replacement or Change of Life Insurance Policies or Annuity Contracts” [and the completed “Disclosure Statement” have] has been received and read; [and]

[(5)] (6) submit with the application to the insurer replacing the life insurance policy or annuity contract: a list of all life insurance policies or annuity contracts proposed to be replaced; a copy of [any proposal, including] the sales material, including the proposal used in the sale of the [proposed] life insurance policy or annuity contract; and proof of receipt by the applicant of the “IMPORTANT Notice Regarding Replacement or Change of Life Insurance Policies or Annuity Contracts”[; and the completed “Disclosure Statement”, including the primary reason(s) for recommending the new life insurance policy or annuity contract and why the existing life insurance policy or annuity contract cannot meet the applicant’s objectives.]; and

(7) prior to the delivery of the life insurance policy or annuity contract, submit to the insurer replacing the life insurance policy or annuity contract an accurate and complete “Disclosure Statement” signed by the agent or broker in the appropriate form prescribed in Appendices 10A or 10B to this Part. The statement shall specify the primary reasons for recommending the new life insurance policy or annuity contract and why the existing life insurance policy or annuity contract cannot meet the applicant’s objectives.

**(Section 6.4c)**

**Section 51.6 Duties of insurers.**

(a) Each insurer shall:

(1) inform and train its insurance agents and the insurance brokers that place business with the insurer with respect to the requirements of this Part;

(2) require with or as part of each application, a completed “Definition of Replacement” signed by the applicant and insurance agent or broker;

(3) maintain signed and completed copies of the “Definition of Replacement” [for six calendar years or until after the filing of the report on examination in which the transaction was subject to review by the appropriate insurance official of its state of domicile, whichever is later] in accordance with Part 243 of this Title (Regulation 152); and

(4) require with or as part of each application a statement signed by the insurance agent or broker as to whether, to the best of [his or her] the agent’s or broker’s knowledge, replacement of a life insurance policy or annuity contract is involved in the transaction.

(b) Where a replacement has occurred or is likely to occur, the insurer replacing the life insurance policy or annuity contract shall:

(1) require with or as part of each application a list prepared by the insurance agent or broker representing, to the best of [his or her] the agent’s or broker’s knowledge, all of the existing life insurance policies and annuity contracts proposed to be replaced;

(2) require with or as part of each application a copy of [any proposal, including] the sales material including any proposal, used in the sale of the [proposed] life insurance policy or annuity contract, and proof of receipt by the applicant of the “IMPORTANT Notice Regarding Replacement or Change of Life Insurance Policies or Annuity Contracts” [and the completed “Disclosure Statement”];

(3) prior to the delivery of the life insurance policy or annuity contract, require an accurate and complete “Disclosure Statement” signed by the insurance agent or broker in the form prescribed in Appendices 10A or 10B to this Part, including the primary reason or reasons for recommending the new life insurance policy or annuity contract and why the existing life insurance policy or annuity contract cannot meet the applicant’s objectives;

[(3)] (4) examine [any proposal used, including] the sales material, including any proposal, used in the sale of the [proposed] life insurance policy or annuity contract, and the “Disclosure Statement”, and ascertain that they are accurate and meet the requirements of the Insurance Law and [this Part] regulations promulgated thereunder;

(5) deliver the completed “Disclosure Statement” to the policy or contract holder no later than the time of delivery of the policy or contract. The insurer may, at its discretion, require the “Disclosure Statement” to be signed by the applicant, a copy of which shall be provided to the applicant at the time the applicant signs the “Disclosure Statement”;

[(4)] (6) within [10] ten days of [receipt of the application] the delivery of the life insurance policy or annuity contract, furnish to the insurer [whose] that issued the coverage that is being replaced [a copy of any proposal, including] the completed “Disclosure Statement” and a list of the sales material, including any proposal, used in the sale of the [proposed] life insurance policy or annuity contract[, and] with an offer to provide a copy of such material within ten days of a request for the [completed “Disclosure Statement”] material;

[(5)] (7) submit [quarterly] annual electronic reports [within 30 days of the end of each quarter, beginning at the end of the first full calendar quarter after the effective date of this Part.] by February 1 of each year to the [Superintendent of Financial Services] superintendent, indicating which insurers, if any, have failed to provide the information as required in paragraph (c)(2) of this section;

[(6)] (8) [where the required forms are received with the application and found to be in compliance with this Part,] maintain copies of: [any proposal, including] the sales material, including any proposal, used in the sale of the [proposed] life insurance policy or annuity contract; proof of receipt by the applicant of the “IMPORTANT Notice Regarding Replacement or Change of Life Insurance Policies or Annuity Contracts”; the signed and completed “Disclosure Statement”; and the notification of replacement to the insurer [whose] that issued the life insurance policy or annuity contract that is to be replaced, indexed by insurance agent and broker, [for six calendar years or until after the filing of the report on examination in which the transaction was subject to review by the appropriate insurance official of its state of domicile, whichever is later] in accordance with Part 243 of this Title (Regulation 152);

[(7)] where the required forms are not received with the application, or if the forms do not meet the requirements of this Part or are not accurate, within 10 days from the date of receipt of the application either have any deficiencies corrected or reject the application and so notify the applicant of such rejection and the reason therefor. In such cases, the insurer shall maintain any material used in the proposed sale, in accordance with the guidelines of paragraph (6) of this subdivision;

[(8)] (9) treat the proposed life insurance policy or annuity contract in all respects as if it were a new issuance of the life insurance policy or annuity contract subject to no differences in underwriting or in other considerations including[, but not limited to]: premium discount, interest rate credit, insurance agent [and/or] or broker compensation or expenses, or incentives such as bonuses or other inducements to agents [and/or] or brokers. This provision, however, shall not prevent an insurer from paying lower compensation or expenses to agents [and/or] or brokers on the proposed life insurance policy or annuity contract; and

[(9) in the event the life insurance policy or annuity contract issued differs from the life insurance policy or annuity contract applied for, ensure that the requirements of this Part are met with respect to the information relating to the life insurance policy or annuity contract as issued, including but not limited to the revised “Disclosure Statement”, any revised or additional sales material used and acknowledgement by the applicant of receipt of such revised material.]

(10) if an initial “Disclosure Statement” was provided to the applicant prior to the delivery of the life insurance policy or annuity contract and the life insurance policy or annuity contract is issued other than as applied for, then the insurer shall provide the owner a revised “Disclosure Statement” that conforms to the life insurance policy or annuity contract as issued no later than the time of delivery of the policy or contract, except that a revised “Disclosure Statement” does not need to be provided where there are changes in the amount of expected initial or additional premiums and any changes in amounts of exchanges pursuant to section 1035 of the Internal Revenue Code, rollovers or transfers if the changes do not impact the key benefits and features of the life insurance policy or annuity contract as applied for.

(c) Where a replacement has occurred or is likely to occur, the insurer [whose] that issued the life insurance policy or annuity contract that is to be replaced shall:

(1) upon notice that its existing coverage may be replaced, maintain copies of such notification, indexed by insurer notifying it of such replacement, [for six calendar years or until after the filing of the report on examination in which the transaction was subject to review by the appropriate insurance official of its state of domicile, whichever is later] in accordance with Part 243 of this Title (Regulation 152); and

(2) within 20 days of receipt of a request from a licensee of the department, for information necessary for completion of the “Disclosure Statement” with respect to the life insurance policy or annuity contract proposed to be replaced, together with proper authorization from the applicant, furnish the required information simultaneously to the insurance agent or broker of record of the existing life insurance policy or annuity contract being replaced and the agent or broker and insurer replacing the life insurance policy or annuity contract. This information shall include the insurer's customer service telephone number, the current status of the existing life insurance policy or annuity contract, and the currently illustrated dividends/interest and other non-guaranteed costs and benefits.

(d) Any insurer that issues a replacement life insurance policy or annuity contract shall provide to the policy or contract owner the right to return the policy or contract within 60 days from the date of delivery of such policy or contract and receive an unconditional full refund of all premiums or considerations paid on it, or in the case of a variable or market value adjustment policy or contract, a payment of the cash surrender benefits provided under the policy or contract, plus the amount of all fees and other charges deducted from gross considerations or imposed under the policy or contract. Payment of such refund shall be made within [10] ten days following receipt of the policy or contract for cancellation in accordance with the right to cancellation provision of the policy or contract. During this period, an insurer [whose] that issued the policy or contract that has been replaced shall reinstate or restore, without underwriting or a new contestable or suicide period, such policy or contract as of the date of replacement, upon receipt by the insurer [whose] that issued the policy or contract that has been replaced of:

(1) written proof that the replacement policy or contract has been canceled, including the date of cancellation;

(2) any funds, previously released under such replaced policy or contract; and

(3) any premium or consideration due on the original policy or contract which shall be calculated from the paid-to-date. The insurer [whose] that issued the policy or contract that has been replaced shall reinstate or restore the original policy or contract to its former status to the extent possible and in accordance with its published reinstatement rules to the extent that such rules are not inconsistent with the provisions of this Part.

(e) Both the insurer [whose] that issued the life insurance policy or annuity contract that is being replaced and the insurer replacing the life insurance policy or annuity contract shall establish and implement procedures to ensure compliance with the requirements of this Part. These procedures shall include a requirement that all material be dated upon receipt. Such insurers shall also designate a principal officer specifically responsible for the monitoring and enforcement of these procedures. All insurers covered under this Part shall furnish the [Superintendent of Financial Services] superintendent with these procedures and the name and title of the designated principal officer by the effective date of this Part. Any changes in these procedures or the designated principal officer shall be furnished to the [Superintendent of Financial Services] superintendent within 30 days of such change.

**(Section 6.4d)**

**Section 51.7 Prohibited acts.**

(a) No insurer[, ] or insurance agent or broker shall:

(1) make or give any deceptive or misleading information in the “Disclosure Statement” or in [any proposal, including] the sales material, including any proposal, used in the sale of the [proposed] life insurance policy or annuity contract;

(2) in completing the application, fail to ask the applicant the pertinent questions relating to the probability of replacement;

(3) incorrectly record an answer;

(4) counsel an applicant to answer the [question(s)] questions with respect to replacement negatively in order to prevent notice to the insurer to be replaced; or

(5) counsel an applicant to write directly to the insurer in such a way as to attempt to bypass such insurer's agency representation or obscure the identity of the insurance agent or broker replacing the life insurance policy or annuity contract.

(b) No insurer, insurance agent, insurance broker, [representative, officer, or employee of an insurer] or any other licensee of this department, or any representative, officer, or employee of an insurer, shall fail to comply with or engage in other practices that would prevent the orderly working of this Part in accomplishing its intended purpose in the protection of policyholders and contractholders. Any person failing to comply with this Part, or engaging in other practices that would prevent the orderly working of this Part, shall be subject to penalties under the Insurance Law [of the State of New York], which may include[, but shall not be limited to,] monetary restitution, restoration of policies or contracts, removal of directors or officers, suspension or revocation of agent's, broker's or company's licenses, and monetary fines.

(c) Although policyholders and contractholders have the right to replace existing life insurance policies or annuity contracts after having indicated in or as a part of an application for new coverage that such was not their intention, patterns of such action by policyholders or contractholders having the same insurance agent or broker shall be deemed *prima facie* evidence of the agent's or broker's knowledge that replacement was intended in connection with such transactions, and such patterns of action shall be deemed *prima facie* evidence of the agent's or broker's intent to violate this Part.

**Section 51.8 Exhibits.**

The forms set forth in [Appendixes] Appendices 10A, 10B, 10C and 11 of this Title are hereby approved for use as specified in this Part. The forms shall be set forth in at least 12-point type and shall be highlighted as indicated herein. [Substantially equivalent] In lieu of the forms set forth in the appendices, an insurer may adopt and use forms [may be adopted with the prior approval of] that the [Superintendent of Financial Services] superintendent has determined to be substantially equivalent to the forms set forth in the appendices.

**Appendices 10A, 10B, 10C, and 11 of this Title are repealed. New Appendices 10A, 10B, 10C and 11 of this Title are added.**



NEW YORK STATE  
DEPARTMENT *of*  
FINANCIAL SERVICES

---

Andrew M. Cuomo  
Governor

Benjamin M. Lawsky  
Superintendent

I, Benjamin M. Lawsky, Superintendent of Financial Services, do hereby certify that the foregoing is the Third Amendment to Part 51 of Title 11 of the Official Compilation of Codes, Rules and Regulations of the State of New York (Insurance Regulation 60), entitled "Replacement Of Life Insurance Policies And Annuity Contracts", signed by me on January 5, 2015 pursuant to the authority granted by Financial Services Law Sections 202 and 302 and Insurance Law Sections 301, 2123, 2403 and 4226, to take effect 90 days after publication in the State Register.

Pursuant to the provisions of the State Administrative Procedure Act, prior notice of the proposed rule was published in the State Register on November 5, 2014. No other publication or prior notice is required by statute.

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Benjamin M. Lawsky  
Superintendent of Financial Services

Date: January 5, 2015

(Section 6.5)

## Life Insurance Review

*“Benefit Societies”* and *“Guilds”* have been providing death benefits for centuries, even millennia.

**Insurable Interest** is the provision that the insured be in a position to lose money at the time of a loss.

**Mutual Companies.** (A company owned and controlled by its policyholders. Mutual insurance companies issue participating policies.) Excess profit would be returned to them as **dividends**.

Industrial life policies had a low premium and relatively low benefit and were targeted to the laboring community

All insurance companies can be classified either as **Participating** or **Non-Participating**. There are two major categories of life insurance, **Term** and **Whole Life/Permanent**

A **Key Man** policy may be taken out by a business on the life of a valuable employee

The life of a child can also be covered with a **Juvenile life** policy or **Endowment** policy often used to save for a child’s wedding or education.

Every policy has an **owner**, an **insured** and a **beneficiary**

Today, annuities are **Fixed, Indexed** or **Variable**.

**Annuity** sales are regulated by the **Securities Exchange Commission (SEC)** requiring specific licensing.

Annuities have several payment options general categorized as **immediate** or **deferred**. An immediate annuity is typically **single purchase payment**

**A producer (Agent of Broker) who makes false statements about an insurance company or another producer may be guilty of misrepresentation.**

**Misrepresentation** is a false statement on an application for a policy.

An **Agent** represents a particular company. An agent may share commission only with other agents of the same company.

A **Broker** represents the buyer. A broker may share commission with any other licensed broker. A broker may be held personally liable to its client for not acting with reasonable care, skill and diligence to obtain effective coverage. A broker has a duty to obtain the coverage requested by their client. Brokers often perform a variety of additional services for their client, such as processing claims and payments.

**Pensions** are a **defined benefit** retirement plan

**Pensions** provide a **tax deduction available to employers**.

**Qualified Pension Plans** are those that meet specific requirements of the Internal Revenue Service (IRS).

**Section 401 (k)** of the Internal Revenue Code provided for **Deferred Compensation Plans**.

**Regulation 60** In New York State relates to specific disclosure of sale of life insurance and fixed annuity products.

## Health Insurance

### Chapter 7

(Section 7.1)

#### Healthcare

In the history of healthcare, from the beginning through to the mid-19<sup>th</sup> Century, it must be stated clearly that there was almost no understanding of disease, the cardio system, pulmonary functions, or the role of organs in a body. Healthcare beyond homemade remedies used to attempt to alleviate fever or cover wounds to the flesh, was virtually non-existent. The little that was understood was passed from one family member to another or written for those who were literate and had access to medical books. For most, life was short. The average life expectancy from birth was under 40 years and at age 20 could extend to about 60 years. (*Decennial Life Tables for the White Population of the United States, 1790–1900 J. David Hacker 2010*)

During the 18<sup>th</sup> century, the theories of Hermann Boerhaave (1668-1738) were the most commonly held in colonial medicine. Boerhaave worked together the best parts of the medical theories he had studied into a system which held that disease was an imbalance of “natural activities”. He believed that fever was the body’s attempt to keep from dying. He also felt that digestion and circulation could be explained by mechanical ideas. Boerhaave recognized three conditions that might have led to disease: salty, putrid, and oily conditions in the body. His remedies were to sweeten the acid, purify the stomach, and rid impurities through bleeding and purging. Boerhaave’s system of medicine was the most commonly used theory by doctors in colonial America. (*Colonial Medicine – Jamestown-Yorktown Foundation – historyisfun.org/pdfbooks/colonial\_medicine.pdf*)

In 1751, once again Benjamin Franklin added a building block for the development and prosperity of Philadelphia when he founded the **Pennsylvania Hospital**. Its stated goal was to care for the sick, poor and insane who wander the streets of Philadelphia, an official seal motto “Take Care of Him and I will repay Thee”. The hospital has grown; and, like the Philadelphia Contributorship for the Insurance of Houses from Loss by Fire, continues to operate today.

In The New York City Almshouse, founded in 1736, became **Bellevue Hospital in 1824**. The Massachusetts Health Insurance Company was formed in 1847 providing accident and sickness coverage to subscribers. Insurance coverage for injuries relating to travel by steamboat and railroad became common in the mid-19<sup>th</sup> century and Travelers Insurance issued its first policy in 1864.

Accident and sickness policies grew demonstrably as employers offered benefits to entice and retain workers. Unions also played a significant role in the expansion of coverage. Many of these plans had more in common with what would eventually become our workers compensation and disability programs, than they have with the modern health insurance policy. Workers compensation would be introduced, after decades of debate, by Wisconsin in 1911. Within a decade, 36 additional states would add workers compensation statutes.

Starting in 1875, a number of mutual benefit associations called "establishment funds" were formed by and for the employees of a single employer, sometimes with some help from the employer. The development of group health insurance by private insurance companies is related closely to an establishment fund created for the employees of Montgomery Ward & Co., Inc. Montgomery Ward decided to investigate the possibility of replacing the voluntary and poorly supported plan with an insurance product and after protracted and complex negotiations with a number of insurers, the disability income coverage was placed with the London Guarantee and Accident Company of New York in 1911. This contract provided, after a three-day waiting period, loss of time benefits for employees under age 70 equal to one-half of an employee’s weekly wage, subject to a minimum benefit of \$5 per week and a maximum benefit of \$28.85 per week. There was no maximum time limit for payments. This plan is generally regarded as the first group health insurance plan.

<http://www.mrm-gmu.com/StopLoss101/AShortHistoryofMedicalInsurance>

In 1846, the **American Medical Association** was established. It was not until 1893 that Johns Hopkins University Medical School required medical students to have completed 4 years of college prior to acceptance into their 4 year training program for physicians. Healthcare was finally moving into a modern age of science-based practice.

The age of the modern hospital has its origin around 1880 when **sterilization** was proven to reduce the rate of infection. Many will remember from grade school the names **Louis Pasteur** and **Joseph Lister**. These two proved that **pasteurization and sterilization saved lives**. This change brought hospitals into a new age of **curing illness** and significant injury with dramatically improved recovery rates for individuals undergoing surgical and medical procedures. In addition, the perception of the public toward hospitals improved.

The Progressive Movement, which President Theodore Roosevelt championed, sought to improve living and working conditions for the country's working class. At that time, advanced medical care was available to those who could afford its cost, leaving the poor with little if any medical care at all. Although large employers continued to provide **accident and sickness coverage**, the majority were predominantly left without access to care. Various proposals to provide **universal health coverage**, including Roosevelt's 1912 Bull Moose campaign proposal, were opposed by the American Medical Association. Insurance companies and employers also objected to the plans. Roosevelt is often quoted for saying "no country could be strong whose people were sick and poor".

Little progress was made toward improved access to health care through insurance for much of the early 20<sup>th</sup> century. Employer based coverage, including the **Dallas Teachers** program, which evolved into **Blue Cross**, were the most common, yet program availability was scarce.

The emphasis of health reform shifted during the 1920s as medical care became both more effective and more expensive; soon, medical costs and access to care replaced wage support as reformers' primary concern. However, the character of reform leadership changed little, and health reformers continued to share the elite status of their predecessors. The most prominent reform group of the 1920s, the **Committee on the Costs of Medical Care (CCMC)**, which was financed by large foundations and made up of physicians, academic economists, and representatives of private interest groups, again relied on research rather than popular mobilization. The CCMC's modest proposals for group medicine and voluntary insurance were denounced by the American Medical Association (AMA) as "socialized medicine," but the battle was fought in the pages of newspapers and academic journals, with no attempt to enlist ordinary people as advocates for the reformers' recommendations.

**Health Care Reform and Social Movements in the United States - [Beatrix Hoffman, PhD](#)**

With the onset of the Great Depression focus of progressive program supporters shifted from healthcare access to support for unemployment. President Franklin Roosevelt's social security program was successful in providing unemployment and old age financial assistance, however health care was not included. **Social Security** developed out of the Committee on Economic Security in 1934.

This Committee was established by President Roosevelt in June 1934 (Executive Order No. 6757) to develop a comprehensive social insurance system covering all major personal economic hazards with a special emphasis on unemployment and old age insurance. The Committee's legislative recommendations were presented to the President in January 1935, and introduced to Congress for consideration shortly thereafter. A compromise Social Security Bill was signed by the President on August 14, 1935.

**[www.ssa.gov/history/orghist.html](http://www.ssa.gov/history/orghist.html)**

Health insurance hit its stride in the 1950's when the Federal Government allowed a **tax deduction for health insurance premiums**. Employers provided "**pre-paid**" health insurance plans as an incentive to attract and retain employees and Blue Cross was the dominant provider on health insurance. The Blue Cross system developed following the contract between Baylor University Hospital and the Dallas teachers union. **The Baylor Plan** provided 21 days of hospitalization for a fixed \$6.00 payment. The Baylor Plan insured that people were able to pay their hospital bills. Later, the **American Hospital Association (AHA)** expanded the concept as a way for hospitals to **have stable funding**. A key component early on was a provision allowing the free choice of physicians and hospitals.

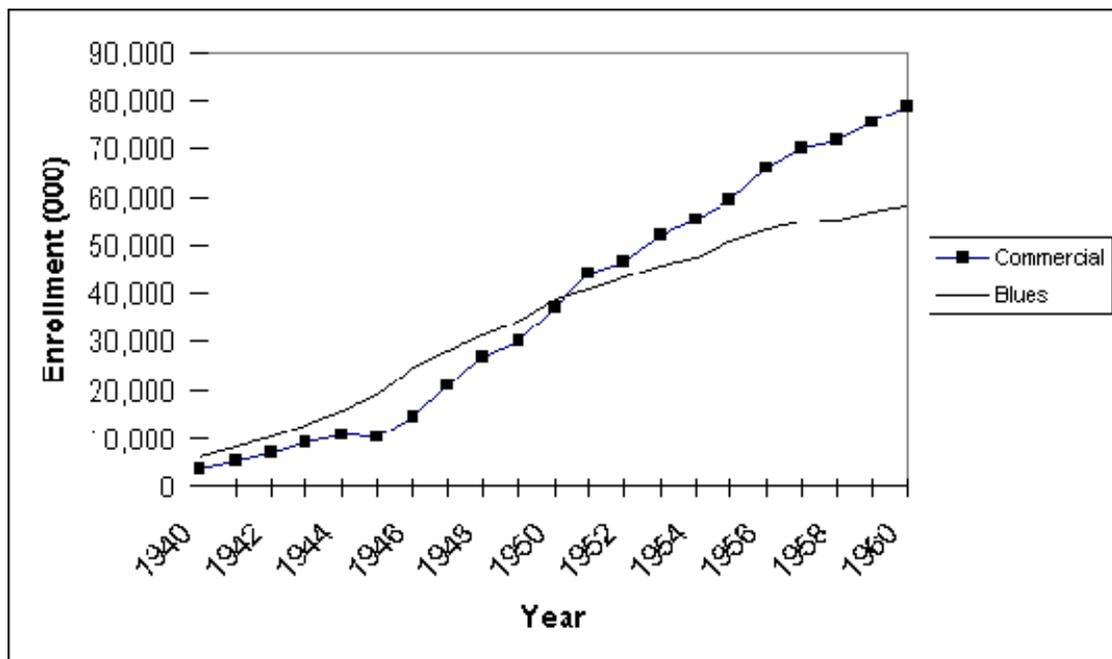
The AHA designed the Blue Cross guidelines so as to reduce price competition among hospitals. Prepayment plans seeking the Blue Cross designation had to provide subscribers with free choice of physician and hospital, a requirement that eliminated single-hospital plans from consideration. Blue Cross plans also benefited from special state-level enabling legislation allowing them to act as non-profit corporations, to enjoy tax-exempt status, and to be free from the usual insurance regulations. Originally, the reason for this exemption was that Blue Cross plans were considered to be in society's best interest since they often provided benefits to low-income individuals (Eilers 1963, p. 82).

<https://eh.net/encyclopedia/health-insurance-in-the-united-states/>

The Blue Cross system demonstrated that **group health insurance** could be managed profitably. Changes in tax law encouraged employers to provide their workers with the benefit. It can be argued, however, that **experience rating** rather than **community rating** was the main draw for private insurance companies entering the health industry. Blue Cross programs were non-profit and charged the same premium to all customers, healthy or sick. Commercial companies were able to charge individuals with poor health experience a higher premium.

The success of commercial companies was aided by two factors. First, the competitiveness of Blue Cross and Blue Shield was limited by the fact that their non-profit status required that they community rate their policies. Under a system of community rating, insurance companies charge the same premium to sicker people as they do to healthy people. Since they were not considered to be nonprofit organizations, commercial insurance companies were not required to community rate their policies. Instead, commercial insurance companies could engage in experience rating, whereby they charged sicker people higher premiums and healthier people lower premiums. As a result, commercial companies could often offer relatively healthy groups lower premiums than the Blue Cross and Blue Shield plans, and gain their business. Thus, the commercial health insurance business boomed, as shown in Figure 2.

**Figure 2: Enrollment in Commercial Insurance Plans v. Blue Cross and Blue Shield**



<https://eh.net/encyclopedia/health-insurance-in-the-united-states/>

Private insurance in the early 1960's was in place for a majority of working families while the **poor and elderly were largely unserved by health insurance**. As high cost and low-income populations, the Federal government recognized the need for publicly funded programs and passed **Medicaid and Medicare in 1965**.

By the 1960s, the system of private health insurance in the United States was well established. In 1958, nearly 75 percent of Americans had some form of private health insurance coverage...

### **Medicare Provisions**

The political atmosphere became much more favorable towards nationalized health insurance proposals after John F. Kennedy was elected to office in 1960, and especially when the Democrats won a majority in Congress in 1964. Passed in 1965, Medicare was a federal program with uniform standards that consisted of two parts. Part A represented the compulsory hospital insurance program the aged were automatically enrolled in upon reaching age 65. Part B provided supplemental medical insurance, or subsidized insurance for physicians' services. Ironically, physicians stood to benefit tremendously from Medicare. Fearing that physicians would refuse to treat Medicare patients, legislators agreed to reimburse physicians according to their "usual, customary, and reasonable rate." In addition, doctors could bill patients directly, so that patients had to be reimbursed by Medicare. Thus, doctors were still permitted to price discriminate by charging patients more than what the program would pay, and forcing patients to pay the difference. Funding for Medicare comes from payroll taxes, income taxes, trust fund interest, and enrollee premiums for Part B. Medicare has grown from serving 19.1 million recipients in 1966 to 39.5 million in 1999 (Henderson 2002, p. 425).

### **Medicaid**

In contrast to Medicare, Medicaid was enacted as a means-tested, federal-state program to provide medical resources for the indigent. The federal portion of a state's Medicaid payments is based on each state's per capita income relative to national per capita income. Unlike Medicare, which has uniform national benefits and eligibility standards, the federal government only specifies minimum standards for Medicaid; each of the states is responsible for determining eligibility and benefits within these broad guidelines. Thus, benefits and eligibility vary widely across states. While the original legislation provided coverage for recipients of public assistance, legislative changes have expanded the scope of benefits and beneficiaries (Gruber 2000). In 1966, Medicaid provided benefits for 10 million recipients. By 1999, 37.5 million people received care under Medicaid (Henderson 2002, p. 433).

<https://eh.net/encyclopedia/health-insurance-in-the-united-states/>

## **(Section 7.2)**

### **HMO Act 1973**

While providing health care services has been a goal of many within the public and private sector in the 20th and 21st Centuries, expenses have consistently outpaced inflation and earnings increases. To expand healthcare services, control over insurance costs would be essential.

A major attempt to address the increasing costs of health insurance was introduced in **1973** with the **Health Maintenance Act**.

The HMO Act introduced a healthcare delivery alternative to the Fee-For-Service Indemnity Insurance coverage approach provided by Blue Cross and Blue Shield. Based largely on the Kaiser Foundation health plan, which had been operating since 1942, providers would cover expenses incurred by participants for a set premium. Participants, however, would need to use providers within their programs network.

**Managed Care** is a term that is used to describe a health insurance plan or health care system that coordinates the provision, quality and cost of care for its enrolled members. In general, when you enroll in a managed care plan, you select a regular doctor, called a primary care practitioner (PCP), who will be responsible for coordinating your health care. Your PCP will refer you to specialists or other health care providers or procedures as necessary. It is usually required that you select health care providers from the managed care plan's network of professionals and hospitals.

Managed care plans pay the health care providers directly, so enrollees do not have to pay out-of-pocket for covered services or submit claim forms for care received from the plan's network of doctors. However, managed care plans can require co-pays paid directly to the provider at the time of service.

There are many different types of managed care plans. Most managed care plans certified by the New York State Department of Health offer health education classes or other programs to help enrollees stay healthy. Depending on the type of managed care plan you join, there may be additional services, such as transportation, available to you. [http://www.health.ny.gov/health\\_care/managed\\_care/](http://www.health.ny.gov/health_care/managed_care/)

## **HMO**

A large number of New York residents are covered by **Health Maintenance Organizations**, or HMOs. HMOs provide a number of coverage plans through employers and directly to individuals. These plans vary widely and the New York State Insurance Department has developed a comprehensive new web portal, <https://nystateofhealth.ny.gov>, to assist consumers with their review of plans available in New York State.

## **Child Health Plus**

Since 1990, there has been a significant effort to provide health insurance coverage for New York's children and un-insured adults. **Healthy NY, Child Health Plus and Family Health Plus** have made great strides in achieving this objective. The program started in **1990** with children up to **13 years** of age living in families with income below 222% of the Federal Poverty Level (FPL) eligible. In The age limit was raised to **17** in 1996 and to **19** in **1997**.

New York State has a health insurance plan for kids, called Child Health Plus. Depending on your family's income, your child may be eligible to join either Children's Medicaid or Child Health Plus. Both Children's Medicaid and Child Health Plus are available through dozens of providers throughout the state.

Starting January 1, 2014, you can apply for Child Health Plus coverage through the New York State of Health Marketplace: <https://nystateofhealth.gov>/ Paper, fax, or email applications for Child Health Plus will not be accepted by Child Health Plus Health Plans after December 31, 2013.

## **A Note on The Affordable Care Act**

The Health Maintenance Act of 1973 significantly changed the way in which most individuals in the United States receive healthcare and purchase health insurance with a transition from indemnity plans to provider pay plans. The **Patient Protection and Affordable Care Act of 2010** (ACA – commonly referred to as Obama Care) did not fundamentally alter the form of insurance in our Country; however it did significantly restructure the regulatory framework of the US healthcare system. A major drive behind the Act was a pure concept of insurance; i.e.; the spread of risk among a group and the reduction of preferred selection of risk.

## (Section 7.3)

### The Patient Protection and Affordable Care ACT of 2010

#### Key Features of the Affordable Care Act

The Affordable Care Act was enacted On March 23, 2010. The law put in place comprehensive health insurance reforms to make health care more affordable and accessible for families, seniors, businesses, and taxpayers alike. The ACT includes coverage for previously uninsured Americans, and Americans who had insurance that did not provide them adequate coverage and security.

#### About the Law

The Affordable Care Act puts consumers back in charge of their health care. Under the law, a new “Patient’s Bill of Rights” gives the American people the stability and flexibility they need to make informed choices about their health.

#### Coverage

- **Ends Pre-Existing Condition Exclusions for Children:** Health plans can no longer limit or deny benefits to children under 19 due to a pre-existing condition.
- **Keeps Young Adults Covered:** If you are under 26, you may be eligible to be [covered under your parent’s health plan](#).
- **Ends Arbitrary Withdrawals of Insurance Coverage:** [Insurers can no longer cancel your coverage](#) just because you made an honest mistake.
- **Guarantees Your Right to Appeal:** You now have the [right to ask that your plan reconsider its denial of payment](#).

#### Costs

- **Ends Lifetime Limits on Coverage:** Lifetime limits on most benefits are [banned for all new health insurance plans](#).
- **Reviews Premium Increases:** Insurance companies must now publicly justify any unreasonable rate hikes.
- **Helps You Get the Most from Your Premium Dollars:** Your premium dollars must be spent primarily on health care – not administrative costs.

#### Care

- **Covers Preventive Care at No Cost to You:** You may be eligible for [recommended preventive health services](#). No copayment.
- **Protects Your Choice of Doctors:** [Choose the primary care doctor you want](#) from your plan’s network.
- **Removes Insurance Company Barriers to Emergency Services:** You can seek emergency care at a hospital [outside of your health plan’s network](#).

[www.hhs.gov/healthcare/about-the-law/index.html](http://www.hhs.gov/healthcare/about-the-law/index.html)

## Healthy New York

New York State has been among the most aggressive states to provide healthcare insurance and services to all residents. Affordability has consistently been a major hurdle to access and the **Health Care Reform Act of 2000** was a significant step toward achieving the goal of covering all individuals, either through an employer-sponsored plan or individually.

The Health Care Reform Act of 2000 introduced the Healthy NY program to provide more affordable health insurance to New Yorkers who need it most. The New York State Department of Financial Services oversees the program, which is governed by state law and regulation.

Since 2001, Healthy NY has offered comprehensive health insurance to individuals, sole proprietors and small businesses. Beginning in 2014, Healthy NY will be available as a small employer program only.

In 2014, Healthy NY will include more comprehensive coverage for essential health benefits including inpatient and outpatient hospital services, physician services, maternity care, preventive health services, diagnostic services, mental health services, chiropractic care, prescription drugs, ambulance and emergency services. <http://www.dfs.ny.gov/healthyny/index.html>

The official Health Plan Marketplace website for New York State residents to investigate and enroll in a program is **www.nystateofhealth.ny.gov**. Approved provider websites also provide specific information including their rate information for individuals and small businesses.

# New York State of Health: The Official Health Plan Marketplace

## 2016 Qualified Health Plan Map

Oct 16, 2015

Qualified Health Plans offered in NY State of Health are available in four easy-to-compare metal tiers (platinum, gold, silver and bronze). All plans on the Marketplace cover doctor’s visits; hospital stays; emergency care; maternity and newborn care; mental health and substance abuse disorder services; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services, chronic disease management and pediatric dental and vision. Preventive care such as routine office visits and recommended screenings are free. Some plans include additional benefits such as adult dental and vision coverage.

Click on a county or borough shape on the map to view the certified plans for that area. (You may need to allow pop-ups in your browser.)

The map of 2015 qualified health plans is [available here](#).



### Available Downloads:

 <a href="#">2016 Individual Marketplace Plans by county.pdf</a>	41.68 KB
 <a href="#">2016 Small Business Marketplace Plans by county.pdf</a>	33.3 KB
 <a href="#">2016 Dental Plans by county.pdf</a>	151.11 KB

## **New York Dependent Care Coverage Extension to Age 29**

New York State expanded eligibility for “Young Adults” to remain on a parent’s group health insurance policy until the age of 29 in September 2009.

***Insure Dependents through Age 29:*** This law, outlined by the Governor in his State of the State address, requires insurers to allow unmarried children through age 29 – regardless of financial dependence – to be covered under a parent’s group health insurance policy. Young adults ages 19 to 29 represent 31 percent of uninsured New Yorkers. They often become ineligible for coverage under their parents’ policies at age 19 or upon high school or college graduation, find themselves in entry-level jobs that do not provide employer-based health insurance, and cannot afford to pay premiums for individual insurance policies – which are much more expensive than group policies. Under the new law, premiums will be paid for by families, not employers, and would cost less because coverage is under group policies rather than individual policies. The law also requires insurers to offer employers an option to purchase coverage that includes young adults as dependents in family policies through age 29.

**(Section 7.4)**

**Health Insurance Review**

**Dallas Teachers** program, which evolved into **Blue Cross**

Social Security developed out of the Committee on Economic Security in 1934.

In the 1950's the Federal Government allowed a **tax deduction for health insurance premiums**

The Baylor Plan developed into the **Blue Cross** system following the contract between Baylor University Hospital and the **Dallas Teachers Union**.

**Experience rating** rather than **community rating** was the main draw for private insurance companies entering the health industry

Federal government recognized the need for publicly funded programs and passed **Medicaid and Medicare in 1965**

The HMO Act introduced a healthcare delivery alternative to the Fee-For-Service Indemnity Insurance coverage approach provided by Blue Cross and Blue Shield.

**Managed Care** is a term that is used to describe a health insurance plan or health care system that coordinates the provision, quality and cost of care for its enrolled members.

**Child Health Plus** started in **1990** with children up to **13 years** of age living in families with income below 222% of the Federal Poverty Level (FPL) eligible. The age limit was raised to **17** in 1996 and to **19** in **1997**.

The **Patient Protection and Affordable Care Act of 2010** (ACA) is commonly referred to as Obama Care

The official Health Plan Marketplace website for New York State residents to investigate and enroll in a program is **[www.nystateofhealth.ny.gov](http://www.nystateofhealth.ny.gov)**.

New York State expanded eligibility for "Young Adults" to remain on a parent's group health insurance policy until the **age of 29** in September 2009.

## Federal and State Programs

### Chapter 8

#### (Section 8.1)

### Social Security, Medicare and Medicaid

#### State Old-Age Pensions

During the Great Depression, poverty among the elderly grew dramatically. In 1934, more than half of the elderly in America were too poor to support themselves. State welfare pensions for the elderly were practically non-existent before 1930. Thirty states had some form of **old-age pension** program by 1935 covering about 3% of the elderly with an average benefit amount that was about 65 cents a day.

#### The Committee on Economic Security (CES)

In 1934, **President Franklin D. Roosevelt**, proposed a program for Social Security. Under an Executive Order, the **Committee of Economic Security** (CES) was established. The Committee studied the problems related to economic insecurity and made recommendations to Congress that would serve as the basis for legislative action.

The two major provisions relating to the elderly were Title I- Grants to States for Old-Age Assistance, which supported state welfare programs for the aged, and Title II-Federal Old-Age Benefits. It was Title II that was the new social insurance program we now think of as Social Security. In the original Act benefits were to be paid only to the primary worker when he/she retired at age 65. Benefits were to be based on payroll tax contributions that the worker made during his/her working life. Taxes would first be collected in 1937 and monthly benefits would begin in 1942. (Under amendments passed in 1939, payments were advanced to 1940.)

*[www.ssa.gov/history/briefhistory3.html](http://www.ssa.gov/history/briefhistory3.html)*

On January 31, 1940, Ida May Fuller received the first monthly retirement check in the amount of \$22.54. Miss Fuller retired in November 1939 and started collecting benefits in January 1940 at age 65 and lived to be 100 years old, dying in 1975.

In 1972, Federal law changes provided for automatic annual **cost-of-living allowances** (i.e., **COLAs**) based on the annual increase in consumer prices. No longer do beneficiaries have to await a special act of Congress to receive a benefit increase and no longer does inflation drain value from Social Security benefits.

#### Disability

In **1965**, President Lyndon Baines Johnson signed the **Medicare** bill which created a new social insurance program and established the **SSA** (Social Security Administration) as administrator, extending coverage to nearly all Americans **65 and older**.

Today, the Social Security Administration (SSA) oversees benefits for Retirement, Disability, Medicare, Survivors and Supplemental Security Income. The **Centers for Medicare & Medicaid Services (CMS)**, which is under the umbrella of the department of **Health and Human Services (HHS)**, administers **Medicare, Medicaid, the Children's Health Insurance Program (CHIP)** and the **Health Insurance Marketplace**. The Federal Government and States pay for Medicaid jointly; however, states manage Medicaid programs individually.

### ***What is the difference between Medicare and Medicaid?***

#### ***Medicare***

Medicare is an insurance program. Medical bills are paid from trust funds which those covered have paid into. It serves people over 65 primarily, whatever their income; and serves younger disabled people and dialysis patients. Patients pay part of costs through deductibles for hospital and other costs. Small monthly premiums are required for non-hospital coverage. Medicare is a federal program. It is basically the same everywhere in the United States and is run by the Centers for Medicare & Medicaid Services, an agency of the federal government.

For more information regarding Medicare and its components, please go to <http://www.medicare.gov>.

#### ***Medicaid***

Medicaid is an assistance program. It serves low-income people of every age. Patients usually pay no part of costs for covered medical expenses. A small co-payment is sometimes required. Medicaid is a federal-state program. It varies from state to state. It is run by state and local governments within federal guidelines. To see if you qualify for your state's Medicaid (or Children's Health Insurance) program, see: <https://www.healthcare.gov/medicaid-chip/eligibility/>

***Full retirement age is the age at which a person may first become entitled to full or unreduced retirement benefits.***

#### ***Social Security Benefits***

If your full retirement age is older than 65 (that is, you were born after 1937), you still will be able to take your benefits at age 62, but the reduction in your benefit amount will be greater than it is for people who were born before 1938.

Here's how it works if your full retirement age is 67.

- If you start your retirement benefits at age 62, your monthly benefit amount is reduced by about 30 percent. The reduction for starting benefits at age
  - 63 is about 25 percent;
  - 64 is about 20 percent;
  - 65 is about 13.3 percent; and
  - 66 is about 6.7 percent.
  
- If you start receiving spouse's benefits at age 62, your monthly benefit amount is reduced to about 32.5 percent of the amount your spouse would receive if his or her benefits started at full retirement age. (The reduction is about 67.5 percent.) The reduction for starting benefits as a spouse at age
  - 63 is about 65 percent;
  - 64 is about 62.5 percent;
  - 65 is about 58.3 percent;
  - 66 is about 54.2 percent; and
  - 67 is 50 percent (the maximum benefit amount).

<b>Age To Receive Full Social Security Benefits</b> (Called "full retirement age" or "normal retirement age.")	
<b>Year of Birth *</b>	<b>Full Retirement Age</b>
1937 or earlier	65
1938	65 and 2 months
1939	65 and 4 months
1940	65 and 6 months
1941	65 and 8 months
1942	65 and 10 months
1943--1954	66
1955	66 and 2 months
1956	66 and 4 months
1957	66 and 6 months
1958	66 and 8 months
1959	66 and 10 months
1960 and later	67

*\*If you were born on January 1st of any year you should refer to the previous year. (If you were born on the 1st of the month, we figure your benefit (and your full retirement age) as if your birthday was in the previous month.)*

The earliest you can start receiving Social Security retirement benefits will remain age 62.

**Note:** If you delay your retirement benefits until after full retirement age, you also may be eligible for [delayed retirement credits](#) that would increase your monthly benefit. If you decide to delay your retirement, be sure to [sign up for Medicare at age 65](#).

In some circumstances, medical insurance costs more if you delay applying for it.

Coverage under Medicare Part A covers Hospitalization only! Medicare Part A coverage is provided by the Federal Government and no premium is paid; it is funded by contributions made by workers through payroll withholdings under the Federal Insurance Contributions Act or FICA. Medicare **Part B** covers **Medical Insurance** and requires the payment of a premium, which is generally deducted from your Social Security benefit payment. Part B covers clinical research, ambulance services, durable medical equipment, mental health services (inpatient, outpatient and partial hospitalization), getting a second opinion before surgery and limited outpatient prescription drugs. Because Medicare Part B has gaps in coverage private insurance is available as a supplement. Part B supplemental coverage is known as **Medigap** insurance.

<b>Medigap Benefits</b>	<b>Medigap Plans</b>									
	<b>A</b>	<b>B</b>	<b>C</b>	<b>D</b>	<b>F*</b>	<b>G</b>	<b>K</b>	<b>L</b>	<b>M</b>	<b>N</b>
<b>Part A coinsurance and hospital costs up to an additional 365 days after Medicare benefits are used up</b>	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
<b>Part B coinsurance or copayment</b>	Yes	Yes	Yes	Yes	Yes	Yes	50%	75%	Yes	Yes***
<b>Blood (first 3 pints)</b>	Yes	Yes	Yes	Yes	Yes	Yes	50%	75%	Yes	Yes
<b>Part A hospice care coinsurance or copayment</b>	Yes	Yes	Yes	Yes	Yes	Yes	50%	75%	Yes	Yes
<b>Skilled nursing facility care coinsurance</b>	No	No	Yes	Yes	Yes	Yes	50%	75%	Yes	Yes
<b>Part A deductible</b>	No	Yes	Yes	Yes	Yes	Yes	50%	75%	50%	Yes
<b>Part B deductible</b>	No	No	Yes	No	Yes	No	No	No	No	No
<b>Part B excess charge</b>	No	No	No	No	Yes	Yes	No	No	No	No
<b>Foreign travel exchange (up to plan limits)</b>	No	No	80%	80%	80%	80%	No	No	80%	80%
<b>Out-of-pocket limit**</b>	N/A	N/A	N/A	N/A	N/A	N/A	\$4,960	\$2,480	N/A	N/A

**(Section 8.2)**

**Social Security Medicare & Medicaid Review**

An Executive Order established the *Committee of Economic Security in 1934*.

In 1972, Federal law changes provided for automatic annual *cost-of-living allowances* (i.e., *COLAs*)

The *Medicare* bill which created a new social insurance program and established the *SSA* (Social Security Administration) as administrator, extending coverage to nearly all Americans *65 and older* was established in 1965.

*Medicare* is an insurance program.

*Medicaid* is an assistance program.

*Full retirement age* is the age at which a person may first become entitled to full or unreduced retirement benefits.

People born after 1960 reach *full retirement* at *age 67*.

Coverage under *Medicare Part A* covers *Hospitalization only!*

No premium is paid for Medicare Part A.

Medicare *Part B* covers *Medical Insurance* and requires the payment of a premium.

Medicare Part B has *gaps* in coverage, which *private companies can fill* with policies known as *MediGap* plans.

## **Workers Compensation & Disability**

### **(Section 9.1)**

**Workers' Compensation** is insurance that provides cash benefits and/or medical care for workers who are **injured or become ill as a direct result of their job**.

Employers pay for this insurance, and may not require the employee to contribute to the cost of compensation. Weekly cash benefits and medical care are paid by the employer's insurance carrier, as directed by the Workers' Compensation Board. The **Workers' Compensation Board** is a state **agency that processes the claims** and determines, through a judicial proceeding, whether a worker will receive benefits and/or medical care, and how much he/she will receive.

In a workers' compensation case, no one party is determined to be at fault. The amount that a claimant receives is not decreased by his/her carelessness, nor increased by an employer's fault. However, **a worker loses his/her right to workers' compensation if the injury results solely from his/her intoxication from drugs or alcohol, or from the intent to injure him/herself or someone else.**

A claim is paid if the employer or insurance carrier agrees that the injury or illness is work-related. If the employer or insurance carrier disputes the claim, no cash benefits are paid until the Workers' Compensation Law Judge decides who is right. If a worker is not receiving benefits because the employer or insurance carrier is arguing that the injury is not job-related, he/she may be eligible for Disability Benefits in the meantime. Any payments made under the Disability Program, however, will be subtracted from future workers' compensation awards.

### **Who Can Sell Workers Comp**

New York State employers are required to provide workers' compensation and disability benefit coverage to their employees. The Workers' Compensation Law states that employers may provide this coverage in one of the following ways: (1) by insuring and keeping insured the payment of such compensation in the **State Insurance Fund**; (2) by insuring and keeping insured the payment of such compensation with any **insurance carrier authorized to transact such business** in New York State; or (3) by **becoming self-insured**.

Employers who wish to self-insure for either workers' compensation or disability benefits must apply to and be approved by the Board's Office of Self Insurance. As part of this process, each approved self-insurer must post with the Board a security deposit (cash, securities, letter of credit and/or surety bond), which will be used in the event that the self-insurer defaults on their obligation to provide benefits to their employees.

Employers may seek coverage directly through the State Insurance Fund or direct a representative, including an accountant or payroll administrator, or insurance broker to do so on their behalf. Self-Insuring, either through a dedicated Trust Fund or an individual plan does not require the involvement of a licensed producer, however several Trusts operate exclusively through licensed insurance producers. Only coverage with traditional carriers require a licensed insurance producer to place business on behalf of an employer.

# *Volunteer Firefighter's and Ambulance Worker's Guide to Benefits*

## **Introduction to the VFAW Law**

The Volunteer Firefighters' and Volunteer Ambulance Workers' Benefits Laws provide cash benefits and/or medical care for volunteer members who are injured or become ill in the line of duty. Recognizing the unselfish service of volunteer firefighters and volunteer ambulance workers, laws designed to protect such volunteers who are injured, or who become ill, in the line of duty, were enacted in 1957 and 1989, respectively.

The local political subdivision pays for this insurance, and cannot require the volunteer member to contribute to the cost of coverage. Weekly cash benefits and medical care are paid by the subdivision's insurance carrier, in accordance with the applicable law. The Workers' Compensation Board is a state agency that administers these laws, and if disputes arise, adjudicates them through a quasi-judicial proceeding.

In a volunteer firefighters' or ambulance workers' benefits case, no one party is determined to be at fault. The amount that a claimant receives is not decreased by his/her carelessness, nor increased by the company's fault. A volunteer member loses his/her right to benefits if the injury results solely from his/her intoxication from alcohol or drugs, or from the intent to injure him/herself or someone else.

### **Who is Covered by the Law?**

All New York State **volunteer firefighters** are entitled to benefits under the law if they are active volunteer members of a fire company of a county, city, town, village or fire district and are injured in the line of duty.

Most New York State **volunteer ambulance workers** are entitled to benefits under the law if they are active volunteer members of an ambulance company and are injured in the line of duty. Volunteer ambulance companies which are not under contract with a county, city, town, village or other political subdivision, or that do not wish to become special improvement districts of towns, may provide optional coverage to their workers.

### **What Is and Is Not "In the Line of Duty"?**

*What is "In the Line of Duty" for Firefighters?*

Any of the following activities, pursuant to orders/authorization:

- Participation at a fire, alarm of fire, hazardous material incident, or other emergency situation that triggers response by the fire company or its units;
- Travel to, from and during fires or other calls to which the company responds; travel in connection with other authorized activities;
- Some duties in the firehouse, such as construction, repair, maintenance and inspection;
- Inspection of property for fire hazards or other dangerous conditions;
- Fire prevention activities;
- Attendance at fire instructions or fire school; instruction at training;
- Participation in authorized drills, parades, funerals, inspections/reviews, tournaments, contests or public exhibitions conducted for firefighters;
- Attendance at a convention or conference as an authorized delegate;
- Work on or testing of fire apparatus/equipment, fire alarm systems and fire cisterns;
- Meetings of the fire company;
- Pumping water or other substances from a basement or building;
- Inspection of fire apparatus prior to delivery;
- Response to a call for general ambulance service by a member of an authorized emergency rescue and first aid squad;
- Participation in a supervised physical fitness class; or
- Fundraising activities (non-competitive events).

***What is "In the Line of Duty" for Volunteer Ambulance Workers?***

- Travel to, working at and travel from an accident, alarm of accident or other duty to which the ambulance company has responded; travel in connection with other authorized activities;
- Personal assistance rendered to another ambulance company;
- Performance of duties at the ambulance facility or elsewhere, directly related to the prevention of accidents or other disasters or the delivery of emergency health care;
- Instruction or being instructed in ambulance duties; attendance at a training school or course of instruction for ambulance workers, or attendance at, or participation in, any noncompetitive training program;
- Attendance at, or participation in, authorized drills, parades, funerals, inspections or reviews;
- Attendance or work at meetings of the ambulance department or ambulance company, or any organized unit thereof, at the ambulance facility or other regular or special headquarters of the department, company or unit;
- Work in connection with the construction, testing, inspection, repair or maintenance of the ambulance facility and the fixtures, furnishings and equipment thereof, and the ambulance vehicles, ambulance apparatus and equipment used by the ambulance department, ambulance company, or other unit;
- Practice for, or participation as a contestant or an official in any competitive tournament, contest or public exhibition conducted for ambulance workers which is intended to promote the efficiency of the ambulance department, ambulance company or any unit;
- Inspection of ambulance vehicles and ambulance apparatus prior to delivery under a contract or purchase, or performance of duties in relation to the delivery;
- Attendance at a convention or conference of ambulance workers or ambulance officers as the authorized delegate or representative of the ambulance department, ambulance company or any unit; or
- Work in connection with a fundraising activity of the ambulance company, not including competitive events in which volunteer ambulance workers are competitors.

***What is NOT "In the Line of Duty?"***

- Participation, including practice, in any recreational or social activity, other than noncompetitive fundraising activities;
- Work rendered in the service of a private employer; public corporation or special district;
- Work rendered while on leave of absence or suspended from duty, or work that the volunteer has been ordered not to perform; or
- Competitive events in which volunteer members are competitors, such as baseball, basketball, football, bowling, tugs of war, donkey baseball, donkey basketball, boxing, wrestling, contests between bands or drum corps, or other competitive events in which volunteer members are competitors and which involve physical exertion on the part of the competitors.

## **(Section 9.2)**

### **New York State Insurance Fund**

Due to the fact that New York employers are required to provide workers compensation for their employees, a residual market was established as a resource when voluntary market coverage is unavailable.

The **New York State Insurance Fund (NYSIF)** is the largest writer of workers' compensation insurance in New York State. By law, it is required that workers' compensation premiums offered by NYSIF are fixed at the **lowest possible cost sufficient to maintain a solvent fund**.

NYSIF does not provide any compensation to insurance producers placing business on behalf of employers. However, the NYSIF also oversees a number of **Safety Groups** which may provide a commission to producers as well as a dividend to group members.

### **Admitted Carriers**

New York State remains a competitive market for a number of property casualty carriers active in the workers compensation market. Admitted carriers, operating through licensed insurance producers, have established underwriting guidelines limiting the eligibility of prospective customers. While many carriers may offer workers compensation as a benefit to their commercial policyholders, larger accounts may be aggressively sought.

### **Self-Insuring & Trust Funds**

An employer who wishes to self-insure for workers' compensation can do so in one of two ways: (1) by becoming an individual self-insurer or (2) by becoming a member of a self-insured group. Political subdivisions must also provide workers' compensation coverage to their employees, and they may elect to self-insure those benefits

### **Individual Self Insurance - Workers' Compensation**

An employer who wishes to self-insure on an individual basis for workers' compensation must submit the following as part of the application process:

- SI-1 Application for Self-Insurance - Workers' Compensation;
- Original copy of the applicant's most recent independently audited financial statement;
- Current payroll report of applicant broken out by classification code;
- Payroll history, broken down by classification code, for the last five years;
- Most recent carrier premium audit, with the current experience modification;
- Foundation documents (i.e. certificate of incorporation; partnership agreement; etc.);
- Applicant's safety program; and
- Incurred loss history of the applicant for the last five years.

If the applicant is deemed a good candidate for self-insurance, based upon all the information submitted, a conditional approval will be issued. Final approval will become effective when all documentation, as well as an adequate security deposit, have been received.

The amount of the initial security deposit will be based upon the current payroll report of the applicant broken down by classification code, and rates developed by the Compensation Insurance Rating Board (CIRB). The current minimum security deposit is determined as described in Rule 316.1, usually \$624,000. Every year that the employer remains self-insured, the security deposit is reviewed for adequacy, based upon the payroll codes, CIRB rates, and the employer's reported payroll.

The Self Insurance Office will utilize this information to determine that the Group Self Insurer is adequately funded. Group self-insurers must also report who their licensed third party administrator is if claims are not self-administered. Failure to meet any of the reporting requirements may result in termination of the group's status as a self-insurer.

### ***Political Subdivisions - Workers' Compensation***

Political subdivisions that elect to self-insure their workers' compensation must file a Notice of Election (Form SI-26), together with a resolution from its governing body, which states that they have elected to provide workers' compensation benefits through self-insurance.

Political subdivisions that elect to self-insure their workers' compensation are exempt from posting security deposits, and they are not required to submit annual reports. However, political subdivisions must report who their licensed third party administrator is, if claims are not self-administered.

### **Incurred losses**

If necessary, the employer must adjust the security deposit to adequate levels as determined by the Board. Failure to maintain security deposits in the amount determined by the Board may result in termination of the employer's self-insured status.

While actively self-insured, employers must submit the following information to the Office of Self Insurance on an annual basis:

- The most recent certified, independently audited financial statement;
- A payroll report filed by classification code;
- Statement of outstanding death and disability claims; and
- Statement of compensation and medical losses incurred by the self-insurer.

The Self Insurance Office will utilize this information to determine adequate security amounts for each self-insurer. Self-insurers must also report who their licensed third party administrator is if claims are not self-administered. Failure to meet any of the reporting requirements may result in termination of the employer's status as a self-insurer.

A self-insurer who has discontinued business in New York State, or has arranged for the payment of compensation by alternate methods (State Fund or carrier coverage), may terminate their status as a self-insurer at any time. The Board will maintain a security deposit for the discontinued self-insurer until all claims have been finally adjudicated and fully paid, and all expenses and assessments have been paid.

### ***Group Self Insurance - Workers' Compensation***

Joining a group is an alternative to carrier or State Fund coverage for employers who may not be able to self-insure on an individual basis. To qualify as a group self-insurer and to maintain authorization to operate as a group self-insurer, the group must: (1) include two or more employers that perform related activities in a given industry and that have been in business for a period of time which is acceptable to the Chair; (2) have and maintain an aggregate net worth of members which is at least one million dollars; and (3) have and maintain a combined annual payroll of group members which, when multiplied by the current rates promulgated by the New York Compensation Insurance Rating Board (CIRB), is at least \$500,000.

Any group of employers seeking initial authorization to operate as a group self-insurer must submit the following as part of the application process:

- GSI-1, Application for Group Self Insurance - Workers' Compensation Law;
- Trust Agreement and By-Laws of the Group Self-Insurer;
- GSI-1.1, Application for Participation in Group Self Insurance Plan, and Participation Agreement, for each employer participating in the group;
- A description of the safety program, if any, proposed for the employer group;
- An actuarial feasibility study directed and certified by an independent qualified actuary;
- Information about the group's trustees;
- Information about the officers, directors and general managers of the group administrator;

- A report identifying the projected rate of contribution and assessments to be paid by each member for the first year of the group's operation, and the manner in which such contributions and assessments were calculated;
- A description of the group's organization for the administration of claims as well as the duly executed contract between the board of trustees, the group administrator and the claims administrator;
- Any duly executed contract between the board of trustees and either an attorney-at-law licensed to practice in New York State or a representative of self insured employers licensed by the Workers' Compensation Board pursuant to subdivision (3-b) or (3-c) of Section 50 of the Workers' Compensation Law, pertaining to the representation of group members before the Workers' Compensation Board; and
- Evidence of relevant experience from the group administrator.

If the applicant is deemed a good candidate for group self-insurance, based upon all the information submitted, a conditional approval will be issued. Final approval will become effective when all documentation, as well as an adequate security deposit, have been received.

The amount of the initial security deposit will be based upon the current payroll report of the group members broken down by classification code, and rates developed by the Compensation Insurance Rating Board (CIRB). Group self-insurers are required to establish and maintain trust assets in an amount that exceeds trust liabilities, as those terms are defined in Section 317.2 of the Rules and Regulations. Group self-insurers who fail to comply with this capitalization standard shall be deemed "under-funded" and shall immediately provide the chair with an acceptable plan of action as may be appropriate in order to make up the deficiency in a timely manner. Such under-funded groups may also be subject to any or all of the provisions set forth in Section 317.9 of the Rules and Regulations.

In the event of the insolvency of a group self-insurer, participating members would be held jointly and severally liable for the unpaid obligations of the group incurred during the time of the employers' participation. For this reason, employers interested in participating in a group should review all relevant documentation of the group self-insurer, including, but not limited to: the group's independently audited financial statement; the trust document and by-laws; and the group's methodology for developing contribution levels.

Group self-insurers are required to notify the Board, on properly executed prescribed forms, any time employers join or leave the group self-insurance program. In addition, group self-insurers must submit the following information to the Office of Self Insurance on an annual basis:

A financial summary report in a form prescribed by the Chair;

- Certified, independently audited financial statements;
- Certified, independent actuarial report;
- A payroll report filed by classification code, for each group member and in aggregate.

### ***Who is Covered?***

- Workers in all employments conducted for profit. Part-time employees, borrowed employees, leased employees, family members and volunteers are also included under the workers' compensation law.
- Employees of counties and municipalities engaged in work defined by the law as "hazardous".
- Public school teachers, excluding those employed by New York City, and public school aides, including New York City.
- Employees of the State of New York, including some volunteer workers.
- Domestic workers employed forty or more hours per week by the same employer (including full-time sitters or companions, and live-in maids).
- Farm workers whose employer paid \$1,200 or more for farm labor in the preceding calendar year.
- Any other worker determined by the Board to be an employee.
- All corporate officers if a for-profit corporation has more than two officers and/or two stockholders.
- Officers of one-or-two person corporations if there are other individuals in employment. These officers may choose to exclude themselves from coverage.
- Volunteer Firefighters and Volunteer Ambulance Workers are provided benefits for death or injuries suffered in the line of duty under the Volunteer Firefighters' Benefit Law and Volunteer Ambulance Workers' Benefit Law.

### *Who is not Covered?*

- Individuals that volunteer their services for nonprofit organizations and receive no compensation. {compensation includes stipends (stipends used solely to offset expenses incurred while performing activities for the nonprofit are not counted as stipends), room and board, and other "perks" that have monetary value.}
- Clergy and members of religious orders that are performing religious duties.
- Members of supervised amateur athletic activities operated on a non-profit basis, provided that such members are not otherwise engaged or employed by any person, firm, or corporation participating in such athletic activity.
- People engaged in a teaching capacity in or for a nonprofit religious, charitable or educational institution (Section 501(c)(3) under the IRS tax code). To be exempt, the teachers must only be performing teaching duties.
- People engaged in a non-manual capacity in or for a nonprofit religious, charitable or educational institution (Section 501(c)(3) under the IRS tax code). [Manual labor includes but is not limited to such tasks as filing; carrying materials such as pamphlets, binders, or books; cleaning such as dusting or vacuuming; playing musical instruments; moving furniture; shoveling snow; mowing lawns; and construction of any sort.]
- Persons receiving charitable aid from a religious or charitable institution who perform work in return for such aid and who are not under any express contract of hire, and certain persons receiving rehabilitation services in a sheltered workshop.
- People employed in certain maritime trades, interstate railroad employees, federal government employees and others covered under federal workers' compensation laws.
- People, including minors, doing yard work or casual chores in and about a one-family, owner-occupied residence. Casual means occasionally, without regularity, without foresight, plan or method. Coverage is required if the minor handles power-driven machinery, including a power lawnmower.
- The spouse and minor children (under 18 years old) of an employer who is a farmer as long as they are not under an express contract of hire.
- Certain employees of foreign governments and Native American Nations.
- New York City police officers, firefighters, and sanitation workers. Uniformed police officers and firefighters in other municipalities may also be excluded.
- Certain real estate salespersons who sign a contract with a broker stating that they are independent contractors.
- Certain insurance agents or brokers who sign a contract stating that they are independent contractors.
- Sole proprietors, partners, and one/two person corporate officers with no employees (although coverage may be obtained voluntarily).

**(Section 9.3)**

**Wage Replacement (Cash) Benefits**

Claimants who are totally or partially disabled for more than seven days receive benefits for lost wages. The amount you receive is based on your average weekly wage for the 52 weeks prior to the date of injury, including overtime. It's based on your gross earnings, not your take-home pay. The Board will use two-thirds of your average weekly wage, and then adjust it by the extent of your disability:

$$2/3 \times \text{average weekly wage} \times \% \text{ of disability} = \text{weekly benefit}$$

The weekly **maximum benefit is two-thirds your average weekly wage. If you suffer a total disability, you get two-thirds** your weekly wage, up to the maximum (see below). For example, if you earn \$750 per week and are totally (100%) disabled as of today, you receive two-thirds of \$750, or \$500 per week. You're 100% disabled, so you receive all of the benefit.

If you're 50% disabled and earned \$750 per week, your benefit is \$250. To calculate it: two-thirds your \$750 average weekly wage equals \$500. Then, because you are 50% disabled, your benefit is half of \$500, or \$250.

The benefit rate is computed the same way, whether you are temporarily or permanently disabled. The maximum weekly wage benefit is based on accident date. It does not increase as maximum benefits increase.

***Schedule of Benefits***

<b><i>Date of Accident</i></b>	<b><i>Weekly Maximum Total / Partial</i></b>
July 1, 1985 - June 30, 1990	\$300 / \$150
July 1, 1990 - June 30, 1991	\$340 / \$280
July 1, 1991 - June 30, 1992	\$350 / \$350
July 1, 1992 - June 30, 2007	\$400 / \$400
July 1, 2007 - June 30, 2008	\$500 / \$500
July 1, 2008 - June 30, 2009	\$550 / \$550
July 1, 2009 - June 30, 2010	\$600 / \$600
July 1, 2010 - June 30, 2011	\$739.83 / \$739.83
July 1, 2011 - June 30, 2012	\$772.96 / \$772.96
July 1, 2012 - June 30, 2013	\$792.07 / \$792.07
July 1, 2013 - June 30, 2014	\$803.21 / \$803.21
July 1, 2014 - June 30, 2015	\$808.65 / \$808.65
July 1st of each succeeding year	2/3 of NYSAWW*

\* The New York State Average Weekly Wage is calculated on March 31 for the previous calendar year.

If you're disabled more than 14 days, you may get wage benefits from the first day. Otherwise, the first 7 calendar days of the disability are not covered. Medical care for your injury is provided as long as it's needed, as determined by the Board. **Note: If the insurer disputes your case, it may withhold your wage replacement benefit until the Board directs it to pay you.**

### **Reduced Earnings Benefits**

If you can return to work but your injury keeps you from earning the same wages you once did, you may be entitled to a benefit that will make up two-thirds of the difference. These are reduced earnings benefits.

<http://www.wcb.ny.gov/content/main/onthejob/CashBenefits.jsp>

### **(Section 9.4)**

### **Disability Insurance**

Disability Insurance, or “**Sick Pay**”, is perhaps the most overlooked, yet affordable, employee benefit available to employers. While the **New York Disability Benefits Law (DBL)** mandates that all employers provide disability insurance to their employees, the **coverage is minimal**, short term and often highly insufficient to meet the basic needs of covered individuals. Higher limit DBL (short term) and long term disability insurance coverages are available from several carriers.

### **Disability Benefits Law (DBL)**

New York State requires payment of cash benefits to wage earners who become disabled as a result of a **Non-Occupational injury or illness**. Any Employer in the State of New York with one or more employees in a calendar year becomes a "Covered Employer." This includes employers of one or more domestic employees working in a private home for at least 40 Hours per Week.

Employees are **eligible for 50% of their average weekly wage** (based upon the last eight weeks earnings) to a maximum benefit of \$170 per week. Benefits are paid beginning with the 8th consecutive day of disability, for up to a maximum of 26 Weeks. The minimum weekly benefit is \$20.

DBL premiums may be paid entirely by the employer. If the employee contributes to the cost, the employee may not contribute more than one half of one percent of the first \$120 of weekly wages, to a maximum of \$.60 per week.

- Most Employees in the State of New York are eligible if working for a covered Employer.
- Full-time Employees, new to working are eligible after working for 4 consecutive weeks.
- Part-Time Employees, new to working are eligible on the 25th day of regular employment for one Employer.
- Employees receiving Unemployment Benefits are eligible Immediately upon beginning work.
- New Employees who have previously established eligibility with another Employer are eligible immediately upon beginning work, as long as the gap in employment is not more than four weeks.
- Personal or Domestic Employees working for the same Employer in a private home at least 40 hours a week.
- A Spouse working for a Sole Proprietor or Partnership unless an exclusion is elected.
- College Students are eligible for DBL Benefits if they meet any of the above requirements.
- A Corporate Officer is an Employee and will be covered, unless he receives no wages or remuneration for services.

## Who is Not Eligible for Benefits?

- Minor Children of an Employer.
- Government, Railroad, or Maritime Employees.
- Ministers, Priests, Rabbis, Members of a Religious Order, Sextons, or Christian Science readers.
- Persons engaged in a professional or teaching capacity for a non-profit religious, charitable, or educational institution; persons receiving rehabilitation in a sheltered workshop, under a certificate issued by the Department of Labor.
- Persons receiving aid from religious, charitable, or educational institutions, who perform services in exchange for such aid.
- Golf caddies.
- Daytime elementary or high school students who work part-time during the school year or during vacation periods.
- Independent contractors.
- Employees during the first 45 days of "extra employment". These are persons not normally in the labor market who are hired to do work for a limited special period of time.
- Employees in "casual employment". An employee who normally works in a different occupation, who is hired for a day or less.
- Corporate Directors, acting only as such, and not as employees.
- Partners and Proprietors are not required to be covered. They must however cover any eligible employees.
- Executive Officers of an incorporated non-profit, religious, charitable, or educational institution. (President, Vice-President, Secretary or Treasurer)
- An Employer may elect to provide voluntary benefits to an excluded class of employees by filing an application for voluntary coverage with the Worker's Compensation Board.
- Employees working outside of New York are covered if their service is not localized in any other state, and some of their service is performed in New York State;  
or if there is no base of operation in any state, but the Employee is directed and controlled from New York State;  
or the place from which the Employee is directed or controlled is not in any state in which some part of the service is performed, and the Employee's residence is in New York State.

## **DBL Pregnancy & Coverage**

Pregnancy is treated like any other disability. Eligibility for benefits is based upon medical certification of disability, which may occur at any time during pregnancy. However, an employee on unpaid maternity leave who become disabled is eligible only within 4 weeks of the last day actually worked.

## **Disabilities Caused by an Automobile Accident**

DBL is **Primary over No Fault** Automobile insurance. No Fault benefits may be reduced accordingly. DBL claims must be filed within the 30 day time limit.

## **Employees Collecting DBL and S. S. Retirement Benefits**

Eligibility for Social Security Retirement Benefits does not affect the right to DBL.

## **FICA Tax Withholding from DBL Benefits**

The Employee's regular share of FICA tax (7.65%) is withheld. The Employee may also elect to have Withholding Tax taken out as well.

## **Additional Disability Coverage**

Additional disability insurance is available with short-term DBL and through Long-Term Disability plans. Many DBL carriers offer increased benefit plans that double the statutory maximum weekly benefit to \$340.

Length of benefits under DBL short-term plans is limited to 26 weeks. Long-term disability coverage can provide benefits for terms that expire when the insured reaches retirement age. Long-term disability may be purchased with higher benefit limits than DBL. Monthly benefits provide up to 60% of insured's wages.

## Need for Disability Insurance

Despite the relative affordability of long-term disability insurance, it is the least likely benefit to be provided.

*Average annual medical benefit costs to employers among those companies reporting payments in 2000.*

*SOURCE: U.S. CHAMBER OF COMMERCE, FEBRUARY 2002*

Benefit	Dollars per employee	Percentage of payroll
Hospital, surgical medical and major- medical insurance	\$3,028	7.2%
HMO plan only	2,260	6.0
PPO plan only	2,623	6.8
Point-of-service plan	3,906	7.5
Indemnity plan only	5,417	8.4
Dental insurance	349	0.7
Vision care	35	0.1
Retiree health insurance	2,245	3.6
Prescription drug coverage	514	1.1
Health plan administration	397	0.8
Short-term disability	333	0.6
Long-term disability	114	0.3

The **1985 NAIC Commissioners Disability Table** continues to be the national standard for indicating the percentage of people who can expect to suffer a long term disability of 90 days or more before they reach the age of 65.

<b>Age</b>	<b>Percentage</b>	<b>Disabled</b>
25	52%	1 out of 2
30	51%	1 out of 2
35	48%	4 out of 9
40	45%	4 out of 9
45	40%	2 out of 5
50	34%	1 out of 3
55	27%	1 out of 6
60	16%	1 out of 6

If a disability of 90 days or more lasts two years, it will probably continue longer.

<b>Age when disabled 90 days</b>	<b>Percentage still disabled after 2 years and 90 days</b>	<b>Percentage still disabled after 5 years</b>
25	63.5%	44.2%
35	69.7%	52.6%
45	73.6%	58.0%
55	77.6%	59.6%

Employers and employees should consider their individual income needs and the relative affordability of long-term disability insurance when reviewing their benefit plans.

**Monthly Income Required**

Let's look at your obligations which will continue even if you are disabled and are unable to work:

- a) Mortgage/Rent \$ \_\_\_\_\_
- b) Utilities \$ \_\_\_\_\_
- c) Auto Payment \$ \_\_\_\_\_
- d) Auto and Homeowner's Insurance \$ \_\_\_\_\_
- e) Life and Medical Insurance \$ \_\_\_\_\_
- f) Groceries \$ \_\_\_\_\_
- g) Medical/Dental Expenses \$ \_\_\_\_\_
- h) Other Fixed Expenses such as  
credit card payments, school loans, etc. \$ \_\_\_\_\_
- i) Savings \$ \_\_\_\_\_
- Total** \$ \_\_\_\_\_

**(Section 9.4)**

Workers Compensation & Disability Review

**Workers' Compensation** is insurance that provides cash benefits and/or medical care for workers who are ***injured or become ill as a direct result of their job***

The **Workers' Compensation Board** is a state ***agency that processes the claims*** and determines, through a judicial proceeding, whether a worker will receive benefits and/or medical care, and how much he/she will receive

A worker loses his/her right to workers' compensation if the injury results solely from his/her ***intoxication from drugs or alcohol, or from the intent to injure him/herself or someone else.***

The **New York State Insurance Fund (NYSIF)** is the largest writer of workers' compensation insurance in New York State.

The **NYSIF** also oversees a number of **Safety Groups** which may provide a commission to producers as well as a dividend to group members.

Claimants who are ***totally or partially disabled*** for more than ***seven days*** receive benefits for lost wages.

The weekly ***maximum benefit*** is ***two-thirds*** your average weekly wage.

The **New York Disability Benefits Law (DBL)** mandates that all employers provide disability insurance to their employees

Under statutory disability (DBL), employees are ***eligible for 50% of their average weekly wage*** (based upon the last eight weeks earnings) to a maximum benefit of \$170 per week

DBL benefits are paid beginning with the ***8th consecutive day of disability***, for up to a maximum of 26 Weeks.

**Pregnancy** is treated like any other disability under DBL

## Development of Regulation

### Chapter 10

#### (Section 10.1)

#### **Regulation of the Insurance Industry**

Regulation of the insurance industry, as discussed in this text, dates back to Hammurabi, in general terms, and to the early middle-ages with “Charters” granted by the Crown to Guilds in Europe. In the modern era, regulation has developed more quickly, giving us the state of regulation we operate under today. Governments, from early Colonial times through most of the first century of our existence as a nation, first granted charters and steadily increased oversight of the growing insurance industry.

Through the 1840’s, insurance companies were granted Charters to operate from the New York State Legislature. Between 1849 and 1859, the framework changed to provide more control over the business of insurance when “Article of Incorporation” were first required to be filed with the Secretary of State. During this period, the State Comptroller had power to require annual financial reports from insurers and halt operation if a company was financially unsound.

Until 1849, insurance companies doing business in New York State were chartered by special acts of the Legislature. A law was passed that year requiring prospective insurance companies to file incorporation papers with the Secretary of State. The law also vested regulatory power over insurance companies with the State Comptroller, who was authorized to require the companies to submit annual financial statements and to deny a company the right to operate if capital securities and investments did not remain secure.

<http://www.dfs.ny.gov/about/history.htm>

New Hampshire was the first state to create a state insurance department with a Superintendent in 1851. New York followed with the establishment of its own State Insurance Superintendent in 1859.

The Insurance Department was created in 1859 by the New York State Legislature and assumed the functions of the Comptroller and Secretary of State relating to insurance. The Department began operations in 1860.

<http://www.dfs.ny.gov/about/history.htm>

Individual states had always managed insurance without significant coordination. In 1871, a **National Insurance Convention** was organized. One of the primary concerns was the **oversight of multi-state insurers**. The convention was successful and led to the formation of the **National Association of Insurance Commissioners (NAIC)**. The NAIC itself has no regulatory authority. The NAIC general provides “Model” legislation for individual State Regulators to follow in developing their own Laws, Rules and Regulations. Perhaps the most well know model is the New York Standard Fire Policy form adopted in 1887.

As the United States gained its independence and progressed through the industrial revolution, insurance companies formed and became more active. By the mid-1800s, insurers were thriving in New England and developing their own customized fire insurance contracts. The absence of standard wording in these contracts presented many problems, however, in the interpretation of coverage. It became clear that a more uniform approach was desirable. Massachusetts adopted a standard form for writing fire insurance in 1873, followed in the next few years by several other states. The New York state legislature, in collaboration with the insurance industry, adopted a standard fire policy form in 1887, revised it in 1918, and by July 1, 1943, it had evolved into the “165 line form,” popularly referred to as the New York Standard Fire Policy. The 165 line form was soon approved by reference in most states, with some states during that period incorporating the exact wording into statute.

[http://www.naic.org/documents/prod\\_serv\\_marketreg\\_pfr\\_hdb.pdf](http://www.naic.org/documents/prod_serv_marketreg_pfr_hdb.pdf)

The regulation of insurance at the Federal level has been debated off and on for more than 150 years; from *Paul v. Virginia* in 1859, where the Supreme Court decided that “issuing a policy of insurance is not a transaction of commerce” (NAIC Center for Insurance Policy and Research) to the McCarran-Ferguson Act of 1945.

### ***Paul v. Virginia***

The question of whether the states or the federal government should regulate the business of insurance has been with us since the mid-1800s. To help clarify the matter, in 1869 the U.S. Supreme Court, in *Paul v. Virginia*, held that insurance was not commerce and was, therefore, not subject to federal regulation under interstate commerce laws. This quintessential case has shaped the regulation of insurance to this day.

The following paragraphs describe events and arguments related to *Paul v. Virginia*:

In May 1866 Samuel Paul, a resident of Virginia, was appointed the agent for a number of New York insurance companies. Earlier that year the Legislature of Virginia had passed a statute providing that no person shall, without a license authorized by law, act as agent for any foreign (other state) insurance company. The New York insurance companies were hoping to invalidate the Virginia statute through the court case.

Samuel Paul did not comply with all requirements of the Virginia statute for obtaining the required license, so it was disallowed. However, Mr. Paul subsequently sold a fire insurance policy in Virginia and was therefore convicted by the Virginia Circuit Court. The case ultimately was appealed to the United States Supreme Court on the grounds of writ of error, principally being that the judgment violated the Commerce Clause, which empowers Congress “to regulate commerce with foreign nations, and among the several states.”

The U.S. Supreme Court decision on *Paul v. Virginia*, read Nov. 1, 1869, upheld the Virginia court decision and added that such law does not conflict with the provisions of the Constitution—that Congress shall have power to regulate commerce among the several states. The Supreme Court justices further noted the following:

Issuing a policy of insurance is not a transaction of commerce. The policies are simply contracts of indemnity against loss by fire, entered into between the corporation and the assured, for a consideration paid by the latter. These contracts are not articles of commerce in any proper meaning of the word. Such contracts are not interstate transactions, though the parties may be domiciled in different states. The policies do not take effect—are not executed contracts—until delivered by the agent in Virginia. They are, then, local transactions governed by the local law.

*Paul v. Virginia*, therefore, was the reason that the states were initially charged to regulate the business of insurance. The National Insurance Convention of the United States was formed in 1871 in large part because of *Paul v. Virginia*. The National Insurance Convention of the United States provided the insurance commissioners with a national forum for discussion of common issues and interests that transcended the boundaries of their own jurisdictions (known since December 1935 as the National Association of Insurance Commissioners, or NAIC).

[http://www.naic.org/documents/prod\\_serv\\_marketreg\\_pfr\\_hdb.pdf](http://www.naic.org/documents/prod_serv_marketreg_pfr_hdb.pdf)

The National Association of Insurance Commissioners’ (NAIC) has played a key role in **coordinating the licensing and continuing education requirements** of the individual states. The NAIC Consumer Affairs Committee (D Committee) runs the Producer Licensing Working Group (PLWG), which continues to work on developing new “Producer Licensing Model Acts” (PLMA) for adoption by individual states. One main recommendation contained in the NAIC PLMA Licensing Handbook 2008 Draft Edition is that individual licensees complete a minimum of 3 hours in Ethics in each biennial compliance period.

Great emphasis has been placed on the professionalism of insurance licensees and their legal, moral and ethical conduct. While there has always been an expectation for insurance agents and brokers to act in a moral and ethical manner, the current push to expand ethics education is linked directly to passage of the Gramm-Leach-Bliley Act.

The process for licensing insurance producers has had numerous phases. The first NAIC model on this subject was the NAIC Agent and Broker Model. The next phase was the NAIC Single License Producer Model. Although development of the newest model began in the late 1990's, it was Congress' passage of the Gramm-Leach-Bliley Act (GLBA) that caused the NAIC to speed the development of the new NAIC Producer Licensing Model Act (PLMA).

One of the major provisions of GLBA was a provision to create an organization known as the National Association of Registered Agents and Brokers (NARAB). If created, NARAB would provide a mechanism through which uniform licensing, appointments, continuing education and other insurance producer sales qualification requirements and conditions could be adopted and applied on a multistate basis. To prevent the creation of NARAB, the states had the option either 1) to enact in at least 29 states reciprocity laws and regulations governing the licensure of nonresident individuals and entities authorized to sell and solicit insurance within those states, or 2) to enact uniform laws and regulations governing the licensure of individuals and entities authorized to sell and solicit the purchase of insurance within the states. If the states failed to accomplish at least one of these options by November 12, 2002, the NARAB provisions would pre-empt state insurance licensing laws.

The NAIC moved quickly to meet the reciprocity threshold of GLBA to avoid preemption of state licensing laws. The PLMA was adopted, which contained guidelines for states to comply with reciprocity and established uniform guidelines on a number of licensing issues. In addition, the PLMA grants a commissioner the authority to waive any existing state requirement that violates reciprocity. A sufficient number of states adopted the reciprocity provisions of the PLMA prior to the 2002 deadline and NARAB was not created.

Through the efforts of the Producer Licensing Working Group (PLWG) and its subgroups, the NAIC monitors state compliance with reciprocity guidelines. Under GLBA, NARAB could still be formed if the states fail to maintain the minimum reciprocity specified.

The NAIC also set a goal to create uniform licensing practices. The PLWG has adopted a number of uniform resident licensing standards (URLS) and guidelines and continues to strive toward a more efficient licensing system among the states.

***NAIC State Licensing Handbook 2008 edition (May Draft)***

## **(Section 10.2)**

### **Modern Era Federal Regulations**

While some may take offense to having their ethical, moral and professional values called into question, a closer look at the history behind these changes is helpful in understanding regulators' reasoning in implementing these requirements.

Throughout our history, the United States has had periodically changed insurance industry regulations. The most notable changes are:

- The Glass Steagall Act of 1933 prohibiting national and state banks from affiliating with securities companies;
- The Bank Holding Company Act of 1956 prohibiting a bank from controlling a non-bank company;
- The 1982 Bank Holding Act further prohibiting banks from general insurance underwriting and agency activities.
- The 1999 Graham-Leach-Bliley (GLBA), instituting sweeping changes across the financial industry, changing the regulation of banks, insurers and financial institutions.

However, the GLBA was prompted in large part by the European Union (EU) Data Protection Directive of 1995.

*“the EU passed the Data Protection Directive, which required that international data exchanges that used EU citizens' personal data be accorded the same level of protection that their home country would afford them. This meant that US companies would have to ensure that when they used EU citizens' personal data they provided the same level of protection these citizens were afforded within the EU. The EU was especially concerned with the US government's preference for self-regulatory approaches to privacy and the lack of federal privacy legislation. While the EU-US agreed to a Safe Harbor proposal, which allowed for companies to self-regulate under FTC oversight, financial services industries were not included in the original agreement.” **Electronic Privacy Information Center**  
<http://epic.org/privacy/glba/>*

Since GLBA set certain frameworks for the future of the financial services industry, existing organizations have devoted significant resources and many new groups have formed to address the changes required by the 1999 legislation. Of significance to this course are the activities of the National Association of Insurance Commissioners (NAIC), the New York State Insurance Department and findings of various other groups including the Bloomberg-Schumer Report “Sustaining New York’s and the US’ Global Financial Services Leadership”.

The Bloomberg-Schumer report released in January 2007 shows that New York remains the world’s largest financial market and the most important in many measures. However, the report outlines significant challenges facing the US financial services industry.

*“the findings also identify three factors that clearly dominate financial services leaders views of New York -- and by extension the United States – as a place to do business: skilled workers, the legal environment, a regulatory balance (including responsiveness by regulators and the overall regulatory environment). In each area, there are growing concerns that policy makers should consider in order to reverse the declining appeal and competitiveness of the United States and New York City”. Bloomberg-Schumer pf 15.*

Specifically, the report notes:

*“New York and the US were at a competitive disadvantage with the UK due to “a propensity toward litigation and concerns that the US legal environment is less fair and less predictable than the UK environment”. Bloomberg-Schumer pg16.*

While it is clear that business leaders respect the need for strong enforcement and punitive penalties for corporate malfeasance, the report states:

*“business leaders increasingly perceive the UK’s single, principles-based financial sector regulator – the Financial Services Authority (FSA) – as superior to what they see as a less responsive, complex US system of multiple holding company and industry segment regulators at the federal and state levels.” Bloomber-Schumer pg 16.*

Among the Bloomberg-Schumer report recommendations is the development of a shared vision for financial services and a set of supporting regulatory principles.

To address various GLBA requirements, industry concerns and the changing global insurance market, the NAIC has established a Principal-Based Reserving Working Group (PBR) under the Executive Committee. The initial focus of the PBR has been on the activities of the NAIC Life and Health Actuarial Task Force (LHATF). Following its’ work with the LHATF, the PBR Working Group will begin working with other area, including the Property Casualty and Corporate Governance. The PBR has been charged with the following:

1. To serve as a coordinating body with all NAIC technical groups involved with projects related to a principles-based approach to regulation.
2. To consider policy and practice issues related to principles-based regulation for life insurance and thereafter property and casualty insurance, including but not limited to the impact on areas such as corporate governance, examination and analysis, as well as staff resources and other insurance department administrative concerns.

3. To focus on balancing theoretical approaches with effective regulatory practices to achieve desired end-results in solvency monitoring efforts, and further coordinate with NAIC leadership to provide direction to NAIC technical groups, including whether and to what degree principles-based approaches should be pursued, setting timelines for such pursuit, and ensuring other issues are addressed prior to or concurrently with implementation of principles-based approaches by the technical groups.
4. To report the status of its work to, and seek guidance from, the Executive Committee no less frequently than a quarterly basis.
5. To evaluate necessary changes to existing state insurance laws, regulations or administrative policies to effectuate a principles-based regulatory framework.

### **Dodd-Frank Wallstreet Reform Act of 2010**

The institutional failures of financial companies in 2007 initiated the most significant economic recession since 1929. While largely attributed to mortgage lending institutions' failures to adhere to minimal underwriting principals, the facts point to a wider lack of discipline within large financial institutions to act with an appropriate level of care for investor resources and consumer welfare.

The **Dodd-Frank Wall Street Reform and Consumer Protection Act**, signed into law on July 1, 2010, is considered to be the most sweeping overhaul of US financial regulations since the Glass-Steagall Act of 1933. The Act creates more than 240 new rules, requires the completion of more than 60 studies and requires nearly 2 dozen periodic reports.

### **HIGHLIGHTS OF THE LEGISLATION**

- Consumer Protections with Authority and Independence
- Ends Too Big to Fail Bailouts
- Transparency & Accountability for Exotic Instruments
- Executive Compensation and Corporate Governance
- Protects Investors
- Enforces Regulations on the Books
- NEW OFFICES OF MINORITY AND WOMEN INCLUSION
- MORTGAGE REFORM
- Raising Standards and Regulating Hedge Funds
- New Requirements and Oversight of Credit Rating Agencies
- Gives Shareholders a Say on Pay and Creating Greater Accountability
- IMPROVEMENTS TO BANK AND THRIFT REGULATIONS
- CREDIT SCORE PROTECTION
- SEC and Improving Investor Protections

With respect to insurance, the Act leaves nearly all regulatory authority with the States. However, the Act does address non-admitted carriers, reinsurance and requires monitoring of marketplace activities.

### **INSURANCE**

- **Federal Insurance Office:** Creates the first ever office in the Federal government focused on insurance. The Office, as established in the Treasury, will gather information about the insurance industry, including access to affordable insurance products by minorities, low- and moderate- income persons and underserved communities. The Office will also monitor the insurance industry for systemic risk purposes.
- **International Presence:** The Office will serve as a uniform, national voice on insurance matters for the United States on the international stage.
- Streamlines regulation of surplus lines insurance and reinsurance through state-based reforms.

The impact of the Dodd-Frank Act on financial service representatives will be determined in the coming years. Studies are currently being conducted in the complex industry and new rules will continue to develop. Significant focus is placed on “standards of care for brokers, dealers and investment advisors, with respect to advice given to retail customers”.

## SEC and Improving Investor Protections

- **Fiduciary Duty:** Gives SEC the authority to impose a fiduciary duty on brokers who give investment advice --the advice must be in the best interest of their customers.
- **Encouraging Whistleblowers:** Creates a program within the SEC to encourage people to report securities violations, creating rewards of up to 30% of funds recovered for information provided.
- **SEC Management Reform:** Mandates a comprehensive outside consultant study of the SEC, an annual assessment of the SEC's internal supervisory controls and GAO review of SEC management.
- **New Advocates for Investors:** Creates the Investment Advisory Committee, a committee of investors to advise the SEC on its regulatory priorities and practices; the Office of Investor Advocate in the SEC, to identify areas where investors have significant problems dealing with the SEC and provide them assistance; and an ombudsman to handle investor complaints.
- **SEC Funding:** Provides more resources to the chronically underfunded agency to carry out its new duties.

### (Section 10.3)

## Principles Based Regulation Modern Era Federal Regulations

With the NAIC continuing to take action on GLBA, the release of the Bloomberg-Schumer Report and continuing pressure from global markets to move business away from New York and the United States, it is no coincidence that New York formed a new commission in May 2007 to modernize its' regulation of financial services. The New York State Commission to Modernize the Regulation of Financial Services is a 45 member of the industries powerhouses, consumer protection groups, federal and state agency representatives and state legislators. Notable members include the Chairman and CEO of the Goldman Sachs Group, Executive Vice President of JP Morgan Chase, Chairman of Swiss RE America Holding Corporation, President and CEO of NASDAQ, President and CEO of AIG, and Chairman and CEO of Merrill Lynch.

In November 2007, New York State Insurance Department Superintendent, Eric Dinallo, introduced a proposal to the Commission to Modernize the Regulation of Financial Services for a transition to Principals-Based Regulations. The proposal includes one set of Principles for the Insurance Industry and a second set of Principles for Regulators. This proposal was made to the New York State Commission to Modernize the Regulation of Financial Services, which is reviewing current financial services statutes, regulations and policies, and will propose legislative and other necessary changes to promote competition and the growth of business, while protecting both consumers and honest businesses from unfair or unethical practices.

### **Principles-Guided Regulation**

A more principles-based approach to regulation aims to reduce unnecessary regulatory and administrative burdens, ensure that regulation and its enforcement are proportionate, accountable, consistent, transparent and targeted, and provide benefits for consumers from more efficient markets, more effective protection and better responsiveness to consumers' needs.

The essential goal of regulation is not rote compliance with a long list of rules, but ensuring appropriate outcomes. These principles focus both the regulator and the regulated on such outcomes and tell regulated companies our expectations for how they will conduct their business. It brings the issue of compliance to the highest levels of a company – to the Board of Directors and the management committee. It provides the flexibility to fit the different business models of thousands of different companies, while improving consumer protection.

A more principles-based approach to regulation gives the regulator the right tools to begin changing its relationship with the regulated. An essential part of a principles-based approach is an open door between the regulator and companies so the companies can seek and receive guidance, instead of having regulation become a periodic "gotcha" exam. Companies that deal honestly with a regulator should expect to be treated honestly in return.

On November 5, 2007, Eric Dinallo, Superintendent of the New York State Insurance Department and Chair of the Commission, released a draft regulation that would make the New York Insurance Department the first in the nation to establish principles-based regulation. The draft includes 10 principles for industry and is accompanied by 10 principles for regulators. ([http://www.fsc.ny.gov/rfs\\_pgr.htm](http://www.fsc.ny.gov/rfs_pgr.htm))

**ISSUED 11/05/2007 FOR IMMEDIATE RELEASE**

**New York Insurance Department Issues First Principles-Based Regulation Proposing Principles for Both Regulated and Regulators**

Insurance Superintendent Eric Dinallo today released a [draft regulation](#) that would make the New York Insurance Department the first in the nation to establish principles-based regulation. The draft includes 10 principles for industry and is accompanied by 10 principles for regulators. The draft regulation will be distributed for discussion by the industry and consumers and will be on the agenda of the New York State Commission to Modernize the Regulation of Financial Services, which Dinallo chairs.

Principles-based regulation aims to reduce unnecessary regulatory and administrative burdens, ensure that regulation and its enforcement are proportionate, accountable, consistent, transparent and targeted, and provide benefits for consumers from more efficient markets, more effective protection, and better responsiveness to consumers' needs.

"New York must have the best, most effective regulation of financial services in order to remain the financial capital of the world," Dinallo said. "Today that means principles-based regulation. The financial services marketplace is extremely creative and innovative and our regulation must be just as nimble. Thus, the best way to protect consumers and promote fair and honest competition is with principles-based regulation."

"The essential goal of regulation is not rote compliance with a long list of rules, but ensuring appropriate outcomes. These principles focus both the regulator and the regulated on such outcomes and tell regulated companies our expectations for how they will conduct their business. It brings the issue of compliance to the highest levels of a company – to the Board of Directors and the management committee. It provides the flexibility to fit the different business models of thousands of different companies, while improving consumer protection," Dinallo said.

"As a code of conduct, the principles are reasonable rules that can be easily incorporated into the business philosophy and operations of regulated parties with little or no expense. In fact, most regulated entities should already be operating in accordance with such principles," Dinallo said. "Importantly, the principles will not expose companies to additional private lawsuits because New York's Insurance Law generally does not provide for private rights of action. Only the regulator can enforce the principles. This is, in fact, a significant competitive advantage for New York."

"The principles ask companies to be ethical to their core, rather than focusing on technical requirements. Indeed, if a company is generally conforming to the principles, but violates a rule in a way that does not harm the public, we should take that into account," Dinallo said. "It is clear that detailed rules alone have not prevented misconduct. In fact, principles eliminate loopholes and gaps between rules that could allow activities that harm consumers or mislead regulators."

"The Commission will discuss the principles at the upcoming January meeting. This is an opportunity for the Commission to focus on a key competitiveness issue – the ability of our regulatory system to keep up with ever-evolving and innovative markets," said Scott Rothstein, Executive Director of the Commission. "The principles do not pre-empt existing law or regulation. But they make clear the fundamental purposes behind those laws and regulations and can serve as scaffolding around the existing regulatory structure, providing support and guidance as products, practices and markets evolve."

"Principles-based regulation gives the regulator the right tools to begin changing its relationship with the regulated. An essential part of a principles-based approach is an open door between the regulator and companies so the companies can seek and receive guidance. We expect to turn regulation from periodic 'gotcha' exams into a continuing dialogue. Companies that deal honestly with the Department can expect to be treated honestly in return. But we will, if anything, be more stern with serious violations," Dinallo said.

The [proposed new regulation](#) continues and codifies the Insurance Department's move towards principles and risk-based regulation under Superintendent Dinallo, who took office this year. This approach has already been applied in the settlement of the World Trade Center insurance claims and in the implementation of the

workers' compensation reforms, where the Department has introduced free-market principles. This is the third significant draft regulation circulated by the Department for public comment in the last month that reflects the new principles-based approach. The first requires property insurers to create a reserve for catastrophes such as hurricanes. The second treats top-rated non-U.S. reinsurers the same as U.S. companies on the issue of posting collateral.

The Department has also developed a proposed list of principles for regulators, which it intends to issue as a Circular Letter. The principles for the regulators will establish a baseline for interactions between the Department and regulated entities, and are intended to focus regulatory action on key areas of risk, while fostering competition and innovation.

Implementing a principles-based approach will require continuation and acceleration of the changes already begun in the Insurance Department's movement towards a risk-focused approach to regulation of financial solvency. Under the principles-based approach, the staff's new role in assessing adherence to outcomes and recognizing prospective risk in insurance companies will require robust professional judgment, reinforcement from management and continual training. The list of principles for regulators will assist in this migration as it provides the foundation for the professional judgment exercised by staff.

In developing the principles, the Insurance Department has already reached out to several insurers, insurance trade groups and other interested parties. The Insurance Department will continue to conduct outreach by circulating a working draft of the proposed 10 principles-based regulations to the insurance industry and consumers. It will then go through the formal proposal process, which includes publication in the New York State Register and a formal 45-day comment period for written comments.

### ***10 Principles for the Insurance Industry***

- (1) A licensee shall lawfully conduct its business with integrity, due skill, and diligence.
- (2) A licensee shall take reasonable care to organize and control its affairs responsibly and effectively, with adequate risk management systems.
- (3) A licensee shall maintain adequate financial resources.
- (4) A licensee shall observe proper standards of market conduct.
- (5) A licensee shall pay due regard to the interests of its clients and treat them fairly.
- (6) A licensee shall pay due regard to the information needs of its clients, and communicate information to them in a way that is clear, fair and not misleading.
- (7) A licensee shall manage conflicts of interest fairly, both between the licensee and its clients and between clients.
- (8) A licensee shall take reasonable care to ensure the appropriateness or suitability of its advice and discretionary decisions for any person or other entity that is entitled to rely upon such.
- (9) A licensee shall ensure that the assets of any client for which the licensee is responsible are adequately protected.
- (10) A licensee shall interact with the superintendent and other regulators in an open and cooperative way, and shall disclose to the superintendent any information relating to the licensee of which the superintendent would reasonably expect notice.

### **10 Principles for Regulators**

- (1) Regulators, and the regulatory system as a whole, should assess risk comprehensively and concentrate resources on the most important areas.
- (2) Regulators should be accountable for the efficiency and effectiveness of their activities, while remaining independent and objective in the decisions they make.
- (3) Guidance from the regulator should be readily available and easily understood.
- (4) Interested parties should be consulted as appropriate prior to issuance of written guidance by the regulator.
- (5) When developing new regulations, the regulator should consider how they can be implemented and enforced using existing systems and data to minimize the administrative burden on regulated entities.
- (6) No investigation or inquiry should take place without an appropriate basis.
- (7) The regulator should not require a regulated entity to provide unnecessary or needlessly duplicative information.
- (8) All regulatory action should be proportionate to the issue being addressed.
- (9) Regulators should allow and encourage competition and innovation, while ensuring against insolvency and protecting consumers and markets, and only intervene as necessary to protect consumers and markets.
- (10) Regulators should respect the responsibility of a firm's senior management for its activities and for ensuring that its business complies with requirements and hold senior management responsible for risk management and controls.

**(Section 10.4)**

Regulation Review

The **National Association of Insurance Commissioners (NAIC)** does not have regulatory authority over insurance sales.

The **NAIC** general provides “Model” legislation for individual State Regulators to follow in developing their own Laws, Rules and Regulations.

The **NAIC** has played a key role in coordinating the **licensing** and **continuing education** requirements of the individual states.

The **Glass Steagall Act of 1933** prohibiting national and state banks from affiliating with securities companies

The **Bank Holding Company Act** of 1956 prohibiting a bank from controlling a non-bank company;

The **1982 Bank Holding Act** further prohibiting banks from general insurance underwriting and agency activities.

**The 1999 Graham-Leach-Bliley (GLBA)**, instituting sweeping changes across the financial industry, changing the regulation of banks, insurers and financial institutions.

The **Dodd-Frank Wall Street Reform and Consumer Protection Act**, signed into law on July 1, 2010, is considered to be the most sweeping overhaul of US financial regulations since the Glass-Steagall Act of 1933.

## Best Practices

### Chapter 11

#### Best Practices (Section 11 a)

#### INSURANCE BROKERS *Best Practices or Malpractice?*

By John R. Murphy  
*Special Counsel – Stroock & Stroock & Lavan, LLP\**

Must a broker's client be provided with the absolute "best" coverage at "the best" price with "the best" insurer? And, does a broker have a continuing responsibility to advise clients to obtain additional or supplemental coverage? The Answer: NO, unless a special relationship, i.e, a special position of confidence or trust and reliance, exists between the parties.

New York Insurance Law ("Insurance Law") Section 2101 defines the terms "insurance agent" and insurance broker". An *insurance agent* is defined to mean "any authorized or acknowledged agent of an insurer . . . who acts as such in the solicitation of, negotiation for, or procurement of making of an insurance . . . contact, other than as a licensed insurance broker...".<sup>1</sup>

An insurance broker is "any person firm, association or corporation who or which for any compensation . . . acts or aids in any manner in soliciting, negotiating, or procuring the making of any insurance or annuity contract . . . on behalf of an insured other than himself or

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The New York office of the Insurance and Reinsurance Corporate and Regulatory Practice Group at Stroock & Stroock & Lavan LLP is located at 180 Maiden Lane in New York City. It is chaired by Donald D. Gabay, former First Deputy Superintendent and General Counsel of the New York State Insurance Department as well as former General Counsel of the New York Workers' Compensation Board and Vincent L. Laurenzano, a non-lawyer Insurance Finance Consultant who retired from the New York State Insurance Department after thirty-three years of service as Chief of the Property Companies Bureau.

1 N.Y.Ins. Law s2101(a)

Itself...".<sup>2</sup> Insurance Law Section 2104 (b)(1), in pertinent part, provides that an insurance brokers' license

Shall confer upon the licensee authority to act in this state as an insurance broker . . . with respect to any and every kind of insurance, *except life insurance and annuities*.<sup>3</sup>

In addition to their respective insurance product authorizations under the insurance Law, the difference between an insurance agent (whether a life or property / casualty agent) and an insurance broker is that, generally, while an insurance agent acts on behalf of a particular insurance company, an insurance broker acts on behalf of the prospective insured. However, the facts of a particular case and the Insurance Law, in certain circumstances, may place the responsibility for a broker's actions on the insurance company.

In the case of an insurance agent (life or property / casualty), actual authority is often conferred by an agency agreement which may make the agent responsible for clerical functions or decision making functions, or both.<sup>4</sup> Property / casualty insurance agents are often also given authority to legally bind the insurer they represent.<sup>5</sup> Thus, the practical differences between an agent and a broker result not only from their treatment under the Insurance Law for licensing purposes, but from

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2 N.Y.Ins. Law s2101(c).

3 N.Y. Ins. Law s2104(b)1 (emphasis added).

4 Written agreements between brokers and insureers are not common in the property / casualty insurance business. Where they do exist, they typically would be required by the insurer as a condition precedent to

accepting business offered by the broker, and would require the broker to refund its unearned commissions in the event of the mid-term cancellation of a policy.

- 5 See *Robert J. McRell Assoc. v. Insurance Co. of North America*, 677 F.Supp. 721, 723 (S.D.N.Y. 1987) (agency agreement made agent, apparently a “general agent”, responsible for reviewing applications, analyzing the insurance risk, determining whether to accept the risk, calculating the premium rate, quoting the rate, processing and insuring the policy, billing and collecting premiums, mailing nonrenewal and cancellation notices, and maintaining records with respect to the foregoing). A managing general agent (more commonly found in the property / casualty insurance business) is “any person, firm, association or corporation who or which manages all or part of the insurance business of an insurer (including the management of a separate division, department of underwriting office) and acts as an insurance agent”. 11 NYCRR s33.2(c).  
their contracts with insurers and their relationships (contractual or otherwise) with the insuring public.<sup>6</sup>

Because the broker acts as agent for the insured and not for the insurer, brokerage contracts often are not entered into by and between insurers and brokers. Where brokerage agreements do exist, they generally grant only limited authority to the broker to act on behalf of the insurance company. Thus, the broker, consistent with the broker’s position as the agent of the insured, would not be authorized to bind the insurer. The broker is, however, authorized to collect premium on business sold by the broker and issued by the company, and to retain commissions before remitting the net premium to the insurance company.

It is a general tenet of the law of agency that an agent (i.e., the broker as the agent of the insured) who acts within the scope of his authority binds his principal (i.e., the insured), and that the agent’s knowledge is imputed to the principal. Thus, a broker is an agent of the insured and, therefore, the broker’s acts bind the insured and not the insurer. With respect to insurance brokers, the general rule is altered by Insurance Law Section 2121; delivery by the insurer of its policy to the broker, or any insured represented by a broker, authorized such broker to receive on behalf of the insurer “payment of any premium which is due on such contract at the time of its issuance or delivery or payment of any installment of such premium or any additional premium which becomes due or payable thereafter”.<sup>7</sup> Thus, the Insurance Law creates a situation where (without requesting or requiring the consent of the insured) a broker is at the same time acting as agent for the insured and the insurer. Insurance Law Section 2121 was enacted to protect the insureds in the event brokers failed to remit the premium to the insurer – the insurer may not deny coverage or require a “duplicate” payment of the premium from the insured. Section 2121 does not, however, apply to agents, because under the Insurance Law and the law of agency, payment of a premium by the insured to the insurer’s agent is equivalent to payment to the insurer.

6 Brokers can be classified as “retail” or “wholesale” brokers. A retail broker is one that works directly with prospective insureds. A wholesale broker would work exclusively with agents and other brokers, on the one hand, and insurers on the other. Large brokers commonly have both retail and wholesale divisions.

7 N.Y. Insurance Law s 2121(a).

Brokers have traditionally been viewed as the intermediary through whom the insured and the insurer are brought together for the making of an insurance contract, and as a general matter, a broker is held to have fully earned its commission at the moment the broker has brought about the desired contractual relationship of insurer and insured and the premium has been paid.<sup>8</sup>

Brokers have a duty to obtain the coverage requested by their clients and, to forestall possible liability to the insured for breach of that duty, it is clearly also in the broker's interest to see that the insured's valid claims are paid by the insurer. If the prospective insured is not provided with coverage or is provided with the wrong coverage or coverage with a "faulty or worthless company" the broker may be held personally liable to its client;<sup>9</sup> an insurance broker is obligated to act with reasonable care, skill and diligence to obtain the requested coverage. However, a broker cannot reasonably have access to all property / casualty insurers, therefore it is impractical to require unequivocally that the broker provide the absolute "best" coverage at "the best" price, with "the best" insurer.<sup>10</sup>

Brokers often perform a variety of additional services, including representation of the insured in collecting claims under policies placed through those brokers.<sup>11</sup> A broker may also attempt to conciliate disputes between insured and insurer, thereby bringing about a settlement of a disputed claim without the parties having to bear the burden and expense of formal proceedings.<sup>12</sup>

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8 See e.g., *Western Nat'l Ins. Co. v. Haph Brokerage, Inc.*, 192 Misc. 765, 81 N.Y.S.2d 777 (N.Y.C. Mun. Ct. 1948), aff'd, 196 Misc. 300, 93 N.Y.S.394 (Sup.Ct. App. T. 1<sup>st</sup> Dep't 1948), aff'd, 277 A.D. 6, 97 N.Y.S.2d 447 (1<sup>st</sup> Dep't 1950), aff'd, 302 N.Y. 678, 98 N.E.2d 481 (1951). In addition to commissions which are paid by the insurer, the Insurance Law permits brokers to collect certain fees from insureds. N.Y. Ins Law s2119(c) (1).

9 Harnett, *Responsibilities of Insurance Agents and Brokers* s3.01 (Matthew Bender & Co., Inc. 1993).

10 *Id.* At S 3.03.

11 Cf. N.Y. Ins. Law s2101(g)(2)© (licensed insurance broker who acts as adjuster of losses under policies placed by that broker is exempted from public adjuster license requirement).

12 See *Slifka v. Johnson*, 161 F.2d 467 (2d Cir. 1947), cert. denied, 322 U.S. 758 (1947).

**(Section 11 b)**

***The broker (the insured's agent) has a clear duty to use reasonable diligence to secure the requested coverage or to promptly notify the client in the event it cannot be obtained.*** In *Port Clyde Foods, Inc. v. Holiday Syrups, Inc.*,<sup>13</sup> loss was incurred when Holiday's truck that was transporting goods owned by others was involved in an accident. The policy delivered to Holiday, contrary to Holiday's requests, did not provide coverage for transporting goods owned by others. The court, in finding that the insurer and the broker were liable to Holiday in equal amounts, reiterated the general rule:

New York courts have held that an insurance broker is liable for failing to acquire coverage providing for the requested risks. *An insurance broker is liable for the loss incurred by his principal due to the (broker's) failure to exercise reasonable diligence in obtaining effective insurance coverage on the [client's] behalf.*<sup>14</sup>

***New York courts also hold that a brokers duty is not simply to procure coverage, but to procure the correct amount of coverage.***<sup>15</sup> ***It has been suggested that it is also the broker's duty to place insurance on the best terms available and, in that regard, to be knowledgeable as to the different companies and terms available.***<sup>16</sup>

Is the agent or broker bound to get the "best deal," the "best rate"? The best possible? Assuming that it is possible, is it realistic? There are practical questions intermingled with theoretical ones in this type of inquiry. Price or premium is not the sole test of goodness in insurance. Factors such as insurance company solidity and service figure [in the decision], as do varying insurance company loss adjustment and as do varying insurance company loss adjustment and payment practices. It is well-known that some companies are

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13 563 F. Supp 893 (S.D.N.Y. 1982).

14 *Id.* At 897 (emphasis added). See also *Wings & wheels Express, Inc. v. Sisak*, 73 Misc.2d 846, 342 N.Y. 2d 891 (Sup. Ct. 1973) (unless knowingly waived in advance of loss by insured, broker is liable for loss incurred for failure to obtain appropriate insurance coverage).

15 See *Fobare v. Mohawn Natinal Bank*, 77 Misc.2d 210, 352 N.Y.S.2d 138 (Sup.Ct. 1974)

16 *Harnet, Responsibilities of Insurance Agents and Brokers* S2.0

tighter than others in paying claims. And some relationships are better than others.

The Supreme Court of Alaska has stated the rule to be: An insurance agent or broker owes a duty to the insured to exercise reasonable care, skill, and diligence in procuring insurance, but this does not mean that he has an absolute duty to obtain the lowest possible rates. Applying that rule, the court upheld a claim by an insurance broker in a suit to recover for insurance premiums advanced, thereby rejecting the claim by the insured that the broker breached his promise to obtain the insurance at the lowest rates available. 17

Then, too, there is the difficulty of comparing coverages, which vary in content, with absolute premium rates. Apparently slight differences in coverage may make significant premium rate differences. Underwriting, that is risk selection or willingness to write a policy, is another variable. Here, judgment factors of the insurers combine with the desirability of the insured's account to forge results. These often vary with the representative's own standing with the insurance company.

Further, the personal situation or preferences of the agent or broker may affect the situation. He may only deal with one or a limited number of companies, either because of habit, convenience, confidence, relationships, or necessity. The company selected may service his best, or offer higher

- 17 Id. At S3.07 (emphasis added) citing *Eagle Air v. Corroon & Black / Dawson & Co.*, 648 P.2d 1000 (Sup. Ct. Alaska 1982) (broker owes duty to insured to exercise reasonable care skill and diligence in procuring insurance, but does not have absolute duty to obtain lowest possible rates unless agrees to do so). See also *Tunison v. Tillman Ins. Agency*, 362 S.E.2d 507, 509 (Ct. of App. Ga. 1987) (“The duty of an insurance agent to procure the represented coverage does not create a duty to obtain coverage at any particular rate. Absent an express promise to do so, an insurance agent, like any other merchant, is under no duty to sell to his customers at the most competitive price”) (emphasis added).

Commissions, or sales inducements such as convention trips and sales promotion contest prizes.

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Most of these considerations are factors to weigh in determining “best” placement. So it is apparent that “best terms” is relative, depending upon the particular situation involved. It would appear pragmatically that the agent or broker has a great deal of placement leeway. He is not likely to be held legally liable for improper placement unless he has done at least one of three things: (1) he has demonstrably acted unreasonably in his own behalf and against his client’s interest, (2) he has in some way misled or fooled the client, or (3) he has failed to deliver expertise or performance he promised.<sup>18</sup>

***It is not unreasonable for an insured to expect that its broker will place insurance with authorized insurers and with insurers that are not insolvent.***<sup>19</sup> As a general rule:

An insurance broker, while not an insurer of the financial condition of a company from which he obtains policies, must use reasonable care, skill and judgment, with a view to the security or indemnity for which insurance is sought. He may, accordingly, be liable for damage resulting from placing insurance with the company not admitted to do business in the state.

Although an agent or broker is generally not a guarantor of the financial condition or solvency of an insurer from which he obtains a policy, he is required to use reasonable care, skill and judgment . . . and failure in such respect may render him

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18 Id. (emphasis added)

19 Procuring coverage from insurers not authorized to transact business in New York is in certain circumstances the business of authorized excess lines brokers. Such brokers must make “thorough inquiry into such insurer’s financial stability and capacity”. 11 NYCRR S27.5

liable to the insured for resulting losses due to the insolvency of the insurer.

[However] . . . a broker will not be held liable, where he has acted in good faith and with reasonable judgment, because a company which he selected later becomes insolvent, where he did not know such condition, and reasonably could not have known such fact, when the insurance was placed, if such company was generally considered solvent.<sup>20</sup>

**(Section 11 c)**

The Supreme Court of Wisconsin clearly stated the general rule applicable to a broker's responsibility to place insurance with solvent carriers. *Master Plumbers Ltd. Mutual v. Company & Bird*<sup>21</sup> involved allegations the defendants were negligent in obtaining reinsurance with Citizens Casualty Company of New York which, ultimately, was declared insolvent and was liquidated. The broker

Introduced and the court admitted pages from Best's insurance Guide which digest financial data for various companies. While they indicate that Citizens sustained underwriting loss for five years . . . these figures did not establish insolvency.<sup>22</sup>

The court reiterated the general rule:

The general rule is that where an agent provides a policy in a company which is solvent or generally considered so, he is not personally liable for a loss which occurs when the company subsequently becomes insolvent.<sup>23</sup>

In New York, a broker who directly places insurance with an unauthorized insurer (on other than a permissible excess lines basis) may be liable for

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20 Appleman, Insurance Law and Practice S8842 9wewst Publishing Co. 1981).

21 79 Wis. 2d 308, 255 NW2d 533 (Sup. Ct. Wisc. 1977).

22 Id. At 315.

23 Id. At 314 (alleged negligence of defendant must be considered in light of knowledge when policy was delivered, not at time of loss and insurer's subsequent failure to pay the claim).

any loss sustained by the insured. For example, in *Hammond v. Hunkele*,<sup>24</sup> plaintiff commenced the action against his insurance broker for "assisting" the plaintiff to enter into an automobile theft and the collision policy with the American Motor Club, Inc. ("AMC") which was not licensed in New York to engage in the business of insurance. Plaintiff's automobile was stolen and AMC denied his claim. The plaintiff's summary judgment on the question of the broker's liability was sustained:

The evidence presented by the defendant in support of his motion established that the defendant was negligent in that he assisted the plaintiff in obtaining a contract with a company that was not licensed to engage in the insurance business in New York, in violation of Insurance Law S2117.<sup>25</sup>

Most property / casualty insurance policies require the insured to timely notify the insurer of any covered loss. Notification to the insurer can come directly from the insured or from the broker at the insured's request. ***If a broker undertakes to submit a notice of claim to the insurer, the broker has a duty to maintain active contact with the insurer concerning the status of the claim.***

A broker might, at the request of the insured, submit a notice of claim to the insurer, or act on behalf of the insured in any dispute between the insured and the insurer; it is not unusual for a broker to attempt to assist the insured in obtaining a satisfactory claim settlement from the insurer.<sup>26</sup>

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24 170 A.D.2d 484, 566 N.Y.S.2d 69 (2d Dept. 19910

25 Id. At 484. Insurance Law Section 2117(a) in pertinent part provides:

a. No person, firm, association or corporation shall in this state .. act as insurance broker in soliciting, negotiating or in any way effectuating any insurance or annuity contract of, or in

placing risks with, any [insurer which is not licensed or authorized to do a business in this state]...

N.Y.Ins. Law S2117(a).

26 See e.g., *Federal Ins. Co. v. Cowen*, 145 Misc.2d 992, 549 N.Y.S.2d 338 (Sup. Ct. N.Y. Co. 1989). The broker, after receiving the insured's expert's assessment of the damage to a painting, recommended to the insurer that the full limit of liability be paid without regard to the question of the disposition of salvage; a dispute arose between the insurer and insured as to whether the damaged painting must be returned to the insurer as salvage after the insurer paid the property's full insured value. The Court held that the insured could keep the

However, brokers may be liable for failing to pursue the determination of the insured's notice of claim (submitted to the insurer by the broker) or for making misrepresentations to the insured as to the effect of a notice of claim.

**(Section 11 d)**

*The following cases are illustrative of the broker's role in the claim settlement process.*

In *Medtech Corporation v. Indiana Insurance Company*,<sup>27</sup> the insured corporation sought damages from its broker for failing to preserve the insured's claim for damaged inventory. The insured reported to the broker its loss of equipment, supplies and inventory due to a leaky roof undergoing repairs. The broker prepared a property loss notice designated "For Reporting Purposed Only" and forwarded the notice of loss to the insurer. The insureds were advised by the broker that the insurer would request more information if needed. The broker further assured the insureds that the property loss notice would preserve the insured's claims under the policy, and that the notice would protect the insureds if the roofing company performing the repairs did not compensate the insureds for the damage incurred. When the roofing company that performed the repairs refused to pay and the insureds tried to recover under the policy placed by the broker, the insurer denied the insured's claim for failure to file a sworn proof of loss within sixty days and for failing to bring suit against the insurer within one year of the date of the loss as required by the policy. The court determined that the insureds could bring claims against the broker on the theories of promissory estoppel, actual and constructive fraud, and breach of agency.

In *Byrne v. Reardon*,<sup>28</sup> an insured's award of compensatory and punitive damages for negligence, breach of fiduciary duty and fraud arose out of the broker's failure to forward complaints filed in a legal action against the insured's business to the insurer. In *Byrne*, the insured's broker had on several occasions forwarded accident reports from the insured to the insurer. However, two complaints that were filed in legal actions against

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Damaged painting – "The plaintiff [insurer] has failed its burden of showing that either under the policy or under applicable law, the insured has a duty to return the damaged insured item once its full insured value was paid by the insurer pursuant to the broker's recommendations." *Id.* At 994 (emphasis added).

27 555 N.E.2d 844 (Ind. Ct. App. 1990)

28 196 Ga. App. 735, 397 S.E.2d 22 (1990).

the insured, which the broker advised the insured to forward to him so he (the broker) could “take care of” were not forwarded to the insurer by the broker until after the lawsuits were in default.

In a New York case, *General Sportwear Company, Inc. v. Case*,<sup>29</sup> plaintiff was served with a summons and complaint in a personal injury lawsuit which it forwarded to its liability insurance broker. Concluding that the incident underlying the claim occurred prior to the inception of coverage under the current policy, the broker returned the pleadings and advised plaintiff to deliver them to its previous broker (“Case”). Case forwarded the summons and complaint to the “sub-broker” through whom he had acquired plaintiff’s prior general liability insurance coverage. It is not known whether the complaint was ever forwarded to the insurer. Case advised plaintiff that the documents had been received and forwarded to plaintiff’s insurer.

Plaintiff later discovered that a default judgment had been entered against it. Plaintiff contacted Case and received assurances that the claim had been taken care of, however, two months later, Case returned to plaintiff all the papers relating to the claim, indicating that an amended complaint filed in the proceeding stated that the incident occurred before inception of the insurance coverage placed by Case

Plaintiff unsuccessfully attempted to vacate the default judgment and, thereafter, commenced an action alleging that Case negligently failed to diligently review and properly handle the claim resulting in plaintiff’s non-representation and default. The court, noting that insurers generally have no duty to defend claims outside policy term, stated:

[When] an insurance agent[or broker in this case] affirmatively represents that a defense has been undertaken on behalf of the insured, [the insured’s] agent has a duty to use reasonable care to assure that the uninsured’s interests are protected.<sup>30</sup>

The court determined that Case assumed a duty by representing to plaintiff that the summons and complaint had been processed and that a defense of the claim had been undertaken by the insurer. The court found that questions of fact existed as to defendant’s actions after

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29 158 A.D.2d 884, 551 N.Y.S.2d 678 (3d Dep’t 1990).

30 Id. At 680.

receiving the summons and complaint and affirmed the lower court’s denial of defendant’s motion for summary judgment.

In another New York case, *Ben Heller, Inc. v. St. Paul Fire & Marine Insurance Company*,<sup>31</sup> the insured sued its brokers for negligence for failing to timely notify the insurers of the losses claimed. In denying the brokers’ motion to dismiss based on the statute of limitations, the court acknowledged that a cause of action exists if a broker fails to notify the insurer of insured’s losses: “[W]hether the defendant-brokers’ neglect could be construed as malpractice is a question of fact for the jury to determine”.<sup>32</sup>

**The following cases, which are in addition to the New York cases reviewed above, are typical of those that deal with the responsibilities and liabilities of property /casualty brokers in New York.** Unless otherwise noted, the cases did not specify damages in dollar amounts.

In *American Mutual Services Corp. v. United States Liability Ins. Co.*<sup>33</sup>, a federal district court held that an agent would be personally liable for placing insurance with a company that is not authorized to do business in New York unless, the policyholder also knew that the insurer was not licensed. In this case, the insurer became insolvent, preventing the collection of a loss from unauthorized insurer.

In *Designcraft Jewel Industries, Inc. et al. v. Rampart Brokerage Corp.*<sup>34</sup>, claimants were jewelry dealers who sued their broker (Rampart) for his failure to provide appropriate excess theft insurance. Rampart had arranged for inadequate excess coverage and impleaded the “sub-broker” he used for placing the excess coverage with the issuing insurer. The court held Rampart liable finding that the policy issued was exactly what he had requested from the sub-

broker. The court denied Rampart's request for reformation of the insurance contract by reason of mutual mistake because , in the court's opinion, Rampart had ample opportunity

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31 108 Misc.2d 687, 435 N.Y.S.2d 669 (Sup.Ct. New York County 1981).

32 Id. At 670 (emphasis added).

33 293 F.Supp 1082 (E.D.N.Y. 1968).

34 63 A.D.2d 926, 406 N.Y.S.2d 97 (1<sup>st</sup> Dept. 1978), aff'd mem. 46 N.Y. 2d 981, 415 N.Y.S.2d 991, 389 N.E.2d 472 (1979).

To correct the insurance after the policy was issued, before loss was insured, and failed to do so.

In *Erica Trading Corp. v. Nathan Butwin Company, Inc.*,<sup>35</sup> the insured requested that its insurance broker obtain a special multi-peril insurance policy. The broker confirmed that coverage had been procured. However, when the insured was sued, the insurer denied coverage on the grounds that the policy had been canceled. The insured subsequently filed a declaratory judgment action alleging that the broker was liable for any losses for failure to properly maintain the policy or notify the insured of its cancellation. The court affirmed that if the facts were as the insured alleged, the broker bears the same liability as the insurer. As such, the broker would be obligated to provide a defense and indemnify plaintiff (the insured) for any judgments awarded against it that would have been covered by the canceled policy. The broker's motion to dismiss the complaint was denied.

In *Trans World Maintenance v. Accident Prevent Brokerage Corp.*<sup>36</sup>, the insured filed a motion to set aside the jury verdict in his action seeking indemnification by his broker for amounts paid to his insurer for premiums due on a liability policy. Following the plaintiff's cancellation of the policy, the insurer sued to recover approximately \$853,000 for premiums due on the policy. Plaintiff settled the suit and agreed to pay the insurer \$210,000 The plaintiff in this action sought indemnification from the defendant broker for the amount of the settlement, attorney's fees for amounts expended defending the action by the insurer seeking premiums due, interest and costs. Plaintiff alleged that defendant had undertaken to obtain a policy of insurance which provided coverage comparable to earlier coverage and that the coverage actually obtained was unnecessarily costly and contained additional exclusions. Plaintiff also claimed he was intentionally misled about the coverage. After a trial the jury concluded that the defendant was not obligated to indemnify the plaintiff because defendant's negligence was not a proximate cause of plaintiff's loss. The court reversed the jury determination and found that the broker had been negligent. The court ordered a new trial to determine the measure of damages, if any, noting that damages to plaintiff were not certain in view of plaintiff's settlement with the insurer.

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35 100 Misc.2d 830, 420 N.Y.S.2d 87 (Sup. Ct. 1979).

36 148 Misc.2d 518, 560 N.Y.S.2d 914 (Sup. Ct. 1989).

In *Truax v. State Farm Ins. Companies*<sup>37</sup> an insured filed a declaratory action against his insurer and broker after his insurer refused to defend a claim under his homeowner's liability policy. The insurer maintained it was not obligated to provide a defense as no policy was in effect on the day of the accident. The broker alleged plaintiff had advised him to cancel his homeowner's liability coverage as he was moving residences and would no longer need insurance on the old property. The plaintiff denied making the statement. The court found the purported cancellation ineffective under either version of the facts, as cancellation is not effective until notice is received by the company regardless of the insured's intentions. Thus, the court noted, even if it accepted the broker's version of the facts, the insurer did not receive notice of the cancellation until after the accident and, even if the broker had received notice of plaintiff's intention to cancel the policy, no proof had been offered to the court that he was authorized to receive and accept such notice on the company's behalf. The court stated: "... there is no presumption that an agent authorized to solicit insurance has authority to cancel policies at the request of the insured. And it has been held that notice to an agent or broker through whom the insurance was effected is not notice to the company".<sup>38</sup> The court held that absent proof of the broker's authority to act for the insurer, cancellation did not occur until the insurer was in actual receipt of the insured's cancellation request.

**(Section 11 e)**

In *Lefrak organization, Inc. v. Employers Insurance of Wausau, et al*<sup>39</sup>, the plaintiff, Lefrak, an owner and operator of more than 200 multi-unit residential properties, brought a claim against Trio Brokerage Corp. for failing to replace Lefrak's prior comprehensive general liability ("CGL") policy (which contained a one million dollar per occurrence limit) with a CGL policy with similar limits. When it appear that Lefrak's prior carrier might be placed into liquidation, Lefrak asked Trio to replace its CGL policy with a policy providing equivalent coverage and gave a copy of its prior policy to Trio for that purpose. The policy Trio placed, with Employers Insurance of Wausau, contained a one million dollar aggregate limit of liability. Trio claimed it had requested a per occurrence limit and that, when the policy was received and reviewed, believed the aggregate

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37 101 Mis.2<sup>nd</sup> 1031, 422 N.Y.S.2d 592 (Sup.ct. 1979).

38 Id. At 595, citing 6A, Appleman, Insurance Law & Practice S4226 (1972).

39 195 Ad2d 367, 600 N.Y.S.2d 412 (Sup. Ct. 1993). This matter was successfully represented by Litigation Department at Stroock & Stroock 7 lavan LLP (representing Lefrak).

limit applied only to certain risks, such as products liability (in accordance with what trio understood as the then prevailing industry practice). Trio also claimed that Lefrak was a sophisticated insurance purchaser which received a copy of the policy and could just as easily have discovered the aggregate limit provision. Neither Lefrak nor Trio realized that the policy had a one million dollar aggregate limit until Wausau advised that the aggregate claims limit had been reached. The umbrella carrier refused to defend or pay any claims until one million dollars per occurrence had been paid. Lefrak sought to hold Trio liable for this "coverage gap".

The court held that Trio was liable to Lefrak to the extent losses would have been covered had the replacement CGL policy contained the same per occurrence limit as the prior policy. Thus, the broker was liable for the costs of providing Lefrak with a defense and indemnification against all claims up to one million dollars per occurrence. The court rejected Trio's defenses, including its claim that Lefrak had the right "to rely upon the agent's [its insurance broker's] presumed obedience" to its instructions and that the broker, not the insured, "bore the ultimate responsibility" for determining that the policy contained the proper coverage limits.

Because the claim against the broker was stated as one for breach of a contract to procure insurance coverage rather than for negligence, the court also rejected Trio's defense that the claim was barred by the three-year negligence statute of limitations (contract claims, in New York, may be brought within six year) and also rejected a defense of contributory negligence.<sup>40</sup>

However, in a recent case, the New York Court of Appeals (the State's highest court) in *Murphy v Kuhn*<sup>41</sup> observed that insurance brokers are not personal financial counselors and risk manager and that insureds are

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40 The Lefrak case also illustrates the growing trend among assureds to state their claims against their brokers in contract, rather than in negligence. Generally, this permits them, as in Lefrak, to take advantage of the longer limitations period applicable to contract claims.

41 90 N.Y.2d 266, 660 N.Y.S.2d 371, 682 N.E.2d 972 (1997).

Better positioned to be aware of their personal assets and to protect themselves, *unless*

[e]xceptional and particularized situations ... arise in which [brokers], through their conduct or by express or implied contract with customers and clients, may assume or acquire duties in addition to those fixed at common law. [T]he issue of whether such additional responsibilities should be recognized and given legal effect is governed by the particular relationship between the parties and is best determined on a case by case basis ...<sup>42</sup>

In *Murphy*, the broker's relationship with the insured dated from 1973. In 1990, the insured's personal auto insurer threatened to cancel the policy because of his children's poor prior driving records. The insured transferred such coverage to his commercial policy which had a lower policy limit. The insured never requested an increase in the limits to meet his personal and family needs, and settlement of a suit based on the insured's son's negligence required the payment of approximately \$200,000 by the insured, the basis for the insured's claim against the broker. There was no record that the insured discussed policy limits with his broker. The court therefore held:

Such lack of initiative or personal indifference [by the insured] cannot qualify as legally recognizable or justifiable reliance. Therefore, there was no evidence of reliance on the [broker's] expertise ...<sup>43</sup>

In *Universal Builders Supply, inc. v. Bayly, Martin & Fay, Inc.*<sup>44</sup>, an insured sued his broker for failure to disclose on the policy that the insurer was not under New York supervision and not insured by New York's Property / Casualty Insurance Security Fund.<sup>45</sup> The court noted that the

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42 Id. At 272..

43 Id. At 271.

44 150 A.D.2d 365, 540 N.Y.S.2d 539 92<sup>nd</sup> Dep. 1989).

45 The Property / Casualty Security Insurance Fund is found at Insurance Law Article e76. It comprises payments made to it by insurers and of securities acquired by and through the use of moneys belonging to the fund. N.Y. Ins. Law S7601(c). The Fund is used in the payment of allowed claims remaining unpaid

Accident for which the plaintiff lacked coverage took place in Boston. It further pointed out that the only risks covered by the Property Casualty Security Fund are those located in New York. As a result, notwithstanding the insurer was not licensed to do business in New York and was subsequently declared insolvent, the court refused to hold the broker liable finding that his failure was not the proximate cause of the insured's loss because the accident would not in any event have been covered by the fund.

In *Reschke v. Salbione Insurance Agency*<sup>46</sup>, plaintiff sued his insurance agent for negligently failing to procure underinsured coverage and for failing to advise plaintiff that no such coverage had been obtained Prior to moving to

New York, plaintiff lived in New Jersey and was covered by a policy issued in that state. When plaintiff moved to New York, he presented his New Jersey policy to the agency and requested identical New York coverage. Plaintiff's son was subsequently injured as a passenger in an automobile which did not have sufficient coverage. When plaintiff inquired regarding submitting a claim for his son he learned that under-insurance coverage was not included in this policy. A unanimous jury found the defendant liable for failing to obtain the coverage and for failing to inform the plaintiff he did not procure the requested coverage, but also found that plaintiff was contributorily negligent in failing to examine his insurance policy. The jury determined that the coverage lost by plaintiff was \$500,000. The jury attributed sixty-five percent liability to the defendant and thirty-five percent to the plaintiff. The case was settled for \$50,000 while post-trial motions were pending.

In *Bankers life & Casualty, as subrogor for Martin Bernsteing v. Coverage Concepts., Inc.*<sup>47</sup>, an underlying action had been commenced against the plaintiff by his insurer seeking \$850,000 in additional premiums which were claimed to be owed on three consecutive one-year policies covering an apartment complex that was in receivership. The plaintiff was

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By reason of the inability due to insolvency of an authorized property/casualty insurer to meet its insurance obligations for the kinds of insurance specified in paragraphs four through fourteen, sixteen, nineteen through twenty-one, twenty-four, and subparagraphs (A) and (B) of paragraph 26 of Section 1113(a). N.Y. Ins. Law S7603(a)(1)(b).

46 Civ. 940041/95 (Montgomery Count, N.Y. Sup. Ct. June 12, 1995). This decision is unpublished.

47 Civ. 22093/91 (N.Y. Sup. Ct. Aug. 1, 1995). This decision is unpublished.

found liable in the underlying case for \$139,887 in additional premiums based on the difference of the alleged square footage and the square footage as determined by the jury. The policy provided that the insurer was permitted to audit the square footage and to charge additional premiums retroactively. Plaintiff sued his insurance broker for breach of brokerage company had breached its duty of care by subjecting the plaintiff to liability for premiums in disregard of its express instructions to the contrary (because the property was in receivership, plaintiff required that the receiver be responsible for any audit premium). The plaintiff alleged that the broker failed to disclose (i) that the insurance policy permitted the insurer to conduct a square footage audit and charge additional premiums even after the policy period had terminated and (ii) the basis for determining the square footage and its relevance for the coverage delivered by the broker. The jury awarded the plaintiff \$177,388.

## **SUMMARY**

Insurance brokers generally are not their clients "keepers" unless, a special relationship upon which a client relies is established. Brokers must, however, act with reasonable care, skill and diligence in all matters including obtaining any clearly requested coverage, and must communicate with clients concerning the availability of or limits on such coverage, transmit claims to insurers, deal with authorized insurers that are not insolvent, and clarify the extent of their relationship with their clients.

The foregoing does not address all aspects of the subject matter addressed therein. Interested persons all aspects of the subject matter addressed therein. Interested persons should consult legal counsel for a further discussion of the issues and applicability to a particular set of circumstances.

## Section 11.2

### Best Practice Review

A **broker is not required** to provide their client with the absolute “best” coverage at “the best” price with “the best” insurer.

An insurance **agent** is defined to mean “any authorized or acknowledged agent of an insurer.

An insurance **broker** is “any person firm, association or corporation who acts or aids in any manner in soliciting, negotiating, or procuring the making of any insurance or annuity contract ... on behalf of an insured other than himself or itself.

Brokers have a **duty to obtain the coverage** requested by their clients.

A broker may also attempt to conciliate disputes between insured and insurer.

In New York, a broker who directly places insurance with an unauthorized insurer (on other than a permissible excess lines basis) may be liable for any loss sustained by the insured.

Brokers must act with reasonable care, skill and diligence in all matters including obtaining any clearly requested coverage.

## Regulatory Process

### Chapter 12

#### (Section 12.1)

## Legislative Process

The New York State insurance regulatory system is a construction of the State Government for the protection of insurance consumers. New York has a two-house Legislative branch (**Senate** and **Assembly**), an executive (**Governor**) and a judicial branch (**the Court of Appeals** is the highest State Court). All ideas to establish or modify a law begin with creation of a “Bill” containing specific language that meets the creator’s goal. The Bill must receive approval by a majority of the Members in each house of the Legislature and then receive the approval and signature of the Governor to become law. Once approved, disputes over the law are settled by our Courts.

Every law requires an enforcement mechanism. That process begins with developing Rules and Regulations. Insurance related laws are implemented by the Superintendent of the Department of Financial Services. The **Superintendent has the authority to investigate violations** of insurance law, rules and regulations. **Violations** can result in license **revocation** or other **disciplinary action**, including fines.

The State Legislature is responsible for enacting the general laws in New York. In doing so, the Legislature often delegates “rule making powers” to the state’s administrative departments and agencies. These agencies are then empowered to develop and enforce the rules and regulations they find necessary to implement the broad policies adopted by the Legislature.

The phrase “**rules and regulations**” is often confusing. Actually, **the two words are interchangeable**. In New York, the term “rule” is used most frequently. Hence, the procedures that are followed by state agencies when adopting rules have become known as “the rule making process.” This process is designed to ensure that the public has an opportunity to comment on, and participate in, the adoption of such rules.

#### ***The rule making process***

The Department of State is responsible for producing the weekly New York State Register, which plays a central role in the rule making process. The Register contains notices of newly proposed rules as well as proposed changes to existing rules. Included in a “**Notice of Proposed Rule Making**” are the text of the rule if under 2,000 words or a summary if over 2,000 words; the time, date and location of any public hearing(s); and the name and address of the agency contact person to whom comments can be addressed. Publication of this notice initiates the rule making process.

In many cases, public hearings will be held around the state to better provide people with an opportunity to argue for or against a proposal. If no hearing is scheduled, or if you cannot attend a hearing, both written and oral comments must be taken into consideration by the agency prior to adoption of a rule. Because it is important for citizens to have this opportunity to comment, the Legislature has provided that agencies must accept comment for a required statutory period of time (minimum of 45 or 60 days, depending on situation) after the proposal is first published in the Register. Agencies often allow more than the minimum number of days for comment and hold public hearings although they may not be required to do so.

**After publication in the Register and receipt of public comment**, the agency may either adopt, revise or withdraw the proposal. If adopted, the agency must file the full text of the rule with the Department of State. At the same time, a “**Notice of Adoption**” is published in the Register, indicating that the proposal has in fact, been adopted. If the final rule will be substantially different from the proposed rule, the agency must publish a “**Notice of Revised Rule Making**” and accept public comment for at least another 30 days.

If a proposal is withdrawn, the agency cannot adopt the same or a similar proposal without first providing the public with another opportunity to comment.

To help readers track rule making activities, the regular weekly Register contains an Action Pending Index that lists all proposed rules still under consideration. Additionally, a cumulative calendar year list of all rule making activity is printed as a supplement to the Register four times each year. This Quarterly Index includes the date each rule was proposed, revised, adopted or withdrawn, etc. By using these references, readers can quickly and easily learn the status of any proposed rule.

***New York State Register***

Each subscription to the Register includes 52 weekly and 4 Quarterly Index issues. The price is \$80 for a first-class mail subscription or \$40 for periodical (second class). To order, send a check or money order payable to "NYS Department of State" to: Department of State, Division of Administrative Rules, One Commerce Plaza, 99 Washington Avenue, Suite 650, Albany, NY 12231. Our telephone number is (518) 474-6957; fax inquiries may be sent to us at (518) 473-9055; e-mail to [adminrules@dos.ny.gov](mailto:adminrules@dos.ny.gov).

***Official Compilation of Codes, Rules and Regulations*** of the State of New York

The full text of all state agency rules is published in the NYCRR. This is an 82-volume, loose-leaf publication that is supplemented semi-monthly with the text of new and amended rules.

The print version of the NYCRR is available as a full set, by individual volume or by Title. When you purchase the printed NYCRR, you automatically receive semi-monthly supplements through the end of that calendar year's filing. Thereafter, you may subscribe to an annual update service. The CD-ROM contains all 22 Titles and is updated quarterly. For order information, please contact Thomson West, at 1-800-344-5009.

[http://www.dos.ny.gov/info/pdfs/whatisrulemaking\\_flyer.pdf](http://www.dos.ny.gov/info/pdfs/whatisrulemaking_flyer.pdf)

The following are two examples of proposed changes to the New York State Insurance Law. The "bills" have at least one sponsor. **The New York State Legislature provides online access to view current status of all current legislation.** In many instances memos in support of the legislation are included online. The public can search for legislation currently pending at <https://www.nysenate.gov/legislation>. (Section 12.2a)

S7814 - BILL DETAILS

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**See Assembly Version of this Bill:** [A3212](#)

**Current Committee:** [Senate Insurance](#)

**Law Section:** Insurance Law

**Laws Affected:** Add §2616, amd §§2108, 2110 & 2132, Ins L

**Versions Introduced in Previous Legislative Sessions:**

2013-2014: [S5183A](#), [A908A](#)

2011-2012: [A3729A](#), [S7802](#)

2009-2010: [A7088](#)

S7814 - BILL TEXTS

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## SUMMARY

Relates to claims for loss or damage to real property; creates continuing education requirements for licensed persons and qualifications for public and independent adjusters; allows for a revocation of licenses with an opportunity to reapply for such licenses.

## SPONSOR MEMO

BILL NUMBER: S7814

### TITLE OF BILL :

An act to amend the insurance law, in relation to claims for loss or damage to real property, continuing education for licensed persons and qualifications for independent adjusters

### PURPOSE :

This bill intends to curb the potential for fraud and abuse by unscrupulous public or independent insurance adjusters. It does so by:

\*Requiring continuing education for public and independent insurance adjusters;

\*Prohibiting an adjuster from receiving anything of value in exchange for a referral of a potential client;

\*Prohibiting any public or independent adjuster from having a controlling interest in any construction, salvage or building appraisal firm; and

\*Allowing and setting the conditions under which the Insurance Superintendent may revoke, suspend or refuse to renew the license of public or independent adjusters.

### SUMMARY OF PROVISIONS :

Section 1 adds a new § 2616 to the Insurance Law, to prohibit an insurer from requiring repairs to be completed by any particular entity or individual and from suggesting or recommending a particular entity or individual unless specifically asked by the insured, in which case the insurer would have to disclose any controlling or business interest that it has in any entity or individual that it recommends or suggests.

Sections 2 and 3 amend various subsections of § 2108 of the Insurance Law, to require that independent adjusters participate in continuing education.

Section 4 amends subsection (a) of § 2110 of the Insurance Law and allows the superintendent of the Insurance Department to refuse to renew, revoke, or suspend the license of any insurance agent, insurance broker, reinsurance intermediary, insurance consultant or adjuster that has violated any law regarding his or her professional capacity, for a duration the superintendent deems appropriate. The superintendent can also suspend or refuse to renew a license for a duration that he or she determines adequate to discipline a violation of this section.

Section 5 amends paragraph 2 of subsection (c) of § 2132 of the insurance law to indicate that during the same calendar year biennial licensing period, independent adjusters may use accumulated continuing education credits to meet the requirements of similar classes of licenses. In doing so, independent adjusters are provided the same benefit as public adjusters.

#### JUSTIFICATION:

In the past decade, fraud committed by a small number of unscrupulous public and independent adjusters has placed a black cloud over much of the insurance industry. The actions of these few have caused undue harm to both policy holders and adjusters who operate under the highest professional standards. Most of those accused of committing fraud have pled guilty, received fines and or jail time. To date, many of them retain their New York State licenses.

This legislation will help the adjusting industry rid itself of "bad apples" by imposing continuing education requirements and imposing revocation and suspension guidelines for public and independent adjusters alike.

The bill will also prevent conflicts of interest that may arise when an insurer or adjuster has controlling interest in a construction firm. For example, an insurance company may consult a sister construction firm in which it has controlling interest -- to adjust housing repair claims.

In return for the free adjustment, the construction firm may receive the contract for the repairs or other construction. A conflict of interest arises when the construction company receives such a contract and inflates the estimate, resulting in higher premiums to policy holders. This practice causes a public interest to be violated due to the lack of objectivity.

The bill helps avoid such conflicts in three ways. First, it prevents insurers from requiring repairs be made by a particular construction firm. If recommendations are made that repairs be done by a particular firm, the insurer must disclose to the insured whether the insurer has a controlling interest in such firm. Second, it prohibits public and independent adjusters from paying or giving gifts to people or companies in exchange for potential client referral. Third, it prohibits public or independent adjusters from having any controlling interest in a construction, salvage or appraisal firm.

#### LEGISLATIVE HISTORY :

2016: New Senate Bill/A.3212, Referred to Insurance on 1/6/2016.

2015: A.3212 (Weprin); Referred to Insurance on 1/22/2015

2014: A.908-A/S.5183-A(Martins); A.908- Died on Third Reading Rules

Ca1.47 on 6/9/2014; S.5183-A was amended and recommit to Insurance on 5/23/14.

2013: A.908 advanced to third reading cal.294; S.5183 (Martins) referred to Insurance.

2012: A.3729-A/S.7802 (Robach); Passed the Assembly

2011: A.3729 Referred to Insurance

2009-2010: A.7088 (Carozza) Referred to Insurance

2007-2008: A.6472 (Carozza) Referred to Insurance

2005-2006: A.6798 (Carozza)/S.1997 (Balboni) Referred to Insurance in both houses.

2004: A.6915-A/S.4752-B Amended and Recommit to Insurance in the Assembly;  
S.4752-B (Balboni) Passed the Senate.

2003: A.6915 Referred to Insurance

2002: A.6009-A (Carozza)/S.2067 (Balboni) Amended and Recommit to Insurance in both houses.

2001: A.6009/S.2067 (Balboni) Referred to Insurance.

2000: S.6592 (Balboni) Referred to Insurance

#### FISCAL IMPLICATIONS :

None to the state.

#### EFFECTIVE DATE :

This act shall take effect on the first of January next succeeding the date on which it shall have become a law.

**(Section 12.2b)**

STATE OF NEW YORK

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7814

IN SENATE

May 12, 2016

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Introduced by Sen. AVELLA -- read twice and ordered printed, and when printed to be committed to the Committee on Insurance

AN ACT to amend the insurance law, in relation to claims for loss or damage to real property, continuing education for licensed persons and qualifications for independent adjusters

THE PEOPLE OF THE STATE OF NEW YORK, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. The insurance law is amended by adding a new section 2616 to read as follows:

§ 2616. CLAIMS FOR LOSS OR DAMAGE TO REAL PROPERTY; REPAIRS.

(A) WHENEVER AN INSURED SUFFERS A LOSS OR DAMAGE TO REAL PROPERTY, NO INSURER PROVIDING COVERAGE THEREFOR SHALL REQUIRE THAT REPAIRS BE COMPLETED BY A PARTICULAR ENTITY OR INDIVIDUAL. (B) IN PROCESSING ANY SUCH CLAIM, THE INSURER SHALL NOT RECOMMEND OR SUGGEST REPAIRS BE MADE BY A PARTICULAR ENTITY OR INDIVIDUAL UNLESS EXPRESSLY REQUESTED BY THE INSURED, IN WHICH CASE THE INSURER SHALL DISCLOSE TO THE INSURED WHETHER THE INSURER HAS A CONTROLLING OR BUSINESS INTEREST IN ANY ENTITY OR INDIVIDUAL THAT THE INSURER RECOMMENDS OR SUGGESTS.

§ 2. Paragraph 1 of subsection (f) of section 2108 of the insurance law is amended to read as follows:

(1) The superintendent shall, in order to determine the trustworthiness and competency to act as an independent adjuster of each individual applicant for such license, and of each proposed sub-licensee, except in the case of a renewal license, require every such individual to take and pass, to the satisfaction of the superintendent, a personal written examination. AN INDIVIDUAL SHALL NOT BE DEEMED QUALIFIED TO TAKE THE EXAMINATION WITHOUT HAVING DEMONSTRATED BY EVIDENCE SATISFACTORY TO THE SUPERINTENDENT THAT:

(A) THE INDIVIDUAL POSSESSES A MINIMUM OF ONE-YEAR'S EXPERIENCE IN THE INSURANCE BUSINESS, WITH INVOLVEMENT IN SALES, UNDERWRITING, CLAIMS, OR OTHER EXPERIENCE CONSIDERED SUFFICIENT BY THE SUPERINTENDENT; OR

(B) THE INDIVIDUAL SUCCESSFULLY COMPLETED FORTY HOURS OF FORMAL TRAINING IN A COURSE, PROGRAM OF INSTRUCTION, OR SEMINARS APPROVED BY THE SUPERINTENDENT. The superintendent may

prescribe the types of written examinations according to the kind or kinds of insurance claims [which] THAT the applicant is to be licensed to investigate and adjust.

§ 3. Subsection (r) of section 2108 of the insurance law, as added by chapter 264 of the laws of 1998, is amended to read as follows:

(r) (1) The following continuing education requirements shall apply to resident and non-resident persons licensed as public OR INDEPENDENT adjusters.

(2) Resident and non-resident persons licensed as public OR INDEPENDENT adjusters and any person previously so licensed whose license was not in effect on the effective date of this subsection and who has subsequently

been relicensed pursuant to the provisions of this article, shall biennially satisfactorily complete such courses or programs as may be approved by the superintendent, as follows:

(A) Any person holding a license as a public OR INDEPENDENT adjuster shall, during each full biennial licensing period, satisfactorily complete courses or programs of instruction or attend seminars as may be approved by the superintendent equivalent to fifteen credit hours of instruction.

(B) During the same calendar year biennial licensing period, a licensee may use accumulated continuing education credits to meet the requirements of similar classes of licenses including those authorized by subsection (b) of section two thousand one hundred three, section two thousand one hundred four, section two thousand one hundred seven of this article with respect to general insurance consultants, and THIS section [two thousand one hundred eight of this article] with respect to public AND INDEPENDENT adjusters.

(C) Excess credit hours accumulated during any biennial licensing period shall not carry forward to the next biennial licensing period for that same class of license.

(3) (A) The courses or programs of instruction successfully completed, which shall be deemed to meet the superintendent's standards for continuing education shall be:

(i) Courses, programs of instruction or seminars, approved as to method and content by the superintendent, covering portions of the principal branches of insurance related to the kinds of insurance covered by the public OR INDEPENDENT adjusting license, and given by a degree conferring college or university whose curriculum is registered with the state education department at the time the person takes the course, whether such course be given as part of such curriculum or separately, or by any other institution, association, trade association or insurer, which maintains equivalent standards of instruction and which shall have been approved for such purpose by the superintendent.

(ii) Continuing education as required by the state in which a non-resident licensee resides and maintains an office, provided the superintendent deems them equivalent to New York continuing education requirements. If the state in which the non-resident licensee resides and maintains an office has no continuing education requirements, or the superintendent does not deem them equivalent, the licensee must satisfy New York continuing education requirements.

(B) The number of credit hours assigned to each of the courses or programs of instruction set forth in paragraph one of this subsection shall be determined by the superintendent.

(4) A person who teaches any approved course of instruction or who lectures at any approved seminar, and who is subject to these continuing education requirements shall be granted the same number of credit hours as would be granted to a person taking and successfully completing such course, seminar or program, provided that such credit hours shall be credited only once per approved course during any biennial licensing period.

(5) Every person subject to these continuing education requirements shall furnish, in a form satisfactory to the superintendent, written certification attesting to the course or programs of instruction taken and successfully completed by such person, and executed by the sponsoring organization or its authorizing representative.

(6) (A) Any person failing to meet applicable continuing education requirements shall not be eligible to renew the license.

(B) Any person whose license was not renewed shall not be eligible to become relicensed during the next biennial licensing period until that person has demonstrated to the satisfaction of the superintendent that continuing education requirements for the last biennial licensing period were met.

(C) Any person whose license was not renewed pursuant to subparagraph (A) of this paragraph, who accumulates sufficient credit hours for the prior licensing period to qualify for relicensing in the biennial period following such non-renewal, may not apply those same credit hours toward the continuing education requirements for the current biennial licensing period.

(7) (A) Any entity eligible to provide continuing education courses, programs of instruction, or seminars shall file for approval by the superintendent on a biennial basis, to conform with its areas of instruction, a provider organization application and a course submission application for each course, program, and seminar.

(B) The provider organization application shall include the names of all instructors to be used during the contract period, and instructors may be added during the period by notifying the superintendent and paying the appropriate filing fee.

(C) The completed applications shall be returned in a timely manner, as specified by the superintendent with a non-refundable filing fee of two hundred dollars per organization, fifty dollars per course, program, and seminar, and fifty dollars per instructor.

(D) Approval of the application shall be at the discretion of the superintendent.

(8) Each licensee shall pay a biennial fee of ten dollars per license, for continuing education certificate filing and recording charges, to the superintendent, or, at the direction of the superintendent, directly to an organization under contract to provide continuing education administrative services.

S 4. The opening paragraph of subsection (a) of section 2110 of the insurance law, as amended by chapter 499 of the laws of 2009, is amended to read as follows:

The superintendent may refuse to renew, revoke, or may suspend for a period the superintendent determines the license of any insurance producer, insurance consultant, PUBLIC OR INDEPENDENT adjuster or life settlement broker, if, after notice and hearing, the superintendent determines that the licensee or any sub-licensee has:

S 5. Paragraph 2 of subsection (c) of section 2132 of the insurance law, as amended by chapter 264 of the laws of 1998, is amended to read as follows:

(2) During the same calendar year biennial licensing period, a licensee may use accumulated continuing education credits to meet the requirements of similar classes of licenses, as follows: (A) subsection

(a) of section two thousand one hundred three and section two thousand one hundred seven of this article with respect to life insurance consultants; or (B) subsection (b) of section two thousand one hundred three, section two thousand one hundred four, section two thousand one hundred seven of this article with respect to general insurance consultants, and section two thousand one hundred eight of this article with respect to public AND INDEPENDENT adjusters.

S 6. This act shall take effect on the first of January next succeeding the date on which it shall have become a law.

EXPLANATION--Matter in ITALICS (underscored) is new; matter in [ ] is old law to be omitted.

**(Section 12.3a) Senate Bill S7661**

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May 12, 2016      REFERRED TO INSURANCE

S7661 - BILL DETAILS

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**Current Committee:** [Senate Insurance](#)

**Law Section:** Insurance Law

**Laws Affected:** Amd §§2324 & 4224, Ins L

S7661 - BILL TEXTS

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**SUMMARY**

Relates to prohibitions on rebating and discrimination in rates and payments under insurance policies; provides that certain services shall not be considered to be an inducement or rebate unless the superintendent determines that the offer and sale of such services constituted the sole reason for the purchase of such insurance policy.

**SPONSOR MEMO**

BILL NUMBER: S7661

TITLE OF BILL : An act to amend the insurance law, in relation to prohibitions on rebating and discrimination

PURPOSE :

To modernize the anti-rebating statutes of the Insurance Law, by adding a provision to each statute which requires the imposition of a quid pro quo standard as necessary for the Superintendent to find that a violation of those statute's prohibitions have occurred.

SUMMARY OF PROVISIONS :

Sections 1 and 2 of the bill amend sections 2324(g) and 4224(c) of the insurance law to provide that services offered or delivered as part of the sale or renewal of an insurance policy, contract or group insurance policy shall not be considered to be an inducement or rebate when the offer and sale of such services does not constitute the sole reason for the purchase of such insurance policy, contract or group insurance policy such services shall not be considered to be an inducement or rebate prohibited by this section unless the Superintendent determines, after a notice and hearing, that the offer and sale of such services constituted the sole reason for the purchase of such insurance policy, contract or group insurance policy and that, but for the offer or delivery of such service, the purchase of such policy or contract would not have taken place.

Section 3 is the effective date.

JUSTIFICATION :

Sections 2324 and 4224 prohibit "rebating" and "inducements" being used in the sale of an insurance policy. This situation occurs when an insurance agent or company offers to return all or a portion of the premium paid by an insured for a policy directly back to that insured for the sole purpose of "inducing" that insured to buy the policy in the first place. Thus, the returned premium is "rebated" to the insured.

The anti-rebating provisions have their origin in the historically significant investigation conducted by the New York Legislature in 1905 known as the "Armstrong Commission". That commission conducted a comprehensive investigation of allegations concerning extravagant spending and political payoffs by the Equitable Life Assurance Society which were undertaken at the expense of the company's policyholders. The Armstrong Commission found a number of abuses including interlocking directorates, the creation of subsidiary financial institutions to evade investment restrictions, the use of proxy voting to frustrate policyholder control of mutual, unlimited company expenses, tremendous spending for lobbying activities, and rebating.

The Armstrong Commission recommended changes to the insurance law which were enacted in the 1907 session, including the prohibition of rebating.

The insurance business has changed significantly since those original anti-rebating provisions were enacted. Some companies have sought legislative exemptions for services offered to insureds in order to ensure that the service does not run afoul of the anti-rebating statutes. In addition, the Department of Financial Services has sought to administratively expand the list of services which companies and producers wish to offer their insured's in conjunction with the policy, and have labeled such services, "rebates". The DFS has created an ever-expanding list of goods and services which violates the anti-rebating provisions. (See DFS circular letter No. 22, 2009) As a result, a great deal of confusion exists in the insurer, producer and insurance consumer communities as to exactly which services may or may not be offered with the policy.

A need has arisen to create a clear standard with which all parties may use to ensure compliance with the law and also which allows insurers and producers to convey value to insureds along with the insurance policy, while returning to the original intent and purpose of the anti-rebating statutes.

This legislation imposes a standard for services offered by insurance companies and producers which requires that in order to show a violation, the Superintendent must show through evidence at a hearing that the offered service was the sole reason for the sale of the policy and that such sale would not have taken place without the offered service. This standard will restore the original intent of the statute to prevent insurance sales made solely to obtain the service while allowing the provision of valuable services to insureds which happen to come along with the purchase of their insurance policies.

LEGISLATIVE HISTORY : New bill.

FISCAL IMPLICATIONS : None.

EFFECTIVE DATE : The bill will take effect 60 days after it is signed.

**(Section 12.3b)**

STATE OF NEW YORK

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7661

IN SENATE

May 12, 2016

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Introduced by Sen. SEWARD -- read twice and ordered printed, and when printed to be committed to the Committee on Insurance

AN ACT to amend the insurance law, in relation to prohibitions on rebating and discrimination

THE PEOPLE OF THE STATE OF NEW YORK, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Section 2324 of the insurance law is amended by adding a new subsection (g) to read as follows:

(G) NOTWITHSTANDING THE PROVISIONS OF SUBSECTION (A) OF THIS SECTION, ANY SERVICES PROVIDED, OR OFFERED TO BE PROVIDED, BY AN AUTHORIZED INSURER, LICENSED INSURANCE AGENT, LICENSED INSURANCE BROKER OR AN EMPLOYEE OR OTHER REPRESENTATIVE OF ANY SUCH AUTHORIZED INSURER, LICENSED INSURANCE AGENT OR LICENSED INSURANCE BROKER; PROVIDED THAT SUCH SERVICES ARE OFFERED OR DELIVERED AS PART OF THE SALE OR RENEWAL OF AN INSURANCE POLICY, CONTRACT OR GROUP INSURANCE POLICY AND OFFERED OR DELIVERED IN A NON-DISCRIMINATORY MANNER TO ALL SIMILARLY SITUATED INSUREDS OR POTENTIAL INSUREDS, WHETHER OR NOT SUCH SERVICES ARE SPECIFIED IN SUCH POLICY OR CONTRACT; SHALL NOT BE CONSIDERED TO BE AN INDUCEMENT OR REBATE PROHIBITED BY THIS SECTION UNLESS THE SUPERINTENDENT DETERMINES, AFTER A NOTICE AND HEARING, THAT THE OFFER AND SALE OF SUCH SERVICES CONSTITUTED THE SOLE REASON FOR THE PURCHASE OF SUCH INSURANCE POLICY, CONTRACT OR GROUP INSURANCE POLICY AND THAT, BUT FOR THE OFFER OR DELIVERY OR SUCH SERVICE, THE PURCHASE OF SUCH POLICY OR CONTRACT WOULD NOT HAVE TAKEN PLACE.

S 2. Subsection (c) of section 4224 of the insurance law, as amended by chapter 496 of the laws of 2013, is amended to read as follows:

(c) (1) Except as permitted by section three thousand two hundred thirty-nine of this chapter or subsection (f) of this section, no such life insurance company and no such savings and insurance bank and no officer, agent, solicitor or representative thereof and no such insurer doing in this state the business of accident and health insurance and no officer, agent, solicitor or representative thereof, and no licensed insurance broker and no employee or other representative of any such insurer, agent or broker, shall pay, allow or give, or offer to pay,

EXPLANATION--Matter in ITALICS (underscored) is new; matter in brackets  
[ ] is old law to be omitted.

allow or give, directly or indirectly, as an inducement to any person to insure, or shall give, sell or purchase, or offer to give, sell or purchase, as such inducement, or interdependent with any policy of life insurance or annuity contract or policy of accident and health insurance, any stocks, bonds, or other securities, or any dividends or profits accruing or to accrue thereon, or any valuable consideration or inducement whatever not specified in such policy or contract other than any valuable consideration, including but not limited to merchandise or periodical subscriptions, not exceeding twenty-five dollars in value; nor shall any person in this state knowingly receive as such inducement, any rebate of premium or policy fee or any special favor or advantage in the dividends or other benefits to accrue on any such policy or contract, or knowingly receive any paid employment or contract for services of any kind, or any valuable consideration or inducement whatever which is not specified in such policy or contract.

(2) NOTWITHSTANDING THE PROVISIONS OF PARAGRAPH ONE OF THIS SUBSECTION, ANY SERVICES PROVIDED, OR OFFERED TO BE PROVIDED, BY A LIFE INSURANCE COMPANY OR ANY OFFICER, AGENT, SOLICITOR OR REPRESENTATIVE THEREOF, BY AN INSURER DOING IN THIS STATE THE BUSINESS OF ACCIDENT AND HEALTH INSURANCE OR AN OFFICER, AGENT, SOLICITOR OR REPRESENTATIVE THEREOF, OR BY A LICENSED INSURANCE BROKER, AN EMPLOYEE OR OTHER REPRESENTATIVE OF ANY SUCH, INSURER, AGENT OR BROKER; PROVIDED THAT SUCH SERVICES ARE OFFERED OR DELIVERED AS PART OF THE SALE OR RENEWAL OF AN INSURANCE POLICY, CONTRACT OR GROUP INSURANCE POLICY AND OFFERED OR DELIVERED IN A NON-DISCRIMINATORY MANNER TO ALL SIMILARLY SITUATED INSURED OR POTENTIAL INSURED, WHETHER OR NOT SUCH SERVICES ARE SPECIFIED IN SUCH POLICY OR CONTRACT, SHALL NOT BE CONSIDERED TO BE AN INDUCEMENT OR REBATE PROHIBITED BY THIS SECTION UNLESS THE SUPERINTENDENT DETERMINES, AFTER A NOTICE AND HEARING, THAT THE OFFER AND SALE OF SUCH SERVICES CONSTITUTED THE SOLE REASON FOR THE PURCHASE OF SUCH INSURANCE POLICY, CONTRACT OR GROUP INSURANCE POLICY AND THAT, BUT FOR THE OFFER OR DELIVERY OF SUCH SERVICE, THE PURCHASE OF SUCH POLICY OR CONTRACT WOULD NOT HAVE TAKEN PLACE.

S 3. This act shall take effect on the sixtieth day after it shall have become a law.

**(Section 12.4)**

**Circular Letters**

Senate Bill S7661 relates to rebating, or the return of premium to an insurance customer. The Department of Financial Services has issued several Opinions that provide specific directions to producers and clarify the Department's interpretation of the Law or Regulation. The following Circular Letter establishes current policy toward rebating.



***Circular Letter No. 9 (2009)***

***March 3, 2009***

**TO: All licensed insurance agents and brokers**

**RE: Permissible services of insurance agents and brokers; rebating and inducements**

***STATUTORY REFERENCE: Sections 2324, 2502, 4224, 6409, 6504, and 6904 of the Insurance Law***

The purpose of this Circular Letter is to provide guidance and clarification to licensed insurance agents and brokers (collectively, "insurance producers") as to what kinds of services (often referred to as "value-added" services) may be provided to insureds or potential insureds without running afoul of the rebating and inducement provisions set forth in the New York Insurance Law. In response to numerous inquiries regarding these services, the Insurance Department's Office of General Counsel ("OGC") has in recent years issued a number of opinions on the subject. The Department recognizes that the nature of services that an insurance producer may provide in connection with sale or service of insurance continue to evolve, but even in changing conditions, certain underlying principles can guide licensees in their conduct.

There are a number of sections of the Insurance Law that pertain to rebating and inducements, and each has specific applicability to different kinds of insurance or, in the case of Insurance Law § 2502, a specific kind of relationship. Although the language and scope of Insurance Law §§ 2324, 4224, 6409, 6504, and 6904 differ in some respects, collectively those provisions prohibit an authorized insurer, licensed insurance producer, or any person acting on behalf of any such insurer or insurance producer from directly or indirectly paying or offering to pay an insured any rebate from the insurance premium specified in the insurance policy or contract, or giving or offering to give any valuable consideration or inducement, not specified in the insurance policy or contract.<sup>1</sup> Insurance Law § 2502 imposes similar prohibitions against inducements on banks and other specified financial entities, including persons engaged in the business of financing the purchase of real or personal property.

As a general matter, an insurer or insurance producer may not provide or offer to provide an insured or potential insured with any special benefit or discount, including any rebate from the premium, or any service or other incentive in conjunction with the sale of insurance, that is not specified in the policy or contract, or vice versa.<sup>2</sup> For example, an insurer or insurance producer may not provide "free" insurance or offer to pay part of the insurance premium for an insured or potential insured as an incentive to purchase goods, services or even other insurance. The purpose of New York's rebating and inducement provisions is to require an insurer or licensed insurance producer to provide insurance in a nondiscriminatory manner to like insureds or potential insureds, and to prohibit such an insurer or insurance producer from providing an insured or potential insured with any special benefit not

afforded to other insureds or potential insureds. See, e.g., McGee v. Felter, 75 Misc. 349 (Co. Ct. Kings Co. 1912) (“The vice is not in the giving of a rebate, inducement, or consideration, but the giving of any rebate, inducement, or consideration not specified in the policy.”). Indeed, the legislative history of Insurance Law §§ 2324 and 4224 shows that the two statutes are intended to reach discrimination, through rebating of any special favor or advantage, between insureds who are equal risks, without specifying the favor or advantage in the policy or contract.

Of course, under the Insurance Law, an insurance broker, but not an insurance agent, may charge an insured a service fee for providing insurance-related services, provided that the broker obtains a written service fee agreement in accordance with Insurance Law § 2119(c). Further, both an insurance broker and an insurance agent may, in accordance with Insurance Law § 2119(a) and (b), charge a fee for insurance consulting services pursuant to a written consulting agreement. However, the fees charged should be reasonable, and like insureds (or potential insureds) should be charged the same amounts for the same services. See Circular Letter No. 9 (2006) (discussing service fee agreements).

Apart from an arrangement pursuant to Insurance Law § 2119, an insurer or insurance producer may provide a service not specified in the insurance policy or contract to an insured or potential insured without violating the anti-rebating and inducement provisions of the Insurance Law if:

1. the service directly relates to the sale or servicing of the policy or provides general information about insurance or risk reduction<sup>3</sup>; and
2. the insurer or insurance producer provides the service in a fair and nondiscriminatory manner to like insureds or potential insureds.

The following services generally will fall within the scope of services that an insurance producer may lawfully provide in connection with insurance sold by the producer if provided incidental to the insurance and in a fair and nondiscriminatory manner:

- Risk assessments, including identifying sources of risk and developing strategies for eliminating or limiting those risks;
- Insurance consulting services<sup>4</sup> or other insurance-related advice;
- Insurance-related regulatory and legislative updates;
- Certain claims assistance services (including the preparation of claims forms), but excluding claims adjustment, unless the exceptions set forth in Insurance Law § 2101(g) are satisfied;<sup>5</sup>
- Tax preparation on behalf of an employer of Schedule A of the Internal Revenue Service Form 5500 Annual Return/Report of Employee Benefit Plan, which requests information regarding insurance contract coverage, fees, and commissions, investment and annuity contracts, and welfare benefit contracts;
- Information to group policy or contract holders and members under group insurance policies currently in place, as well as forms needed for plan administration, enrollment in a plan, insurer website links, and answers to frequently asked questions related to the insurance (including, for example, access through a website, created by the insurance producer, to an employee benefit portal that contains such information);
- Certain services performed pursuant to the federal Consolidated Omnibus Budget Reconciliation Act (“COBRA”), such as billing former employees, collecting the insurance premiums, and forwarding the aggregate premiums to the employer policy or contract

holder or to the insurer, when offered in connection with the provision of accident and health insurance; and

- Certain services provided in accordance with the federal Health Insurance Portability and Accountability Act, such as those pertaining to health care access, portability, and renewability, when offered in connection with the provision of accident and health insurance.

However, because they are too attenuated to the provision of insurance, or would otherwise violate the law because the services are not specified in the policy, the following services, if provided by an insurance producer to an insured or prospective insured for “free” or at a reduced fee, or otherwise offered in conjunction with insurance services, could, in the Department’s estimation, run afoul of the rebating and inducement provisions set forth in the Insurance Law. Thus, careful consideration should be given to:

- Flexible spending administration services;
- Legal services;
- Payroll services, such as providing employers with check creation and distribution services for their employees;
- Referrals to third-party service providers through which an insured or prospective insured may receive a discounted rate while the producer is the producer of record;
- Advice regarding compliance with federal and state laws concerning human resource issues not relating to the insurance provided;
- Management of employee benefit programs, such as retirement programs and time-off/leave of absence programs, other than the insurance sold by the producer;
- Preparation of employee benefit statements listing all of the benefits provided to employees by the employer that are unrelated to the insurance purchased;
- Development of employee handbooks and training, which are unrelated to the insurance purchased; and
- Services related to employee compensation, discipline, job descriptions, leaves of absence, organizational development, business policies and practices, safety, staffing, and recruiting that are unrelated to the insurance purchased.

Special mention of so-called “wellness programs,” too, is warranted. Generally speaking, a wellness program is one designed to promote health and prevent disease, and which provides rewards or incentives for participation. On September 25, 2008, Governor David A. Paterson signed Chapter 592 of the Laws of 2008 into law. Chapter 592 adds a new section to the Insurance Law, § 3239, which is styled “Wellness programs.” The statute authorizes an insurer to offer a wellness program in conjunction with a group accident and health insurance policy or group subscriber contract, provided that the program is specified in the policy or contract. The legislation also amends Insurance Law § 4224(c) to expressly exclude a wellness program, as described in Insurance Law § 3239, from the rebating and inducement prohibitions set forth in the Insurance Law, provided that the program is specified in the policy or contract. Chapter 592 confirms the Department’s practice of requiring an insurer to specify in an accident and health or life insurance policy or contract any wellness program offered in conjunction with the policy or contract in order to comply with the rebating and inducement provisions of Insurance Law § 4224(c).

Please be advised that the above lists are not exclusive, and are instead intended for illustrative purposes. To be sure, the Department intends, from time to time, to revisit the instant Circular Letter to update the list of services that, based on the Department's interpretation of the governing legal framework, insurance producers may lawfully offer to insureds and prospective insureds.

Please direct any questions regarding this circular letter to Joana Lucashuk, Senior Attorney, at [jlucashu@ins.state.ny.us](mailto:jlucashu@ins.state.ny.us) or (212) 480-2125.

Very truly yours,

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Paul A. Zuckerman  
Assistant Deputy Superintendent and Counsel

<sup>1</sup> Section 2324 applies to most kinds of insurance that § 4224 does not, including most property/casualty insurance; § 4224 applies to life insurance, accident and health insurance, and annuities; § 6409 applies to title insurance; § 6504 applies to mortgage guaranty insurance; and § 6904 applies to financial guaranty insurance. Under Insurance Law §§ 2324 and 6409, the recipient of the rebate or inducement also stands in violation of the law.

<sup>2</sup> Even if the policy or contract specifies a particular good or service and makes it available to all persons of the same class, the Department still may find the endorsement unacceptable, if the policy or contract and/or the insurer's activities run afoul of any other relevant provisions of the Insurance Law, separate and apart from the rebating and inducement provisions. Thus, in reviewing policy or contract forms, the Department looks to see that the goods or services offered in the policy or contract have a legitimate nexus to the insurance coverage provided under the policy or contract, and are necessarily or properly incidental to the insurer's insurance business. See Insurance Law § 1113(a); see also Insurance Law §§ 1106, 1610, 1714 and 4205.

<sup>3</sup> OGC opinions have stated that the service must be a service that the producer "normally performs or arranges." See, e.g., OGC Opinion 07-10-13 (Oct. 31, 2007); OGC Opinion 07-07-17 (July 23, 2007); and OGC Opinion 06-09-14 (Sept. 21, 2006). However, on reflection, this standard implies an inelastic and unadaptable approach to producer activities, which was not the Department's intent.

<sup>4</sup> Insurance consulting services include "examining, appraising, reviewing or evaluating any insurance policy, bond, annuity or pension or profit-sharing contract, plan or program," as well as "making recommendations or giving advice" with regard to the foregoing. Ins. Law § 2119(a)(1).

<sup>5</sup> This is one instance where the distinction between an insurance agent and broker is meaningful. Whereas an insurance agent may, under certain circumstances, adjust claims only on behalf of the insurer, a broker may do so only on behalf of the insured.

**(Section 12.5)**

**Unlicensed and Support Staff Guidelines**

Any person who "Acts as such in the solicitation of, negotiation for, or making of an insurance or annuity contract" must be licensed. Anyone who performs these acts without a license is guilty of a misdemeanor.

The following are exempt from being licensed:

- A. Regular salaried officers of employees who do not solicit or accept applications or orders outside the office of the Insurance Agent.
- B. Regular salaried officers and employees who do not receive compensation or commission dependent upon the amount of business transacted.
- C. A regular salaried employee of an insurer who devotes very little of his time to the soliciting of insurance and whose compensation doesn't depend directly on the amount of business obtained.
- D. Licensed attorneys acting in their capacity as such.
- E. Actuaries of CPA's not soliciting insurance.

If you have unlicensed employees setting appointments for licensed agents and you pay them a "bonus" for each appointment, this may be a violation of this section of the Law. It is better that you pay them a regular salary that is based on performance. The only alternative is to have them licensed as agents.

## **Authorized Activities**

- Perform secretarial/receptionist duties such as:
  - Answering the phone.
  - Scheduling appointments (provided there are no discussions about insurance coverages, cost, or related issues).
  - Maintaining files and records.
  - Referring prospect or customer to the Agent or a licensed Sales Producer, where appropriate.
  - Word processing and data entry.
  - Assisting with advertising and mailing campaigns.
- Accept payments on existing policies that are made in the office in situations in which there are no coverage discussions.
- Secure expiration dates from prospects limited to the date the policy expires and the current carrier, and whether they would be interested in speaking to the Agent or a licensed Sales Producer.
- Take loss information from customers and report this information to the Claims Department.
- Handle changes to existing policies that do not involve any discussion of coverages or require the binding of additional coverages, increasing or decreasing coverages, removal of coverages, or the addition of vehicles.
- Receive requests for coverage for transmittal to the Agent or a licensed Sales Producer.

## **Unauthorized Activities**

### **Don't:**

- Prospect or solicit for insurance.
- Quote premiums.
- Discuss or provide advice concerning coverages, limits, or deductibles
- Interview customers for the purpose of developing information as part of the completion of an application.
- Bind new policies or make changes to existing policies that require the binding of additional coverages, increasing or decreasing coverages, removal of coverages, or the addition of vehicles
- Accept payments on new policies.
- Accept payments on existing policies outside the office.
- Receive compensation based on sales.
- Be involved in any activity or transaction that is not in compliance with company policies and procedures or that is in violation of state licensing or other laws.

**(Section 12.6)**

**Waiver of Pre-Licensing Criteria**

Under certain circumstances, individuals **may receive a waiver** of the requirement to complete **the pre-licensing requirement**. The waiver does not eliminate the requirement for individuals to successfully pass the required examination for their individual license class.

The following form may be used by individuals seeking licensure as either a Life Accident and Health, or Property Casualty **Broker**. Agents are not eligible to apply for licensure with a waiver of the pre-licensing requirement. However, a currently licensed broker may apply for an Agent license.

**STATEMENT OF EMPLOYER FORM PROPERTY AND CASUALTY BROKER  
THIS FORM MUST BE COMPLETED BY THE EMPLOYER**

1. \_\_\_\_\_  
Employee's Name Date of Birth Social Security Number

2. \_\_\_\_\_  
Employee's Address

3. \_\_\_\_\_  
Employer's Name

4. \_\_\_\_\_  
Employer's Address

5. Under what license number was the above employer continually licensed by the Superintendent of Insurance? \_\_\_\_\_  
License Number

6. Is/was the above employee regularly employed by the above employer for a period of not less than one year during the last three years in responsible insurance duties relating to the underwriting or adjusting of losses in any one or more of the following branches of insurance: Fire, Marine, Liability and Workers' Compensation, Fidelity and Surety, Property and Casualty? Yes \_\_\_\_\_ No \_\_\_\_\_

6a. If question 6 was answered "No," is/was the above employee regularly employed by the above employer in responsible insurance duties relating to the underwriting or adjusting of losses in any one or more of the following branches of insurance: Fire, Marine, Liability and Workers' Compensation, Fidelity and Surety, Property and Casualty for less than one year? Yes \_\_\_\_\_ No \_\_\_\_\_

6b. If question 6a was answered "Yes," include the dates of employment below:  
FROM \_\_\_\_\_ TO \_\_\_\_\_  
FROM \_\_\_\_\_ TO \_\_\_\_\_

Under penalty or perjury, I affirm that I have completed this statement and the information set forth is true.

7. \_\_\_\_\_ 8. \_\_\_\_\_ 9. \_\_\_\_\_  
DATE / SIGNATURE OF EMPLOYER / TITLE

**NOTE:** If the employer is a Corporation, Partnership, Limited Liability Company or Insurance Company, this form must be signed by an officer, director or member.

EMP-1-032601

## Section 12

### Legislative Process Review

The **Superintendent has the authority to investigate violations** of insurance law, rules and regulations.

Violations can result in **license revocation** or other **disciplinary action**, including **fin**es.

A bill must be passed by a majority vote in the **Assembly** and **Senate** and signed by the **Governor** to become **law**.

The words **Rules** and **Regulations** are interchangeable.

**The New York State Legislature provides online access to view current status of all current legislation.**

**Violations** of Law or Rules and Regulations can result in **license revocation** or other **disciplinary action**, including **fin**es.

Any person who "Acts as such in the solicitation of, negotiation for, or making of an insurance or annuity contract" must be licensed.

Unlicensed support staff **may accept payments on existing policies** that are made in the office.

Unlicensed support staff may **inform insureds as to coverages indicated in the policy record**.

### Section 13.1

#### Ancient Insurance Fraud

The history of insurance fraud is nearly as old as insurance itself. Like insurance, insurance fraud was documented in ancient texts. The Greek statesman and orator Demosthenes spoke of a great scheme to defraud insurance creditors in a speech that is still discussed today. This speech, one of many written by Demosthenes on papyrus in the ancient Greek language around 340BC, explains the plan of how Hegestratus and Zenotheris secured contracts of bottomry in which creditors loaned a sum of money that was to be repaid when a ship carrying a load of grain reached its destination port. Hegestratus, however, had no grain to load onto the ship, and after three days at sea planned to sink the ship with its crew and escape in a life boat. The plan was discovered and Hegestratus drowned; a fate he planned for the crew.

Men of the jury, having entered a plea that the action is not admissible, I wish first to speak concerning the laws in accordance with which the plea was entered. The laws, men of the jury, ordain that actions for shipowners and merchants shall be upon loans for shipments to or from [Athens](#), concerning which there shall be written agreements; and if anyone brings suit in violation of this provision, the action shall not be maintainable.

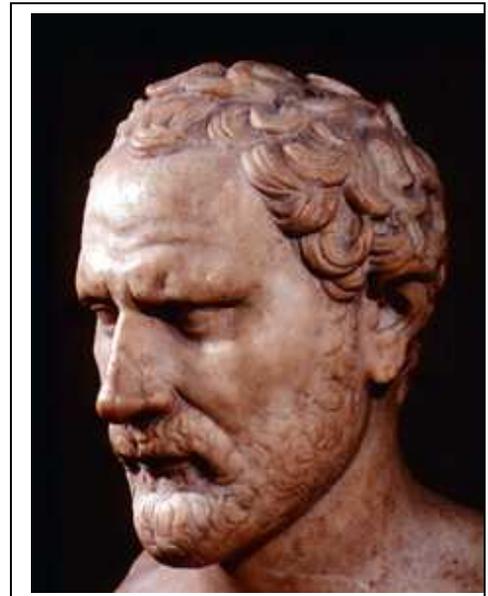
Now between this man Zenotheris and myself there has been no contract or agreement in writing, as he himself acknowledges in his complaint. He states that he made a loan to Hegestratus, a shipowner, and that after the latter was lost at sea, we appropriated the cargo. This is his charge in the complaint. The same speech will suffice to prove to you that his action is not maintainable, and to make you see the whole of his plot and his rascality.

I beg of you all, men of the jury, if you ever attended closely to any matter, to attend to this. You will hear of a man's audacity and villainy that go beyond all bounds, provided I am able, as I hope to be, to tell you the whole tale of what he has done.

Zenotheris, who is here before you, being an underling of Hegestratus, the shipowner, who he himself in his complaint states to have been lost at sea (how, he does not add, but I will tell you) , concocted with him the following fraud. Both of them borrowed money in [Syracuse](#). Hegestratus admitted to those lending money to Zenotheris, if inquiries were made, that there was on board the ship a large amount of grain belonging to the latter; and the plaintiff admitted to those lending money to Hegestratus that the cargo of the ship was his. As one was the shipowner and the other a passenger, they were naturally believed in what they said of one another.

But immediately on getting the money, they sent it home to [Massalia](#), and put nothing on board the ship. The agreement being, as is usual in all such cases, that the money was to be paid back if the ship reached port safely, they laid a plot to sink the ship, that so they might defraud their creditors. Hegestratus, accordingly, when they were two or three days' voyage from land, went down by night into the hold of the vessel, and began to cut a hole in the ship's bottom, while Zenotheris, as though knowing nothing about it, remained on deck with the rest of the passengers. When the noise was heard, those on the vessel saw that something wrong was going on in the hold, and rushed down to bear aid.

Hegestratus, being caught in the act, and expecting to pay the penalty, took to flight, and, hotly pursued by the others, flung himself into the sea. It was dark, and he missed the ship's boat, and so was drowned. Thus, miserable as he was, he met a miserable end as he deserved, suffering the fate which he purposed to bring about for others.



As for this fellow, his associate and accomplice, at the first on board the ship immediately after the attempted crime, just as though he knew nothing of it but was himself in utter consternation, he sought to induce the sailing-master and the seamen to embark in the boat and abandon the vessel with all speed, declaring that there was no hope of safety and that the ship would presently sink; thinking that thus their design might be accomplished, the ship be lost, and the creditors thus be robbed of their money.

In this he failed, for our agent,<sup>1</sup> who was on board, opposed the plan, and promised the sailors large rewards if they should bring the ship safe into port. The ship safely brought to Cephallenia, thanks chiefly to the gods, and after them to the bravery of the seamen. Again after this he schemed together with the Massalotes, the fellow-countrymen of Hegestratus, to prevent the vessel from completing her voyage to [Athens](#), saying that he himself was from [Massalia](#); that the money came from thence; and that the shipowner and the lenders were Massalotes.

*1 Presumably Protus, who seems to have sailed as supercargo.*

In this, too, he failed; for the magistrates in Cephallenia decided that the vessel should return to [Athens](#), from which port she had set sail. Then the man, whom no one would have thought audacious enough to come here, after having plotted and wrought such deeds—this man, Athenians, has so surpassed all in shamelessness and audacity, that he has not only come, but has actually laid claim to my grain, and has brought suit against me!

What, then, is the reason for this? And what can have induced the fellow to come here and commence this suit? I will tell you, men of the jury, though Heaven knows it gives me pain to do so; but I must. There exists in the Peiraeus a gang of scoundrels<sup>1</sup> closely leagued with one another.

You would know them at once, should you see them. When this man Zenothemis was scheming to prevent the vessel from completing her voyage to [Athens](#) we chose one of these men after consulting with one another<sup>1</sup> as our representative. He was known to us after a fashion, but we had no idea of his real character. This was in fact a piece of misfortune for us as great, if so much may be said, as our having to deal with rascals at the start. This man who was sent out by us—his name was Aristophon, and he is the same one, as we now hear, who managed the business of Miccalion—has entered into an agreement with the plaintiff, and has sold him his services. In a word he is the one who is managing the whole affair, and Zenothemis has been glad to accept this help.

For when he failed in his scheme to destroy the vessel, not being able to pay back their money to his creditors—how could he pay, when at the start he had put nothing on board?—he lays claim to my goods, and declares that he has lent money to Hegestratus on the security of the grain which our agent sailing with him had purchased. The creditors, who had been deceived in the first instance, seeing that instead of receiving their money, they have a scoundrel as their debtor and nothing more, and hoping that, if you are imposed upon by Zenothemis, they may recover their own out of my property, are forced to make common cause with him in order to protect their own interests, although they know him to be making these false charges against me.

Such, to speak briefly, is the matter on which you are to cast your votes. But I wish first to bring before you the witnesses to what I am saying, and then to instruct you regarding other aspects of the case.

*Demosthenes with an English translation by A. T. Murray, Ph.D., LL.D. Cambridge, MA, Harvard University Press; London, William Heinemann Ltd. 1939.*

Bottomry continues to be practiced today, with a common example occurring when a ship takes on cargo and fuel in one port with the promise to pay for the fuel upon reaching the destination port and offloading their cargo for sale. **Cargo fraud** is also still common; shipping containers are often hijacked during transport.

Until recently, investigation of suspicious claims were the sole responsibility of insurers. State and Federal actions to combat fraud in the 19<sup>th</sup> and early 20<sup>th</sup> centuries focused principally on unscrupulous company and agent activities, as outlined previously in this text. Organized efforts to address fraud perpetrated by claimants gained ground slowly after the introduction of automobile insurance and has grown steadily to be an important part of the industry today.

In 1912, Boston Insurance Company hired Fred Sauter to investigate the theft of one of their insureds automobiles. The investigation quickly uncovered the fact that two other Chalmers automobiles (Now Chrysler) insured by other insurance companies were also reported stolen. Mr. Sauter saw the benefit of cooperation between insurers in this investigation and shortly thereafter the **Automobile Protection and Information Bureau (APIB)** was formed. In 1929, Mr. Sauter was elected Chairman of the newly formed **National Automobile Theft Bureau (NATB)**.

## **Section 13.2**

### **Insurance Fraud Organizations**

The **Insurance Crime Prevention Institute (ICPI)** was created in 1971 as an independent investigative agency to assist with prosecution of insurance fraud. In 1992, the ICPI joined with the NATB to combine their efforts and the **National Insurance Crime Bureau (NICB)** was established. The NICB is a founding member of the **Coalition Against Insurance Fraud**, which was organized in 1993.

In 1945, North Carolina became the first state to establish a statewide agency dedicated to fighting insurance fraud. They were 30 years ahead of Florida which established their Division of Insurance Fraud in 1976, followed by California's Division of Insurance Fraud which was created in 1979. New York Law established the Insurance Frauds Bureau in 1981 as a law enforcement agency.

#### *More About the Insurance Frauds Bureau*

##### ***Bureau Structure***

The Insurance Frauds Bureau was created by an act of the Legislature in 1981 as a law enforcement agency within the New York State Insurance Department. The law established the Bureau to effectively detect, investigate and prevent insurance fraud and to refer for prosecution those persons or groups who commit insurance fraud.

As part of the 2011-2012 budget, Governor Andrew M. Cuomo merged the New York State Insurance Department and the New York State Banking Department to create a new Department of Financial Services, effective October 3, 2011. Integrating these agencies under a single leadership and management structure allows for greater efficiency and helps to modernize regulatory oversight of the financial services industry in New York State.

The Bureau is headquartered in New York City, with six additional offices across the State: Garden City, Albany, Syracuse, Oneonta, Rochester and Buffalo. For contact information about the Bureau offices, please [select this link](#).

Insurance Frauds Bureau investigators are designated as peace officers. This designation gives them the authority to carry firearms and make arrests. Investigators are seasoned professionals with years of experience in law enforcement and insurance and financial fraud investigation.

The Bureau consists of specialized units: Major Case, General, Mortgage and Title, Arson, Auto, No-Fault, Workers' Compensation, Medical and Upstate. The responsibilities of the Bureau's units are described below.

- Major Case Unit - takes the lead in investigating complex cases involving all types of financial and insurance fraud including commercial rate evasion, no-fault, health care fraud and workers' compensation premium fraud. The Unit also focuses on the investigation of systemic fraud perpetrated by organized conspiracies and rings.

- No-Fault Unit - investigates fraudulent medical claims submitted under no-fault auto insurance coverage and individuals who engage in such fraudulent activity as staged and caused accidents, runner/steerer activity, jump-ins and fraudulent medical claims, among others.
- General Unit - investigates reports of fraud involving life, homeowners and agent/broker fraud, larceny, burglary and types of fraud not assigned to other units.
- Mortgage and Title Unit - is responsible for combating schemes that target consumers in the real estate market.
- Arson Unit - coordinates insurance-related arson investigations in conjunction with New York State Department of Homeland Security – Emergency Services. (formerly the New York State Office of Fire Prevention and Control), the New York City Fire Department’s Bureau of Fire Investigation, the New York City Police Department’s Arson Explosion Squad and local fire departments across the State, as well as the FBI and the Bureau of Alcohol, Tobacco, Firearms and Explosives, among others.
- Auto Unit - investigates individuals who fraudulently report their vehicles stolen, as well as body shop operators suspected of enhancing auto damage and related fraudulent activities.
- Workers' Compensation Unit - investigates individuals who file fraudulent claims related to injuries in the workplace or who collect workers’ compensation benefits while they are employed. This unit also investigates employers who submit applications for workers’ compensation and general liability insurance coverage containing false information about the number of employees on the payroll and/or the nature of the work being performed. In addition, its investigators also conduct investigations involving employers who submit fraudulent Certificates of Insurance as proof of coverage when in fact no coverage exists.
- Medical Unit - investigates policyholders who submit false or exaggerated medical claims, as well as doctors and other health care providers who bill for services that were not rendered, bill for more expensive procedures that were actually provided and perform medically unnecessary procedures.
- Upstate Unit - investigates all types of insurance fraud and includes the Bureau’s Albany, Rochester, Syracuse, Oneonta and Buffalo Offices.

<http://www.dfs.ny.gov/insurance/frauds/fdlabout.htm>

The steady change in attitude of governments and their regulatory and prosecutorial agencies towards insurance frauds shows an attempt to control the impact of fraud on honest, hard working insurance consumers. The insurance industry, however, has been slow to react on its own to the growing costs of fraudulent claims to their customers and their stock holders.

...the U.S. insurance industry continued to expand, largely free of stringent government oversight until well into this century. Remarkably, insurance fraud “received little public attention until the 1980s,” the Insurance Information Institute has noted. In part, that was because law enforcement officials “had other priorities and were reluctant to provide the training needed to investigate and prosecute cases of insurance fraud.”

At the same time, individual companies hesitated to seize the initiative in attacking fraud. “[G]iven the fine line between investigating suspicious claims and harassing legitimate claimants, some insurers were afraid that a concerted effort to eradicate fraud might be perceived as an anti-consumer move,” the institute observed. “In addition, the need to comply with the time requirements for paying claims imposed by fair-claim-practice regulations in many states make it difficult to adequately investigate suspicious claims.”

By **Richard L. Worsnop** *Will a new crackdown reduce the losses?* CQ Researcher 10/11/1996

Attitudes were beginning to change in the 1980's and 90's. Insurers funded efforts to fight fraud with the development of **Special Investigative Units (SIU's)** and through education campaigns to educate the public on the cost of insurance fraud to the individual consumer. New York State passed a law in 1981 establishing, among other items, that certain insurers create Special Investigation Units.

## **RULES AND REGULATIONS OF THE STATE OF NEW YORK**

### **TITLE 11. INSURANCE DEPARTMENT**

#### Chapter IV — FINANCIAL CONDITION OF INSURER AND REPORTS TO SUPERINTENDENT

##### Subchapter A. — Rules of General Application

##### Part 86. — Reports of Suspected Insurance Frauds to Insurance Frauds Bureau; Required Warning Statements (Regulation 95)

The law and Department Rules and Regulations have been updated periodically over the decades to require insurers to have an active "Plan" for educating the public about insurance fraud. The **Coalition Against Insurance Fraud** is a lead agency for insurance companies in this effort, although carriers also have independent fraud awareness marketing efforts.

### **Why should Producers learn about Insurance Fraud?**

Under New York's Insurance Law, **licensees of the Insurance Department (such as insurers, agents, and brokers) are required to report any suspected fraudulent acts** to the Department's Insurance Frauds Bureau. Reporting fraud is the first step to reducing the frequency and costs of illegitimate claims, which contribute to increased premium rates for all consumers.

In your career as an insurance professional, you are likely to come into contact with a client that is trying to defraud an insurance company. Insurance fraud costs Americans at least \$80 billion a year, or nearly \$950 for each family, according to the Coalition Against Insurance Fraud. Property/casualty insurance fraud cost insurers an estimated **\$30 billion annually**, according to the Insurance Information Institute. The **National Health Care Anti-Fraud Association** estimates conservatively that health care fraud costs the nation about **\$68 billion annually**.

At this time, there are dozens of organizations dedicated to fighting insurance fraud, including:

- Federal Bureau of Investigation (FBI)

- New York Attorney General Investigations Division

  - Organized Crime Task Force (OCTF)

  - Medicaid Fraud Control Unit (MFCU)

  - Automobile Insurance Fraud Unit (AIFU)

- The New York Department of Financial Services Insurance Fraud Bureau

- New York State Chapter of the International Association of Special Investigation Units (NYSSIU)

- Coalition Against Insurance Fraud

- National Health Care Anti-Fraud Association

- The National Insurance Crime Bureau (NICB)

Agents and Brokers have to be alert to the reasons, extent, and effect that fraud causes. They also need to become aware of how the war against this crime is being waged.

Fraud occurs at many different stages in the process of an insurance transaction. It can occur in the application process, when an individual is a policyholder, as well as by third-party participants. Professionals that provide services to claimants, also sometimes get into the fraud act. Some common frauds include misrepresenting information on the insurance application, inflating actual claims, staging accidents and claiming serious injury when only minor injury occurred.

Investigating suspicious claims is not a simple matter. Law enforcement agencies need special training to investigate and prosecute cases of insurance fraud. In addition, obviously it must be a concerted effort from many fronts to be successful. It is a war with many battles. It is also a delicate situation, as there is a fine line between investigating questionable claims and harassing legitimate insureds. The industry does not want to be labeled anti-consumer. Further, insurance companies are continually made aware of the fact that time factors are involved. In order to follow the fair claim practices set in many states, they need to decide on a claim in a timely fashion. This can occasionally put a strangle hold on investigating suspicious claims.

Sometimes insurance companies also find fighting fraud a problem with cost effectiveness. It is sometimes cheaper to pay a claim than investigate it. With that mentality, enforcement can become even more difficult. This may also encourage certain types of crime to be repeated over and over.

Successful fraud prosecutions block certain fraud activities from continuing, plus they help in the publicity of fraud cases. This hopefully deters others from trying the same tactic. But once again, in order to be successful, an organized effort is necessary. If one state does a good job in fighting fraud, it might just force criminals into another state. Federal statutes are needed, as well as cooperation and communication between states.

An investigation into the extent of the problem examines the processes of combating fraud and hopefully convinces everyone that they too can be a part of the eradication of this serious problem.

## **Section 13.3**

### **NY Insurance Fraud Bureau**

#### **Insurance Frauds Bureau**

##### **Highlights of 2015**

- 490 new cases were opened for investigation;
- Investigations led to \$2.4 million in court-ordered restitution;
- Investigations resulted in 330 arrests, 79 of which were for health care fraud;
- Prosecutors obtained 355 convictions in cases in which the Bureau was involved;
- 57% of all fraud reports received by the Bureau were for suspected no-fault fraud.

##### **Background**

The Bureau has a longstanding commitment to combating insurance fraud. It is responsible for the detection and investigation of insurance and financial fraud and the referral for prosecution of persons or entities that commit those frauds. The Bureau is headquartered in New York City, with offices in Garden City, Albany, Syracuse, Oneonta, Rochester, and Buffalo.

##### **Reports of Suspected Fraud/Investigations**

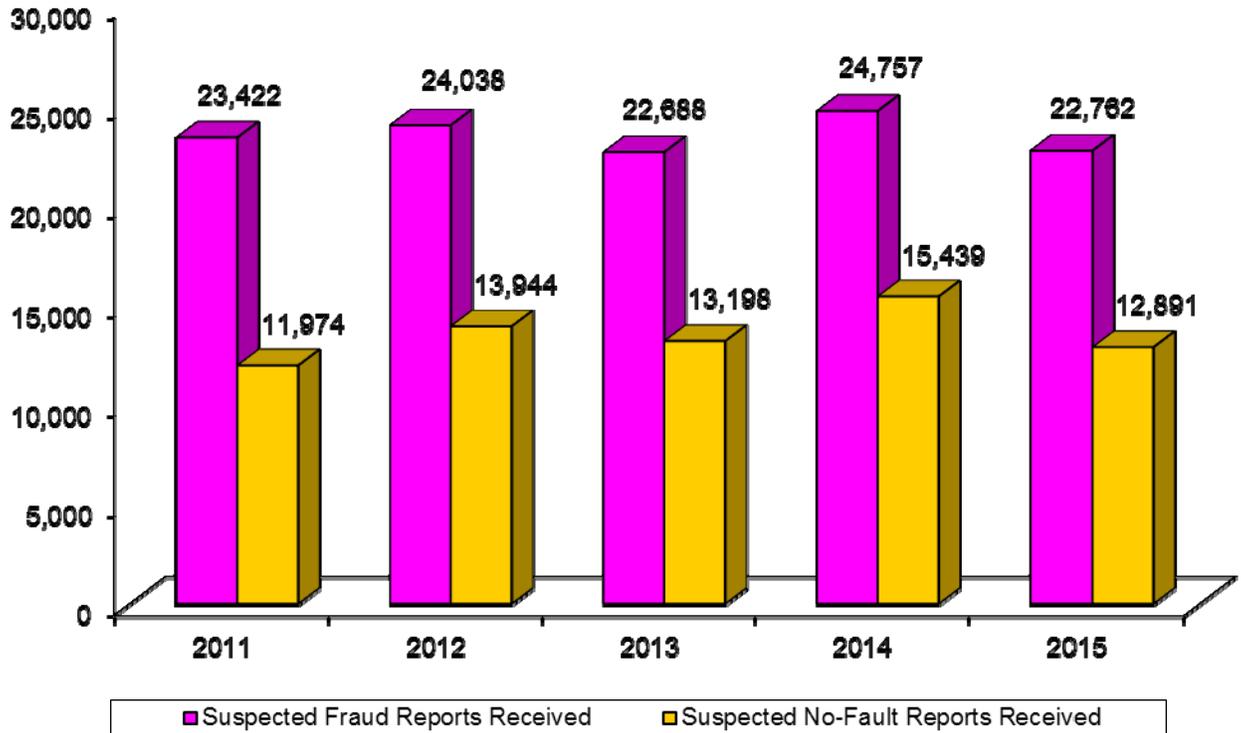
The Bureau received 22,762 reports of suspected fraud in 2015. The vast majority of those reports—21,827—were from licensees required to submit such reports to the Department. The remaining reports were from other sources, such as consumers or anonymous tips. The Bureau opened 490 cases for investigation in 2015. Tables showing the number of fraud reports received, investigations opened, and arrests by type of fraud appear in the Appendices.

During 2015, the Bureau referred 131 cases to prosecutorial agencies for prosecution. Prosecutors obtained 355 convictions in Bureau cases.

##### **No-Fault Fraud Reports and Investigations**

The number of suspected no-fault fraud reports received by the Bureau accounted for 7% of all fraud reports received by the Bureau in 2015.

**Number of Suspected Fraud Reports Received Compared with  
Number of Suspected  
No-Fault Reports Received 2011 - 2015**



**Major Insurance Fraud Cases During 2015**

An attorney was arrested for his participation in the sale of fake insurance bonds for construction of the World Trade Center PATH transportation hub. He allegedly sold fraudulent bonds to a construction subcontractor with a \$6.2 million subcontract for work at the site; the attorney wired a sizable portion of the premium to himself and a co-conspirator. The IFB participated in this investigation with the Office of the Inspector General of the Port Authority of New York and New Jersey, a member of Financial Fraud Enforcement Task Force.

The owner of a construction company was arrested after the State Insurance Fund reported suspected fraud to the IFB based on a workers' compensation insurance application submitted by the owner. An investigation conducted by the IFB and Suffolk County District Attorney's Office found evidence that the owner had underreported the number of company employees and the amount of the company payroll for a six-month period. During that time, the company allegedly conducted \$732,882 in unreported business, thereby avoiding payment of \$83,600 in premiums to the Fund.

An investigation revealed that for more than three years, a licensed wholesale insurance broker who had secured a policy for a client had created invoices reflecting inflated premiums and had pocketed \$58,000 in illegal profits. The broker also failed to forward more than \$200,000 in premium payments to the insurer. He was arrested following a joint investigation by the IFB and the Nassau County District Attorney's Office.

An individual who had lost his license in 2002 to transact business with the New York Automobile Insurance Plan (NYAIP), New York's auto insurer of last resort, was arrested for submitting more than 2,500 insurance applications to the NYAIP. He placed the new business among 27 insurance companies using the license of a former co-worker (who was unaware of the scheme). The insurers issued 485 checks totaling more than \$1.3 million in commissions and fees in the former co-worker's name, the suspect forged the former coworker's signature on all but four of the checks and deposited them in his own account. The IFB and the NYAIP conducted the investigation with the assistance of the FBI.

The treasurer/secretary of a volunteer fire department in upstate New York was arrested and charged with using a fire department debit card to make ATM cash withdrawals and using the cash for personal expenses. The fraudulent activity began sometime in 2013 and amounted to more than \$83,000. The investigation was conducted by the Otsego County District Attorney's Office and the IFB.

## **Section 13.4**

### **Insurance Scams**

Insurance Scams come in different shapes, sizes and colors. Life insurance fraud is perpetrated in many different ways. Insurance producers may be tempted to "upgrade" client policies without permission or under false pretense, which is one reason for New York Regulation 60 disclosure. Pocketing premiums is another producer fraud that is often run as a Ponzi type scheme. The following are common life insurance fraud schemes:

- ***Fraudulently changing a beneficiary***
- ***Faking a death***
- ***Murder for profit***
- ***Pocketing premiums***
- ***Upgrade churning***
- ***Stranger Owned Life Insurance (StOLI)***

Some life insurance scams are incredible tales that become folklore. Many result in the demise of an unwitting character, was the case of Mike Malloy, a bar fly with few friends.

#### ***Sunday, October 14, 2007 New York Daily News***

In May 1933, gravediggers exhumed Mike Malloy's body from a 12-foot-deep pauper's plot in the charity section of Westchester County's Ferncliffe Cemetery. Lobar pneumonia, according to the death certificate, had killed him, but Bronx District Attorney Samuel Foley suspected otherwise.

The subsequent autopsy revealed the most clumsily executed insurance scam in New York City history. It also gave birth to an urban legend: Malloy, survivor of six murder attempts and who withstood alcohol and food laced with poison, proved indestructible - until a rubber tube placed in his mouth delivered enough carbon monoxide gas to end his life. That was the conclusion drawn by Dr. Harry Schwartz, the assistant city toxicologist who performed the autopsy.

#### ***Suitable victim***

In the waning days of Prohibition, Anthony Marino owned a speakeasy on E. 177th St. in the Bronx. Still mired in the Depression, the city's unemployment rate neared 50% and desperate men sought ways to make a dollar any way they could. Marino, along with his barkeep, Joe Murphy, undertaker Frank Pasqua and friend Dan Kriesberg, devised a plot to bilk insurance companies by taking out policies on drunks and then hastening their deaths with booze.

Malloy seemed a suitable victim. The 50-year-old had worked as a fireman and engineer, but alcoholism had prevented him from holding down regular jobs. He now spent his time living the life of a derelict, frequenting Marino's speakeasy, among many others. Certainly, the gang believed, it was only a matter of time before Malloy drank himself to death.

They began backslapping Malloy and gave him free drinks. Malloy, accustomed to getting the bum's rush because of his lack of funds, was so thrilled that he eagerly signed a petition that would help elect Marino for local office. What he actually signed was an insurance policy from Metropolitan Life for \$800, and two from Prudential for \$495 each. The gang even provided Malloy with a crash pad in the back of the bar to sleep off his hangovers.

After several weeks of feeding Malloy free liquor, Marino noted that it was starting to cost him money. More distressing was Malloy's health: His pallor had lifted and spirits soared courtesy of the free booze. More active measures would be required to hasten Malloy's demise. Murphy, a former chemist, told Malloy that some "new stuff" had come in. Malloy drank it, commented on how smooth it tasted and then collapsed to the floor. They dragged him to the back room and anticipated that they would need to pay off a physician for a "hush job" death certificate.

One hour later, a refreshed Malloy bounded back to the bar with a mighty thirst, unaffected by the alcohol Murphy had laced with car antifreeze. Over the next few days the gang spiked Malloy's drinks with stronger doses of antifreeze, then turpentine

and, finally, horse liniment with rat poison. Malloy kept beaming and kept drinking, soaking up the good times spent with his new friends. The crew decided a switch to food would best hasten Malloy's death.

Marino served him raw oysters - soaked in wood alcohol. After downing two dozen, Malloy was so enthused by the cuisine that he encouraged Marino to open up a restaurant. The next course included an entrée of rotten sardines mixed with tin shavings. Same result.

Next, the plotters got Malloy stupefied and escorted him to Claremont Park, stripped off his coat, and in the middle of winter opened his shirt and poured 5 gallons of water on him before dumping him into a snowbank. If poisoned liquor and food couldn't kill Malloy, then the cold blasts of a New York winter would.

Or so they thought. The next evening, Malloy showed up at the speakeasy wearing a new suit. He had really tied one on the night before, he explained, and wound up nearly naked in the park. Fortunately, the police had found him and a welfare organization outfitted him with new clothes.

### ***Unconsciously drunk***

Exasperated, the gang hired a cab driver, Harry Green, and offered him \$150 to run Malloy down with his vehicle. On Jan. 30, 1933, a nearly unconsciously drunk Malloy was driven from Marino's to Pelham Parkway. Murphy stood him up in the middle of the roadway, and Green backed up his taxi two full blocks to build up enough speed to complete the job. Somehow, Malloy stumbled to safety. They then took Malloy to Gun Hill Road. This time, Green hit him.

The gang gleefully retreated to Marino's and again waited for an announcement of Malloy's demise. For days nothing appeared in the newspapers. Where was he? Malloy was recovering in the hospital under a different name, having sustained a fractured skull, a concussion and a broken shoulder. The indestructible barfly returned several weeks later to the speakeasy and announced he had an awful thirst. The boys' jaws dropped.

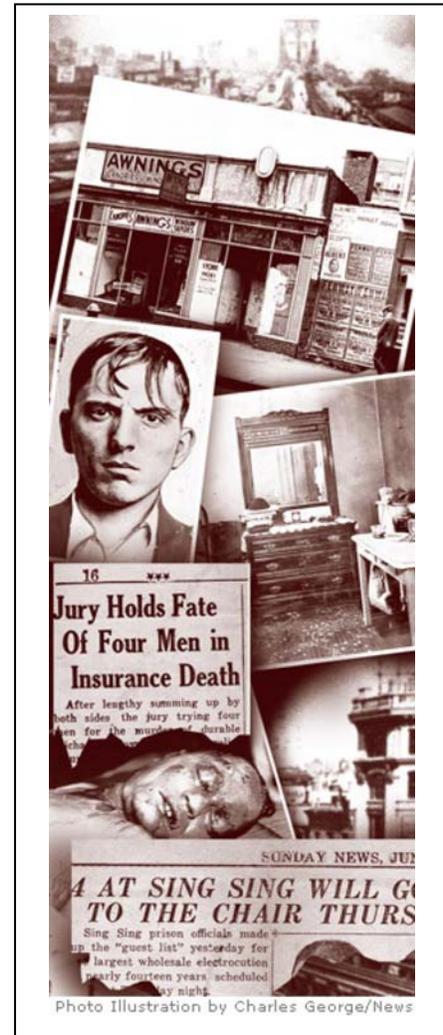
Now desperate, they contacted a professional hit man, but his \$500 fee was too expensive. They then shanghaied another drunk, Joe Murray, stupefied him with liquor and stuffed his coat pocket with Malloy's ID and ran him over with a cab. Murray, a substitute for Malloy in every way, recovered from his injuries after two months in Lincoln Hospital. The only way to knock off Malloy, the gang determined, was murder, clean and simple.

### ***Hissing sound***

On the night of Feb. 22, Marino challenged Malloy to a drinking match. Marino drank whisky, Malloy wood alcohol. When Malloy appeared insensibly drunk, Murphy and Kreisberg hurried him to a furnished room on Fulton Ave. They dropped him on the floor, stuffed a hand towel in his mouth and attached a rubber hose to a gas jet in the wall. After inserting the hose in the side of Malloy's mouth, Kreisberg turned the jet on, and a hissing sound confirmed its working order. The pair left Malloy's lifeless clump and returned to the speakeasy.

They hired Dr. Frank Manzella, a former Bronx alderman, to issue a false death certificate. "Lobar pneumonia," he wrote, "with alcoholism as a contributing cause." The gang paid him \$50 for the service. Pasqua didn't embalm Malloy, who had no next of kin, and he was buried without a wake in a \$12 wooden box, some four hours after his death.

Murphy, posing as Malloy's brother, collected the \$800 from Metropolitan Life, and when agents from Prudential came around to press more money in his hand, they couldn't find him. Murphy was in jail on another charge, and this aroused suspicion among the insurance agents, who contacted the police.



Police started piecing together the puzzle of this murderous ring. Green hadn't been paid his full share and started talking, while a professional hit man told friends that an insurance ring had been set to hire him, but his fee was too high. Police learned of another victim, Betty Carlson, who had died of pneumonia in mysterious circumstances in the same speakeasy. The life insurance beneficiary for her death was Marino. After police arrested the gang, District Attorney Foley pursued the death penalty.

At trial at the Bronx County Court House, the four murderers either claimed insanity or shifted the blame to each other, and then finally accused "Tough" Tony Bastone, a gangster who they said forced them to kill Malloy. Bastone couldn't testify, having been killed a month after Malloy's death.

In June and July 1934, Marino, Pasqua, Kreisberg and Murphy died in the electric chair at Sing Sing prison. Manzella was convicted as an accessory and sentenced to an indeterminate prison term. Malloy was reburied, and took with him to the grave the secret of a hardy and nearly indestructible constitution.

## **Section 13.5**

### **Types of Insurance Fraud**

#### **Over Insurance**

Companies need to underwrite coverages to make sure that a piece of property is not over insured. The agent needs to reevaluate and inspect his long-time customer's properties to determine if the property value was decreased over the years and policy limits should be lowered. This is especially true for inner-city properties. What may have been correct 15 years ago could very well be an over insured property today. The insured could never sell for the amount they are insuring it for, in such a case.

#### **Arson for Profit**

Even if a property is not over-insured, there are still circumstances when a fire could put the insured in a better financial condition and provide a profit he might now realize. High alimony, a decrease in business profits, seasonal risks, higher taxes, and other inner-city homes that are hard to sell, may all be suspect as reasons for arson.

Homeowners are a group that may resort to arson to collect insurance money. Some consider it because they are unable to sell their property, while others may watch as their neighborhood downgrades itself. They decide arson is their way out to make money. Some homeowner policies contain riders for expensive articles, like jewelry or artwork, also. If such articles are not found to be part of a fire's debris, fraud may be involved.

Small businesses have a higher tendency to consider arson as a way out of financial difficulties than large businesses. Often a large business has set aside a cushion or reserve to help them handle periods of economic depression. Small businesses, on the other hand, generally rely on their sales to cover their monthly expenses. As long as the business can make profits from its sales, its value as a business is greater than its insured value. But once expenses overtake income, a small business doesn't have the benefit of profit. Then the business value may drop below its insured value. This situation often tempts small businesses to consider torching their sites and collecting the insured value. Statistics show that there is always a rise in small business fires during economic lows. Businesses facing bankruptcy sometime contemplate burning their stock and taking insurance money, rather than letting it get sold at auction or seized by creditors.

It has been estimated that the Insurance Industry loses approximately a half billion dollars a year to arson. Arson squads and firefighters have their work cut out for them in proving arson. It has become a specialized investigation with professional trained to detect arson. Arson specialists can often tell if a fire was set by examining the speed of the fire and its burn pattern. Sometimes they find proof of accelerant use, too.

Prosecuting those who burn for profit is about the only deterrent. Those companies that are members report fire loss claims to the Fire Marshall Reporting Service (FMRS). This resource can be checked for previous fires. The Property Insurance Loss Register (PILR) has also been set up by the American Insurance Association. This data is computerized to inform companies of other claims with similar characteristics that may have been filed previously by the claimant.

Generally, the "torch" is the only one that gets convicted for arson. So some businesses will hire individuals to do the torching by paying them off. But those that hire the torch can be prosecuted for fraud under most state statutes.

Evidence to prove fraud can include altered proofs of loss, such as receipts, inventories and accounting books. If it is found that inventories are removed before the fire occurred, this information could also be important.

### **Section 13.5a**

#### **Auto Insurance Fraud**

There are several types of fraud in this area”

##### **Arson**

Most car fires are electrical or stem from carburetor or fuel line or fuel pump. If a claim does not stem from these, there is a possibility of arson. Arson is sometimes used to cover up fraud. A fire can be used to disguise the falsehood that other expensive articles were in the car at the time of the fire.

##### **Theft**

While there are many auto thefts, approximately 20% of all car thefts are cases of fraud, perpetrated by the insured. Some of these also involve arson, as the insured will report their vehicle stolen, but the car is recovered burned. Many fraud claims involved theft from autos, which are easily perpetrated by breaking windows or prying the trunk open. Investigators often find forged or altered receipts for the supposed stolen items. Expensive items like jewelry and cameras are common items reported being stolen.

Stolen cars don't involve appraisals, so stolen car claims have become big business. Whether a car is new or old or non-existent, its claim of being stolen may render big money to its owner or crime ring. Such claims are common in cities, although they may be a scheme used anywhere.

Cars are sometimes purposely left or abandoned in high risk areas for theft. Once they are allowed to be stolen, a claim is put in for the hope of securing book value for their loss. In other cases, crime rings not only are involved claiming losses due to theft of cars, but are also involved with stripping the cars and selling the parts at even bigger profits.

#### **Staged Vehicle Collision Schemes**

There are cases when an insured will deliberately hit a stationary object or roll it down a ravine, in order to collect on the collision portion of the policy. Another common ploy has been to stop short in front of another car or back into another vehicle. Some professional criminals are even good at “accidentally” walking in front of moving vehicles and then claiming serious injury. It is also not rare to hear of cases where a perpetrator will climb into a vehicle after the accident occurred.

Fraud rings have also been known to stage accidents by bringing previously damaged vehicle to a location and setting up what looks like an accident. If rental or company cars are involved, financial claims are also made against those companies/agencies.

#### **Auto BI & PD Liability Fraud – Staged Accidents**

Approximately one-third of all bodily injury claims for auto accidents contain some amount of fraud, but only 3% are totally fraudulent claims that result from deliberate scams such as staged accidents.

Examples of this would include faking injuries and crashing cars on purpose. This information comes from 1996 Insurance Research Council (IRC) poll. It found that most of the 33 out of 100 BI Claims were from padding claims and exaggerated injuries. The IRC pointed out that this type of fraud has become convenient for dishonest doctors, lawyers, and individuals to take advantage of insurance companies.

Today's auto insurance includes coverage for those in the car that are injured, as well as to the occupants of the other car that is in the accident. No-fault insurance provides only personal injury protection, which has limits. With this fact in mind, sometimes comes the temptation by unscrupulous individuals to scheme. Some will fake injuries and try to

beef up their medical expenses from an accident to claim money from insurance companies. Others have been caught faking an injury entirely. Injuries like whiplash, backache, and headache are common pretenses. They are often hard to prove, and some individuals try this ploy over and over again. In terms of costs, it is estimated that the fraudulent part of these claims accounts for 17 to 20 cents of every payment dollar. This accumulates to about \$6.3 billion every year to the U.S.'s auto insurance policyholder's bills. Ninety percent of the dollars that would have been paid out would have come from opportunistic fraud and padded claims from real accidents, while ten percent arose from accidents that were set up.

This IRC study provided information and statistics from 15,000 injury claims from 9 states. It verified earlier findings concerning the variation in the amount and type of fraud different areas of the country. If compared fraud in urban, rural and suburban areas. As an example, fraud was twice as high in California as it was in Michigan. It found that in Los Angeles 67% of claims had some fraud, while 45% of the claims in the state as a whole had some fraud. Texas showed similar results where 36% of the state's claims had fraud involved. And the city of Houston showed fraudulent claims at a 54% rate. New York State and New York City, on the other hand showed only a 3% difference. The city showed a 33% rate to the State's 30% rate.

Staged auto accidents have become so common to be frightening. There are many different scams. Many of these are rear end type collisions, where the vehicle stops suddenly, causing the injured vehicle to rear end it. Hot targets for this type are luxury cars, as they offer the promise of high BI Liability Limits.

Bogus witnesses are often used to support the criminal's story. These claimants many times team up with dishonest providers and attorney who inflate injuries. There are also professional pedestrians who make their living by pretending they were injured in the accident.

### **Inflated Claims**

Inflated claims are probably the most frequent cases of fraud in the auto insurance area. Back injury is the hardest type of claim to disprove, and the most common claim by these criminals. They are also many times combined with dishonest providers and attorneys who inflate injuries.

Inflating the damage of a car accident is also very common. Dishonest body shops will do a variety of things to make extra money. One scam involves substituting damage. A damaged door can be placed on a friend's undamaged car, by temporarily removing the good door. A claim is put in for a supposed accident, which the friend and body shop will split the profit.

Another method of inflating damage comes from an auto body shop that fools an insurance company with the use of photographs it may keep on file for illegal uses. If it gets away with using photographs of another similar car with more damage than the car it really has in its shop, it can claim a bigger share from the insurance company.

With large amounts of money available for the taking, these types of crimes sometimes involve more than the body shop. Sometimes the car's owner is involved. Other times, unscrupulous insurance appraisers make deals with body shops. And we must not forget that doctors and lawyers often get involved, too.

Another tactic used to defraud insurance companies comes from the claim of auto accidents that don't even occur. A body shop may provide bills from repair it never did, yet get paid for it. With the use of a bribed appraiser, a written claim and a fed photo of a damaged auto, the occasion is ripe for criminals to attempt stealing money from insurance companies.

It is even conceivable that a claim can be put in for a car that doesn't exist. A wrecked car is sometimes bought just for its title and VIN and then scrapped. Possessing the title and VIN, a car can be insured after being registered. From there the criminals can claim that an accident occurred, when in fact, the care never existed.

If a real accident, staged accident, or faked accident occurs late at night, or in a secluded place, it is possible that the police may not be on hand to make a report on the scene. A criminal may show up the next day and report the supposed accident at the police station. With the police report, completed accident forms, and damage estimates, it may not be long before another fraudulent case is on record.

## **Section 13.5b**

### **Medical / Accident / Health Fraud**

We have all read stories of doctors, dentists, etc. who have padded bills to defraud both Medicare and Medicaid Insurance. They present charges for treatment not provided to their patients or overcharge for services that they render.

Prosecutors are hard pressed to bring cases against doctors unless they have strong proof. Sometimes doctors even have teamed up with lawyers to work a scam. It may even start with a lawyer that contacts accident victims. They pressure victims to go to unscrupulous doctors who encourage long-term treatment, missed work, and a large claim for pain and suffering. Investigations on this type of fraud are tedious. Often the only way this fraud is discovered is through the testimony of the original claimant. Once the injured realize how much more money the doctor and lawyer are getting at their expense, they may have a tendency to give up information to an investigator.

### **Property / Homeowner Fraud**

There is a variety of ways that insureds make fraudulent claims (other than arson) against these policies. Small fires are set to activate sprinkler systems for Water Damage Claims. Theft Claims are presented for property the insured never owned or that the insured had to sell in order to get money. Phony appraisals of antiques are secured to inflate a loss. Inflated estimates on damaged property are also common. This type of fraud can occur in homes as well as apartments.

Insurance companies sometimes hire contractors to repair or replace damaged homes or property. It has been discovered that some contractors have tried to charge for work not completed. Other times, they have charged for substandard materials that they used.

### **Workers' Compensation & DBL Fraud**

The most common fraud in Workers' Compensation is for injuries not suffered on the job and faked or exaggerated injuries. Again, whiplash and muscle strains are the most common. Dishonest providers and lawyers are also involved with many of these claims. Employer premium fraud is also prevalent. Employers "misstate" their payroll to secure a lower premium payment to the insurance carrier. Working while collecting Workers' Compensation or DBL is also a common fraud case problem. Surveillance is often used if this is suspected.

### **White Collar Crime**

#### **Slip and Fall BI**

This is one of the most widely perpetrated crimes. The claimant threatens to sue for a bogus injury because he slipped and fell on either a broken stair or slippery surface. The scam artist often uses this ploy to collect money from businesses and other buildings that collect enough insurance for him to drain. Stores, restaurants, public or government buildings are all common sites targeted.

Witnesses are also often part of the fraud claim.

#### **The Yank Down**

Claimants pull display items down on top of themselves and then file a claim for an injury stemming from the "falling" object. This sometimes occurs at the individual's workplace.

#### **Tripping**

Usually a sidewalk situation, where it is broken or obstructed in some fashion, is a common fraud site. Curbs, stairs, or obstacles can all be used for a scam artist's props.

## Product Liability

Lawsuits concerning products are balanced with liability insurance. Companies carry this insurance to cover injuries to cover injuries consumers may suffer from using their products. Unfortunately, individuals looking for quick cash have targeted liability insurance.

Scam artists claim finding bugs or other objects in their food they ate in a restaurant, illness caused by food they ate in a restaurant, or cuts and bruises or shocks from appliances or other products they bought. Companies have had a tendency to settle quickly to avoid bad publicity over such issues. This may make them easy prey to the professional scam artist.

As you can see, there are numerous ways that insurance fraud can be perpetrated. We have highlighted the main categories, yet the list is endless and keeps growing.

## Section 13.6



### ***Former Insurance Broker Sentenced to Prison in Massive Phony Trucking Cargo Insurance Fraud Scheme***

#### ***U.S. Attorney's***

***Office*** August 25, 2015

#### ***Northern District of***

***Georgia*** (404) 581-6000

ATLANTA—John Paul Kill, the former operator of Appeal Insurance Agency, LLC, has been sentenced to four years in federal prison for insurance fraud. Kill illegally collected over \$3.7 million from nearly 800 trucking companies nationwide for selling/brokering fictitious cargo insurance policies.

“The defendant held himself out as an honest broker to hundreds of trucking companies, but he simply pocketed their premium payments instead of securing legitimate insurance coverage,” said U.S. Attorney John Horn. “His scam tricked clients into believing they had proper insurance coverage and endangered small businesses operating in more than 20 states.”

“I’m thankful for the diligence of the U.S. Attorney’s Office,” said Insurance Commissioner Ralph Hudgens, whose office referred the case. “This investigation proves that when agencies like the Department of Insurance and the U.S. Attorney’s Office work together, bad actors will be stopped.”

According to U.S. Attorney Horn, the charges, and other information presented in court: John Kill operated an insurance brokerage firm, Appeal Insurance Agency, LLC, in Norcross, Georgia. He began offering cargo insurance policies to trucking companies in 2013. Kill issued policy binders to clients falsely representing that Lloyd’s of London would provide insurance coverage. In reality, Kill never brokered any agreement with Lloyd’s to provide coverage and instead pocketed the premium payments. Most of the victims received no insurance policies at all, and Kill instead attempted to pay claims for losses out of the premium payments he collected from new victims.

In total, nearly 800 trucking companies located in Alabama, Arkansas, Colorado, Florida, Georgia, Illinois, Indiana, Kentucky, Louisiana, Missouri, Mississippi, New Jersey, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Utah, and Virginia paid approximately \$3.75 million in premiums for these fraudulent insurance policies from 2013 through mid-2014.

John Kill, 63, of Norcross, Georgia, was sentenced by U.S. District Court Judge Eleanor L. Ross to four years in federal prison to be followed by three years of supervised release, and he was ordered to pay approximately \$1.23 million in restitution to victims. Kill was convicted on this charge on May 6, 2015, after he pleaded guilty.

This case was investigated by the Federal Bureau of Investigation and the Georgia Office of Commissioner of Insurance.

Assistant U.S. Attorney Nathan P. Kitchens prosecuted the case.

For further information please contact the U.S. Attorney's Public Affairs Office at USAGAN.Presse-mails@usdoj.gov or (404) 581-6016. The Internet address for the home page for the U.S. Attorney's Office for the Northern District of Georgia Atlanta Division is <http://www.justice.gov/usao/gan/>.

### (Section 13.7)

#### Insurance Fraud Review

Cargo fraud is also still common; shipping containers are often hijacked during transport.

In 1929, the **National Automobile Theft Bureau (NATB)** was formed.

The **Insurance Crime Prevention Institute (ICPI)** was created in 1971 as an independent investigative agency to assist with prosecution of insurance fraud.

The **National Insurance Crime Bureau (NICB)** was established in 1992.

The NICB is a founding member of the **Coalition Against Insurance Fraud**, which was organized in 1993.

The following are common life insurance fraud schemes:

- Fraudulently changing a beneficiary
- Faking a death
- Murder for profit
- Pocketing premiums
- Upgrade churning
- Stranger Owned Life Insurance (StOLI)

Types of Insurance Fraud include:

- Over Insurance
- Arson for Profit
- Theft
- Staged Vehicle Collision Schemes
- Auto BI & PD Liability Fraud – Staged Accidents
- Inflated Claims
- faked or exaggerated injuries
- Working while collecting Workers' Compensation or DBL
- Slip and Fall BI

Insurers are required to fund **Special Investigative Units (SIU's) to combat insurance fraud.**

Property/casualty insurance fraud cost insurers an estimated **\$30 billion annually.**

Health care fraud costs the nation about **\$68 billion annually.**

Under New York's Insurance Law, **licensees of the Insurance Department (such as insurers, agents, and brokers) are required to report any suspected fraudulent acts** to the Department's Insurance Frauds Bureau.

(Section 14)

New York State  
Department of Financial Services

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ISSUED: May 6, 2016

**NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES TAKES  
DISCIPLINARY ACTIONS AGAINST COMPANIES, AGENTS, BROKERS &  
ADJUSTERS**

The New York State Department of Financial Services has taken disciplinary action against the following licensees. Those categorized as stipulations have been agreed to by the licensee.

Department actions that result from Department hearings are subject to judicial review and possible stay of enforcement.

**INSURANCE COMPANIES**

<b>LICENSEE</b>	<b>ADDRESS</b>	<b>PENALTY</b>
***** Life Insurance Company of New York	Binghamton, NY 13902	\$50,000 fine
Respondent, during the period August 1, 2008 through January 1, 2015, violated Section 3201(c)(1) of the Insurance Law by including an impermissible discretionary clause in its policy forms, Section 3220(a)(6) of the Insurance Law by failing to include a standard provision in certain group life insurance policies regarding the payment of death benefits and Regulation No. 143 [11 NYCRR 41) by including impermissible exclusions in its policy forms. [Stipulation approved March 8, 2016.]		

<b>LICENSEE</b>	<b>ADDRESS</b>	<b>PENALTY</b>
***** Life Insurance Company	New York, NY 10017	\$29,325 fine
Respondent failed to furnish to the insurer whose coverage was being replaced a copy of any proposal, including the sales material used in the sale of the proposed life insurance policy or annuity contract, and the completed Disclosure Statement within ten days of receipt of the application; failed to examine the Disclosure Statements in order to ascertain that they were accurate and meet the requirements of the Insurance Law and Regulation No. 60; failed to date all the documentation related to the replacement transaction upon receipt; and issued policies with illustrations that were not signed and dated by the applicant or policy owner and by the agent. [Stipulation approved March 30, 2016.]		

<b>LICENSEE</b>	<b>ADDRESS</b>	<b>PENALTY</b>
***** Insurance Company of New York	Hartford, CT 06103	\$225,000 fine
With relation to policies of student health insurance coverage issued in New York for the 2014/2015 academic policy year, Respondent issued coverage that did not conform to the provisions of Section 3240 of the Insurance Law; delivered or issued for delivery policy forms that were not filed with and approved by the Superintendent; made a binding commitment to issue a student blanket health insurance policy to a school prior to approval of such policy and premium rates; failed to submit for approval a basic policy, any riders providing variable benefits, and premium rates for each benefit before offering to sell any coverage under such policies; and solicited and enrolled students prior to approval of the student blanket health insurance program. [Stipulation approved March 30, 2016.]		

**STIPULATIONS**

**Region: Buffalo**

<b>LICENSEE</b>	<b>ADDRESS</b>	<b>PENALTY</b>
(Bail Bond Agent)	Lackawanna, NY 14218	\$1,000 fine
Respondent violated a law of New York State, for which he was convicted. [Stipulation approved March 11, 2016.]		

**Region: Mid-Island**

<b>LICENSEE</b>	<b>ADDRESS</b>	<b>PENALTY</b>
(Agent and Broker)	Jericho, NY 11753	License Revoked
Respondent collected insurance premium payments from insureds and failed to remit or otherwise properly account for said premiums and as a result of the foregoing, Respondent is currently the subject of a criminal prosecution. [Stipulation approved March 24, 2016.]		

**Region: New York**

<b>LICENSEE</b>	<b>ADDRESS</b>	<b>PENALTY</b>
***** of New York Inc. (Agent, Broker and Excess Line Broker) ***** (Broker, Excess Line Broker and Sublicensee)	Wall Street Plaza New York, NY 10005  Same as above	\$3,600 fine
Respondents transacted excess line insurance business in the State of New York and failed to timely file documentation as required for certain policies with the excess line association for stamping and recording. [Stipulation approved March 31, 2016.]		

<b>LICENSEE</b>	<b>ADDRESS</b>	<b>PENALTY</b>
(Broker)	Staten Island, NY 10304	\$2,000 fine
Respondent failed to report to the Superintendent within 30 days of the initial pretrial hearing date that he was the subject of a criminal prosecution. Respondent also failed to timely submit to the Department information and documentation that was requested in Department letters, and thereby hampered and impeded the Department's investigation. [Stipulation approved March 15, 2016.]		

**Region: Out of State**

<b>LICENSEE</b>	<b>ADDRESS</b>	<b>PENALTY</b>
(Agent)	San Diego, CA 92131	\$1,500 fine
Respondent failed to disclose on her original application for an agent's license and in an application for an appointment with an insurer that she was a party to a lawsuit that involved allegations of fraud. [Stipulation approved March 25, 2016.]		

<b>LICENSEE</b>	<b>ADDRESS</b>	<b>PENALTY</b>
(Life Broker)	Brookfield, WI 53045	License Revoked
<p>Respondent failed to report to the Superintendent within 30 days of the final disposition of the matter that the North Carolina Department of Insurance fined Respondent; that the Wisconsin Office of the Commissioner of Insurance fined Respondent; and that the California Department of Insurance revoked Respondent's unrestricted license to act as a life-only agent with variable contract authority, issued to Respondent a restricted license to act as a life-only agent with variable contract authority and fined Respondent. Respondent also failed to disclose the aforementioned North Carolina, Wisconsin and California administrative actions in his renewal application for a life broker's license. [Stipulation approved March 3, 2016.]</p>		

<b>LICENSEE</b>	<b>ADDRESS</b>	<b>PENALTY</b>
(Agent)	Houston, TX 77099	\$750 fine
<p>Respondent failed to disclose in her renewal application for an agent's license that her application for licensure as an agent was denied by the Florida Department of Financial Services. [Stipulation approved March 30, 2016.]</p>		

<b>LICENSEE</b>	<b>ADDRESS</b>	<b>PENALTY</b>
(Agent)	Greenville, SC 29607	\$750 fine
<p>Respondent failed to disclose in his original application for an agent's license that he was convicted of a crime. [Stipulation approved March 15, 2016.]</p>		

## *Glossary*

Many of the coverage terms used in this course are familiar to all insurance producers. However, certain terminology does not carry across the P&C / L&H boundary.

### *Accident*

An unforeseen, unintended, unexpected event, mishap, or casualty.

### *Actual cash value*

An amount equivalent to the replacement cost of lost or damaged property at the time of the loss, less depreciation

### *AD&D*

Accidental Death and Dismemberment.

### *Additional PIP*

Additional First Party Benefits that pay for extended loss on account of personal injuries sustained by an eligible injured person. Coverage applies to named insured's and other persons sustaining injuries.

### *Additional Disability Coverages*

Wage loss benefits exceeding state minimums typically opted for by high income earners.

### *Admitted Company*

An insurance company authorized and licensed to do business in a given state.

### *Adverse Selection*

The tendency of a disproportionate number of poor risks to by insurance or maintain existing insurance in force. Also called "Selection against the company".

### *Agent*

One who solicits, negotiates, or effects contracts of insurance on behalf of an insurer.

### *Annuity*

A contract affording periodic income payments for a fixed period of time or usually during the lifetime of a person who is called the Annuitant. If the annuity payments are limited to a certain period, it is called a Temporary Annuity; if the payments are terminated only upon the death of the Annuitant, it is known as a Life Annuity.

### *Application*

A signed statement submitted to the insurance company by an applicant, who may or may not be the proposed insured. The application form contains a series of questions designed to elicit pertinent information, i.e., age, medical history, beneficiary(ies), etc., which serves as a basis for underwriting the risk and which become part of the policy.

### *Arbitration clause*

The provision in a property insurance contract which states that if the insurer and insured cannot agree on an appropriate claim settlement, each will appoint an appraiser, and they will select a neutral umpire.

### *Article 78*

A proceeding used to challenge an action of an agency, or officer of the government, which will bring the case to the Supreme Court.

### *Assignment*

Transfer by the policy owner of legal rights or interest in the policy contract to a third party.

*Auto Liability*

Covers against bodily injury and property damage for which the insured may become liable. The Minimum limit in NYS is 25,000/50,000/10,000.

*Beneficiary*

A person(s) or other entity designated to receive specified cash payments(s) in the event of the Insured's death.

*BI – Bodily Injury*

Bodily Injury means bodily harm, sickness or disease, including required care, loss of services and death that result. BI coverage is provided to a named insured under auto coverage policies.

*Binder*

A temporary contract or agreement executed by an agent or insurer putting the insurance in force before the contract has been written or the premium paid.

*Broker*

One who represents an insured in the solicitation, negotiation, or procurement of contracts of insurance, and who may render services incidental to those functions including additional services such as processing payments on claims. Traditionally are viewed as the intermediary between the insured and the insurer.

*Buy Sell Agreement*

In the sale of a business, a buy-sell clause (or shotgun clause) in a shareholder agreement preserves continuity of ownership in the business and insures that everyone is fairly treated, the buyer as well as the seller. It is a binding contract between business partners or [shareholders](#) about the future ownership of the business.

*Cancellation*

When a portion of the premium is returned by insured and coverage has ended. Possible reasons for cancellation include fraud and non-payment of premiums.

*COBRA (CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1988, 1989).*

Employers of 20 or more employees maintaining a group health plan are required to offer employees and their dependents the option of continuing membership in the group plan at their own expense after they leave employment under certain circumstances. The cost of the COBRA extension can be charged to the employee at 102 percent of the group's cost for an active employee. Furthermore, the law adds a "portability" feature to coverage wherein an insurer must credit the time a person was covered under a prior health insurance policy toward satisfying any pre-existing condition waiting period imposed by the subsequent policy, as long as the prior coverage was in force at least 63 days before the effective date of the subsequent policy.

*Coinsurance clause for property*

A clause under which the insured shares in losses to the extent that he is underinsured at the time of loss.

*Coinsurance clause for health*

A provision stating that the insured and the insurer will share all losses covered by the policy in a proportion agreed upon in advance. If a provision specifies a 75% -25% the company pays 75% and the insured pays 25%.

*Collision*

Sudden damage to a vehicle caused by it coming in contact with another object. This definition is usually modified by terms and conditions in an automobile insurance policy.

### *Commercial General Liability (CGL)*

CGL Policy provides coverage for the insured in the event a third party suffers an injury because of business activities of the insured. An insured's liability may be for Bodily Injury (BI), Personal Injury (PI), Advertising Injury (AI) or Property Damage (PD). Also covered under the liability section of the policy are Medical Expenses incurred for bodily injury caused by an accident regardless of negligence on the part of the insured and the obligation for the insurer to provide a defense of its policy holder against all valid suits.

### *Community rating*

A rating system in which the charge from insurance to all insured's depends on the medical and hospital costs in the community or area to be covered. Individual characteristics of the insured's are not considered at all

### *Compliance*

Also known as laws, rules, and regulations set up by state and federal government.

### *Comprehensive*

This is the broadest form of coverage and will provide for any loss except for collision or overturn of the vehicle. An example is a deer crashing into the side of the vehicle.

### *Conditions*

These are provisions of an insurance policy which state either the rights and duties of the insured or the rights and duties of the insurer

### *Coordination of Benefits*

Coordination or non-duplication of benefits may apply when an individual is covered under more than one group insurance contract. Coordination ensures that the total amount of the benefits under all contracts does not exceed 100% of the actual medical expenses.

### *CMAP (Coastal Market Assistance Program)*

Assists property owners living along the coast with securing insurance coverage for wind storms, including hurricanes.

### *Cross Purchase Agreement*

With a cross-purchase agreement, each owner of the corporation purchases an insurance policy on the other shareholders. The purchaser is both owner and beneficiary of the policies.

### *Declaration*

A term used in insurance other than life or health to denote that portion of the contract in which is stated such information as the name and address of the insured, the property insured, its location and description, the policy period, the amount of insurance coverage, applicable premiums, and supplemental representations by the insured.

### *Disability Income (DBL)*

Standard disability income insurance provides wage earners with temporary cash payment/benefits to partially replace wages lost for disabilities due to non-occupational injury or illness. A person who becomes disabled while unemployed is also eligible under certain circumstances. The New York Disability Benefits Law (DBL) provides for payment of 50% of the average weekly wage to a maximum of \$170 per week for maximum of 26 weeks within a consecutive 52 week period and commences on the eight day of disability. The minimum benefit is \$20 or 100% of the claimant's coverage weekly wage. DBL does not cover rehabilitation expenses.

### *Direct loss*

A loss, which is a direct consequence of a particular peril. Fire damage to a refrigerator would be a direct loss.

### *Dividend Options*

The insured is given the option to apply dividends as follows: receive the dividend in cash, apply the dividend toward the payment of any premium due on the policy, apply the dividend to the purchase of paid-up insurance, or leave the dividend with the insurance company to accumulate at interest. Some companies have additional options.

*ERISA (EMPLOYEES RETIREMENT INCOME SECURITY ACT OF 1974)*

Self-insured plans that are not governed by state insurance law must meet the requirements of ERISA. ERISA requires a “creditable” claims review procedure and notices that state the reason for claim denials.

*Ethics*

Honesty, integrity i.e. Insurance professionals should give full disclosure of information used for underwriting decisions.

*Excess and Surplus Market*

When an admitted market is unavailable to an insurance producer. Only a broker may pursue a non-admitted market or excess and surplus lines market. Lloyds of London is an example of an excess and surplus business regulated in NYS.

*Exchanges (1035)*

Used with the transfer of securities or variable products. A form of disclosure similar to Regulation 60.

*Fair Credit Reporting Act (FCRA)*

A federal law that regulates how credit reporting agencies use your information.

*Felony*

A charge in criminal conduct. The most serious form of a crime, such as committing insurance fraud.

*Fidelity Bond*

Protects insured regarding money and securities. Protects retirement plans against loss resulting from acts of fraud and dishonesty on the part of the fiduciary either directly or in collusion with others.

*Fiduciary*

A person holding the funds or property of another in a position of trust.

*Flexible Savings Accounts (Section 125 Plan)*

Permits employees to purchase fringe benefits with pre-tax dollars instead of after tax dollars. This election for employees to voluntarily reduce their gross taxable income results in an employee paying fewer taxes in the area of Federal, State, and FICA taxes

*Flood Insurance*

Property Insurance set up by the federal government for primarily single family dwellings. Live stock can also be covered.

*Fraud*

Deliberate deception used as a means of obtaining money, goods, and/ or services.

*Free Look Provision*

The right of an Insured to change his mind and return the policy within a certain number of days (usually between 10 and 30) following the delivery thereof. The Insured is permitted to void the contract and receive a full refund of the Premium he has paid. No charge is made by the insurance company either for any expenses incurred or for the interim coverage.

*Glass Steagall Act of 1933*

This act changed the insurance industry by prohibiting national and state banks from affiliating with securities companies.

*Grace Period*

A specified period (usually 31 days) after a Premium payment is due, during which the protection of the policy continues even though the payment for the Renewal Premium has not yet been received.

### *Graham-Leach Bliley (GLBA)-*

This act changed the insurance industry in 1999 by instituting sweeping changes across the financial industry, changing the regulations of banks, insurers, and financial institutions.

### *Hazard*

A specific situation that increases the probability of the occurrence of loss arising from a peril, or that may influence the extent of the loss.

### *Health Insurance*

A broad term covering the various forms of insurance relating to the health of persons. It includes such coverage as accident, sickness, disability, and hospital and medical expense. This term is used instead of sickness and accident insurance. This insurance can be written by those with a life accident and health agent license (LH), a life accident and health broker license (LB) license and property and casualty broker license (BR). Consultants and property casualty agents cannot write health insurance.

### *Health Maintenance Organization (HMO)*

An organization that provides for a wide range of comprehensive health care services for a specified group in consideration of fixed periodic premium payments. An HMO may be sponsored by a medical school, hospital, employer, labor union, consumer group, insurance company, hospital medical plan, or the government.

### *Health Saving Accounts*

Tax sheltered savings account similar to the IRA but enacted by the laws of NYS and the Federal Government, they are earmarked for medical expenses. They apply to high deductible health care insurance coverage.

### *HIPAA*

Health Insurance Portability and Accountability Act

### *Home Care*

A provision in health insurance policies. Home care must be covered if inpatient hospital care is covered for residents of NYS.

### *Home Owners Policy*

A multi-line policy for owner occupied residences. Homeowner's policies provide property and liability coverage for dwelling and other structures and personal property. The basic limit for personal liability coverage is \$100,000. The conditions section of the policy states that the insured must file a proof of loss statement.

### *Indirect loss*

Loss resulting from a peril but not caused directly and immediately by that peril

### *Insurable Interest*

Relationship between the Beneficiary or Owner and the Insured, i.e., a blood relationship, marriage, or economic dependence.

### *Insurance Company*

- Alien, one that was organized under the laws of a country other than the United States
- Domestic, one conducting business in the State in which it was organized
- Foreign, one conducting business in a State other than the State in which it was organized

### *Insurance fraud*

Deliberate deception used as a means of obtaining money, goods, and/ or services in the insurance industry. Common types include arson, theft, staging vehicle accidents

### *Insurance Law*

Statutory laws made by the assembly, senate and governor. Violation of these laws may also be imposed by the Superintendent of Insurance in addition to civil and criminal penalties.

### *Insurance Risk Score*

An underwriting tool that most property and casualty insurance companies use in establishing premiums.

### *Insurance scheme*

A plot to receive money from unsuspecting customers looking to buy insurance. Insured's should be suspicious of the price of insurance seems too good to be true. They should contact the NYS Insurance department in order to make sure the agent and company are licensed as well as always check the bills closely for accuracy.

### *Insurance Services Organization (ISO)*

An organization of the property and liability insurance business designed to gather statistics promulgate rates, and develop policy forms. They print and distribute manuals, provide rules and forms. They also collect and compile data.

### *Insuring agreement*

That proportion of an insurance contract which states the perils insured against, the persons and/or property covered, their locations, and the period of the contract. The obligations assumed by the insurance company in contract of insurance are found in the insuring agreement.

### *IRA*

An Individual Retirement Account (or IRA) is a retirement plan account that provides some tax advantages for retirement savings in the United States.

There are a number of different types of IRAs which may be either employer-provided or self-provided plans. The types include:

- Roth IRA – contributions are made with after-tax assets, all transactions within the IRA have no tax impact, and withdrawals are usually tax-free. Named for Senator William Roth.
- Traditional IRA – contributions are often tax-deductible (often simplified as "money is deposited before tax" or "contributions are made with pre-tax assets"), all transactions and earnings within the IRA have no tax impact, and withdrawals at retirement are taxed as income (except for those portions of the withdrawal corresponding to contributions that were not deducted).
- SEP IRA – a provision that allows an employer (typically a small business or self-employed individual) to make retirement plan contributions into a Traditional IRA established in the employee's name, instead of to a pension fund account in the company's name.
- SIMPLE IRA – a simplified employee pension plan that allows both employer and employee contributions, similar to a 401(k) plan, but with lower contribution limits and simpler (and thus less costly) administration. Although it is termed an IRA, it is treated separately.
- Self-Directed IRA – a self-directed IRA that permits the account holder to make investments on behalf of the retirement plan.

### *Joint Life Insurance*

Insurance on the lives of two or more persons with the face amount payable in the event of the death of either (or any one) of them, or, in some policies, at the death of each of the insureds.

### *Key Person Insurance*

An Individual Policy designed to reimburse an employer for the loss of a key person's service due to his death. Usually, the employer pays the Premium and is the Beneficiary.

### *License Renewal*

Individuals and corporations must renew their license online. You can now change your address online at time of renewal, and print off a copy of the invoice document for your records. The renewal application is accessed through the NYSID website. Licenses are issued within 48 hours to those who pay NYS by credit card. The NYSID has established a dedicated telephone and website for licensees. If you are going to sell insurance to outside of NYS you will need to secure a non-resident license in that state. There is a statutory late fee for applicants that renew their license within the last two months of the expiration date.

### *Life Insurance*

Insurance upon the lives of human beings that creates an immediate and guaranteed estate at the death of an insured and which may also provide living benefits through cash value. In life insurance comparisons, only 'net' premiums should be compared.

### *Life Settlements*

The sale, assignment, transfer, or bequest of the death benefit or ownership of a life insurance policy by the owner of the policy where the insured does NOT have a catastrophic or life-threatening illness or condition. Typically, the owner of the policy receives cash (generally an amount greater than the cash surrender value in the policy, but less than the full amount of the death benefit); and the life settlement company becomes the new owner and beneficiary of the policy and is responsible for the payment of all future premiums. Upon the death of the insured, the death benefit is paid to the life settlement company. Life settlements usually involve the sale of life insurance policies by owners where the insured is a senior citizen or where the insured may have a medical condition that will likely result in a shortened life expectancy.

### *Limit of Liability*

The maximum amount which an insurance company agrees to pay in case of loss.

### *Litigation*

To contest in legal proceedings. Legal actions are typically employed by an injured individual against an insurance company to gain policy benefits to stated maximums. Litigation based on liability of an insured may also be used as a measure to obtain additional money to provide for additional losses.

### *Loan Value*

The amount specified in a policy which the insurance company will lend to an Insured at a rate of interest which the insurance company may charge for such loans (as indicated in the policy). If the debt is not fully repaid at death, the company can subtract the unpaid amount of the loan, and loan interest from the death proceeds.

### *Long Term Care*

Insurance available through private insurance companies as a means for individuals to protect themselves against the high costs of long-term care. Long term care is the type of care that you may need if you can no longer perform "activities of daily living" by yourself, such as eating, bathing or getting dressed. It also includes the kind of care you would need if you had a severe cognitive impairment like Alzheimer's disease. Care can be received in a variety of settings, including your own home, assisted living facilities, adult day care centers or hospice facilities. Long term care can be covered completely or in part by long term care insurance. Most plans let you choose the amount of the coverage you want, as well as how and where you want to use your benefits. A comprehensive plan includes benefits for all levels of care, custodial to skilled.

### *Material misrepresentation*

The most serious type of misrepresentation; i.e. a fraudulent statement made by the application of an insurance policy (also see Misrepresentation).

### *Medical Payments (Med Pay)*

Medical Payments paid as reimbursement for medical and funeral expenses because of bodily injury, paid on a per-person, per-accident basis. Benefits are paid only to third parties under homeowner's policies and to first and third parties under auto coverage. Claims generally must be made within 3 years. Auto medical payments cover the insured driver injured in an auto accident, a passenger in the insured's vehicle involved in the auto accident, or the insured as a pedestrian hit by a motor vehicle.

### *Medicare*

A program of health insurance and medical care for persons who are 65 years of age or over, and certain other disabled persons under age 65, operated under the provisions of the Social Security Act. Medicare has two parts: Part A (Hospital Insurance), and Part B (Medicare Insurance, helps cover doctors' services, outpatient hospital care, and some other medical services that Part A does not cover). Under Part A, a new benefit period begins when a person has been out of a hospital for 60 days, and covers psychiatric hospital benefits to a life time maximum of 190 days. Part B is voluntary, and covers 80% of approved doctor's charges. Medicare supplement policies will cover both members of a married couple as long as they are both at least 65 years old. They are regulated by the Federal Government.

### *Medigap policies*

Issued to supplement Medicare benefits (paying for deductibles, coinsurance and even charges not covered by Medicare). In 1991, Congress established 10 standardized Medigap policies. All policies must contain a disclosure statement. Medigap policies will cover both members of a married couple as long as they are both at least 65 years old.

### *Miscellaneous expenses*

Hospital charges other than room-and-board; i.e. X-rays, drugs, laboratory fees, etc. (in connection with hospital insurance).

### *Misdemeanor*

Criminal conduct i.e. filing an insurance claim which contains a fraudulent statement. It is less serious than a felony. An example is making a false insurance claim.

### *Misrepresentation*

A false statement, which the prospective insured makes in an application for a policy. A misrepresentation is material if the insurance company, having known the true facts, would have refused to issue the policy or taken other underwriting action such as charge an additional premium or requiring the attachment of an impairment waiver. Statements are considered representations and not warranties. If an insurance company discovers an insured's misrepresentation on a policy they may cancel any coverage not required by law, giving the named insured usually 20 days notice.

### *Moral hazard*

A condition of morals or habits that increases the probability of loss from a peril.

### *Morale hazard*

Hazard arising out of an insured's indifference to loss because of the existence of insurance.

### *Motives for insurance fraud*

Reasons why people file false claims and commit insurance crimes. They include loss of a large account, desire to change locations, gambling debts, economic loss, facing bankruptcy, inability to fill contracts, etc

### *NAIC*

National Association of Insurance Commissioners.

### *Non admitted Insurer (unauthorized or unlicensed insurer)*

An insurer not licensed to do business in the jurisdiction in question.

### *Non Forfeiture Options*

In the event of a default in payment of the premium, there shall be three basic options available. 1<sup>st</sup>- Take the cash surrender value in a lump sum. 2<sup>nd</sup>- extended term insurance. 3<sup>rd</sup>- reduced paid up insurance. Whole life policies can provide continuing cash value build up under the reduced paid up insurance addition provision.

### *Non-Owned Auto Coverage*

Covers bodily injury and property damage for your company while vehicles are used by employees for your business use. Coverage for the physical damage to non-owned autos is found in part D (physical damage coverage) of the contract.

### *Non Renewal*

When an insurance company does not renew a policy. In auto and home owners insurance the non-renewal notice is sent to the insured and must include the reason for non renewal.

### *NY Property Insurance Underwriting Association (Fair Plan)*

The plan that insures the residential and commercial properties in the state where the homeowner cannot find coverage elsewhere. "Extended coverage," which includes windstorm coverage, is written by authorized insurers engaged in writing fire and other extended coverage insurance.

### *NYS Fraud Bureau*

The investigative unit that are assigned to insurance fraud cases. They often work with law enforcement agencies as well as the insurance company's special investigative unit. They require insurance companies to develop thorough plans for prevention and detection of insurance fraud.

### *OBEL – Optional Basic Economic Loss*

Basic Economic Loss consists of medical expense, work loss, other expense and death benefit not to exceed \$50,000. Basic Economic Loss coverage is provided under statutory personal injury protection (PIP). Optional Basic Economic Loss provides an additional \$25,000 of coverage that may be applied as directed by the recipient, subject to policy language.

### *Occurrence-*

An event that causes loss over time.

### *Open Enrollment Period*

A period of time during which people, who would otherwise have to submit evidence of insurability, can apply for group insurance or HMO coverage, without such evidence.

### *Ordinary Life Insurance*

A policy which provides coverage for the entire life of the policyholder and for which the Premiums are payable until death. It is also called Whole Life or Straight Life.

### *Paid Up Insurance*

Life insurance on which future Premium payments are not required. For example, the term is used to identify a 20-Payment Life Insurance Policy on which 20 Annual Premiums have been paid. Reduced Paid-Up Insurance is the term applied to the policy which is issued under the Non-forfeiture Option, i.e., when the Insured does not wish to pay further Premiums on his policy and elects this option.

### *Peril*

The cause of a possible loss.

### *Permanent Insurance*

Permanent covers a person for life, as long as he or she is paying the premium.

### *Physical hazard*

Any hazard arising from the material, structural, or operational features of the risk itself apart from the persons owning or managing it.

### *PIP - No Fault*

Personal Injury Protection coverage provides reimbursement for basic economic loss sustained by an eligible injured person on account of personal injuries caused by an accident. Benefits include Basic Economic Loss, Medical Expense, Death Benefit and Other Expenses defined in a policy. Benefits are limited by the insuring agreement. Basic coverage provides up to \$2,000 per month for lost wages resulting from an auto accident. Loss of hearing would also be covered. Workers comp, Medicare and dbl are the primary coverages before PIP pays. There is no coverage if a loss is caused while committing a felony.

### *Photo Inspection Regulation 79-*

Instituted in 1979 the requirement that most vehicles covered by comprehensive and collision insurance must be inspected and a photo record maintained by the insurance carrier. There was a high frequency of "phantom" vehicles insured with comprehensive coverage reported as stolen, when follow up investigations determined that no vehicle originally existed.

### *Preferred Provider Organization (PPO)*

Health Insurance that is affiliated with approved hospitals and doctors.

*Property Damage Liability Insurance-*

Protection against liability for damage to the property of another not in care, custody and control of the insured as distinguished for liability and bodily injury.

*Pro Rata*

Distribution of the amount of insurance under one policy among several objects or places covered in proportion to their value or the amounts shown.

*Regulation 60*

The New York State Insurance Department Regulation governing the replacement of life insurance policies and annuity contracts in New York State. Regulation 60 primarily relates to disclosure information. Incomplete comparisons are strictly prohibited. Penalties include a return of commission by the agent, liability to any agent of an insurance company for the amount of the commission lost by such license, or even imprisonment, revocation, or suspension.

*Regulation 79*

Verification of the existence of each vehicle to be covered with Collision and Comprehensive coverage by a photo inspection. Also known as "Phantom Vehicles" auto regulation.

*Regulation 87*

A requirement for producers to notify the New York State Insurance Department when insurance covering a municipality is written.

*Reinstatement*

The resumption of coverage under a policy which lapsed. The Insured is required to pay overdue Premiums plus interest and to provide satisfactory evidence of insurability to effect a reinstatement.

*Rental Car Coverage*

Includes coverage to rent a vehicle in the event of a covered loss.

*Replacement cost*

The cost of replacing property without a reduction for depreciation.

*Representation*

A statement in legal terms, made on an application for insurance that the applicant represents as correct to the best of his knowledge and belief.

*Sarbanes Oxley*

The Sarbanes-Oxley Act of 2002 (often shortened to *SOX*) is legislation enacted in response to the high-profile Enron and WorldCom financial scandals to protect shareholders and the general public from accounting errors and fraudulent practices in the enterprise.

*Section 125 Plan*

Section 125 Plans go by a variety of names, such as Premium Only Plans (POP), Salary Reduction Plans, Flexible Benefit Plans and Premium Conversion Plans, all are based on the guidelines of the Internal Revenue Code Section 125. In layman's terms, a Section 125 Plan permits employees to purchase fringe benefits with PRE-TAX dollars instead of AFTER TAX dollars.

*Self Insurance*

Making financial preparations to meet pure risks by appropriating sufficient funds in advance to meet estimated losses, including enough to cover possible losses in excess of those estimated.

*Small Business Fraud*

A small business committing insurance fraud. They have a higher tendency to consider arson and other crimes as a way out of financial difficulties. Statistics show a rise in small business fires when facing economic loss and/or bankruptcy.

*Social Security*

A government program which provides economic security for portions of the public.

*Soft Fraud*

When a normally honest person tells little white lies to their insurance company i.e. a homeowner inflating the value of their stereo stolen during a robbery.

*Special Investigative Unit (SIU)*

An insurance company's fraud investigation department. They investigate fraudulent practices.

*Spendthrift Clause*

A clause which protects the proceeds of the policy from claims of creditors of a Beneficiary. Generally, the Insured must request that this provision be incorporated in a chosen Settlement Option Provision of the policy.

*Split Limit Insurance*

The Amount of Insurance for bodily injury liability and property damage liability are stated separately.

*State Insurance Fund*

A fund set up by a state government to finance a mandatory insurance system such as Workers Compensation and Non occupational disability benefits.

*Stock Redemption Agreement*

A stock redemption agreement is an agreement in which the corporation owns insurance policies on the lives of the shareholders. When a shareholder dies, the corporation buys the deceased shareholder's interest in the company with the insurance proceeds.

*Subrogation*

The right of one who has taken over another's loss to also take over his right to pursue remedies against a third party. The insurer pays its insured for a loss then assumes the insured's right of action against the responsible party for reimbursement of the loss.

*Superintendent of Insurance*

The person in charge of the NYS Insurance department i.e. commissioner. He may revoke a license for any violation of the NYS Insurance law. Punishments include possible fines and imprisonment for up to one year plus suspension or revocation of all licenses. All fines must be paid within 15 days. The superintendent enforces the insurance laws and regulations.

*Supplemental Spousal Liability*

Supplemental Spousal Liability Insurance means coverage against liability of an insured because of death or injuries to his or her spouse up to the liability insurance limits provided under the policy even where the injured spouse, to be entitled to recover, must prove the culpable conduct of the insured spouse.

*Support Staff*

*Non-licensed employees in an insurance agency prohibited by law from prospecting or soliciting insurance, quoting premiums, or receiving compensation based on sales.*

*Term Insurance*

A term policy provides coverage for an allotted amount of time. Most group life insurance policies are term policies – covering employees only while they are working for your business.

*Total Disability*

An illness or injury which prevents an Insured from continuously performing every duty pertaining to his occupation or from engaging in any other type of work for remuneration. (This wording varies from one insurance company to another).

*Towing*

Covers cost to tow an insured vehicle.

### *Twisting*

Inducing an insured to cancel his preset insurance and replace it with insurance in the same or another company by misrepresenting the facts or by presenting an incomplete comparison.

### *Underwriting*

The analysis of information pertaining to an applicant which was obtained from various sources and the determination of whether or not the insurance should be: (a) issued as requested, (b) offered at higher Premium, or (c) declined.

### *Uninsured and Underinsured Motorist*

Pays damages for bodily injury caused by drivers of uninsured vehicles, when such drivers are legally liable for injury to the insured and/or passengers. An example is a hit and run driver or a driver whose insurance company is not solvent.

### *Viatical Settlements*

Funds from a Life Insurance Policy used to subsidize the healthcare and living expenses of terminally ill named insureds.

### *Viaticals*

**Viatical**, or a **life settlement**, is the sale of a life insurance policy by the beneficiary of the policy, before the policy matures. Such a sale, at a price discounted from the face amount of the policy but usually in excess of the current cash surrender value, provides the seller an immediate cash settlement. Generally, viatical settlements involve insured individuals with a life expectancy of less than two years. The life settlement market is currently focused on individuals with life expectancies of three to ten years. A life settlement can be an innovative wealth and estate planning tool, especially when the policy holder encounters changed circumstances, such as bankruptcy, divorce, unaffordable premiums, change in tax laws, or a serious or life threatening illness. From the perspective of the investor, purchasing a life settlement is similar to buying a bond with a negative coupon and an uncertain redemption date. New York State now regulates the sale of all in-force life insurance policies under the Life Settlement statute.

### *Waiver of Premium*

A provision included in many policies which waives the payment of premiums after an Insured has been totally disabled for a specified period of time (usually 6 months).

### *Warranty-*

A provision in a policy that pledges that a condition exists or will exist at some time in the future.

### *Workers Compensation*

Benefits paid for an injury (or causally related disease contracted) arising out of and in the course of employment. The amount of the benefits and the conditions, under which employees are eligible, are determined by the workers' compensation law. In Most states, the insurance providing these benefits may be purchased from private insurance companies. In a few states, only a monopolistic state workers' compensation fund is permitted to issue such insurance. In some states, the coverage may be obtained from either a state fund or from a private insurance company. NYS has a 7 day waiting period which is waived after the 14<sup>th</sup> day. The employee is usually paid directly. Benefits may be denied in cases when the employee's injuries were intentionally self inflicted, or the injuries were sustained while engaged in an activity which had been strictly forbidden by the employer, or if the employee was intoxicated. Benefits cannot be taxed, and the time limit for benefits is the period of disability. The maximum funeral expense is \$6,000. There is no waiting period for medical, hospital and surgical treatment.