



Work Ethics

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Chapter One: Introduction to Ethics

“Ethics” are a body of moral principals. In the insurance profession, these moral principals are developed and impacted by legislation, by those in the profession, and by the standards and beliefs of the individual agent. The effects of the moral or ethical decisions made by the agent are felt by many: the public, the insurer the agent represents, the agent’s customers, insurance regulators, the agent’s competition, and the agent’s coworkers.

Influence of Legislation



The insurance industry is highly regulated. The rates charged, the product delivered, the sales process, even the service provided are subject to legislative and administrative regulation.

Why Insurance is Regulated

There are several reasons insurance transactions are regulated. These reasons include:

- insurance is integral to our society;
- insurance transactions are by nature complex;
- the insurer’s financial stability is a public interest;
- the insurer and agent are in positions of significant consumer trust; and
- the behavior of insurers and/or agents has been unethical at times in the past.

Insurance is Integral to Society

Insurance provides protection against economic misfortune or ruin. Health insurance protects against financial loss due to sickness or accident, life insurance protects against financial loss due to death, property insurance protects against financial loss due to destruction of property, and casualty insurance protects against financial loss due to negligence or even crime. If citizens are not able to purchase insurance to protect their fortunes against these risks, many would suffer economically.

Impact of Uninsured Financial Loss

Uninsured financial loss can harm the individual, his or her family, and any employees the individual may have. Financial loss can effect following generations due to an inability to fund higher education or to fund the development of a trade or skill. Financial harm to members of society can cause a loss of economic health to the public, since business owners may have to lay off employees or may go out of business if the financial harm is severe enough. Because there is an element of welfare in our society, those financially harmed could potentially look to the government for the funds for housing, food and education lost due to the uninsured financial harm, causing taxes to rise. Speaking of taxes, businesses and their employees forced out of work due to uninsured risks do not earn any income on which to pay taxes.

Because of all these negative potentialities, insurance is viewed as an important industry, whose well-being benefits the public-at-large.

Complexity of Insurance Transactions

Insurance contracts are complex in nature. They include legal terms, industry-specific language, potentially complicated premium calculations or return guarantees, and myriad conditions and exclusions limiting the risks the insurer assumes. Over the years, the courts and regulators have observed that consumers can be taken advantage of through the complex language of insurance contracts.

Complexity of contracts has led to the enactment of regulation that created standardized contracts and standardized contract language. Although the various states may require special contract disclosures or special provisions, much of the language of life policies, fire policies, homeowners policies, etc. are similar from state to state and from policy to policy.

Another result of the regulators viewing insurance transactions as complex is that many states have enacted statutes requiring that “plain language” be used in personal policies, such as automobile and homeowners. The size of the font used in the policy is even regulated in some states.

The complexity of insurance transactions has also led to regulations prohibiting agents or insurers from misrepresenting policies or twisting and churning in order to make sales.

Financial Stability of the Insurer

Because the effects of insurance reach deep into society, the financial stability of the insurer is considered important to the public well-being. If an insurer cannot meet its financial obligations, the policyholders of the insurer will be harmed, and as was discussed above, the resultant financial loss the policyholders experience can impact society at large. Therefore, a large body of regulation deals with the amount of reserves and surplus each insurer must have, gives the Commissioner the power to regularly examine insurers, and requires insurers to file several financial reports to the state, and to the National Association of Insurance Commissioners.

Position of Trust

Insurers and insurance agents are in a position of trust. The public expects the insurer to fulfill the promises made in its contracts. The public trusts insurance agents to represent insurance products accurately, to handle premium honestly, and to conduct business fairly. If an agent or insurer is untrustworthy, policyholders will be harmed, the insurer may become insolvent, and again, all the negative ramifications of such insolvency on society can occur.

To discourage untrustworthy behavior, there exists a significant amount of legislation dealing with appropriate trade practices and agent behavior. Included are requirements surrounding confidentiality of customer information, unfair trade practices, appropriate premium handling, and more. If the insurer or agent violates any of these regulations, they may be fined, their license revoked, or even charged with a crime.

This position of trust is also behind the requirement for licensing. Each agent must pass an examination and complete a certain number of hours of continuing education to keep a license. The Commissioner also has the authority to examine an agent's records at any time.

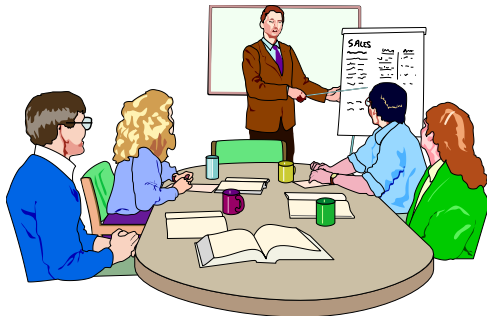
Past Unethical Behavior of Insurers and Agents

Unfortunately, breaches of trust and other unethical behavior have occurred in the industry. Legislation has been enacted due to past real and perceived abuses. Insurers and agents have been found guilty of purposefully writing unclear contracts, of unfairly settling claims, of falsely advertising, and of twisting and churning. Such actions encourage the courts and regulators to create and interpret laws to protect the public from such harm.

The financial insolvency of insurers in the '80's may not have been unethical in terms of illegality, but was viewed by regulators as unethical in terms of prudence and reasonableness. In response, new standards of acceptable investments and capital reserves and surplus were created. State legislators also developed state guaranty associations in order to provide additional security for policyholders within their states.

Both state and federal legislation impacts the ethics of the insurance industry. The state enacts the bulk of the legislation, but federal laws, such as the Fair Housing Act, and the Fair Credit Reporting Act all also regulate insurance transactions.

Influence of the Profession



Those in the insurance profession have an interest in supporting ethical practices within the industry. Promoting ethical practices improves the public image of the industry, helps reduce additional regulation, and aids in the overall competitive health of the industry.

One of the most influential insurance organizations is the National Association of Insurance Commissioners, or NAIC. It is not, strictly speaking, a legislative body. However, it is made up of government regulators: state insurance commissioners. The NAIC has developed several pieces of model regulation which has been adopted by the various states. The NAIC has developed model investment regulations and policy illustration regulations, for example.

The NAIC also compiles national insurance statistics and develops reports on the industry. States require that insurers not only submit reports to the state, but also submit financial reports to the NAIC, who compiles and releases summary and detailed statistics from these reports. Claims experience, amounts of insurance written by line, and other national statistics are generated, which assist both insurers and regulators in the establishment of rates and reserve levels.

In the property-casualty industry, organizations such as ISO, the Insurance Services Office, influence the industry. ISO develops reports and statistics about property-casualty and other insurance, and also creates and files policy forms in the various states. Such activity helps with the process of standardizing contracts in that industry. Other service organizations also exist for other insurance lines, such as the surety industry.

The various insurers also, of course, impact the industry. Insurers want the industry to be healthy, fairly competitive and as free from regulation as possible. Insurers aid in the ethical behavior of the industry by acting ethically themselves, encouraging excellent training for their agents, putting strong supervisory instruments in place to monitor agents' activities, and by cooperating with regulators.

Professional associations also influence the ethics of the agent and the industry. Local and national agent associations provide continuing education, share professional experience, and encourage ethical behavior. Some associations have developed codes of ethics, some have created special designations for advanced education, and some are active in regulatory matters.

Influence of Personal Beliefs and Actions of the Agent

No outside party can force another to act ethically. Although penalties applied after unethical behavior occurs can serve as a deterrent to unethical behavior, the best deterrent is the agent's own decision to transact business ethically.

One of the fundamental beliefs affecting the ethical behavior of an agent is how the agent views success. If an agent focuses on doing the best for each customer and measures success by the means this is accomplished,

he or she is more likely to act ethically than an agent who measures success primarily by the amount of recognition or money gained, with little thought to the means taken to achieve it.

*“When any great design thou dost intend,
Think on the means, the manner and the end.”*

- Sir John Denham



Another important belief is the way in which an agent views responsibility to others. If the agent believes he or she has little responsibility to others, and is interested in watching out for his or her own interests at the expense of others, it is more likely that unethical behavior will occur. As was discussed, the basis for regulation in the insurance industry is to help ensure that insurance activities occur for the best interest of the public. This is in opposition to a belief system that encourages self-interest at the expense of others. More in line with the spirit behind insurance regulation is an ethic that believes helping others also brings good to the one who helps.

Ethics and Agent Relationships

The ethics of the agent do not only affect the agent and his or her customers. Their impact spreads to others, such as the agent’s coworkers, the competition, the insurance company, the regulators, and the general public.

The Public

An agent’s actions have an impact on the public because (1) the agent represents the insurance industry to the public, and (2) the positive or negative results of an agent’s actions may be felt by others in the public besides policyholders.

Representatives of the Insurance Industry

The public perception of insurance is largely built by the actions of the insurers and agents within the industry. If either one of these parties behaves unethically, the general public is more likely to view other insurance agents and insurers as lacking ethics.

Insurers may negatively impact public perception through financial instability, false advertising, or not meeting the real and perceived obligations of the policies they issue. When a major insurer is found to have a problem in one of these areas, the national and local media are likely to announce the insurer's problems on television, magazines and newspapers. The general public then grows more wary of insurers and their products.

Solicitation and Sales. The agent can negatively impact public perception through improper solicitation and selling practices. The pushy insurance agent has become a running joke on television, movies and comic strips. According to the humorists, there is no worse fate than being stuck in an elevator with an insurance salesman, or marrying into a family with one. Part of the public has the impression that insurance agents are unrelenting in their pursuit of sales. Although the insurance agent of today behaves much differently than this stereotype, the fact that this perception exists is an example of how sales tactics of past agents has impacted public opinion about the industry.

By genuinely seeking to serve the public, an insurance agent helps to break such stereotypes. Using reasonable, non-threatening prospecting methods, performing thorough needs analyses and staying away from high-pressure sales tactics are the best ways an agent can best serve both the insurance industry and the public.

Competence. Unethical prospecting or sales methods can result from a lack of knowledge or due to misunderstanding a product's features and uses. Agents must be careful to study and understand the products represented. Ignorance of regulations surrounding prospecting and selling practices can also result in unethical actions.

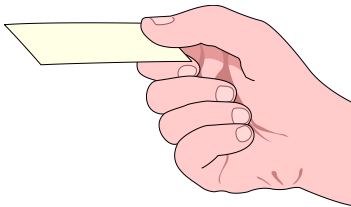
Due Diligence. Another important responsibility to the public an agent assumes is to represent an insurer the agent feels comfortable being associated with. Each agent should represent an insurer whose financial stability, products and marketing methods are agreeable to that agent. Representing an insurer using a method or a product the agent does not support is not in the best interests of the public, the insurer or the agent.

Results of Negative Public Perception

The results of negatively impacting the public's perception of the industry can have the effect of reducing overall sales volume, increasing regulation, and dissuading competent, ethical people from entering the insurance sales profession.

Insurance Company

The agent has ethical responsibilities to the insurance company he or she represents. For example, the agent must stay within the boundaries of authority the insurer grants. The agent solicits insurance, discusses product features, collects premium and performs ongoing customer service on behalf of the insurer. Each of these duties must be performed with care, with an effort to meet the expectations set by the insurer.



The insurer requires the agent to properly perform all of the following duties:

- Accurately disclose product features;
- Write profitable business;
- Accept applications for suitable risks, based on the underwriting specifications of the insurer;
- Accurately complete applications;
- Gather and complete any additional required documentation;
- Perform tasks in a timely manner;
- Keep paperwork and other business organized;
- Appropriately handle premium;
- Maintain required records; and
- Consistently transact business in a legal and ethical manner.

When an agent agrees to represent an insurer, and an insurer agrees to allow the agent to represent it, the relationship is both a legal one and one based on trust and loyalty. The insurer wants the agent to transact business honestly and carefully, and wants the agent to succeed within these parameters. The agent trusts the insurer to provide good product and home office service, pay fair commission or compensation and to keep the commitments made to the agent and policyholders. The relationship between the agent and insurer is an important ethical association.

Customers

The term “customers” is used to mean prospects, applicants and policyholders. These are the individuals and businesses with which the agent develops a working relationship.

Ethical Solicitation and Sales Tactics. Among the many ethical responsibilities to customers is practicing ethical solicitation and sales tactics.

Competence. Customers expect competence on the part of the agent. They want to be able to rely on the agent’s representation of the products and plans represented, as well as the agent’s assessment of the customers situation. The agent has an ethical responsibility to customers to know and understand the scope and content of the business offered and sold.

Appropriate Sales. Agents also have an ethical duty to customers to make appropriate sales. The agent can do so by assessing the needs of the customer, including a review of current insurance owned and the customer’s financial situation, tax situation, risk tolerance and experience. The risk to be insured must be thoroughly profiled as well. Appropriate sales also include proper disclosure of risks, fees, premium calculations, illustration assumptions, and contract provisions. An agent must also take sufficient time to educate the customer and respond to any questions or objections the customer may have.

Confidentiality. The customer relies on the agent to keep information confidential. The agent must be careful not to improperly disclose customer information.

Customer Service. In performing ongoing service, the agent has the responsibility to customers to act on a timely basis, execute service requests accurately, and to be responsive to customers’ needs.

Regulators

Agents are placed in a position of trust by the regulators who authorize them to transact business. The regulators expect agents to obey the laws surrounding their business and to behave ethically toward the public and the insurers agents represent. Among the requirements the regulators hold for agents include the prohibition of:

- rebating;
- improperly disclosing confidential information;
- redlining;
- twisting and churning;
- taking applications with misrepresentations;
- defaming an insurer;
- unfairly discriminating; and
- committing fraud.

The regulators require agents to act in good faith toward the public, be competent and qualified to act as an agent, and to be trustworthy. When an agent applies for and is issued a license, the agent is agreeing to comply with all that the regulators who issue the license require.

Competition

The agent has the ethical responsibility toward competitors to engage in fair trade practices. Specific regulations prohibit agents from making false or malicious statements against any person engaged in the business of insurance. Attempting to make a sale based on false statements against another agent or insurer puts the falsely accused party at an unfair disadvantage in the marketplace. In addition, if enough false information is circulated, an insurer's overall financial stability could be harmed since policyholders could begin to surrender policies in large numbers.

False advertising is also a type of unfair competition, since the facts about a product are distorted. Any type of misrepresentation could also be considered unfair to competitors.

Coworkers

The coworkers of an agent are also impacted by the ethical decisions and actions of an agent. The actions of an ethical agent helps to promote the good reputation of the organization for which he or she works. An unethical agent's actions can mar the reputation of that same organization.

Besides harming the reputation of an organization, an agent who does not hold high standards of professionalism can negatively impact the productivity of his or her coworkers. Sloppy paperwork, not responding to customer requests and an overall lack of care often results in other agents or support staff having to do additional work to "make up" for the

work not properly completed by the irresponsible agent. Each agent owes it to his or her coworkers to take proper care of his or her own business.

Benefits of Ethical Behavior



Ethical behavior brings benefits to the public, the agent's customers, the insurer, the competition, the agent's coworkers and to the agent.

The Public

By taking ethical actions, an agent serves the public and his or her customers by allowing them to make reasonable decisions about insurance coverage, free from pressure or misinformation. The ways insurance benefits the individual and society has already been discussed. Ethical agents put no barriers between this benefit and the public.

Customers

Customers are further benefited by good service, good product recommendations, prompt claim payment and so on. The ethical agent will also provide benefit to his or her customers by not pushing product onto them which is not suitable for their needs. Ethical agents provide product which meets the true financial protection needs of their customers.

Competition

It may sound a little overly generous to want to benefit competition. But ethical practices benefits competition because such practices help the health of the entire industry. "One bad apple..." as the saying goes, can hurt many involved in the insurance profession.

Coworkers

Coworkers, too, find benefit in working with ethical agents. Besides being a motivation to others, ethical agents are not a burden to coworkers. Any agent who has had to work with customers following an agent with poor work practices or following an agent who has taken unethical actions can testify to the harm done by that irresponsible agent. Customers must be "re-sold" and customer confidences rebuilt, consuming much time and effort. Ethical agents want to work with other ethical agents, those who will build up customer trust and accumulate stable production.

The Individual Agent

Ethical behavior benefits the individual agent as well. Successful agents are quick to point out that their longevity and good production are the result of good customer relations. Putting the customer first, they say, leads to additional purchases and referrals.

Besides the strength in business ethical practices bring, the ethical agent can have pride in his or her work, and has the satisfaction of knowing he or she has done the best for every client.

Chapter One Study Questions

1. Each of the following are reasons insurance is regulated, except:
 - a. insurers must be federally licensed to transact business in the United States
 - b. insurance is integral to our society
 - c. the insurer's financial stability is a public interest
 - d. insurance transactions are by nature complex

2. The complexity of insurance contracts has led to the enactment of regulation that created _____ contracts.

3. The belief system below which is more in line with the spirit behind insurance regulation is:
 - a. a belief system that encourages self-interest at the expense of others.
 - b. one that holds the belief that helping others also brings good to the one who helps.

4. _____ is (are) impacted by an agent's ethical practices.
 - a. The public
 - b. The insurer
 - c. The agent's coworkers
 - d. all of the above are impacted by an agent's ethical practices.

5. Insurers may negatively impact public perception through _____ or not meeting the real and perceived _____ of the policies they issue.

6. Put an "x" next to each duty the insurer requires of an agent:

- a. accurate disclosure of product features
- b. purchase of television advertising time
- c. writing profitable business
- d. accurate completion of applications

7. List four expectations customers have of agents:

- a.
- b.
- c.
- d.

8. The primary ethical responsibility an agent has toward competition is to engage in _____ practices.

9. Place an "x" next to each way in which an agent can negatively impact coworkers through unethical actions:

- a. the agent can harm the reputation of an entire organization
- b. because the unethical agent will make more sales, the ethical agent's production will decrease
- c. because the unethical agent may be sloppy in paperwork, may not respond to customer requests, and may demonstrate an overall lack of care, the agent can reduce productivity of other agents and support staff who may have to "make up" for these improper practices.

10. Ethical behavior helps the individual agent in the areas of longevity and good production because putting the customer first leads to _____ and _____.

Chapter Two: Ethics and the Regulatory Environment



The ethical responsibilities of the insurance agent are greatly impacted by the insurance regulatory environment. The state department of insurance has the primary responsibility for the administration of regulations and legislation governing an insurance agent's actions. State legislatures have a significant impact on an agent's ethical responsibilities since they are the bodies which pass the laws the agent must obey. Federal laws also regulate insurance transactions.

State Insurance Department

The Insurance Commissioner is the chief officer of the state insurance department. The Commissioner's power and authority includes making rules and regulations for the following purposes:

1. Organizing the department and assigning duties to members of its staff.
2. Promulgating rules and regulations that are necessary to implement the insurance code.
3. Issuing interpretative rulings or prescribing forms in order to carry out the responsibilities of his or her office.
4. Governing the procedures followed in any proceedings before the department. (*Georgia Code 33-2-9*)

The duties of the department include authorizing and monitoring insurers, approving insurance policy language and regulating rates, and authorizing and monitoring agents.

Authorizing Insurers

A critical responsibility of the insurance department is the authorizing of insurers to transact business in the state. Each insurer must meet financial criteria and comply with the applicable portions of the insurance code in order to be given a certificate of authority to transact business in the state.

The department authorizes insurers of all types. Georgia Code 33-3-5 divides insurance into six different classes:

- (1) Life, accident and sickness;
- (2) Property, marine and transportation;
- (3) Casualty;
- (4) Surety;
- (5) Title; and
- (6) Health Maintenance Organization.

An insurer may have to comply with different regulations depending on the class of insurance the insurer provides.

Insurers are considered to be “domestic,” “foreign,” or “alien.” A domestic insurer is an insurer which is formed in the state and which does business in the state. A foreign insurer is one which is formed in another state and does business in the state. An alien insurer is one which is formed in another country and does business in the state. Domestic, foreign and alien insurers may all be granted a certificate of authority to transact business in Georgia as long as they comply with the applicable regulations in the insurance code.

To be given a certificate of authority to transact business in Georgia, the insurer must be an incorporated stock insurer, an incorporated mutual insurer, a fraternal benefit society, a hospital service nonprofit corporation, a nonprofit medical service corporation, a farmers’ mutual fire insurance company, a Lloyd’s association, or a reciprocal insurer. An insurer which is owned or financially controlled in whole or in substantial part by any state in the United States, by a foreign government, or by any political subdivision, instrumentality, or agency, or is an agency of a state or foreign government or any political subdivision, instrumentality, or agency or either cannot currently be authorized to transact business in Georgia. (*Georgia Code 33-3-3*)

Insurers must meet financial requirements in order to transact insurance business in the state. Minimum capital stock or surplus amounts and additional surplus or paid-in capital amounts must be met in order to be given an original certificate of authority and in order to have authority renewed annually. The insurer must also deposit securities with the state, or provide proof of securities deposited with another state, in order that

policyholders and creditors are financially protected. Certain foreign and alien insurers must meet additional financial requirements as well. (Georgia Code 33-3-6 to 10)

Besides financial requirements, the insurer must meet other requirements. For example, the insurer may not issue any policies covering a subject of insurance resident, located, or to be performed in Georgia without the policy or countersignature endorsement being countersigned by its licensed agent or licensed service representative resident in Georgia. The insurer also may not transact business under a name which would mislead concerning the type of organization of the insurer, or use a name similar to another insurer which would cause uncertainty or confusion.

Exceptions

Not all activities surrounding the transacting of insurance in Georgia require a certificate of authority. Investigating and adjusting a claim in Georgia does not constitute transacting insurance business. An insurer which is not transacting new insurance business but is continuing the collection of premium and is servicing policies written for residents of or on risks in Georgia does not require a certificate of authority. Insurance which was not covering a subject of insurance not resident, located or expressly to be performed in Georgia at the time of issue and solicited, written and delivered outside of Georgia does not require a certificate of authority for subsequent transactions occurring in Georgia.

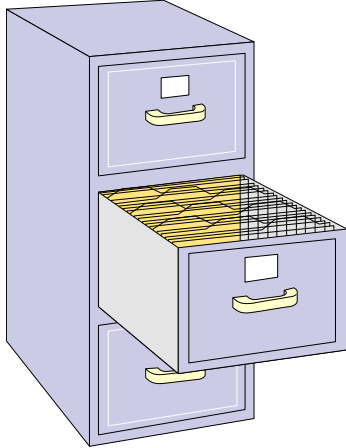
Monitoring Insurers

Once an insurer receives a certificate of authority to transact business in the state, the Commissioner is responsible to monitor the insurer's business. One of the ways in which an insurer is monitored is through reports the insurer is required to submit to the department. Another method is through examination.

Insurer Reports

Each insurer is required to file a report with the Commissioner annually. This report must cover the insurer's affairs and operations during the year. Property-casualty insurers must include in this report information regarding the direct writings made in Georgia. Insurers must also file annual statements with the NAIC. The NAIC compiles reports from insurers across the U.S. and provides important financial and statistical reports to state insurance commissioners.

Examination of Insurers



The Commissioner may examine, or appoint examiners to examine, the affairs, transactions, accounts, records, documents and assets of any authorized insurer whenever the Commissioner deems it expedient. Domestic insurers are examined at least every three years. The Commissioner may accept reports of examinations from other state commissioners for foreign and alien insurers under certain conditions. If an insurer changes its domicile from Georgia to another state, an examination will be performed by the Commissioner once a year for five years, unless such an insurer retains

its principal place of business and keeps its complete record of assets, transactions and affairs in Georgia.

Insurers doing business in Georgia must provide the Commissioner all accounts, records, documents and files related to the examination. Officers, employees and representatives of the insurer being examined must facilitate the examination and aid the examiners in making the examination. (*Georgia Code 33-2-11,13*)

Revocation or Suspension of Certificate of Authority

The Commissioner may refuse to issue a certificate of authority, or revoke or suspend an insurer's certificate of authority, or place an insurer under administrative supervision, if the insurer:

- Violates any provision to which the insurer is subject
- Knowingly fails to comply with or violates any rule, regulation or order of the Commissioner.
- Is found to be in unsound condition or in a condition which renders its further transaction of insurance in Georgia hazardous to its policyholders or to the public.
- Compels claimants to accept less than the amount due or to bring action against the insurer to secure full payment as a "general scheme or plot."
- Refuses to be examined or to produce accounts, records and files when required, or refuses to furnish additional information

required by the Commissioner as necessary to consider the insurer's application for certificate of authority renewal.

- Fails to pay any final judgment rendered against in Georgia within thirty days of the judgment becoming final.
- Is affiliated with and under the same general management or directorate or ownership as another insurer which transacts direct insurance in Georgia without having a required certificate of authority. (*Georgia Code 33-3-17*)

The Commissioner may impose an administrative fine to an insurer for any of the following acts:

- Failure to use due diligence in processing claims, failure to pay claims in a timely manner, failure to provide proper notice when required with respect to the reasons for the insurer's failure to make claims payments when due, or refusing without just cause to pay proper claims;
- Compelling without just cause, insureds, claimants, or other persons entitled to the proceeds of its policies in this state to accept less than the amount due them or to bring action against the insurer or an insured to secure full payment or settlement;
- Accepting money, trade stamps, gifts or other remuneration of any kind in return for referring automobile and other property repair business.

Approving Policies

Another important responsibility of the insurance department is approving the contracts insurers provide. The department generally approves the contract provisions and language and the rates the insurer charges. Some lines of insurance do not have to have contracts and/or rates approved, but the insurer must generally file the contracts or rates with the department.

Insurance contracts have some unique features. Some of these features are due to legislation concerning contract provisions. Others have their roots in contract law.

Contract Language

Contract law is the body of law surrounding the construction and application of contract provisions. Several contract law rules apply to insurance contract language:

- If a contract contains both written and printed portions, the written portion is generally considered to be more valid than the printed portion if there is any contradiction between the two.
- Words in the contract are generally considered to have their ordinary meanings unless the words are used in technical terms.
- If contract language is unclear, the courts will generally interpret the language against the writer of the contract. In the case of insurance, the writer of the contract is the insurer.

Because of these principles of contract law, recent court rulings, and the contract language approved by the insurance department, insurance policy language has become much clearer, especially in personal auto policies and homeowners insurance policies.

Other principles of law related to insurance contracts include that insurance contracts are unilateral, aleatory, and are contracts of adhesion.

Unilateral Contract A unilateral contract is one in which a promise to act is made by only one party. In insurance contracts the insurer is this party.

Aleatory Contract An aleatory contract is a contract which contains promises based on an uncertain event. The insurer may or may not have to perform the acts stated in the contract based on whether or not a loss or claim occurs.

Adhesion A contract of adhesion is one where one party adheres to the terms the other party dictates. The insurer creates the contract; the insured has little input into the contract terms. Because the insurer has control over the contract terms, courts tend to interpret unclear provisions in favor of the insured.

Consumerism

Contract law is not the only reason contract language has become more clear and plain in recent years. Consumerism, the focus on consumer rights, is an important market force today, motivating both the regulators

and the insurance companies to attempt to ensure the public understands any insurance contractual agreement entered into.

Authorizing Agents

The insurance department also has the important duty of authorizing agents to transact insurance business in the state. Each insurer authorized to do business in Georgia is required to obtain an agent's certificate of authority for each agent representing the insurer. The department gives an agent authority to transact business in the state based on the competency of the agent, the professional experience of the agent if licensed previously, and the character of the agent.

Competency

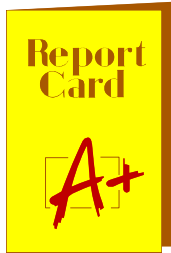
Each applicant for an agent's license must take an examination which is designed to measure the applicant's competency to act in such capacity. In addition to passing this examination, the application for an agent's certificate of authority requires the insurer to supply information regarding the agent's experience and/or the type of instruction received regarding the types of insurance the agent will be transacting. The insurer must also state that the applicant is qualified to act as an agent.

Character and Professional Practices of the Agent

The application for a certificate of authority includes information pertaining to the character and professional practices of the applicant. If the applicant ever had a license refused, surrendered, suspended, restricted or revoked, such an event must be disclosed. The application must state whether the agent is indebted to an insurer, general agent, agent or other person, including the details of any such indebtedness, and whether the applicant ever had a certificate of authority terminated by an insurer or agent, and the details of such an event. If the spouse of the applicant had an insurance license, and such license was ever refused, surrendered, suspended, restricted or revoked, the details of this must be disclosed.

The insurer must also state on the application that the applicant is trustworthy and is able to hold himself or herself out in good faith to the general public as an agent for the insurer.

Monitoring Agents



Once an agent is authorized to transact business in the state, the insurance department is responsible for monitoring the agent's competence, character and professional practices. Competence is monitored through continuing education requirements and through response to complaints against the agent coming through the department. The character and professional practices of an agent may come to the department's attention through a complaint, or through the examination process.

Competence

The agent is required to complete a specified number of continuing education hours based on the number of years the agent has been licensed. Currently, an agent who has been licensed for less than twenty years must take 15 hours of continuing education. An agent licensed for twenty years or more must take 10 hours of continuing education.

Character and Professional Practices

The Commissioner may examine the affairs, accounts, records, documents and transactions of any licensed insurance agent. If a complaint is filed by a citizen of the state, the Commissioner will make inquiry into any alleged illegal or improper conduct of any licensee. Such an inquiry is for the purpose of determining whether a licensee is untrustworthy, not competent, or not qualified to act as a licensee, and may include an examination. Any agent who is examined must produce and make accessible accounts, records, documents and files in his or her possession or control that are related to the examination.

The report generated from such an examination must be given to the agent examined not less than twenty days prior to the report being filed. The agent may request a hearing concerning the facts contained in the report. Depending on the findings of the examination and hearing, the examination findings may be turned over to law enforcement officials if necessary. If an examination of an agent is conducted due to a complaint, and the complaint is found not justified, the agent does not have to bear the expenses of the examination. (*Georgia Code Sections 33-2-12, 33-23-36*)

Revocation or Suspension of Agent Licenses

Any of the following activities can result in the revocation or suspension of an agent's license:

- Violating any provision of the insurance code or any other law relating to insurance;
- Intentionally misrepresenting or concealing any material facts in any application for a license on any form filed with the Commissioner;
- Obtaining or attempting to obtain a license by misrepresentation, concealment or other fraud;
- Misappropriating, converting to his or her own use, or illegally withholding money belonging to an insurer, insured, agent, agency, applicant, or a beneficiary;
- Committing fraudulent or dishonest practices;
- Materially misrepresenting the terms and conditions of an insurance policy or contract;
- Failing to pass a required licensing examination, or cheating on any examination required for a license;
- Failing to comply with or violating any proper order, rule or regulation, issued by the Commissioner;
- Carrying on business not in good faith as an agent, but rather holding a license for the purpose of securing rebates, commissions or controlled business;
- Carrying on business not in good faith under the code;
- Showing lack of trustworthiness or lack of competence to act as a licensee;
- Knowingly participating in the writing or issuance of substantial overinsurance of any property insurance risk;
- Failing or refusing, upon written demand, to pay to any insurer, agent, agency, applicant, beneficiary, or insured any moneys which belong to such insurer, agent, agency, applicant, beneficiary, or insured;
- Failing to comply with the Commissioner in an examination or failing to produce records requested by the Commissioner via proper written request;
- Being convicted of any felony or of any crime involving moral turpitude in the courts of Georgia or any other state, territory or country or in the courts of the United States;

- Being arrested, charged, and sentenced for the commission of any felony, or any crime involving moral turpitude, where first offender treatment without adjudication of guilt pursuant to the charge was granted; or an adjudication of guilt or sentence was otherwise withheld or not entered on the charge, except with respect to a plea of nolo contendere;
- Having a license to practice a business or profession licensed under the laws of Georgia or any other state, territory, country, or the United States revoked, suspended, or annulled by any lawful licensing authority other than the Commissioner; having other disciplinary action taken against him or her by any lawful licensing authority other than the Commissioner; being denied or refused a license by any such lawful licensing authority other than the Commissioner pursuant to disciplinary proceedings; or having been refused the renewal of a license by any such licensing authority other than the Commissioner pursuant to disciplinary proceedings;
- Not notifying the Commissioner within sixty days of being convicted of a felony or having a license revoked as described in the prior two bullets; or
- Not being in compliance with an order for child support.

A person committing any of the following is guilty of committing a misdemeanor:

- making, publishing, disseminating, circulating or placing before the public any untrue, deceptive or misleading assertion, representation, or statement with respect to the business of insurance or with respect to any person in the conduct of his insurance business;
- making, issuing, circulating or causing to be circulated any estimate, illustration, circular or statement misrepresenting the terms of any policy issued or to be issued;
- making, publishing, dissemination or circulating directly or indirectly any pamphlet, circular, article or literature which is false or maliciously critical or substantially misrepresentative of the financial condition of an insurer;
- entering into any agreement to commit any act of boycott, coercion, or intimidation resulting in unreasonable restraint of or monopoly in the business of insurance;

- filing with a supervisory or public official a false statement of financial condition of an insurer with the intent to deceive;
- making any false entry in any book, report, or statement of any insurer with intent to deceive any agent or examiner or willfully omitting a true entry in any book, report or statement of the insurer;
- making or permitting unfair discrimination in the terms of conditions of an insurance contract;
- permitting or offering to make or making a rebate of premium or other favor as inducement to any contract;
- failing to instruct and require properly that agents shall incorporate all material facts in the solicitation of insurance and filling out of applications; or
- encouraging agents to accept applications containing material misrepresentations or to conceal material information.

(Georgia Code Sections 33-5-1, 33-6-9, 33-23-21, 33-23-38)

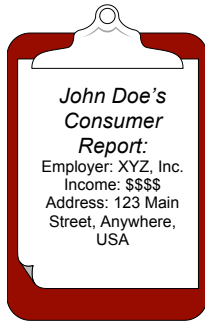
The Commissioner and the insurance department staff are responsible to protect the citizens of the state from improper actions of insurers or agents. They are empowered to fulfill these duties through the authorizing and monitoring of insurers, agents and insurance business in the state.

Trade Practices Legislation

The ethics of the agent are governed by several pieces of trade practices legislation. Much of this legislation is common to most states, in part because the NAIC has developed model laws related to many of these practices. Other legislation is based on federal law.

The purpose of trade practices legislation is to protect the consumer, ensure fair competition, and protect the insurance marketplace.

Standards For The Collection, Use and Disclosure of Information



Georgia Code Section 33-39 governs the use and disclosure of information collected during insurance transactions. The purpose of this code section is to “maintain a balance between the need for information by those conducting the business of insurance and the public’s need for fairness in insurance information practices.” The legislation puts into place a mechanism for people to find out what information is collected about them and gives the ability to verify or dispute the accuracy of such information. It puts limits on the disclosure of information collected in connection with insurance transactions. An insurance applicant or policyholder can also obtain the reasons for any “adverse underwriting decision” under these rules.

In this code section “adverse underwriting decision” is defined as:
Georgia Code



- (A) *Any of the following actions with respect to insurance transactions involving insurance coverage which is individually underwritten:*
 - (i) *A declination of insurance coverage;*
 - (ii) *A termination of insurance coverage’*
 - (iii) *Failure of an agent to apply for insurance coverage with a specific insurance institution which the agent represents and which is requested by an applicant;*
 - (iv) *In the case of property or casualty insurance coverage:*
 - (I) *Placement by an insurance institution or agent of a risk with a residual market mechanism or an unauthorized insurer;*
 - (II) *The charging of a higher rate on the basis of information which differs from that which the applicant or policyholder furnished;*
 - (v) *In the case of life, health or disability insurance coverage, an offer to insure are higher than standard rates; or*
- (B) *Notwithstanding subparagraph (A) of this paragraph, the following actions shall not be considered adverse underwriting decisions but the insurance institution or agent responsible for their occurrence shall nevertheless provide the applicant or policyholder with the specific reasons for their occurrence:*

- (i) *The termination of an individual policy form on a class or state-wide basis;*
- (ii) *A declination of insurance coverage solely because such coverage is not available on a class or state-wide basis;*
- (iii) *the rescission of a policy; or the accommodation of an insured by an agent who places insurance for such insured with any insurer, residual market mechanism, or unauthorized insurer which is satisfactory to such insured when such insured has been canceled, nonrenewed, declined, or otherwise unable to obtain coverage for any reason. (Code 33-39-3)*

Section 33-39 forbids an insurance institution, agent, or insurance-support organization (such as an organization that provides consumer reports) from using “pretext interviews” to obtain information about an insurance transaction except under specific circumstances, such as when there is a reasonable basis for suspecting criminal activity, fraud, material misrepresentation, or material nondisclosure in connection with a claim. A “pretext interview” occurs when a person attempts to obtain information about a natural person by performing one or more of the following acts:

- Pretending to be someone he or she is not;
- Pretending to represent a person he or she is not representing;
- Misrepresenting the true purpose of the interview; or
- Refusing to identify himself or herself upon request.

An insurance institution or agent must provide a “notice of information practices” to all applicants or policyholders. The notice must be provided to applicants no later than the time the insurance policy is delivered if personal information is collected from the applicant or from public records only, or at the time collection of personal information is initiated when personal information is collected from a source other than the applicant or public records.

A notice of information practices must also be provided no later than each policy renewal date as well, unless personal information is collected only from policyholder or public records, or a notice has been provided within the last twenty-four months.

If a policy is reinstated or there is a change in insurance benefits, a notice must be provided when the insurance company receives a request for policy reinstatement or benefits change, unless personal information is collected only from the policyholder or from public records.

The notice of information practices must include the following:

- Whether personal information may be collected from persons other than the individual or individuals proposed to be covered by the insurance;
- The types of personal information that may be collected and the types of sources and investigative techniques that may be used to collect such information;
- An explanation of the types of information that may be provided under any of the circumstances below if they occur in such frequency to be considered a general business practice :
 - * to enable necessary business purposes;
 - * to prevent criminal activity, fraud, material misrepresentation or material nondisclosure related to insurance transactions;
 - * to a medical-care institution or medical professional in order to verify insurance coverage or to inform an individual of a medical problem;
 - * to an insurance regulatory authority, or to a law enforcement or other governmental authority in order to protect the interests of the insurance institution, agent or because the insurance institution or agent reasonably believes illegal activities have been conducted;
 - * for the purposes of conducting actuarial or research reports;
 - * to a person whose only use of the information is in connection with marketing of a product or service, as long as no medical-record information or personal information related to an individual's character, personal habits, mode of living, or general reputation is disclosed and as long as the individual has had the opportunity to indicate, and has not given the indication, that the individual does not want personal information disclosed for marketing purposes;

- * to an affiliate whose only use of the information is in connection with an audit;
- * To a group policyholder for the purpose of reporting claims experience or conducting an audit of the insurance institution's or agent's operations or services, as long as the information disclosed is reasonably necessary for the group policyholder to conduct the review or audit;
- A description of the rights of an individual to obtain personal information collected and to have disputed information corrected, amended or deleted; and
- A statement conveying that information obtained from a report by an insurance-support organization may be retained by the insurance-support organization and disclosed to other persons.

An abbreviated notice may be given, as long as the unabbreviated version is made available to the individual upon request.

Other requirements of this code section include that:

- An insurance institution or agent must clearly specify questions asked of an individual in connection with an insurance transaction which are designed solely for marketing or research purposes;
- No insurance institution, agent, or insurance-support organization may prepare or request an investigative consumer report about an individual in connection with an application for insurance, a policy renewal, a policy reinstatement, or a change in insurance benefits unless the insurance institution or agent informs the individual that he or she may request to be interviewed in connection with the preparation of an investigative consumer report, and that he or she is entitled to receive a copy of the investigative consumer report;
- Individuals can make written request for recorded personal information. The insurance institution, agent or insurance-support organization must provide the individual of the nature and substance of the personal information within 30 business days from the date the request is received, permit the individual to see and copy the recorded personal information, disclose the identity, if recorded, of those persons to whom the insurance institution, agent or insurance-support organization has

disclosed such personal information within the two years prior to the request, and provide the individual with a summary of the procedures by which the individual may request correction, amendment or deletion of recorded personal information.

- Within 30 business days from the date of receipt of a written request from an individual to correct, amend or delete any recorded personal information, an insurance institution, agent or insurance-support organization must either correct, amend or delete the disputed information, or notify the individual of its refusal to do so, provide the reasons for the refusal and inform the individual of his or her right to file a statement containing what the individual thinks is the correct, relevant or fair information. The statement must be made accessible to anyone reviewing the disputed personal information.
- If an adverse underwriting decision is made, the insurance institution or agent responsible for the decision must provide in writing to the applicant, policyholder or individual proposed for coverage with the specific reason or reasons for the adverse underwriting decision, or advise the person in writing that he or she may obtain the specific reason or reasons for the decision, and provide the individual with a notice of his or her rights to obtain information and to have the information corrected, amended or deleted if it is in dispute.

If an insurance institution, agent or insurance-support organization is found to have violated the requirements of Section 33-39, the Commissioner may order payment of a monetary penalty of not more than \$500 for each violation and not to exceed \$10,000 for multiple violations. Any person who violates a cease and desist order of the Commissioner under Section 33-39 may be subject to a monetary fine of not more than \$10,000 for each violation, a monetary fine of not more than \$50,000 if the Commissioner finds that violations have occurred as a general business practice, and/or suspension or revocation of an insurance institution's or agent's license.

Rebating

Rebating is the practice of inducing the purchase of an insurance contract by giving any part of an agent's commission or other item of value.

Georgia Code Section 33-6-4(b) prohibits rebating with the following language:

Georgia Code



(b)The following acts or practices are deemed unfair methods of competition and unfair and deceptive acts of practices in the business of insurance:

...(8)(B)Knowingly permitting or offering to make or making any contract of insurance or agreement as to the contract other than as plainly expressed in the contract issued thereon; paying, allowing, giving, or offering to pay, allow, or give directly or indirectly, as inducement to any contract of insurance, any rebate of premiums payable on the contract, any special favor or advantage in the dividends or other benefits thereon, or any valuable consideration or inducement whatever not specified in the contract, except in accordance with an applicable rate filing, rating plan or rating system filed with and approved by the Commissioner; giving, selling, purchasing, or offering to give, sell, or purchase as inducement to such insurance or in connection therewith any stocks, bonds, or other securities of any company, any dividend or profits accrued thereon, or anything of value whatsoever not specified in the contract; or receiving or accepting as inducement to contracts of insurance any rebate of premium payable on the contract, any special favor or advantage in the dividends or other benefit to accrue thereon, or any valuable consideration or inducement not specified in the contract.

As noted in the introduction to the forbidden activities, rebating is viewed as an “unfair method of competition.” An insurer or agent who practices rebating has an unfair advantage over competitors who do not give gifts in order to make sales. In addition, a citizen is not well served if a rebate causes that citizen to make a purchase which would otherwise not be in his or her best interest, except for the rebate. Rebating is considered “unfair and deceptive” because a person may buy an insurance contract because of the inducement, not because the policy is the best one to meet the policyholder’s insurance needs.

Unfair Discrimination



Unfair discrimination through charging discriminatory rates is prohibited through trade practices legislation. Rates must not be excessive, inadequate, nor unfairly discriminatory. Insurers may charge different rates for different risks, but the rates must not be unreasonably high, nor so inadequate that the insurer's solvency is at risk. The insurer may give consideration

to past and prospective loss experience, risk of catastrophes, a reasonable profit margin, past and prospective expenses, and other reasonable factors in setting rates. Rate classifications may also be created, wherein similar risks have minimum premiums and rates established. Such considerations are not considered unfair discrimination.

Unfair discrimination can occur in property insurance if rates are based solely upon the age or geographical location of property within a rated fire district without taking into consideration objective loss experience. It can also occur in life, accident or sickness insurance if different rates are charged, different benefits are paid, or different terms and conditions of the contract are applied to individuals of the same class, same policy amount, and with the same life expectancy or of the same risk. (*Code Section 33-6-4*)

It is considered unfair discrimination if property or casualty insurance is cancelled, policy coverage modified, or not renewed solely because an applicant or insured, or any employee of such, is mentally or physically impaired. Refusing to insure an individual, not continuing to insure an individual, limiting the amount of insurance on an individual, or charging a different rate to an individual because he or she is blind or partially blind is also considered unfair discrimination.

If any person is found to have engaged in unfair discrimination, the Commissioner may order any one or more of the following:

- Payment of a monetary penalty of not more than \$1000 for each act or violation. If the person knew or reasonably should have known he or she was in violation, the penalty can be as high as \$5000 for each violation;

- Suspension or revocation of the person’s license, if the person knew or reasonably should have known he or she was in violation;
- Any other reasonable and appropriate relief.

Twisting

Twisting is the practice of misrepresenting an insurance product in order to sell a customer a new policy to replace an existing policy. Misrepresentation in this sense includes not disclosing disadvantages of replacing the contract, such as withdrawal charges, loss of premium paid, less liberal coverage provisions, or other items which are important for the customer to understand before making the decision to replace a product. An agent practicing twisting does not disclose these items and so receives commission on a sale made under false pretenses. Twisting by an insurance agent is prohibited.

Churning

Churning is similar to twisting, but involves selling a policy from the **same insurance company** to replace another policy for the purpose of generating a new commission for the agent. Churning exists when the policyholder does not receive a benefit from replacing the policy with another. Churning is a prohibited practice.

Misrepresentation of a Policy

An agent may not misrepresent an insurance policy. Section 33-6-4(a)(2) prohibits misrepresentation in the following manner:

Georgia Code



(2) Making, issuing, circulating, or causing to be made, issued, or circulated any estimate, illustration, circular, or statement misrepresenting the terms of any policy issued or to be issued, the benefits or advantages promised thereby, or the dividends or share of the surplus to be received thereon; making any false or misleading statement as to the dividends or share of surplus previously paid on similar policies; making any misleading representation or any misrepresentation as to the financial condition of any insurer, as to the legal reserve system upon which any life insurer operates; using any name or title of any policy or class of policies misrepresenting the true nature thereof; or making any misrepresentation to any policyholder insured in any company for the purpose of inducing or

tending to induce the policyholder to lapse, forfeit, or surrender his insurance. A dividend estimate prepared on company forms and clearly indicating, in type equal in size to that used in figures showing amounts of estimated dividends, that the dividends are based on estimates made by the company based upon past experience of the company shall not be considered misrepresentation and false advertising within the meaning of this paragraph.

Accepting Application with Misrepresentation

An agent cannot knowingly accept applications with misrepresentations. Those responsible for agents must instruct and require that agents incorporate all material facts relevant to the risk in an application. The agent must incorporate into an application all relevant facts known to the agent, or which could be known by “proper diligence” (Code Section 33-6-4(b)(9)). Agents must not be encouraged to accept applications which contain material misrepresentations nor which do not include material information.

Misrepresentations are a serious matter because they can cause an insurer to issue policies for which they do not have sufficient financial resources. If an insurer carries high risk policies without being aware of them, insufficient reserves will be put aside. This condition can harm all policyholders of the insurer as well as the public at large. State and federal governments can be impacted by an insurer being unable to meet its obligations, since the government may have to step in and provide financial help to citizens who suffer financial harm in a catastrophe if the insurer is unable to do so. This means taxpayers can also be impacted by the insolvency of an insurer.

False Advertising

False advertising is prohibited as an unfair and deceptive insurance business practices. As described in the Code, false advertising includes:
Georgia Code



33-6-4(b)(1): Making publishing, disseminating, circulating, or placing before the public or causing directly or indirectly to be made, published, disseminated, circulated, or placed before the public in a newspaper, magazine, or other publication or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio station or in any other way an advertisement, announcement, or statement containing any

assertion, representation or statement with respect to the business of insurance or with respect to any person in the conduct of his insurance business, which statement, assertion, or representation is untrue, deceptive, or misleading...

Regulators are interested in fair business practices. It is a fundamental legal principal in our society that commerce should occur in a fair and orderly business environment. Fair business practices protect the customers of the business, competitors of the business, and the business itself, including its employees.

False Records

Neither an insurer or agent can make false entries into any book, report, or statement with an intent to deceive an examiner or other public official. Entries may not be omitted with the intent to deceive. (*Code Section 33-6-4(b)(6)*)

“Any director, officer, agent or employee of an insurance company who willfully and knowingly subscribes, makes, or concurs in making any annual or other statement required by law containing any material statement which is false is considered guilty of a misdemeanor” under Georgia law. (*Code Section 33-1-8*)

Defamation of an Insurer

Code Section 33-6-4(b)(3) states:

Georgia Code



Making, publishing, disseminating, or circulating directly or indirectly or aiding, abetting, or encouraging the making, publishing, disseminating, or circulating of any oral or written statement or any pamphlet, circular, article, or literature which is false or maliciously critical of or substantially misrepresents the financial condition of an insurer and which is calculated to injure any person engaged in the business of insurance...

is prohibited. Defaming an insurer is considered another unfair business practice. Notice that injuring “any person engaged in the business of insurance” is also prohibited. An agent must be careful not to make statements which could be construed as maliciously critical of another agent or insurer.

Unfair Claims Settlement Practices

Most states have statutes related to the prohibition of unfair claims settlement. Under Georgia's statutes found in Code Section 33-6-34, the following are considered unfair claims settlement practices:

- Knowingly misrepresenting to claimants and insureds policy provisions or relevant facts at time of issue;
- Failing to acknowledge pertinent communications with respect to claims with reasonable promptness;
- Failing to adopt and implement procedures for prompt investigation and settlement of claims;
- Not attempting to effectuate prompt, fair, and equitable settlement of claims submitted for which the insurer's liability is reasonably clear;
- Compelling insureds or beneficiaries to institute suits in order to recover amounts due them because the insurer offers amounts substantially less than the insured or beneficiary would recover through bringing a suit;
- Refusing to pay claims without conducting reasonable investigations;
- Failing to affirm or deny coverage of claims within a reasonable time after the insured has requested the insurer to do so;
- Making claim payments to an insured or beneficiary without indicating the coverage under which the payments are being made, after having been requested to do so by the insured in writing;
- Unreasonably delaying the investigation or payment of claims by requiring duplicate information;
- Failing to provide promptly a reasonable and accurate explanation of the basis for a claims denial or offer for compromise settlement, after have been requested to do so by the insured in writing; and
- Failing to provide claim forms within 15 calendar days of a request, along with reasonable explanations of their use.

An agent must carefully comply with the claims procedures of the insurer being represented. If the agent is responsible for any of the claims investigation, completion of paperwork, or forwarding of claim

documents, he or she must be careful to work promptly and accurately in order to avoid committing any unfair claims settlement practices.

Fraud

Insurance fraud is a serious violation of the public trust and state statutes. In Georgia, depending on the type of fraud committed, the violator may be convicted of a misdemeanor or a felony.

Insurance fraud is defined in Code Section 33-1-9:

Georgia Code



- (a) Any natural person who knowingly or willfully:
- (1) Makes or aids in the making of any false or fraudulent statement or representation of any material fact or

thing:

- (A) In any written statement or certificate;
- (B) In the filing of a claim;
- (C) In the making of an application for a policy of insurance;
- (D) In the receiving of such an application for a policy of insurance; or
- (E) In the receiving of money for such application for a policy of insurance

for the purpose of procuring or attempting to procure the payment of any false or fraudulent claim or other benefit by an insurer;

- (2) Receives money for the purpose of purchasing insurance and converts such money to such person's own benefit;
- (3) Issues fake or counterfeit insurance policies, certificates of insurance, insurance identification cards, or insurance binders; or
- (4) Makes any false or fraudulent representation as to the death or disability of a policy or certificate holder in any written statement or certificate for the purpose of fraudulently obtaining money or benefit from an insurer

commits the crime of insurance fraud.

Federal Legislation



Besides state legislation, the insurance agent is subject to federal legislation when carrying out insurance transactions. Two federal Acts which have implication for the agent are the Americans With Disabilities Act and the Fair Housing Act.

The Americans With Disabilities Act

The Americans With Disabilities Act, or ADA, was passed in 1990 because the federal government believed it needed to establish standards of conduct relative to Americans with disabilities, to ensure that they were not discriminated against. In Section 2 of the Act, the reasons behind the development of the Act are explained:

SEC. 2. FINDINGS AND PURPOSES. 42USC 12101.

(a) Findings. The Congress finds that

- (1) some 43,000,000 Americans have one or more physical or mental disabilities, and this number is increasing as the population as a whole is growing older;*
- (2) historically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem;*
- (3) discrimination against individuals with disabilities persists in such critical areas as employment, housing, public accommodations, education, transportation, communication, recreation, institutionalization, health services, voting, and access to public services;*
- (4) unlike individuals who have experienced discrimination on the basis of race, color, sex, national origin, religion, or age, individuals who have experienced discrimination on the basis of disability have often had no legal recourse to redress such discrimination;*
- (5) individuals with disabilities continually encounter various forms of discrimination, including outright intentional exclusion, the discriminatory effects of architectural, transportation, and communication barriers, overprotective rules and policies, failure to make modifications to existing facilities and practices, exclusionary qualification standards and criteria, segregation, and*

relegation to lesser services, programs, activities, benefits, jobs, or other opportunities;

(6) census data, national polls, and other studies have documented that people with disabilities, as a group, occupy an inferior status in our society, and are severely disadvantaged socially, vocationally, economically, and educationally;

(7) individuals with disabilities are a discrete and insular minority who have been faced with restrictions and limitations, subjected to a history of purposeful unequal treatment, and relegated to a position of political powerlessness in our society, based on characteristics that are beyond the control of such individuals and resulting from stereotypic assumptions not truly indicative of the individual ability of such individuals to participate in, and contribute to, society;

(8) the Nations proper goals regarding individuals with disabilities are to assure equality of opportunity, full participation, independent living, and economic self-sufficiency for such individuals; and

(9) the continuing existence of unfair and unnecessary discrimination and prejudice denies people with disabilities the opportunity to compete on an equal basis and to pursue those opportunities for which our free society is justifiably famous, and costs the United States billions of dollars in unnecessary expenses resulting from dependency and nonproductivity.

(b) Purpose. It is the purpose of this Act

(1) to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities;

(2) to provide clear, strong, consistent, enforceable standards addressing discrimination against individuals with disabilities;

(3) to ensure that the Federal Government plays a central role in enforcing the standards established in this Act on behalf of individuals with disabilities; and

(4) to invoke the sweep of congressional authority, including the power to enforce the fourteenth amendment and to regulate commerce, in order to address the major areas of discrimination faced day-to-day by people with disabilities.

The Act, as the name states, applies to Americans with disabilities. Section 3 of the Act defines disability in the following manner:

- (2) *Disability. The term disability means, with respect to an individual*
- (A) *a physical or mental impairment that substantially limits one or more of the major life activities of such individual;*
 - (B) *a record of such an impairment; or*
 - (C) *being regarded as having such an impairment.*

The provisions of the Act are broad, and contain regulations regarding employment, public services, including various modes and operations of public transportation, public accommodations operated by private entities, and telecommunications, including telecommunications for the hearing and speech-impaired. The Act discusses the responsibility of those who provide public service or are a public accommodation in terms of their architecture, facilities, hiring practices, and conduct of business.

Section 501 of the Act addresses insurance specifically, and clarifies that risk classification is not necessarily discriminatory:

(c) *Insurance. Titles I through IV of this Act shall not be construed to prohibit or restrict*

(1) *an insurer, hospital or medical service company, health maintenance organization, or any agent, or entity that administers benefit plans, or similar organizations from underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law; or*

(2) *a person or organization covered by this Act from establishing, sponsoring, observing or administering the terms of a bona fide benefit plan that are based on underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law; or*

(3) *a person or organization covered by this Act from establishing, sponsoring, observing or administering the terms of a bona fide benefit plan that is not subject to State laws that regulate insurance.*

The ADA Technical Assistance Manual gives further information on this issue:

III-3.11000 Insurance.

Insurance offices are places of public accommodation and, as such, may not discriminate on the basis of disability in the sale of insurance contracts

or in the terms or conditions of the insurance contracts they offer. Because of the nature of the insurance business, however, consideration of disability in the sale of insurance contracts does not always constitute "discrimination." An insurer or other public accommodation may underwrite, classify, or administer risks that are based on or not inconsistent with State law, provided that such practices are not used to evade the purposes of the ADA.

Thus, a public accommodation may offer a plan that limits certain kinds of coverage based on classification of risk, but may not refuse to insure, or refuse to continue to insure, or limit the amount, extent, or kind of coverage available to an individual, or charge a different rate for the same coverage solely because of a physical or mental impairment, except where the refusal, limitation, or rate differential is based on sound actuarial principles or is related to actual or reasonably anticipated experience. The ADA, therefore, does not prohibit use of legitimate actuarial considerations to justify differential treatment of individuals with disabilities in insurance.

ILLUSTRATION: A person who has cerebral palsy may not be denied coverage based on disability independent of actuarial risk classification.

Can a group health insurance policy have a pre-existing condition exclusion? *Yes. An individual with a pre-existing condition may be denied coverage for that condition for the period specified in the policy. However, the individual cannot be denied coverage for illness or injuries unrelated to the pre-existing condition.*

Can an insurance policy limit coverage for certain procedures or treatments? *Yes, but it may not entirely deny coverage to a person with a disability.*

Does the ADA require insurance companies to provide a copy of the actuarial data on which its actions are based at the request of the applicant? *The ADA does not require it. Under some State regulatory schemes, however, insurers may have to file such actuarial information with the State regulatory agency, and this information may be obtainable at the State level.*

Does the ADA apply only to life and health insurance? No. Although life and health insurance are the areas where the ADA will have its greatest application, the ADA applies equally to unjustified discrimination in all types of insurance, including property and casualty insurance, provided by public accommodations.

ILLUSTRATION: Differential treatment of individuals with disabilities, including individuals who have been treated for alcoholism, applying for automobile insurance would have to be justified by legitimate actuarial considerations.

BUT: An individual's driving record, including any alcohol-related violations, may be considered.

May a public accommodation refuse to serve an individual with a disability because of limitations on coverage or rates in its insurance policies? No. A public accommodation may not rely on such limitations to justify exclusion of individuals with disabilities. Any exclusion must be based on legitimate safety concerns (see III-4.1200), rather than on the terms of the insurance contract.

ILLUSTRATION: An amusement park requires individuals to meet a minimum height requirement that excludes some individuals with disabilities for certain rides because of a limitation in its liability insurance coverage. The limitation in insurance coverage is not a permissible basis for the exclusion.

BUT: The minimum height requirement would be a permissible safety criterion, if it is necessary for the safe operation of the ride.

Enforcement and litigation involving the ADA is going on regularly. A recent case involving a child daycare center gives some insight on the view of the courts and the Department of Justice on the application of the ADA. A copy of the settlement agreement between the daycare center and the United States of America is included at the end of this chapter. Reading through this case, wherein the daycare center used as its defense the fact that an insurance policy disallowed coverage for certain care required by the ADA, provides a greater understanding of this Act's application to the insurance industry.

Although Section 501 indicates that risk classification is not of itself discriminatory, the insurance industry is facing other issues related to the ADA. One of these issues is whether or not the courts will rule that Title III of the Act will be interpreted as being applicable to the terms of insurance contracts. Following is a portion of Title III:

SEC. 302. PROHIBITION OF DISCRIMINATION BY PUBLIC ACCOMMODATIONS.

(a) General Rule. No individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation by any person who owns, leases (or leases to), or operates a place of public accommodation.

(b) Construction.

(1) General prohibition.

(A) Activities.

(i) Denial of participation. It shall be discriminatory to subject an individual or class of individuals on the basis of a disability or disabilities of such individual or class, directly, or through contractual, licensing, or other arrangements, to a denial of the opportunity of the individual or class to participate in or benefit from the goods, services, facilities, privileges, advantages, or accommodations of an entity.

(ii) Participation in unequal benefit. It shall be discriminatory to afford an individual or class of individuals, on the basis of a disability or disabilities of such individual or class, directly, or through contractual, licensing, or other arrangements with the opportunity to participate in or benefit from a good, service, facility, privilege, advantage, or accommodation that is not equal to that afforded to other individuals.

(iii) Separate benefit. It shall be discriminatory to provide an individual or class of individuals, on the basis of a disability or disabilities of such individual or class, directly, or through contractual, licensing, or other arrangements with a good, service, facility, privilege, advantage, or accommodation that is different or separate from that

provided to other individuals, unless such action is necessary to provide the individual or class of individuals with a good, service, facility, privilege, advantage, or accommodation, or other opportunity that is as effective as that provided to others.

(iv) Individual or class of individuals. For purposes of clauses (i) through (iii) of this subparagraph, the term individual or class of individuals refers to the clients or customers of the covered public accommodation that enters into the contractual, licensing or other arrangement.

(B) Integrated settings. Goods, services, facilities, privileges, advantages, and accommodations shall be afforded to an individual with a disability in the most integrated setting appropriate to the needs of the individual.

(C) Opportunity to participate. Notwithstanding the existence of separate or different programs or activities provided in accordance with this section, an individual with a disability shall not be denied the opportunity to participate in such programs or activities that are not separate or different.

(D) Administrative methods. An individual or entity shall not, directly or through contractual or other arrangements, utilize standards or criteria or methods of administration

(i) that have the effect of discriminating on the basis of disability; or

(ii) that perpetuate the discrimination of others who are subject to common administrative control.

(E) Association. It shall be discriminatory to exclude or otherwise deny equal goods, services, facilities, privileges, advantages, accommodations, or other opportunities to an individual or entity because of the known disability of an individual with whom the individual or entity is known to have a relationship or association.

(2) Specific prohibitions.

(A) Discrimination. For purposes of subsection (a), discrimination includes

(i) the imposition or application of eligibility criteria that screen out or tend to screen out an individual with a disability or any class of individuals with disabilities from fully and equally enjoying any goods, services, facilities, privileges, advantages, or accommodations, unless such

criteria can be shown to be necessary for the provision of the goods, services, facilities, privileges, advantages, or accommodations being offered;

(ii) a failure to make reasonable modifications in policies, practices, or procedures, when such modifications are necessary to afford such goods, services, facilities, privileges, advantages, or accommodations to individuals with disabilities, unless the entity can demonstrate that making such modifications would fundamentally alter the nature of such goods, services, facilities, privileges, advantages, or accommodations;

(iii) a failure to take such steps as may be necessary to ensure that no individual with a disability is excluded, denied services, segregated or otherwise treated differently than other individuals because of the absence of auxiliary aids and services, unless the entity can demonstrate that taking such steps would fundamentally alter the nature of the good, service, facility, privilege, advantage, or accommodation being offered or would result in an undue burden;

(iv) a failure to remove architectural barriers, and communication barriers that are structural in nature, in existing facilities, and transportation barriers in existing vehicles and rail passenger cars used by an establishment for transporting individuals (not including barriers that can only be removed through the retrofitting of vehicles or rail passenger cars by the installation of a hydraulic or other lift), where such removal is readily achievable; and

(v) where an entity can demonstrate that the removal of a barrier under clause (iv) is not readily achievable, a failure to make such goods, services, facilities, privileges, advantages, or accommodations available through alternative methods if such methods are readily achievable.

At year end of 1997, the Department of Justice appealed the following case regarding the application of Title III to insurance contracts:

Ford v. Shering-Plough Corporation – The Department urged the U.S. Court of Appeals for the Third Circuit to rule that title III applies to the

terms and conditions of insurance policies. The case involves an employee of Shering-Plough who became totally disabled as the result of a mental disorder. In accordance with the employer's long-term disability policy issued by the Metropolitan Life Insurance Company, the employee's benefits were terminated after two years, although persons disabled by physical disorders were eligible for benefits until age 65. The employee filed an action claiming that this difference in benefits violates the ADA. The district court dismissed the complaint, ruling among other things that Ford did not state a claim under title III, because she did not allege that she was denied access to MetLife's services. The Department's brief on appeal argues that title III's coverage is not limited to the denial of physical access, but that it also extends to discrimination in the terms and conditions of insurance policies.

Only time will tell whether the insurance industry will be making changes in contracts in order to comply with court rulings interpreting the application of the ADA.

The agent should be familiar with the requirements of the Americans With Disabilities Act. If the agent is unsure about its relevance to any customer or case he or she is writing, the agent should contact the insurer for instruction.

Fair Housing Act



The Fair Housing Act regulates discriminatory practices in housing. Title 24, Part 105 explains the reasoning behind the Act:

(a) It is the policy of the United States to provide, within constitutional limitations, for fair housing throughout the United States. No person shall be subjected to discrimination because of race, color, religion, sex, handicap, familial status, or national origin in the sale, rental, or advertising of dwellings, in the provision of brokerage services, or in the availability of residential real estate-related transactions.

The insurance agent and insurer are impacted by this Act because it prohibits the insurer from having any part in this form of discrimination

through improperly rejecting coverage. Part 100.70 includes such action under the heading “Other Prohibited Sale and Rental Conduct:”

b) It shall be unlawful, because of race, color, religion, sex, handicap, familial status, or national origin, to engage in any conduct relating to the provision of housing or of services and facilities in connection therewith that otherwise makes unavailable or denies dwellings to persons...

d) Prohibited activities relating to dwellings under paragraph (b) of this section include, but are not limited to:

1) Discharging or taking other adverse action against an employee, broker or agent because he or she refused to participate in a discriminatory housing practice.

2) Employing codes or other devices to segregate or reject applicants, purchasers or renters, refusing to take or to show listings of dwellings in certain areas because of race, color, religion, sex, handicap, familial status, or national origin, or refusing to deal with certain brokers or agents because they or one or more of their clients are of a particular race, color, religion, sex, handicap, familial status, or national origin.

3) Denying or delaying the processing of an application made by a purchaser or renter or refusing to approve such a person for occupancy in a cooperative or condominium dwelling because of race, color, religion, sex, handicap, familial status, or national origin.

*4) Refusing to provide municipal services or **property or hazard insurance** for dwellings or providing such services or **insurance** differently because of race, color, religion, sex, handicap, familial status, or national origin.*

The Fair Housing Act in its original form was enacted in 1968. Since then it has had amendments, revisions, and has been the subject of many court cases. The insurance industry has responded by careful construction of its underwriting requirements to ensure compliance with the Act. The agent must be careful to work within these underwriting requirements so that fair housing practices are not violated.

SETTLEMENT AGREEMENT UNDER THE AMERICANS WITH DISABILITIES ACT
BETWEEN THE UNITED STATES OF AMERICA AND THE SUNSHINE CHILD
CENTER, INC.

BACKGROUND

1. This action was commenced as the result of a complaint filed with the Public Access Section (now the Disability Rights Section) of the Civil Rights Division of the Department of Justice by Brenda Brock ("Ms. Brock"), alleging that the Sunshine Child Center, Inc., of Gillett, Wisconsin, and its director, Ms. Lu Arndt (collectively referred to as "the Center"), had violated title III of the Americans with Disabilities Act of 1990 ("ADA"), 42 U.S.C. §§ 12181-12189, and the Department of Justice's title III implementing regulation ("the regulation"), 28 C.F.R. Pt. 36, by: (1) failing to remove barriers to access at its facilities; (2) refusing to provide its services to the complainant's daughter, Belinda Brock ("Belinda"), in the most integrated setting appropriate to the child's needs; (3) providing or attempting to provide Belinda with services separate from and unequal to services provided to children without disabilities; and (4) failing to modify existing policies, practices, and procedures where necessary to allow Belinda to participate fully in its services.

2. The Department of Justice investigated the complaint pursuant to § 308(b) of the ADA, 42 U.S.C. § 12188(b). The investigation revealed that several barriers to access exist at the Center, including, but not limited to: (1) an absence of any parking spaces designated as accessible to persons with disabilities; (2) entrances that can be accessed only by climbing stairs and which do not have ramps; (3) a second floor wholly inaccessible to persons with mobility impairments, since it can be reached only by climbing stairs and there is no elevator in the facility; and (4) at least three restrooms almost entirely inaccessible to persons with mobility impairments.

3. The Center is located in an existing facility. It has submitted to the Department of Justice evidence of its financial condition which indicates that removal of most of these barriers is not readily achievable.

4. The investigation further revealed that Belinda, who has cerebral palsy, attended the Center for two years. In June, 1993, Ms. Brock removed her from the Center, just before Belinda's fourth birthday, because of the Center's allegedly discriminatory actions.

5. As the result of her disability, Belinda required diaper changing at an older age than most non-disabled children. Additionally, in June, 1993, she was fitted for braces, which she needed in order to walk.

6. The Center has a policy of providing its services to children aged three and younger in one part of its facility, and to children aged four and older in another part. Diaper changing is routinely provided as a service to children aged three and younger.

7. Ms. Brock's complaint states that she removed her daughter from the Center for two reasons. First, Ms. Brock claims that the Center intended to require Belinda, after her

fourth birthday, to remain in the section of its facility reserved for children aged three years old and younger. She claimed that the Center intended to impose this requirement because Belinda required diaper changing, and the only facilities available for that purpose were in the section of the building occupied by the younger children. The Center denies Ms. Brock's allegation. It states that after her fourth birthday Belinda would have had her diapers changed in the portion of the building reserved for the younger children, but at all other times would be offered the Center's services with children of her own age. The Center asserts that it made this decision because the only space available for diaper changing was in the portion of the building reserved for the younger children, and in an attempt to ensure Belinda's privacy.

8. Ms. Brock further states, as her second reason for removing Belinda from the Center, that the Center's director, Lu Arndt, refused to allow Center staff to put on and to remove Belinda's braces when necessary. The Center admits that it was unwilling to provide this service. It claims that its insurance coverage prohibited provision of such a service, and that § 36.306 of the title III regulation, 28 C.F.R. § 36.306, says that such a service is not required by the ADA.

9. During the course of this investigation, the Department also learned that the Center plans to construct a new facility in which to provide its services. Construction is scheduled to be completed by approximately June of 1997.

THE PARTIES

10. The parties to this agreement are the United States of America and the Sunshine Child Center, Inc. ("the Center"), a non-profit corporation incorporated under the laws of the State of Wisconsin.

11. In order to avoid costly litigation, the parties agree as follows:

IN GENERAL

12. Belinda Brock is an individual with a disability within the meaning of 42 U.S.C. § 12102(2)(a) and 28 C.F.R. § 36.104.

13. The Center is a place of public accommodation within the meaning of 42 U.S.C. § 12102(7)(k) and 28 C.F.R. § 36.104 ("definition of public accommodation"), and is located in an existing facility.

14. As a public accommodation, the Center has and, at the time the events which allegedly resulted in Belinda's being removed from the Center, had an obligation to refrain from discrimination on the basis of disability. 42 U.S.C. § 12182(a); 28 C.F.R. § 36.201(a). Discrimination includes the following:

A. A failure of an existing facility to remove architectural barriers to access where it is readily achievable to do so. 42 U.S.C. § 12182(b) (2)(A)(iv); 28 C.F.R. § 36.304(a).

B. A failure to offer persons with disabilities services in the most integrated setting appropriate to their needs. 42 U.S.C. § 12182(b)(1)(B); 28 C.F.R. § 36.203(a).

C. A failure to make reasonable modifications to existing policies, practices, and procedures when necessary to afford services to persons with disabilities, where such modifications would not fundamentally alter the nature of the goods or services being offered at a place of public accommodation. 42 U.S.C. § 12182(b)(ii)(A)(iii); 28 C.F.R. § 36.302(a).

D. Offering persons with disabilities benefits which are not equal to benefits offered to persons without disabilities. 42 U.S.C. § 12182(b)(1)(A)(ii); 28 C.F.R. § 36.202(b).

E. Offering to persons with disabilities benefits which are separate from those offered to persons without disabilities, unless such action is necessary to provide any person with a disability or class of persons with a disability with services. 42 U.S.C. § 12182(b)(1)(A)(iii); 28 C.F.R. § 36.202(c).

OFFER OF RE-ADMISSION TO BELINDA BROCK

15. The Center shall, within ten days of the effective date of this agreement, offer Belinda Brock re-admission to the Center. If the Center's enrollment is limited by State or local licensing requirements, and if the Center's enrollment for children in Belinda Brock's age group is at capacity on the date when re-admission is required under the terms of this agreement, then the Center may offer such re-admission on a "drop-in" basis. Under such circumstances, however, the Center shall place Belinda Brock's name in the first position on its waiting list for regular admission for children in her age group, and shall offer such admission immediately following any child's withdrawal from the Center.

MODIFICATION OF POLICIES, PRACTICES, AND PROCEDURES

16. The Center shall modify its existing policies, practices, and procedures as follows in order to fulfill its obligation under paragraph 15 of this agreement:

A. The Center shall ensure that staff are instructed in the manner of putting on and removing braces which Belinda Brock may be required to wear because of her disability. The Center shall not require that instruction in this task be explained by a physician, but shall permit a parent or other individual familiar with assisting Belinda with this task to instruct staff.

B. The Center shall provide this service to Belinda Brock under the same terms as it presently provides medication to children who attend the Center. The Center shall not require any parent or guardian of Belinda to sign any document other than or in addition to documents which other parents or guardians are required to sign in order to have medication administered to their children, as a condition for Belinda Brock's receiving this service.

17. The Center shall provide diaper changing to children with disabilities who require the service more frequently and/or at a later age than children who do not have disabilities. The Center shall be permitted to provide this service to children who are four years of age and older in that portion of its facility occupied by children younger than four years of age, but only to the extent necessary to ensure privacy. This paragraph does not alter or affect the Center's obligation to provide other services to such children in the same manner as and in the same location within its facility where services are provided for children of comparable age.

18. The Center shall provide the services in paragraphs 16 and 17 of this agreement for all children whose disabilities require them, shall make other reasonable modifications to its policies, practices, and procedures in order to offer the full and equal enjoyment of its goods and services to children with disabilities enrolled in the Center, including Belinda Brock, and shall not exclude applicants for enrollment in the Center who require such reasonable modifications.

POLICY OF NONDISCRIMINATION ON THE BASIS OF DISABILITY

19. Within thirty days of the effective date of this agreement, the Center shall publish the policy of non-discrimination on the basis of disability that appears as Appendix A to this agreement (which it provides to all parents and guardians of children who attend the Center), in any newspaper serving Gillett, Wisconsin, in the newspaper of any other community from which the Center can reasonably anticipate receiving an application to participate in its services, and in any other written material which the Center uses to advertise its services.

REMOVAL OF ARCHITECTURAL BARRIERS

20. The Center shall submit to the Department, within thirty days of the effective date of this agreement, its plans for taking the following barrier removal measures in the first floor restrooms:

A. installing grab bars that comply with §§ 4.26.2 and 4.26.3 of the Standards (or which comply as nearly as possible with the Standards, if the configuration of any restroom will not permit full compliance), at one toilet in each restroom;

B. lowering one mirror, paper towel dispenser, and/or hand dryer in each restroom to comply with §§ 4.2.5, 4.27.2, and 4.19.6 of the Standards;

C. insulating any exposed pipes beneath lavatories or sinks in each restroom to comply with §§ 4.19.4 and 4.24.6 of the Standards; and

D. installing hardware complying with § 4.13.9 of the Standards on each restroom door and hardware complying with §§ 4.27.4 of the Standards on sinks and lavatories in each restroom.

21. The Center shall complete all of the barrier removal measures in paragraphs 20(A) through (D) within thirty days of the Department of Justice's approval of the plans submitted by the Center, or by January 31, 1996, whichever is the later date. Within ten days thereafter, the Center shall provide to the Department proof that such barrier removal has been accomplished.

22. In addition, with respect to the restroom located on the second floor of the Center, the Center agrees to make the modifications listed in paragraphs 20(A) through (D) as soon as practicable; however, such modifications shall be made within no more than sixty days after:

A. receiving a request that modifications be made to the restroom from an employee with a disability who is assigned to work primarily on the second floor; or

B. relocating activities currently carried out on the first floor to the second floor.

23. The requirements of paragraphs 20(A) through (D), 21, and 22(A) and (B) shall not limit or define the Center's obligation to make reasonable accommodations for employees or candidates for employment under title I of the ADA.

PARKING

24. Within ten days of the effective date of this agreement, the Center shall publish to all parents or guardians of children enrolled in the Center a statement requesting that patrons of the Center, other than those with disabilities or those who have children with disabilities, refrain from parking in the on-street parking space that is near the Center's front entrance and adjacent to a curb ramp. This statement shall be published in writing and shall be posted in a conspicuous location near the Center's front entrance.

NEW CONSTRUCTION

25. The Center agrees that within fifteen days of the date on which they are approved by the relevant State and/or local authority, the Center will provide to the Department copies of the plans for the construction of its new facility. If the Department determines that these plans fail to comply in any manner with the ADA Standards for Accessible Design, which apply strictly to new construction, then the Center shall, within thirty days of having received notification of this determination, modify its plans in accordance with all recommendations by the Department.

EFFECTIVE DATE

26. This agreement shall become effective as of the date of the last signature below, and shall terminate upon completion of the Center's new facility. This agreement shall be binding on all of the Center's successors in interest, and the Center has a duty to so notify all such successors in interest.

ENFORCEMENT

27. The Attorney General is authorized, pursuant to section 308(b)(1)(B) of the ADA, 42 U.S.C. § 12188(b)(1)(B), to bring a civil action enforcing the ADA in any situation where a pattern or practice of discrimination is believed to exist or a matter of general public importance is raised. In consideration of the terms of this agreement set forth above, the Attorney General agrees to refrain from taking more formal enforcement action in this matter, as long as the Sunshine Child Center, Inc. complies with this agreement. In the event that the Center fails to comply in a timely fashion with any requirement of this agreement, all terms of this agreement shall become enforceable in federal district court, and the Attorney General is authorized to seek civil penalties, pursuant to 42 U.S.C. § 12188(b)(2)(C). Failure by the Department of Justice to enforce this entire agreement with regard to any deadline herein shall not be construed as a waiver of its right to do so with regard to future deadlines and provisions of this agreement.

28. The Department may review compliance with this agreement at any time. If the Department believes that this agreement or any requirement thereof has been violated, it may institute a civil action for relief in federal district court. If the Department demonstrates in such a civil action that this agreement or any provision of the ADA has been violated, it shall be entitled to recover civil penalties and compensatory damages on behalf of any person(s) aggrieved by the Center's noncompliance.

29. This document is a public agreement. A copy of this agreement or any information contained herein may be made available to any person. The Center or the Department of Justice shall provide a copy of this agreement to any person upon request.

SCOPE OF AGREEMENT

30. This agreement, including the Appendix to it, constitutes the entire agreement between the parties on the matters raised herein, and no other statement, promise or agreement, either written or oral, made by either party or agents of either party, that is not contained in this written agreement shall be enforceable. This agreement is limited to the facts set forth in paragraphs 1 through 9, and it does not purport to remedy any other potential violations of the ADA or any other federal law. This agreement does not affect the Center's continuing responsibility to comply with all aspects of the ADA.

31. A signor of this document in a representative capacity for a partnership, corporation, or other such entity, represents that he or she is authorized to bind such partnership, corporation or other entity to this agreement.

APPENDIX A

Policy of Non-Discrimination

Sunshine Child Center, Inc. does not discriminate in its personnel practices, intake and services on the basis of race, color, national origin, sex, religion or disability (in compliance with Title VI of the Civil Rights Act of 1964, the Americans with Disabilities Act of 1990, and Wisconsin statutes). The Center will provide services to children with

disabilities in the most integrated setting appropriate to their needs, and will make any reasonable modification to its existing policies, practices, and procedures necessary to ensure full participation in its services by persons with disabilities.

Chapter Two Study Questions

1. The Commissioner has the power and authority to make rules and regulations for which of the following purposes?
 - a. Organizing the department and assigning duties to members of its staff.
 - b. Promulgating rules and regulations that are necessary to implement the insurance code.
 - c. Issuing interpretative rulings or prescribing forms in order to carry out the responsibilities of his or her office.
 - d. All of the above

2. Insurers must meet _____ requirements in order to transact insurance business in the state.

3. The two primary methods the Commissioner uses to monitor insurers are:
 - a.
 - b.

4. Domestic insurers are examined at least every _____ years.

5. True or False. Officers, employees and representatives of an insurer must facilitate an examination performed under the Commissioner's authority. _____
6. If contract language is unclear, the courts will generally interpret the language :
- a. against the writer of the contract
 - b. against the non-writer party of the contract
7. In both authorizing and monitoring agents, the state insurance department is interested in the agent's _____ and _____.
8. One of the activities which can result in the revocation or suspension of an agent's license is committing _____ or dishonest practices.
9. In Georgia, the Standards for the Collection, Use and Disclosure of Information allow an insurance applicant or policyholder to obtain the reasons for any " _____ _____ _____."

10. Under the Standards for the Collection, Use and Disclosure of Information, a notice of information practices must be delivered to applicants no later than the time the policy is _____ if personal information is collected only from the applicant or from public records.
11. True or False. An insurance institution must clearly specify questions asked of an individual in connection with an insurance transaction which are designed solely for marketing or research purposes.
12. Define "rebating."
13. Which of the following is an example of unfair discrimination? (More than one answer may apply.)
- Property insurance rates that are based solely upon the age or geographical location without consideration of objective loss experience.
 - Different life insurance rates are charged to two individuals with the same class, same policy amount, same life expectancy and overall risk.
 - Different health insurance rates are charge to two individuals with the same life expectancy and policy amount, but one individual is asthmatic and the other is not.
 - An individual is refused insurance solely on the basis that she is blind.

14. Which of the following are considered Unfair Claims Settlement Practices? (More than one answer may apply.)

- a. Refusing to pay claims without conducting reasonable investigations.
- b. Failing to affirm or deny coverage of claims within a reasonable time after the insured has requested the insurer to do so.
- c. Making claim payments to an insured or beneficiary without indicating the coverage under which the payments are being made, after having been requested to do so by the insured in writing.
- d. Unreasonably delaying the investigation or payment of claims by requiring duplicate information.

15. Under the Americans With Disabilities Act, placing a person with a disability into a different risk classification than a person without disability is:

- a. always considered discriminatory
- b. never discriminatory
- c. is not discriminatory as long as such classification is not done with the intent to evade the purposes of ADA.

16. Under the Ford v. Shering-Plough Corporation case, the Department of Justice appealed the district court ruling, arguing that Title III's coverage extends to discrimination in the _____ and _____ of insurance policies.

17. Generally, if federal and state legislation both apply to the same issue:

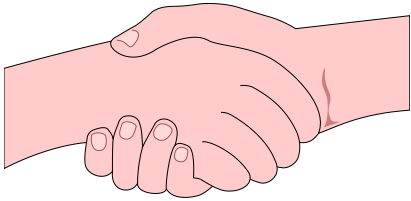
- a. only the federal legislation applies.
- b. only the state legislation applies.
- c. both sets of rules apply, unless there are inconsistencies.

18. Refusing to provide municipal services or property or hazard insurance for dwellings or providing such services or insurance differently because of race, religion, sex, handicap, familial status or national origin is prohibited under:

- a. The Americans With Disabilities Act
- b. The Fair Credit Reporting Act
- c. The Fair Housing Act

19. True or False. Under the Settlement Agreement between the United States of America and the Sunshine Child Center, the Sunshine Child Center was not required to re-admit Belinda Brock because its insurance coverage prohibited provision of services needed because of Belinda's disability. _____

Chapter Three: Ethics of the Agent and the Insurance Company



A significant ethical relationship of the insurance agent is the relationship with the insurance company or companies for whom he or she acts as an agent. The insurer gives the agent authority, power and responsibilities. The agent has the legal and

ethical duty to appropriately wield this authority and power and carry out these responsibilities to meet the insurer's expectations.

Agency

In order to understand the ethical responsibilities of the agent, the rules of agency must be discussed. An agency relationship is one between two or more persons in which one person represents the other. The representative is the agent, and the person represented is the principal. In insurance, an agent may be a general agent, an independent agent, and or a "captive" or "exclusive" agent. A general agent represents the principal in all business of a particular type. An independent agent represents more than one insurance company, and a captive agent represents only one insurer.

Georgia statutes define an agent as:

an individual appointed or employed by an insurer who solicits insurance or procures applications for insurance; who in any way, directly or indirectly, makes or causes to be made any contract of insurance for or on account of an insurer; or who as representative of an insurer receives money for transmission to the insurer for a contract of insurance, anything in the application or contract to the contrary notwithstanding, and who has on file with the Commissioner a certificate of authority from each insurer with whom the agent places insurance. (Code Section 33-23-1(a)(3))

The code, in the same section, goes on to specify what is not included in the definition of an agent:



(b) The definition of agent...shall not be deemed to include:

- (1) Any regular salaried officer or employee of an insurer or of an agent or subagent who performs only clerical or administrative services in connection with any insurance transaction so long as such person is not involved in soliciting insurance or signing or countersigning contracts;*
- (2) An attorney at law admitted to practice in this state, when handling the collections of premiums or advising clients as to insurance as a function incidental to the practice of law or who, from time to time, adjusts losses which are incidental to the practice of his or her profession;*
- (3) Any representative of ocean marine insurers;*
- (4) Any representative of farmers' mutual fire insurance companies as defined in ...this title;*
- (5) A salaried employee of a credit or character reporting firm or agency not engaged in the insurance business who may, however, report to an insurer;*
- (6) A person acting for or as a collection agency; or*
- (7) A person who makes the salary deductions of premiums for employees or, under a group insurance plan, a person who serves the master policyholder of group insurance in administering the details of such insurance for the employees or debtors of the master policyholder or of a firm or corporation by which the person is employed and who does not receive insurance commissions for such service; provide, further, that an administration fee not exceeding 5 percent of the premiums collected paid by the insurer to the administration office shall not be construed to be an insurance commission.*

Agent Authority

An agent is given authority to act for a principal in three ways, through “express authority,” “implied authority,” and “apparent authority.”

Express Authority

Express authority is given by the principal to the agent through a written document. This is typically done through an “Agent’s Agreement,” or “Agent’s Contract.” Such a document details the responsibilities and duties of the agent, the compensation agreed upon, and may include

statements limiting the agent's authority, or defining in what ways the agent may not represent the insurer.

Implied Authority

Implied authority is authority that an agent is believed to have. Rather than being given through written documentation, this authority may be conveyed through previous dealings between the parties. For example, if the agent has been regularly allowed to bind coverage, a court may rule that the agent has this authority even if a written agent agreement does not state that the agent has such authority.

Apparent Authority

Apparent authority exists when an agent acts outside of expressed authority and the principal does nothing to stop the agent. Because the principal does not stop or impede the actions, the principal becomes bound to stand behind them.

Power Given the Agent

The insurer gives the agent several powers to act on the insurers behalf. The agent has the power to *solicit business, disclose product features* during the selling process, *collect premium*, and *perform ongoing customer service* on behalf of the insurer.

Soliciting Insurance

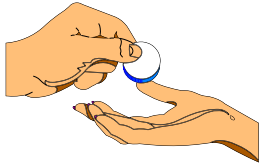
The agent may solicit potential customers through several marketing channels. The agent may use direct mail, telephone solicitation, seminars, and customer or professional referrals to contact customers. Each of these methods of solicitation have ethical and legal requirements related to their use. For example, individuals may request that their names not be part of direct mail or telephone solicitation lists. The agent is both ethically and legally barred from soliciting such individuals through the mail or by telephone. The insurer expects that an agent representing it will solicit responsibly and legally.

Disclosure of Products

The insurer gives the agent the power to disclose product features, benefits, provisions and fees to applicants and policyholders. This represents the central responsibility of the agent on behalf of the insurer. The agent must thoroughly understand the product or products being represented and accurately disclose them. If the agent misrepresents a

product, the insurer may be in put in the position of financial loss in order to remedy the misrepresentation made. If significant misrepresentation occurs, the insurer could suffer regulatory fines and/or suspension or revocation of license.

Premium Collection



Agents may collect premium for the insurer. In some cases, agents collect initial premium only. Other agents may collect additional and renewal premium as well. Collecting premium is an important trust that both the insurer and the customer places in the agent.

Misuse of premiums collected is prohibited in the Georgia Code in Section 33-6-5(6):

Georgia Code



(A) *No person shall knowingly collect any sum as premium or charge for insurance, which insurance is not then provided or not in due course to be provided subject to acceptance of the risk by the insurer by an insurance policy issued by an insurer as permitted by this title.*

(B) *No person shall knowingly collect as premium or charge for insurance any sum in excess of or less than the premium or charge applicable to such insurance, which sum is specified in rates as filed with and approved by the Commissioner. In cases where classifications, premiums, or rates are not required by this title to be filed and approved:*

- (i) *The premiums and charges for insurance, except insurance written in accordance with Chapter 5 of this title, shall not be in excess of or less than those specified in the policy and as fixed by the insurer; and*
- (ii) *The premiums and charges for insurance written in accordance with Chapter 5 of this title shall not be in excess of or less than those specified in the policy.*

Section 33-23-21 also includes regulations regarding premium collection. If an agent performs any of the following actions, his or her license may be suspended or revoked:

(4) Has misappropriated, converted to his or her own use, or illegally withheld money belonging to an insurer, insured, agent, agency, applicant or a beneficiary;...

(13) Has failed or refused, upon written demand, to pay over to any insurer, agent, agency, applicant, beneficiary, or insured any moneys which belong to such insurer, agent, agency, applicant, beneficiary, or insured.

The agent must follow both state regulations and the insurer's requirements in collecting and remitting premium.

Performing Customer Service

Another important power the insurer gives the agent is to perform customer service duties on behalf of the insurer. Customer service can include administrative duties such as answering policyholder questions, forwarding written change of address requests, supplying appropriate forms and providing phone numbers to the insured. It can also include inspecting property, putting a risk management program into place, or adjusting a claim. The insurer trusts the agent to perform these duties as company policy directs and within the professional, ethical and legal requirements of the position.

Agent Responsibilities

Disclosure of products, premium collection and performance of customer service each include several specific responsibilities the agent must perform on behalf of the insurer.

Accurate Disclosure

Accurate disclosure of products involves a thorough understanding of each of the contract's provisions and the terms used and defined in the contract. The agent must also understand how the contract provisions are applied to specific situations. An agent must be as familiar with the policy's disadvantages as with its benefits, and must know how the policy provisions apply in specific circumstances. The agent must know the policy's benefit limitations, what documentation the insured must keep as evidence of loss, what the insured's duties are at time of loss, what activities would cause the insured to no longer be covered by a policy provision, and so on.

The contract terms and provisions must be explained with complete honesty and full disclosure. If the product is the right product for the customer, the agent will be able to demonstrate its suitability by being truthful. An understanding of alternatives available to the customer and an honest comparison of the alternatives to the policy can help the customer select the product that is best for that customer. Sometimes, the agent may have to turn away business because what he or she has to offer is not the best choice. The customer will remember the honesty of that agent, and may come back to that agent, or refer others to that agent because of the care for his or her customers the agent demonstrates.

Field Underwriter

The agent acts as a field underwriter for the insurer. As a field underwriter, the agent attempts to meet the objective of writing profitable business for the insurer, while screening out unacceptable risks and obtaining a complete picture of the risk for final approval through the home office.

Finding Profitable Business



Most insurers are for-profit entities, although some insurers, such as fraternal benefit societies, are not for-profit entities and so do not include a profit margin in business written. When for-profit insurers develop rates and underwriting standards, a reasonable profit margin is included. The insurer requires its agents to follow the rate and underwriting standards it has developed in order for the insurer to make that reasonable profit margin. If business which has a risk level which exceeds the insurer's standards is written, the claim frequency and or amount will be higher than the insurer's expectations, and the insurer's profit margin will be eroded. If an insurer's claim frequency or amount exceeds expectations by too great a margin, the insurer may risk insolvency. It is critical for an insurer for an agent to adhere to the underwriting standards the insurer has established.

The agent must screen out unacceptable risks for the insurer. The primary way the agent does so is through the collecting of complete information about the risk. The insurer expects the agent to faithfully record all

relevant information and find out as much information as due diligence requires. Depending on the type of insurance, the agent may need to ensure the insurance application is correctly and completely filled out, do onsite inspections, take photographic records of a risk, complete detailed forms, order paramedic exams, or perform other duties necessary to gather all necessary information.

While the insurer wants to turn away all unacceptable risks, it wants to retain acceptable risks. At times, the agent will need to submit additional documentation to an insurer so that a risk that might appear at first to be unacceptable is shown to be acceptable. For example, a business may have a poor loss record, but may have implemented new loss control procedures or installed new safety equipment. The insurer expects the agent to take the time to document the current situation accurately so that the now acceptable risk can be underwritten.

Risk Management

The agent also may be called upon to act as a risk manager for the insurer. Risk managers use four methods to deal with risk: avoiding risk, controlling risk, retaining risk, and transferring risk.

Avoiding Risk. One of the methods of managing risk is to avoid it all together. In a business, this may mean eliminating a particular product line or operation. In a home, it may mean tearing down an unsafe structure. For an individual, it may mean eliminating cigarette smoking, or removing certain foods from a diet.

Controlling Risk. Controlling risk can be the least expensive method of handling risk. In a business, risk may be controlled by implementing safety rules. In a home, smoke alarms may be installed so that a fire may be responded to quickly. Exercise can be used to control certain health risks.

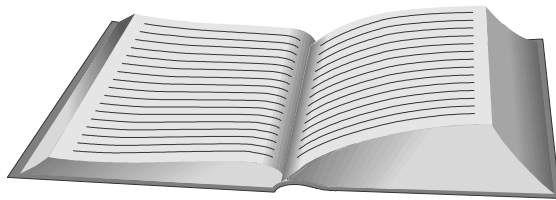
Transferring Risk. Transferring risk means that the consequences of the risk are borne by another party. Insurance is the most common method used to transfer risk. The insured pays a premium based on the amount of risk transferred to the insurer, and the insurer reimburses the insured for the financial loss caused by or to a covered risk.

Retaining Risk. Risks which are infrequent or relatively inconsequential may be retained by businesses, homeowners and other individuals. Sometimes, risks which could be catastrophic are retained, because the likelihood of the risk occurring is very minimal, and insuring the risk would be too expensive.

It is the agent's job to analyze a risk to assist the customer in determining which risk response is best for that customer. The agent follows four steps in risk management: risk identification, risk evaluation, risk response, and risk implementation.

Risk Identification. The risk identification process varies based on the type of risk involved. In commercial property and casualty insurance, the risk must be inspected, business processes reviewed, and primary and secondary risks identified. For example, a primary risk may be the risk of fire. A secondary risk would be the loss of income to the business while it was closed for repairs due to a fire. Insurers generally have detailed forms and checklists to help the agent identify all the risks involved.

Risk identification for life and health insurance can involve reviewing the health history of the individual and his or her relatives. Lifestyle risks are also reviewed, such as alcohol and cigarette consumption, medications taken, occupation, hobbies, and so on. The insurance application is used to identify most of these risks, paramedic or full medical examinations provide additional information, and medical information bureau reports may also be used.



Risk Evaluation. Risks are evaluated on the basis of frequency and severity. Frequency of a risk is how often the loss may occur. Insurers commonly have detailed statistics available on various risk frequencies. Severity of a risk is measured by the amount of financial loss the risk can cause. Statistics can be used, along with the details or profile of a specific risk. The frequency and severity of a risk can help determine whether the best response is to avoid, control, transfer or retain the risk.

Risk Response. As mentioned, risk is responded to in four ways. The agent can help an individual or business make a decision regarding which response is the best.

Today, insurers place a lot of focus on controlling risk. Insurers are responsible for a great deal of health and exercise information disseminated to the public. Safety procedures at the workplace are often devised by insurers or the examiners they hire. Insurers, along with fire fighting organizations, are responsible for the emphasis on smoke alarms in the home. Historically, insurers have been responsible for establishing construction and fire safety codes. Controlling risk not only keeps the insurer from paying out claims on excessive losses, but benefits the individual insured and in some cases, society as a whole since the risk and its negative consequences are less likely to occur.

Risk Response Implementation. Once the appropriate risk response is identified, it must be implemented. The agent can help the customer implement the response to transfer risk by carefully completing the sales process and having the policy issued. In some cases, the agent will visit the risk site regularly to ensure required risk response elements are in place, such as certain safety equipment. By keeping in contact with a policyholder, the agent can review the policyholder's situation and make sure the risk management process in place is the best one on an ongoing basis, and if not, can make suggestions to alter the risk management process for the good of the customer.

Taking The Application

Once the agent has identified the risks, disclosed product features, and the customer has decided to apply for coverage, the agent has the responsibility of taking the application. As has been discussed, the agent must take complete information and do his or her best to make sure no misrepresentations or material omissions are made on the application. The insurer expects the agent to alert it of any item that may need more investigation. The agent represents the insurer, and has an ethical responsibility to inform the insurer of any item which is pertinent to the risk being written. The insurer's best interests must be upheld while the agent is performing duties on behalf of the insurer, including taking the application.

Besides the information on the application, the insurer may require information from an inspection report, consumer or credit report, or medical information bureau report. The last chapter detailed Georgia's legislation regarding information gleaned from such reports and the applicant's and policyholder's rights along with the insurer's and agent's responsibilities to disclose these rights. The agent will need to explain to the applicant the purpose of these reports, and give the appropriate notices and disclosures.

Inspection Reports. An inspection report is also known as an "investigative report" and is referred to as an "investigative consumer report" in Georgia legislation. The purpose of such a report is to give information regarding an individual's lifestyle and character, and is used most commonly for policies issued for large amounts. Georgia Code Section 33-39-3(13) defines this report as meaning:

a consumer report or portion thereof in which information about a natural person's character, general reputation, personal characteristics, or mode of living is obtained through personal interviews with the person's neighbors, friends, associates, acquaintances, or others who may have knowledge concerning such items of information.

An inspection report helps the insurer get a complete picture of a risk to be insured. Neighbors, friends or the individual's employer could be contacted in order for an inspection report to be completed.

Consumer or Credit Reports. If the insurer needs to verify the credit of an applicant or policyholder, a consumer or credit report may be obtained. An insurer may need to know a person's credit history to ensure premiums will be paid, or to assess the moral hazard risk of an applicant. A moral hazard is one that occurs when an insured has an immoral purpose to collect on an insurance policy. An individual with poor credit may be considered to be a moral hazard to an insurer, and as such, may be denied coverage. Georgia Code 33-39-3(6) defines a consumer report to mean:

any written, oral, or other communication of information bearing on a natural person's credit worthiness, credit standing, credit capacity, character, general reputation, personal characteristics, or mode of living which is used or expected to be used in connection with an insurance transaction.

Medical Reports. Medical reports are used to verify medical information disclosed on insurance applications. A primary source of medical reports is the Medical Information Bureau, or MIB. Medical information may also be verified through the applicant's physician, or through the requirement of a paramedic or full medical examination.

Georgia rules require that information relating to a medical condition must be reported directly to an individual or a medical professional designated by the individual. If an adverse underwriting decision results from medical information, the specific terms of medical-record information must be disclosed either to the individual or to a medical professional designated by the individual. (*Code Section 33-39-9, 11*)

Responsibility for Insuring Documents

The insurer also expects the agent to take care of the documents provided by the insurer. For example, some insurers allow "field issue" of policies: the agent completes the application and attaches it to a contract, effectively issuing the policy. Each contract is typically kept secure via a computerized issue system or through an inventory control procedure. The insurer requires that the agent take care in handling these contracts to eliminate the chances of a fraudulent policy being issued.

In addition, the agent is prohibited by insurers and the Georgia Code from signing blank policies:

Georgia Code



Code Section 33-23-30

An agent shall not sign or countersign in blank any policy to be issued outside of such agent's office nor countersign in blank any endorsement of any policy to be issued outside of such agent's office. An agent shall not give power of attorney to or otherwise authorize anyone to sign or countersign the agent's name to policies unless the person so authorized is directly employed by the agent and no other person, and the person has no office files, equipment, or address in regard to the insurance business other than those in the office of the agent. Nothing in this Code section shall prohibit an agent from authorizing an insurer represented by such agent to reproduce

mechanically or electronically such agent's signature on policies, certificates, endorsements, riders, or other insurance contract documents.

Timeliness

The insurer expects the agent to respond to customer requests, submit applications and accompanying documents, remit premium, and complete service duties in a timely manner. In some cases, regulation requires that certain transactions, such as claims processing, be completed within a specified time. The agent's job also includes turning paperwork over to the insurer as rapidly as accuracy and thoroughness allow.

Organization

An underlying necessity to enable an agent to meet the many responsibilities of his or her duties is organization. In order to fulfill the ethical and legal responsibilities of the profession, the agent keeps track of many pieces of policyholder information and documents, responds promptly to client and company requests, and manages prospecting and applicant data. Each agent must maintain a system of organization to control all this information.

Handling Premium

As mentioned, one of the powers given the agent is the collection of premium on behalf of the insurer. The agent has responsibilities to the insurer and the customer to report the actual premium received and turn it over to the insurer. Violating this responsibility can result in a misdemeanor or felony conviction:

Georgia Code



Code Section 33-23-35

- (a) An agent, subagent, or any other representative of an insurer or of any other person in the effectuation of an insurance contract shall report to the insurer or its agent the premium for the contract and the amount shall be shown in the contract. Each willful violation of this subsection shall constitute a misdemeanor.*
- (b) All funds representing premiums received or return premiums due the insured by any agent or subagent shall be accounted for in the licensee's fiduciary capacity, shall not be commingled with the licensee's personal funds, and shall be promptly accounted for and paid to the insurer, insured, or agent as entitled to such funds. Nothing contained in this*

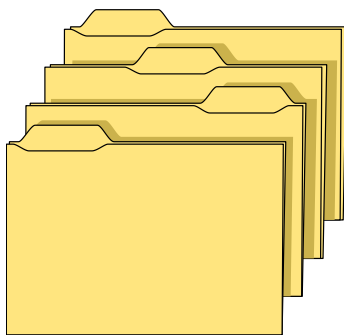
Code section shall be deemed to require any agent or subagent to maintain a separate bank deposit for the funds of each principal, if the funds so held for such principal are reasonably ascertainable from the books of accounts and records of the agent or subagent.

- (c) *Any violation of this Code section shall constitute grounds or cause for action by the Commissioner, including, but not limited to, probation, suspension, or revocation of the license. Each and every act by a licensee shall also constitute grounds for fines and penalties, which amounts shall be set by rule or regulation of the Commissioner. Any willful violation of this Code section shall constitute a misdemeanor unless such amounts involved exceed \$500.00, whereby such violation shall constitute a felony.*

The agent holds a position of trust in the role of fiduciary of another's money. If an incorrect premium amount is reported, the policyholder may be issued a policy without the coverage he or she needs. If premium is held by the agent, and not turned over to the insurer in a timely manner, there is a risk that the policyholder will not be covered as early as the policyholder is entitled.

If such action is "willful," not an error or oversight, a serious violation of fiduciary trust occurs. Dishonesty is not tolerated by the insurance regulators nor by the profession.

Maintaining Required Records



Agents are required to keep certain records by state statute. In Georgia, such records may be kept at the address shown on the agent's license, at the insurer's regional or home office situated in Georgia, or the insurance agency in which the agent is employed and which is licensed in Georgia. The required records must be "in an organized form" and must

include each insurance contract "procured, issued, or countersigned," and:

- the name of the insurers and the insureds;
- the amount of premium paid or to be paid;
- a statement of the subject of insurance;

- the names of any other licensees from whom business is accepted; and
- the names of persons to whom commissions or allowance of any kind are promised or paid.

Records must be kept for five years, beginning immediately after the completion of the transaction or the term of the contract, whichever is **greater**.

5. The primary way the agent screens out unacceptable risks for an agent is through collecting _____ about the risk.

6. List the four methods used by risk managers to handle risk:

7. _____ risk is a risk response which can include implementation of safety procedures at the workplace.

8. "A consumer report in which information about a person's character, general reputation, personal characteristics, or mode of living is obtained through personal interviews with the person's neighbors, friends, associates, acquaintances, or others who may have knowledge concerning such items" is a (an) _____.

9. "Any written, oral, or other communication of information bearing on a natural person's credit worthiness, credit standing, credit capacity, character, general reputation, personal characteristics, or mode of living which is used or expected to be used in connection with an insurance transaction" is a (an) _____.

10. When medical information is obtained on an applicant or policyholder, Georgia rules require that information relating to a medical condition:

- a. must not be disclosed under any circumstance.
- b. must only be disclosed if the condition is “serious,” as defined in the Georgia Code.
- c. must be reported directly to an individual or a medical professional designated by the individual.
- d. none of the above

11. True or False. It is permissible in Georgia for an agent to sign blank applications and mail them to applicants to complete and mail into the insurer during the period the agent takes an annual vacation.

12. Required records may be kept at any of the following places, except:

- a. at the address shown on the agent’s license
- b. at the insurer’s regional or home office outside of Georgia
- c. at the insurer’s regional or home office in Georgia
- d. at the insurance agency in which the agent is employed and which is licensed in Georgia

Glossary

Accident Insurance

Insurance which protects against financial loss due to bodily harm.

Aleatory Contract

A contract which contains promises based on an uncertain event.

Alien Insurer

An insurer which is formed in another country and does business in the state.

Application

An insurance form which is completed using information from the prospective insured pertaining to the risk to be insured.

Captive Agent

Also known as an exclusive agent. An agent under a contract with an insurer or affiliated insurers and which contract limits the agent to represent that insurer or insurers.

Casualty Insurance

Lines of insurance that protect against financial loss due to legal liability and also include lines such as auto, crime, Workers Compensation, and surety.

Churning

Sales practice which involves selling a policy to replace another policy from the same insurance company for the purpose of generating a new commission for the agent.

Coinsurance

A provision found in property insurance which requires that the property be insured for an amount equal to a specified percentage of the property value at the time of loss, or the insured will have to pay for part of the loss incurred.

Contract of Adhesion

A contract wherein one party adheres to the terms another party dictates.

Domestic Insurer

An insurer which is formed in the state and which does business in the state.

Ethics

A body of moral principals.

Exclusive Agent

See Captive Agent

Fraternal Benefit Society

An insurer incorporated without capital stock, which exists solely for the benefit of its own members, and which operates on the lodge system.

Foreign Insurer

An insurer which is formed in another state and does business in the state.

Free-Look Period

The period of time from the date a contract is issued the policyholder has to review the contract and cancel the coverage without paying a surrender fee or suffering any reduction of premium.

Health Insurance

Insurance which protects against financial loss due to sickness or bodily injury. Also known as "Accident and Health," or "Accident and Sickness."

Insurance Services Office

A nonprofit insurance organization serving the property-casualty industry through gathering statistics, creating policy forms, developing standardized contract language and contracts, providing loss costs and conducting rate inspections.

Life Insurance

Insurance which protects against the risk of financial loss due to death.

Lloyd's Association

Named after an insurance association formed in London, an association of individuals or groups of individuals who volunteer to underwrite insurance contracts. Each individual or group is liable for the losses insured by the contracts underwritten.

Misrepresentation

Written or oral statements made by the insured, the insurer, or a representative of the insurer, which misstates information regarding the risk, terms, coverages, benefits, returns, or other material fact related to the contract.

Mutual Insurer

An insurer which is formed without capital stock, and is not owned by stockholders but by its policyholders. The policyholders share in the profits of the company through premium reduction or dividends.

National Association of Insurance Commissioners

Organization comprised of state insurance commissioners which drafts model insurance regulation and collects and reports statistics and other information on the insurance industry.

Premium

The amount paid to keep an insurance policy in force.

Property Insurer

Insurance which protects against financial loss due to property damage.

Rescission

The cancellation of an insurance contract.

State Guaranty Association

An association governed by individual state regulations, wherein member insurers are responsible for contractual obligations to policyholders if another member is unable to meet them.

Stock Insurer

An insurer formed by the issuance of capital stock. The insurer is owned by the stockholders.

Tax-Free 1035 Exchange

Internal Revenue Code regulations which allow the tax-free exchange of life insurance policies under specified conditions.

Twisting

Sales practice which involves selling a policy to replace another policy issued by a different insurer for the purpose of generating a new commission for the agent.

Variable Life Insurance

Insurance which bases cash values on the performance of sub-accounts selected by the policyowner.

Answers to Study Questions

Chapter One

1. a
2. standardized
3. b
4. d
5. financial instability, false advertising, obligations
6. a. x, c. x, d. x (all except b.)
7. any four of the following: ethical solicitation and sales, competence, appropriate sales, confidentiality, good customer service
8. fair trade
9. a. x, c. x (all except b.)
10. additional purchases, referrals

Chapter Two

1. d
2. financial
3. a. insurer reports,
b. examination
4. three
5. true
6. a
7. competency, character, professional practices
8. fraudulent
9. adverse underwriting decision
10. delivered
11. true
12. Rebating is the practice of inducing the purchase of an insurance contract by giving any part of an agent's commission or other item of value.
13. a, b and d are examples of unfair discrimination
14. a, b, c and d are all Unfair Claims Settlement practices
15. c
16. terms, conditions
17. c
18. c
19. false

Chapter Three

1. express, implied and apparent authority
2. a, c and d
3. false
4. a, b, and c are all field underwriting responsibilities
5. complete information
6. a. avoiding risk.
b. controlling risk
c. transferring risk
d. retaining risk
7. controlling
8. investigative report
9. consumer (or credit) report
10. c
11. false
12. b

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