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12-Hour Course

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Section CE 1

INTRODUCTION

Objectives

Welcome to your courseware for **Code and Ethics.** This first unit will give you a **historical background** of the regulation of insurance, dating back to the 1850's.

This unit includes:

- Historical Background
- Federal versus State Regulation
- Ethics and History

1. Historical Background

The following timeline illustrates and explains important court decisions and events in the history of **Insurance Regulation** in the United States. You will come across many of these events again in your study of insurance and further down the road when you are a licensed agent.

A. Early 19th Century

There were no specific laws or regulations in place other than the individual state laws that governed corporations and private businesses. There were no state insurance laws on the books and no federal regulation of the industry. Resulting improprieties and abuses lead to a demand among the industry for regulation.

B. 1850

New Hampshire is the first state to establish a state **Insurance Commissioner**—still a very important office now. The states of Massachusetts, California, Connecticut, Indiana, Missouri, New York and Vermont soon appoint state Insurance Commissioners.

C. 1868

A Supreme Court decision in the case of **Paul vs. Virginia** rules that insurance is not interstate commerce. This establishes that states actually have the right to regulate insurance and not the federal government.

D. 1871

The **National Association of Insurance Commissioners** is formed. The **NAIC** seeks some uniformity with regards to state insurance regulation and reporting requirements. The organization also develops regulations concerning the solvency of insurance companies and methods for the exchanging of information between states.

E. 1905

In New York, the **Armstrong Investigation** of insurance is conducted to improve regulation and lessen abuses.

F. 1910

Again in New York, the **Merritt Committee Investigation** of fire insurers leads to greatly improved state regulation and a new state insurance code.

G. 1939

The state of New York adopts a rule that states all insurance companies doing business in New York *must* comply with the insurance laws of New York with regards to any state they do business in.

H. 1944

Another very important Supreme Court decision concerning ***Paul* vs. Virginia.** The **South-Eastern Underwriters Case** causes the U.S. Supreme Court to overturn **Paul vs. Virginia**, and rules that insurance was indeed interstate commerce when conducted over state lines and that federal anti-trust laws applied to the industry. The effect of this ruling left the industry virtually unregulated.

I. 1945

The **McCarran-Ferguson Act (Public Law 15)** is passed by Congress due to strong opposition against federal regulation of insurance. **This law gave back to individual states the right to regulate and tax insurance to the extent that it is not regulated by the federal government.** This is a landmark moment in the history of insurance regulation, and the **McCarran-Ferguson Act** is still an important law today.

2. Federal versus State Regulation

Current federal influence of the industry includes regulation by the Security and Exchange Commission (SEC) and the National Association of Securities Dealers (NASD) for securities regulation of certain insurance products; and the Internal Revenue Service (IRS)

for tax code provisions regarding products and companies. Pension legislation with regulations from the Labor department such as ERISA, protects plan participants and their beneficiaries. Health insurance legislation, such as the standardization of Medicare supplement policies, as well as long term care insurance, are areas of overlapping regulation by states and the federal government. The sale of insurance products in the banking industry will involve their regulatory organizations, The Federal Reserve and the Office of the Comptroller of the Currency.

Like any other industry, there is debate concerning the influences of federal versus state regulation.

Proponents of **Federal** regulation argue that:

- State regulation is not uniform which, leads to inefficiencies and other tangles. Despite improvement led by the NAIC's model legislation, this situation is unlikely to change.
- State regulation is ineffective in controlling insurance companies that operate on a nationwide basis.
- Federal regulation would be more effective as well as cheaper.

Proponents of continued **State** regulation argue that:

- State regulation is satisfactory, more flexible and capable of meeting individual state insurance needs. There is no real proof that federal regulation would improve conditions or be more efficient.
- The voluntary cooperation of state insurance departments has already made great strides in achieving uniform provisions.

- If federal regulation were imposed, it would lead to two regulatory systems instead of one cohesive system.

The future is likely to see more federal influence of the industry, however it is unlikely to become the sole regulator in all matters relating to insurance.

In state legislatures, and in Congress in recent years, there has been proposed legislation and passed legislation regarding current Life and Health insurance issues including; a tax on the cash value build-up in a life policy, certain mandated benefits such as Family or Maternity leave, privacy and authorization with HIPAA.

3. Ethics and History

The overall purpose of regulation is to **protect the public good** and the insurance consumer.

The state insurance department seeks to provide protection by regulation regarding three primary areas:

1) Company authorization and financial stability or solvency
2) Agent licensing and education
3) Sales practices

These regulations set minimum standards and form the basis of **ethical guidelines** by making certain actions unlawful. There remains a difference however between law and ethics. Witness the business scandals such as **Enron** and **World Com**, breaches in ethical behavior in the securities industry in spite of penalties that

include prison as well as fines or civil penalties. An action may be lawful, but unethical.

Today, higher legal standards for the benefit of consumer protection will likely find an agent or company liable for their actions. Public perception of the industry has been affected by scandal, insolvency, class action lawsuits, and their own personal experiences.

How then, do insurance agents live up to higher expectations and responsibilities? To tell someone “Do the right thing”, may be too simplistic. A personal ethical or moral code is required to answer the question of what one should do in a given situation.

Ethical or moral codes have long existed, a universal norm being “The Golden Rule”, a version of it expressed by most religions including Christianity, Judaism, Islam, Hinduism, Buddhism, and Confucianism.

Ethics is the basis for trust, promises, and reliability in our business. Accepting ethics at the philosophical level is one thing, living the practicality of it in business daily is another. The evolution from insurance agent to insurance professional, and the responsibility of that role may help.

There are **7** requirements for recognition as a professional:

1) Specialized knowledge not understood by a lay person
2) Academic study of the subject
3) Licensing examination is required
4) Professional organization or society

5) Independence in their recommendations
6) Public recognition as professionals
7) A code of conduct (ethics)

Professional organizations include the National Association of Insurance and Financial Advisors (NAIFA), Society of Financial Service Professionals, the Million Dollar Round Table (MDRT), the American College, sponsor of the professional designations; Chartered Life Underwriter (CLU), Chartered Financial Consultant (ChFC) and Life Underwriting Training Council Fellow (LUTCF). Other designations in the industry are the Charted Property Casualty Underwriter (CPCU), and Certified Financial Planner (CFP).

All of these organizations have a code of conduct, code of ethics, or pledge, that have as it's common theme, a recognition of obligations and responsibilities to those they serve:

- The best interests of the client come first
- Obey the law
- Loyalty to the company
- Professional conduct, truthfulness, confidentiality
- Duties to other professions, family, and self

Many of the regulations in our industry have to do with sales practices. Suitability, disclosure, sales illustrations, and replacement, the particulars of which you will learn later in units that follow, are the issues that concern regulators, companies, and ourselves as professionals.

The solicitation, selling, and servicing of insurance properly, may be accomplished by following some basic principles:

- Identify yourself as you are without misleading titles
- Use illustrations and sales materials properly
- Provide options or choices in recommendations
- Record all information requested on the application
- Protect client confidentiality
- Deliver the policy and explain things to your client
- Service with a regular review

Even so, the best professionals realize that mistakes are made, clients fail to remember what was once explained, and complaints occur.

Professional liability or malpractice insurance is a must today, and the professional agent carries **Errors and Omissions (E&O) coverage** for even a baseless lawsuit. If you are sued and the other party wins, E&O coverage will pay the loss, subject to policy limits and a deductible, in addition to defense costs.

Agent Errors & Omissions Insurance

Like many professionals, insurance agents should carry E&O insurance. This is valuable protection for both you and your clients.

There is no standard errors and omissions policy. Most policies are written on a ***claims-made basis*** rather than on an ***occurrence basis***. Claims made means the insurer is ONLY responsible for claims filed while the policy was in force. So, if a claim is made against you after you retire and cancel your E&O policy, it will not be covered.

A typical E&O policy will cover your cost of defense and monetary and perhaps punitive awards you must pay to an offended party. Limitations in coverage can occur due to ***limits*** of the policy, gaps,

caps and deductibles. In addition, there are many other important coverage ***exclusions*** an agent must consider, such as: insurer insolvency, receivership, bankruptcy, liquidation or financial inability to pay; acts by the agent that are dishonest, fraudulent, criminal, malicious or committed while knowing the conduct was wrong; promises or guarantees as to interest rates or fluctuations of interest rates in policies sold, the market value of any insurance or financial product or future premium payments, etc.

An agent's exposure may be in one or more of several areas:

- Alleged misrepresentation of policy terms and coverages
- Misuse of policy illustrations
- Improper licensing for product
- Misunderstanding of tax ramifications
- Downside risk that is not explained
- Premiums or premium offset arrangements
- Incorrect information on an application
- Failure to provide proper coverage
- Inappropriate or unsuitable product recommendations

Agents can protect themselves with documentation of client files with copies of; checklists, questionnaires, factfinds, agendas, notes, illustrations, disclosures, and phone logs. Maintaining client contact is important in the relationship also, and many agents use birthday or greeting cards, client newsletters, and periodic reviews to stay in touch.

Section CE 2

THE COMMISSIONER

& INSURERS

Objectives

In this unit we will discuss the office of **Commissioner of the California Department of Insurance (DOI)**. Another section of the Unit will describe the different types and classifications of Insurance Companies.

1. General Duties and Powers

The **Commissioner of the California Department of Insurance (DOI)** is the elected official responsible for administering and enforcing the laws of the California Insurance Code, and the California Code of Regulations.

Currently, the Commissioner has a **14** member executive team that includes a Chief Deputy Commissioner, General Counsel, Chief Deputy of Operations, and Deputy Commissioners for Enforcement, Financial Surveillance, Rate Regulation, Consumer Services and Market Conduct, Legislative, Community Relations, Communications and Press Relations, as well as several assistants. Together they oversee 1350 employees, a $200 million budget, and nine bureaus made up of Auto Enforcement, Sacrament Enforcement, San

Francisco Enforcement, Corporate Affairs I and II, Policy Approval, Rate Enforcement, Fraud Liaison, and Government Law.

Note: In some states this office is referred to as the **Director** or the **Superintendent of Insurance**.

The **Commissioner** is responsible for enforcing the California Insurance Code, which are laws passed by the state legislature and the California Code of Regulations (official compilation of regulations adopted, amended or repealed by all state agencies) and also the administrative law written by the **Commissioner** and staff to further interpret, explain, and enforce Code.

"Shall and May" and "Persons" and Notice by Mail
Throughout the California Insurance Code the word "shall" means its ***mandatory*** while "may" means its ***permissive***. The word "persons" means any person, association, organization or corporation. Any notice required to be given any person by any provision of the insurance code shall be sufficiently delivered if such ***notice is by mail*** to the person's residence or principal place of business.

It is important to note that the **Commissioner** may *not* make changes to the Insurance code or California Code of Regulations. Only the state legislature may make those changes. However, the **Commissioner** *may* review the Insurance Code and issue recommendations for changes.

A. Issuing Orders

The Commissioner can issue orders, which are oral or written actions given to an insurance company, any representative of an insurance company, or anyone outside the DOI. An official order must include its intent, its effective date, the information the

order is based on, and the specific Insurance Code provision that directly relates to the order.

A **Cease and Desist Order** is a written order from the Commissioner that tells someone they need to stop what they're doing. If the Commissioner determines that a Producer is doing something illegal or dishonest, the Cease and Desist Order means "knock it off or else…"

The Commissioner can issue a Cease and Desist Order to an authorized individual who is:

- Transacting insurance without the proper authorization
- Involved in dishonest or unfair acts
- In a hazardous condition
- In a hazardous financial condition
- Dangerous to the safety of the general public

Note: "Hazardous condition" is a legal term meaning the insurer/company is doing something construed as shifty. This could be filing a falsified financial report, not filing a financial report when its due, or claiming it has more/less money than it really does.

A **Cease and Desist Order** has to contain:

- The name and last known address of the person/organization
- A statement regarding the violations, and which parts of the code or which regulations were specifically violated
- The danger the violations could pose to the public
- The proposed penalty

- A command for the person/organization to immediately stop violating the code

B. Hearings

The Commissioner has the power to hold hearings. These hearings must be held upon written demand to the Commissioner. The written demand must include the reason for the Hearing. During the hearing, the Commissioner may:

- Deliver oaths and affirmations, subpoena witnesses and examine under oath any person who may be able to offer information towards the investigation
- Require the individual being investigated to produce any relevant evidence

The Commissioner may appoint examiners, administrators or deputies in order to collect evidence or conduct hearings. The Commissioner is responsible for the actions of these appointees and may revoke these appointments at any time. The Commissioner may act under the Insurance Code in a quasi-judicial capacity, in that the Commissioner may apply to any judge of any county circuit court for court-ordered contempt orders.

C. Issuing Penalties

The Commissioner can issue **3** different types of penalties towards those in the insurance industry:

1) Civil Penalties
2) Criminal Penalties
3) Disciplinary actions towards applicants or licensed agents

Here's a closer look at those **3** types of penalties:

Civil Penalties can be imposed on any insurance company that violates any provision of the Insurance Code. These penalties could be as high as:

- **$1,000** per violation for individuals
- **$10,000** per violation for companies

A Civil Penalty must be paid within **10** days after the order becomes final.

The Commissioner will impose **criminal penalties** if a violation of the Insurance Code leads to a criminal conviction for an individual. These penalties could be as high as:

- Up to **1** year in county jail, or a maximum fine of **$1,000** for individuals
- A maximum fine of **$10,000** for companies

Disciplinary actions towards applicants or licensed agents are actions the Commissioner may take against any licensed individuals or applicants for license. The Commissioner may revoke, suspend or refuse to renew a license for any business or classification of insurance. Also, the Commissioner may refuse to issue a license or grant authority for license to transact or engage in any business or class of insurance.

The following is a list of violations the Commissioner may penalize for:

- Incompetence or untrustworthiness of an agent

- Any dishonest or deliberately false act in relation to the insurance application or examination
- Violation or noncompliance with the Insurance Code
- Misappropriation, embezzlement or any illegal withholding of customer monies
- Conviction of any felony or imprisonment
- Material misrepresentation of policy terms
- Fraudulent or dishonest practices in transacting insurance business
- Failure to pay a civil penalty, fee, or charge assessed by the Commissioner
- Improper or illegal use of an insurance license
- Cancellation, revocation, suspension or refusal to renew the license by any other state or government agency
- Failure to comply with Continuing Education requirements
- Evidence of dishonesty, fraud, or misrepresentation of an agent even if such activity is not related to the insurance business

D. Financial Statements and Investments

All California insurers are required to submit a financial report to the Commissioner by December 31st **and due by June 30th**. This annual report includes information on the company's/insurer's:

- Capital
- Stock
- Assets
- Liabilities
- Income

- Expenditures
- Balance sheet
- All insurance and premiums written in California.

Note: Audits determine the insurance company's financial condition, nature of operation, ability to fulfill insurance obligations and the presence of any Insurance Code violations. The insurance company under examination pays for any costs associated with these audits. The report becomes a public record.

Conservation: If an insurance company refuses to submit its books, refuses to observe an order of the commissioner, transfers assets without consent and/or represents a hazard to its policyholders, the Commissioner has the ability, through a process called ***conservation***, to take possession of the company, and as conservator, run its business or dispose of its assets. It is a misdemeanor to refuse to deliver any books, records, or assets to the Commissioner.

Insolvent Insurer

The definition of an insolvent insurer is either:

- Any impairment of minimum "paid-in capital" for the class of insurance being transacted.
- An inability ot meet financial obligations when they are due.

An insurer cannot escape insolvency by simply being able to provide for its liabilities. It must also have sufficient "***paid-in capital***" (value of its assets in excess of losses, expenses taxes and debt) to meet code requirements at the time.

2. National Association of Insurance Commissioners (NAIC)

The **NAIC** is an organization formed by the **Insurance Commissioners** from all **50** states, Washington, D.C., and Puerto Rico.

The purpose of the NAIC is to promote and support uniformity between the states in regards to the insurance business. The NAIC

keeps a registry of all agent and producer licenses granted in each state that require such licenses.

Note:

With respect to the NAIC, insurance “agents” are now known as “producers,” unless you’re in a state where they’re still known as “agents.” In California, we call them producers, but if you think of the two as synonymous, you’ll do just fine.

This registry lists both licenses and appointments by state. The NAIC has formed a 'model bill' for each state to present to their state legislatures when attempting to make changes to State Insurance Code.

3. Classification of Insurance Companies

In California, **any person** capable of making a contract **may be an insurer**, subject to the restrictions imposed by this code. A “person” "Person" means any individual, association, organization, partnership, business trust, limited liability company, or corporation.

There are **3** different types of insurance companies for classification purposes:

1) Domestic
2) Foreign
3) Alien

Here’s a closer look at those **3** classifications:

A. Domestic

Domestic insurance companies are ones that are incorporated and domiciled in California.

B. Foreign

Foreign companies are ones formed under the laws of any other state in the U.S.

C. Alien

Alien companies are formed and originate in another country outside of the U.S.

No matter the classification, all insurance companies in California must have a **certificate of authority**, which is issued by the Commissioner.

An **Admitted (Authorized) Insurer** has a certificate of authority and is permitted to do business and appoint agents in the state of California.

All authorized insurance companies have to:

- File detailed annual financial reports
- Pay all fees and expenses of the DOI examiners
- Contribute to appropriate insurance guaranty funds
- Agree to abide by all insurance Laws and Regulations
- Produce insurance business through licensed producers/agents

Note: If someone violates the requirement for a certificate of authority, they could face penalties of:

- Imprisonment in state prison, or in a county jail for up to **1** year
- A fine of up to **$100,000**
- All of the above

An **Nonadmitted (Unauthorized) Insurer** is one that does not have a certificate of authority and is not permitted to appoint agents in the state of California. A surplus lines broker is specially licensed to represent unauthorized insurers.

Putting it into Context:
You might assume that "nonadmitted or unauthorized insurer" is simply the exact opposite of an authorized insurer, but it isn't. An unauthorized insurer isn't allowed to transact normal kinds of insurance, and so they deal with Surplus Lines brokers.

Surplus Lines brokers handle insurance for very high risks. For example, if someone wanted to insure a shipment of volatile chemicals, it would be difficult for them to insure such a high risk through the normal insurance market. The person would then contact a Surplus Lines broker, who would arrange insurance through an unauthorized insurer.

A **Risk Retention Group** is a different kind of insurer. Under the auspices of the Federal Liability Risk Retention Act of 1986, A RRG will allow members who engage in similar or related business or activities to write liability insurance for all or any portion of the exposures of group members, excluding first party coverages, such as property, worker's compensation and personal lines. An equestrian organization, for example, can establish an insurance program for its members only. Authorization under the federal statute allows a group to be chartered in one state, but able to engage in the business of insurance in all states, subject to certain specific and limited restrictions. The

Federal Act preempts state law in many significant ways.

The **limitation** of a RRG as it effects consumers is that risks covered are limited to liability insurance, there is no state guaranty fund backing the plan and they may not be able to comply with proof of financial responsibility laws.

Ways Insurance Companies Are Organized . . .

Fraternal organizations provide charitable and benevolent activities. Ftaernals offer insurance ONLY to their members and beneficiaries and are not for profit. Examples are the Knights of Columbus, Modern Woodmen of America, etc. 1-6

Stock Insurers sell shares of stock to shareholders to raise the money necessary to operate the business. Stockholders receive dividends and share in profits and losses. Policyholders, however, do not, i.e., their policies are ***non-participating***.

Mutual Insurers are funded by policyholders. They become the owners and receive non-taxable dividends. Mutual company insurance policies are ***participating*** policies. ***Demutualization is a process whereby a mutual insurer becomes a stock company.***

4. Distribution Systems

Companies may further be classified by their marketing or distribution systems, such as:

A. Direct Writers (or ***Direct Response***), companies that market by mail, phone, and /or the internet with their own employees.

B. Exclusive or Captive Agency, companies whose agents represent only one company.

C. Independent Agency, agents represent and are appointed with several companies.

D. Managing General Agent (MGA), any person, firm, association, corporation, or partnership who manages all/part of

an insurer's business. MGAs act as an agent and can underwrite up to **5%** of the insurer's annual policyholder surplus and may adjust or pays claims in excess of an amount determined by the Commissioner as well as negotiate reinsurance on the insurer's behalf.

E. **Home Service,** also known as "debit" companies, sell small face amount policies and "industrial" insurance.

5. Fraud and Prevention

The Department of Insurance, Division of Enforcement, has created the Fraud Division to enforce the provisions of the Code and to identify and **combat insurance fraud**. The business of insurance involves many transactions that have the potential for abuse and illegal activities. This division is intended to permit the full utilization of the department so that they may more effectively investigate and discover insurance frauds, halt fraudulent activities, and assist and receive assistance from federal, state, local and administrative law enforcement agencies in the prosecution of persons who are parties in insurance frauds.

Note: Preventing all types of insurance fraud significantly reduces the cost of insurance premiums.

The following ***False and Fraudulent Claims*** statement is required on all claims forms in California:

"Any person who knowingly presents false or fraudulent claims for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison." In addition, if an insured signs a fraudulent claim form he may be guilt of perjury

Note: An insured signing a fraudulent claim form may be found guilty of perjury.

It is unlawful to do any of the following:

- Make or cause to be made a knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying any compensation
- Present or cause to be presented a knowingly false or fraudulent written or oral material statement in support of, or in opposition to, a claim for compensation for the purpose of obtaining or denying any compensation
- Knowingly assist, abet, conspire with, or solicit a person in an unlawful act under this section.

Anyone who commits fraud can be punished in one or more of the following ways:

- Imprisonment in a county jail for one year
- Imprisonment in the state prison, for two, three, or five years,
- Required to pay a fine that could be as high as **$150,000** or required to pay a fine that's double the value of the fraud (whichever is higher)
- Required to pay restitution for any necessary medical evaluations or treatment services
- Possibly required to pay for the costs of the investigation

Note: Anyone who has had a prior felony conviction will also receive an extra **2**-years for each prior conviction in addition to one of the penalties mentioned above.

The point we're trying to make here, folks, is **FRAUD BAD**.

A. The National Automobile Theft Bureau

Every insurer in California is required to report covered automobiles involved in theft and salvage total losses, including the vehicle identification number to the National Automobile Theft Bureau (NATB) or a similar organization engaged in automobile loss prevention.

B. The Arson Information Reporting System

The **Arson Information Reporting System** was created to permit insurers, law enforcement agencies, fire investigative agencies, and district attorneys to deposit arson case information in a common database within the Department of Justice.

C. Fraud and Workers Compensation

When an insurer or rating organization knows or reasonably believes it knows the identity of a person or entity whom it has reason to believe committed a fraudulent act relating to a workers' compensation insurance claim or insurance policy, including any application, the insurer, or agent authorized by an insurer to act on its behalf, or rating organization shall notify the local district attorney's office and the Fraud Division of the Department of Insurance.

D. Insurance Claims Analysis Bureau

An insurance claims analysis bureau performs the following functions:

- Collect and compile information and data from members or subscribers concerning insurance claims.
- Disseminate information to members or subscribers relating to insurance claims for the purpose of preventing and suppressing insurance fraud.
- Promote training and education to further insurer investigation, suppression, and prosecution of insurance fraud.
- Provide, without fee or charge, to the Commissioner, all California data and information contained in the records of the insurance claims analysis bureau in furtherance of the prevention and prosecution of insurance fraud.

Section CE 3

LICENSING

Objectives

This unit discusses how to obtain and maintain an insurance license, the importance of keeping accurate financial records, and which actions could result in suspension or revocation of a license. As future licensees, it is important to know that all of your actions as an insurance Producer will be checked through the Commissioner's office and honesty is critical to the longevity of your business.

1. People Required to have an Insurance License

California requires the following people to obtain an insurance license:

A. Producers

"Insurance Agents" are now known as "producers," except in states where they're still known as "agents". Just think of the two as synonymous and you'll do fine.

License Applications...

When someone applies for an insurance license, the insurance commissioner may conduct an investigation and based on it's outcome deny (without hearing) an application for issues such as a poor business reputation, lack of integrity, previous license suspensions, previous false statements, fraudulent practices, wrongful acts, misrepresentation, etc. If an application is approved, it can later be revoked or suspended for these same offenses.

Producers sell and negotiate insurance policies to applicants and handle ongoing coverage with clients. Unless the producer has

the proper license, they can't sell, solicit, or negotiate any class of insurance.

A **Life-Only Agent** is a person authorized by and on behalf of a life insurer to transact the following types of life insurance: permanent (whole life) life, temporary (term), group life, universal life, credit life, deferred and variable annuities (variables require registration with the NASD),funeral and burial life and long term care.

Life Analyst? Someone who is paid to advise an insured, beneficiary or person of insurable interest concerning his policy terms, conditions, benefits or rights under a policy.

An **Accident and Health Agent** is a person authorized to sell the following forms of insurance: health, disability, workers compensation, credit disability, twenty-four hour coverage and long term care.

A **Fire and Casualty** agent is a person authorized by and on behalf of a Fire and Casualty insurer to transact Fire and Casualty.

A **Personal Lines Agent** is a person authorized to sell ONLY the following insurance: Personal automobile, dwelling and homeowners insurance.

A **Limited-Lines Automobile Agent** is a person authorized to sell automobile liability coverage, automobile physical damage and automobile collision insurance.

That's plenty obvious, so let's move on.

Here are a few other insurance job categories:

- The **Broker** helps put together the insured's policy (any line of insurance except Life).
-

Agent vs. Broker? California law defines and insurance agent as someone authorized by an insurer to transact all forms of insurance except life insurance . . . that would be a task reserved for a life-only agent. "Insurance broker" means a person who, for compensation and on behalf of another ***person***, transacts insurance other than life with, but not on behalf of, an insurer. Know that there is ***NO life broker or NO health broker.*** There are, however, ***life settlement brokers*** . . . intermediaries who bring together policyowners who wish to sell a life insurance policy and providers seeking to purchase them. Brokers, in exchange for a fee, will shop a policy to multiple providers, much as a real estate broker solicits multiple offers for one's home.

- An **Insurance Solicitor** is a person employed to aid an insurance agent or insurance broker in transacting insurance other than life.
- The **Consultant** makes recommendations to the insured for a fee.
- The **Life and Disability Insurance Analyst** advises (for a fee) an insured or a person named as a beneficiary by a Life or Disability policy.
- The **Administrator** works with Life insurance, Health insurance, and Annuities. Their duties include, collecting premiums and adjusting or settling claims.

Note: Legally, none of these people can sell, solicit, or negotiate insurance unless they're licensed or authorized to work under a Producer. If someone does transact insurance without a license, they can be fined up to **$50,000** and/or put in jail for up to **1** year.

Any person who transacts insurance without a valid license is guilty of a misdemeanor and could be fined up to **$50,000**, or imprisoned for a year, or both. So, take that, potential license violators (CIC 703.5).

Sell Real Estate? Working with a Real Estate Agent? *Look Here*…

No person who sells real property shall require, as a condition precedent to the sale of such real property, that the person buying the real property negotiate any insurance or renewal thereof covering such property through a particular insurance agent, insurance broker, or insurance solicitor.

Future producers have to pass a written exam that tests knowledge of the different classes of insurance, the duties and responsibilities of Producers, and the state's statutes and rules.

People who want to be involved in certain kinds of insurance aren't required to take the final licensure exam—though they may still end up taking some form of test of knowledge. For example:

- Livestock

- Mortgage
- Travel and transportation
- Credit Life
- Credit Health
- Baggage, Trip Cancellation, and Interruption
- Lender's Property
- Motor Vehicle Physical Damage
- Mechanical Breakdown
- Credit Involuntary Employment

Note: The CIC defines "Transact" when applied to insurance as any of the following:

- Solicitation
- Negotiations preliminary to execution
- Execution of a contract of insurance
- Any dealings before/after the execution of a contract, or any matters arising from the contract

Selling Insurance To Seniors? Look Here ... California has a special affinity for its seniors. There are many code sections (CIC 785 through 789) devoted to the prevention of senior abuse. In a nutshell . . . All insurers, brokers, agents, and others engaged in the transaction of insurance owe a prospective insured who is 65 years of age or older, a duty of honesty, good faith, and fair dealing. This duty is in addition to any other duty, whether express or implied, that may exist.

2. Licensing Examination

Future producers have to pass a written exam that tests knowledge of the different classes of insurance, the duties and responsibilities of producers, and the state's statutes and rules.

People who want to be involved in certain kinds of insurance aren't required to take the final licensure exam—though they may still end up taking some form of test of knowledge. For example:

- Livestock
- Mortgage
- Travel and transportation
- Credit Life
- Credit Health
- Baggage, Trip Cancellation, and Interruption
- Lender's Property
- Motor Vehicle Physical Damage
- Mechanical Breakdown
- Credit Involuntary Employment

Applicants can take the state's examination after completing one or more of the following requirements:

- Attend a class taught by an authorized instructor (*yawn*)
- Watch a video on prelicensing, licensing, and insurance (*double yawn*)
- Complete a valid and verifiable online prelicensing course, preferably through an association as knowledgeable and fun-loving as ***Affordable Educators***

Pre-examination Licensing Training includes:

- **40** hours of instruction in **Fire and Casualty Insurance**
- **20** hours of instruction in **Life Only**
- **20** hours of instruction in **Accident and Health**
- **12** hours of instruction in **Code and Ethics**
- **20** hours of instruction in **Personal Lines**
- **20** hours of instruction in **Limited Lines Automobile**

3. Resident and Nonresident

A **resident** producer lives in the state they transact insurance for, whereas, a **non-resident** producer doesn't live in the state that they transact insurance for. If you get that one wrong on the final exam, we're coming to your house to slap you in person.

If someone wants to transact in another state, they have to obtain a license in their home state before becoming a nonresident producer.

All **non-resident** producers have to apply to the NAIC. The Commissioner acts as the Attorney-in-fact after the application is accepted. This means the Commissioner handles any legal actions brought against the non-resident producer.

The Commissioner can also arrange a reciprocal agreement, exempting certain people from taking the prelicensing examination. This agreement means that if someone from another state is allowed to transact insurance in California, then

a California insurer will be allowed to transact insurance in that other state.

4. Temporary License

The Commissioner can issue a temporary license to someone before they've completed the final examination. The temporary license is valid for a maximum of **180** days.

A temporary license is granted if:

- A producer dies or is physically/mentally unable to follow through on their duties, a spouse or legal representative can obtain a temporary license to either give the producer time to recover or train their replacement.
- A producer enters into active military duty, a temporary license can be issued to allow the replacement producer time to train and obtain a license.
- The Commissioner revokes a producer's license and a temporary license needs to be issued, in order to give the replacement time to train and obtain their own permanent license.

The Commissioner can limit the temporary licensee's authority or revoke the license at any time.

5. Responsible Producers

California requires all producers to engage in honest and responsible insurance transactions. A producer has to meet certain qualifications before becoming licensed, such as:

- Be **18** years or older

- Establish a residence and business in the state of California
- Not committed a felony involving dishonesty or breach of trust (A violation of Title 18, United States Code, Section 1033-1034 with penalties up to $50,000.
- Completes Pre-licensing Training from a school like Affordable Educators, college, or university registered with the Department of Insurance and received a Completion Certificate verifying educational hours (valid for up to **3** years)
- Passes the state examination with a score of **70% or above**
- Pays the required fees
- Apply to the National Association of Insurance Commissioners (NAIC) Uniform Application. The Commissioner will send an Examination Eligibility Notice, which is valid for 180 days once approved

Title 18 Violations . . .

Title 18 is federal code that prohibits people engaged in the business of insurance, whose activities affect interstate commerce, from knowingly making false statements, with intent to deceive, regarding the value of insured properties, reports to any insurance regulator, or material fact in interstate insurance transactions. The penalties and fines for violating Title 18 are severe:

- Criminal Penalty– Not more than ***5 years*** in prison
- Civil Fine – not more than ***$50,000***

In addition, any person convicted of a felony under Title 18 is to be known as a ***prohibited person***.

Prohibited Persons . . .

Prohibited persons, such as felons, must request written consent from the Commissioner, pay a fee, provide all documentation, and receive consent prior to engaging in any business. It is a criminal offense, punishable by civil penalty up to **$50,000** for each violation, and imprisonment for up to **5** years, to employ or permit prohibited

persons to participate in the business of insurance without consent. The Commissioner may require additional information in some cases.

Businesses applying for Producer status must pay all applicable fees; plus, they are required to designate one person as the business' state rules and regulations compliance specialist.

6. Producer Appointment

Producers have to become affiliated with an insurer before they can transact insurance. Once someone is an affiliated producer, they represent the insurer, not the insured.

Being affiliated or appointed by a company basically means they hire a producer to sell their insurance. Just because you're licensed, doesn't mean you can immediately start selling your own brand of insurance: you need to represent an established insurance company.

Licensed insurance producers only represent the insurer that appointed them. It is possible for a producer to be appointed by more than one company, and then they can transact insurance for each company.

Company Appointments

In general, a producer hasn't been appointed with an insurer, they can't legally transact insurance, even if they're licensed. However, a life or health agent can present a proposal and transmit an application to an insurer he is not appointed with. If the insurer issues the policy, the agent is considered to be appointed. If all of an agent's appointments are terminated by his insurers, his license will be considered inactive.

7. Termination of Appointment

An insurer may Terminate, or cancel, a Producer's Appointment or Affiliation at any time; however, the insurer must notify the Commissioner within **15** days of the termination. The Termination Notice needs to specify the reason(s) for

termination and either be delivered in person or mailed to the Producer's last known address. Whoever initiates the termination (either the insurer or Producer) is responsible to notify the Commissioner within **15** days of the effective termination date.

The insurer is exempt from notifying the Producer of an Appointment termination if the insurer ceases to sell insurance or if the termination is a mutual agreement.

The insurer can also terminate a Producer without written notice if any of the following occur:

- The license is denied, restricted, revoked, suspended, or cancelled
- The business is sold, transferred, or merged
- Bankruptcy is filed
- Fraud or intentional misconduct takes place

License Termination

A licensee may surrender a license for cancellation by delivery to the Commissioner, or by written notice of the intent to cancel. A license terminates upon the death of the licensee. If an organization is the licensee and it ceases to exist or is dissolved by its partners, the right of that entity to transact insurance is also terminated, unless a surviving partner, if any, files, within 30 days, an application to continue transacting insurance.

If a policy of insurance is issued regarding that application, the insurer is considered to have authorized the agent to act on its behalf, and the insurer is responsible for all actions of the agent

that relates to the application and policy, as if the agent had been appointed. This has to happen no more than **14** days after the life agent submits an application for insurance to the insurer for which the insurer issues a policy. The insurer shall forward to the commissioner a notice of appointment of the life agent as the insurer's agent. However, nothing obliges an insurer to accept an application for underwriting from a life agent.

At the same time, a licensed life agent who is NOT specifically appointed for a particular life insurer can't:

- Present a proposal to a prospective policyholder for insurance with that insurer
- Transmit an application for insurance to that insurer if the insurer requires all its life agents to represent only that insurer or a group of affiliated insurers of which that insurer is a member

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

- Acting as agent for a non-admitted insurer to transact insurance
- Advertising a non-admitted insurer to transact insurance
- Aiding a non-admitted insurer to transact insurance

In addition to any other penalties, the person might have to pay **$500** to the state, as well as **$100** per each month the person continues the violation.

8. Obtaining a License

Here are the necessary requirements that must be completed if someone wants to obtain an insurance license in California:

A. Qualifications

Individuals in pursuit of a California insurance license must prove their qualifications to the Commissioner of the Department of Insurance.

The Commissioner will deny an application for any license if:

- The applicant isn't qualified
- Granting the license isn't in the public's best interest
- The applicant doesn't intend to actually engage in business
- The applicant doesn't have a good business reputation
- The applicant lacks integrity
- The applicant has been refused a professional, occupational or vocational license or had such a license suspended or revoked
- The applicant wants the license in order to avoid enforcement of insurance laws in California
- The applicant has knowingly or willfully made a misstatement in a document or application for a license, or a false statement in testimony given under oath before the Commissioner
- The applicant has previously engaged in a fraudulent practice or a dishonest manner
- The applicant is incompetent and untrustworthy
- The applicant has knowingly misrepresented the terms or effect of an insurance policy or contract

- The applicant has failed to perform a duty or has committed an act expressly forbidden
- The applicant has been convicted of:
    - A felony
    - A misdemeanor by this code or other laws regulating insurance
    - A public offense involving a fraudulent act or dishonesty in acceptance, custody or payment of money or property
- The applicant helped someone else do something which could result in the suspension, revocation or refusal of a license
- The applicant has permitted any person in his employ to violate any provision of this code
- The applicant has violated any provision of law under authority conferred by license
- The applicant submits a fake certificate to the Commissioner

Note: A judgment, plea or verdict of guilty or a conviction following a plea of “nolo contendere” is considered to be a conviction, so it’s best not to set even one toe in a courtroom.

In addition, the following acts could result in suspension or revocation of a license:

- The licensee makes the client cosign, or make a loan, investment, or gift of their policy
- The licensee talks the client into making them the beneficiary under the terms of any intervivos or

testamentary trust, or the owner or beneficiary of a life insurance policy or an annuity

- The licensee talks the client into making them or any of their buddies a trustee under the terms of any intervivos or testamentary trust
- The licensee, acting as power of attorney for the client, used their position in order to buy insurance for the client that would give the licensee a commission

Note: All of the above no-no's are so obvious, we're surprised they didn't include:

- Don't shove people into traffic
- Don't steal food stamps from poor people
- Don't incite mass riots

But just in case any of those rules surprised you, we mean it, *don't*.

Producer applicants may eventually be qualified to receive a license in one of the following areas:

- Life Only Insurance
- Accident and Health Insurance
- Variable Life Insurance
- Fire and Casualty Insurance
- Personal Lines Insurance
- Limited Lines Automobile Insurance

B. Written Consent

If a person who has been convicted of a felony or engaged in dishonest activity deemed inappropriate by the Commissioner, he/she may ask for Written Consent to transact insurance. The

Commissioner will review each individual situation and, if applicable, establish rules or procedures for the individual to follow. If the person does not follow the Commissioner's mandates or commits other dishonest acts, he/she may not be able to transact insurance in the state of California.

C. Exemptions and Exceptions

The following people don't have to be licensed:

- An insurance company and its employees that are indirectly involved in insurance transactions. This includes an underwriter, loss control, inspection, processing, or claims settling employees
- Administrative, clerical, customer service, those in the position of receiving insurance premium, taking claims and requesting change
- A Producer or representative of a Fraternal Benefit Society, which is a non-profit group that provides Life and Health Insurance to its members. The Producer must not devote more than **50%** of his/her time to selling insurance, plus not sell more than **$50,000** of Life insurance coverage in a year.
- People who train others to become Producers and do not actually sell, solicit, or transact insurance
- An Attorney-in-fact who represents a Reciprocal Insurer, or an employee of the insurer or attorney
- A Real Estate Licensee who sells Home Protection or Warranty Insurance
- People who advise others regarding insurance, but do not solicit its sale

9. Maintaining a License

An individual is required to do the following in order to maintain their California insurance license:

A. Continuing Education

The Continuing Education Requirement promotes trustworthy and competent insurance agents for benefit of the public. All resident licensees must fulfill California's Continuing Education Requirement. An insurance license remains in effect (unless revoked or suspended) as long as applicable fees are paid and the Continuing Education Requirement is fulfilled.

This requirement does not apply to those persons holding resident licenses for any kind or kinds of insurance for which an examination is not required, nor shall it apply to any limited or restricted license the commissioner may exempt, or licensed nonresident agents who comply with the continuing education requirements or brokers of their state of residence.

Note: A licensee is exempt who submits proof satisfactory to the commissioner that he or she has been a licensee in good standing for **30** continuous years in this state and is **70** years of age or older.

Each new licensee is responsible for obtaining educational credit hours through approved instructional methods.

Upon renewal, these licensees must comply with the following requirement:

- Life-Only Agents -- A minimum of **24** hours per license period (every two years) following the date of the original license issuance.

- Accident and Health Agents -- A minimum of **24** hours per license period (every two years) following the date of the original license issuance.
- Property Brokers-Agent -- A minimum of **24** hours per license period (every two years) following the date of the original license issuance.
- Casualty Broker Agent -- A minimum of **24** hours per license period (every two years) following the date of the original license issuance.
- Property and Casualty Broker Agent -- A minimum of **24** hours per license period (every two years) following the date of the original license issuance.
- Life-Only and/or Accident & Health PLUS Property and Casualty Agents -- A minimum of **24** hours per license period (every two years) following the date of the original license issuance.
- Personal Lines Agent -- A minimum of **24** hours per license period (every two years)
- Limited Lines Automobile Agents -- A minimum of **24** hours per license period (every two years) following the date of the original license issuance.

The courses or programs of instruction that meet the standards for continuing educational requirements, and the number of classroom hours for which they are equivalent, are as follows:

- Any part of the Life Underwriter Training Council (**LUTC**) Course Curriculum totaling **50** hours, including the health course totaling **26** hours

- Any part of the American College **CLU** diploma curriculum totaling **30** hours
- Any part of the Insurance Institute of America's Accredited Advisor in Insurance (**AAI**) program totaling **25** hours
- Any part of the American Institute of Property and Liability Underwriters' Chartered Property Casualty Underwriter (**CPCU**) professional designation program totaling **30** hours
- Any part of the Certified Insurance Counselor (**CIC**) program totaling **25** hours
- Any insurance-related course approved by the curriculum board and the commissioner taught by an accredited college or university per credit hour granted totaling **15** hours
- Any course or program of instruction or seminar developed or sponsored by an authorized insurer, recognized agents' association, or insurance trade association, or any independent program of instruction, if approved by the curriculum board and commissioner, qualify for the number of hours assigned
- Any correspondence course approved by the curriculum board and commissioner qualify for the number of classroom hours assigned

B. Special CE Requirements

- **Ethics:** Every licensed agent must complete a minimum of four hours in specially-approved courses in ethics every renewal period. Personal Lines and Limited Auto agents need only complete two hours. NOTE: This requirement is PART OF not in addition to the continuing education hours required and discussed above.

- **Annuities**: Every life agent who sells annuities shall complete an **annuity eight hour certification** course BEFORE soliciting or selling clients. Thereafter, **four hour certification refresher annuity training** must be taken **every two years** prior to license renewal. NOTE: This requirement is PART OF not in addition to the continuing education hours required and discussed above.
- **Long Term Care:** Every agent that solicits or sells long term care insurance must complete an long term care **eight-hour certification course** BEFORE soliciting or selling long term care insurance. Thereafter, an **eight-hour certification long term care course** must be taken each renewal period. However, if the agent has been in business **less than 4 years, he must take** an eight-hour long term certification care course every year for the first 4 years in business in order to be certified to solicit and/or sell long term care. This does not increase the total continuing education hours required and discussed above.
- **California Partnership for Long-Term Care (PR):** Fire and casualty broker-agents and life-only and accident and health agents who wish to solicit individual consumers for the California Partnership product must (prior to being authorized); complete one specifically designated LTC training course (2004 LTC) and one specifically designated PR course.

  Maintaining authority to solicit individual consumers for the Partnership Product requires:

    - An **8**-hour specifically designated LTC training course (2004LTC) each year and must be accompanied by either a **4**-hour PR course every **12**-month period or an **8**-hour PR course every **2**-year license term.
- **Worker's Compensation:** Any life agent who wishes to sell **24-hour coverage** shall complete a course, or seminar of an approved continuing education provider on workers' compensation and general principles of employer liability. Satisfactory completion of this requirement is by proctored examination, administered or approved by the department.

Any person **failing to meet the requirements** and who has not been granted an extension of time within which to comply by the commissioner shall have his or her **license automatically terminated** until the time that the person demonstrates to the satisfaction of the commissioner that he or she has complied with all requirements.

Where a **person cannot perform the requirements** due to a **disability or inactivity** due to special circumstances, the commissioner will provide a procedure for the person to place his or her **license on inactive status** until the time that the person demonstrates to the satisfaction of the commissioner that he or she has complied with all of the requirements.

C. Change of Address or Place of Business

Every licensee and every applicant for a license shall **immediately notify the Commissioner** in writing of any change in his address.

10. License Renewal, Nonrenewal and Fees

Not less than 60 days before a license will expire, the commissioner will mail, to the latest address of record, an application to renew the license for the succeeding license term. **It is the licensee's responsibility to renew** whether or not a renewal notice is received. (The commissioner may accept a late renewal. Application for renewal of a license may be **filed on or before the expiration date**. The application for **renewal of an expired license** may be filed up to one year later. The regular fee and a **delinquent fee** of **50%** of the regular renewal fee apply. Unless a license is suspended or revoked, a licensee **who has applied to renew** a license is entitled to continue operating under the existing license for **60 days after its specified expiration date**, or until notified the renewal application is deficient, whichever comes first, if the applicant has satisfied all license renewal requirements, including:

- The submission of the applicable renewal application and fee on or before the expiration date of the license.
- The satisfaction of all required continuing education or training requirements.

A. Military Service

If a licensed person enters the military service of the United States and is in the service at a time of a Renewal application, the filing of such application is waived, and the license held shall

remain in force during the period of such military service and until the end of the license year in which he is released from such service but not for less than **6** months after such release. During this period a person can file an application and pay the fee without taking an examination or paying any penalty.

11. Suspension and Revocation of License

The Commissioner may suspend or revoke any license for any of the grounds on which he may deny an application. A suspension or revocation may be with or without notice or hearing based upon the reason for action.

The following are grounds for suspension or revocation:

- Providing false or misleading information in the license application
- Violating any insurance laws or rules
- A violation committed by a partner or associate that was known or should have been known by the Producer
- Fraudulently obtaining or trying to obtain a license
- Mishandling money received through insurance transactions
- Intentionally misrepresenting the terms of a policy
- Having been convicted of a felony or misdemeanor where the Producer (or license applicant) was dishonest or breached the trust of others
- Fraudulently transacted insurance
- Demonstrated dishonesty in a business's financial matters
- Had a license revoked or suspended in another state (U.S. or Mexican) or Canadian Province

- Forged another person's name on an insurance document
- Cheated on the license examination
- Knowingly transacted business with an unlicensed individual
- Failure to pay a civil penalty or any fees to the Commissioner
- Failure to comply with the Continuing Education Requirement
- Refusal to renew a license by the Commissioner

Unlicensed?

Any person who transacts insurance without a valid license is guilty of a misdemeanor punishable by a ***fine not exceeding $50,000*** or by ***imprisonment*** in county jail for a period not exceeding ***one year***, or both.

An accused Producer can request a hearing from the Commissioner. The Producer will have an opportunity to defend him/herself and will receive any decisions in writing.

12. Records Maintenance

It is the obligation of each life, life and disability, and disability insurance agent and any other agent and insurer to preserve and maintain all applicable records in his or her possession, in addition to those records transmitted to the insurer, at his or her principal place of business for a minimum of **5** years. The records must be kept in an orderly manner, readily available, and open to inspection or examination by the commissioner at all times.

A. Reporting of Actions

If any administrative action has been taken against a Producer, he/she must report it to the Commissioner no later than **30** days

after the final disposition or no later than **30** days of the initial pretrial hearing date in the case of criminal prosecution. The Producer must include all relevant documentation, including a copy of the court order, any complaints filed, plus the results of any hearings.

B. Assumed Business Name

Every individual and organization licensee and every applicant for such a License, shall file with the commissioner in writing the true name of the individual or organization and also all fictitious names under which he conducts or intends to conduct his business and after licensing shall file with the commissioner any change in or discontinuance of such names. The commissioner may disapprove the use of any true or fictitious name.

C. Display of License

Every license shall be prominently displayed by the holder thereof in his or her office in a manner whereby anyone may readily inspect it and ascertain both its currency and the capacity in which its holder is licensed to act.

13. Fiduciary Responsibilities

All funds received by an insurance agent, broker, or solicitor, life agent, life analyst, surplus line broker, special lines surplus line broker, motor club agent, bail agent, permittee, administrator, or solicitor, as premium or return premium for any policy of insurance, are held in a fiduciary capacity. Any person who diverts or

appropriates those fiduciary funds to his or her own use is guilty of theft and punishable for theft as provided by law.

Fiduciary . . .

A fiduciary is someone who has undertaken to act for and on behalf of another in a particular manner which give rise to a relationship of trust and confidence.

Producers accept payment for insurance premiums, plus handle money from business and personal use. It is extremely important that these premium funds are placed in a separate trust account and do not end up being mixed with other funds, except money used for the following:

- Advancing premiums
- Keeping reserves to refund premiums
- Paying bank charges and fees
- Paying for any other costs arising out of the process of receiving and returning premiums

A Producer must keep a **Client Trust Account** in the form of a checking account, demand, or savings account and fiduciary funds deposited into this account. If the insured makes the payment payable the insurer, the Producer must forward it directly to the insurer.

Producers/agents must establish and maintain records in an appropriate accounting system for all client payments received. The **Commissioner** may request to see these records at any time during the **Producer's** business hours. If the **Producer** does not make these records available or maintain client premium fund

records for **3** years following the policy cancellation date, serious consequences can result.

When receiving cash from a client for premium payments, the **Producer** must take the following steps:

- Give the person a receipt showing the amount of money paid, the date and time, the policy number, plus the policy holder's name
- Deposit the money into a **Client Trust Account**
- If the **Producer** does not have such an account, he/she must convert it into a money order, certified check, or cashier's check made out to the insurer
- Keep records of all money received and forwarded

14. Internet Advertising

Agents advertising on the internet shall identify all of the following
Information, regardless of whether the **insurance** agent or broker maintains his or her Internet presence or if the presence is maintained on his or her behalf:

(1) His or her name as it appears on his or her **insurance** license, and any fictitious name approved by the commissioner.
(2) The state of his or her domicile and principal place of business.
(3) His or her license number.

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

(1) Provides an **insurance** premium quote to a California resident.
(2) Accepts an application for coverage from a California resident.
(3) Communicates with a California resident regarding one or more
terms of an agreement to provide **insurance** or an **insurance** policy.

15. Effective Date of Coverage

A life agent and a fire and casualty broker-agent shall provide to all insureds or applicants at the time of application or receipt of premium moneys the effective date of coverage, if known, or the circumstances under which coverage will be effective if there exists conditions precedent to coverage. This section shall apply only to coverage for personal lines of **insurance**, such as private passenger automobile, homeowner and renter **insurance**, personal liability, and individual disability and health **insurance**.

16. Return of Premium

A fire and casualty broker-agent or surplus line broker may offset funds due an insured for return premiums on any policy against amounts due him or her from the same insured for

unpaid premiums on the same or any other policy. Any insurer may pay return premiums to any fire and casualty broker-agent for that purpose. This section shall not invalidate an assignment of return premium made concurrently with policy issuance as security for financing that premium, nor the right of the assignee, or his or her assign, to enforce the assignment as a prior claim.

17. Reporting Changes In Your Background Information

There is a continuing requirement to notify the California Department of Insurance (DOI) of changes in the background information you provided on your original insurance applications and/or on renewal certificates. of background changes within 30 days of learning of the change.

What background information changes must be reported to the Department?

- A misdemeanor or felony conviction.
- A filing of felony criminal charges in state or federal court.
- An administrative action regarding a professional or occupational license.
- Discharge or attempt to discharge, in a personal or organizational bankruptcy proceeding, an obligation regarding any insurance premiums or fiduciary funds owed to any company or managing general agent.
- Any admission, or judicial finding or determination of fraud, misappropriation, or conversion of functions, misrepresentation, or breach of fiduciary duty.

The DOI defines a misdemeanor to be any offense punishable by imprisonment in the county jail not exceeding one year in the county jail, or by fine, or by both.

The DOI considers a felony to be any crime for which the maximum authorized punishment exceeds one year. A felony includes any crime in any other state, commonwealth, territory or possession that is identified as a felony in that state, or if not identified as a felony, any offense for which the maximum authorized punishment is one year or more.

The DOI defines a conviction as having been found guilty by verdict of a judge or jury, having entered a plea of nolo contendere, having had any charge expunged, dismissed or plea withdrawn pursuant to California Penal Code §1203.4, or having been given probation, a suspended sentence, or a fine. A licensee should disclose any crimes resulting in convictions relating to reckless driving, driving under the influence, and driving with a suspended license, whether or not the licensee spent any time in jail, and whether or not the licensee believes the conviction has been removed from the licensee's record.

The licensee must report any felony charges filed against him or her by a county or state district attorney or U.S. attorney within 30 days of the felony charges being filed. There is no requirement to report misdemeanor charges. However, if the misdemeanor results in a conviction, the conviction must be disclosed. There is no requirement to report an arrest.

Who Must Comply?

Any and all resident and nonresident producer licensees and applicants who intend to transact insurance in or with California residents must comply with the reporting requirement. That includes officers, directors, partners, members or controlling persons under any resident or nonresident business entity license or an application thereof. Additionally, that includes all unlicensed officers, directors, partners, members or controlling persons, or any other natural person named under the business entity or an application thereof.

In addition to notifying the DOI of a change in background information, if the licensee is listed as an endorsee on a business entity license, the licensee must notify any officer, director or partner listed on the business entity license.

How to Comply

A licensee or applicant for license must complete a Background Information Disclosure Form (Lic Form #2557B), which can be downloaded from the DOI's Web site at www.insurance.ca.gov. The completed form must be submitted with certified copies of all court documents, setting forth the disposition of the matter, together with any other relevant documents or information that the licensee would like to have considered. All such documents must be submitted within 30 days of the change in background. The DOI may request additional information after reviewing the initial submission.

Failure to timely disclose a change in background information may result in sanctions to the licensee, up to and including revocation. Generally, upon discovering an undisclosed change,

the DOI will issue the licensee a letter requesting a description of the change, and certified documentation, and an explanation as to why the licensee failed to respond within 30 days after discovery of the change. The licensee should timely respond to the letter and include a detailed statement as to why the background change was not disclosed in accordance with Insurance Code Section 1729.2.

If the licensee's disclosure of the change in background or failure to disclose results in the filing of an accusation by the DOI, the licensee should immediately seek competent legal counsel familiar with insurance regulatory proceedings.

Section CE 4

MARKETING &

TRADE PRACTICES

Objectives

This unit will cover the Code and Ethics concerning the selling of insurance products in California. The purpose of Regulation concerning the Marketing of Insurance products is to ensure that all insurance companies act in good faith, abstain from deception and that they treat all members of the public with honesty and fairness in all insurance matters. While this is common sense in all business practices, there are several concepts and regulations that are particular to the insurance business.

1. Illegal and Unfair Practices

Insurance products are regulated to make sure that all members of the public are treated with honesty and fairness. Obviously, that's business ethics 101, but there are regulations specific to the insurance industry that could end up on the final exam.

With regard to the marketing or claims handling of insurance products, the following are defined as unfair methods of competition and unfair and deceptive acts or practices:

The Unfair Practices Act

This is federal legislation designed to regulate unfair methods of competition or deceptive acts. We go into greater detail in the following pages, but the focus is as follows:

- Prohibits misrepresentation of policy terms or company financial condition.
- Prohibits the circulation of false information about another insurance company.
- Prohibits discrimination between individuals of the same class and equal expectation of life.
- Prohibits agents discussing the State Guaranty Fund to "sell" the security of any insurance company.
- Prohibits delays, unequal handling and negotiation of client claims.
- Prohibits an agent from not answering policy questions.

Penalties for violation these acts are not more than ***$5,000*** for negligence and not more than ***$10,000*** for willful violation.

A. Misrepresentation

Misrepresentation means any of the following:

- Misrepresenting the terms of a policy, its dividends, the financial condition of an insurer, or making any misrepresentation to any policyholder insured in any company in order to induce them to lapse, forfeit, or surrender their insurance
- Making untrue or misleading statements
- Entering into any agreement to commit any act resulting in unreasonable restraint, or monopoly in the business of insurance
- Publishing or circulating false statements of financial condition in order to deceive
- Making false entries or willfully omitting any material facts in order to deceive
- Making or allowing any unfair discrimination

- Stating that the named insurer is a member of the California Insurance Guarantee Association, or stating that the insurer is insured against insolvency
- Canceling or refusing to renew a policy in violation of the code

B. Premiums

There are **3** main illegal practices regarding premiums:

1) **Commingling** means company money is mixed with the customer's money or the agent's money.
2) **Overcharging premiums** involves overcharging the insured and then keeping the excess.
3) **Charging premiums for unapplied coverage** means a producer accepts premium payments for coverage that isn't in effect.

C. The insurance License

It's illegal to transact insurance without a license, and it's illegal to obtain a license fraudulently. It's also illegal to sell insurance that's outside the scope of the license you have. If a producer is licensed to sell Property and Casualty insurance, they can't transact a Life insurance policy. So, just to reiterate:

- It's illegal to transact insurance without a license
- It's illegal to obtain a license fraudulently
- It's illegal to sell insurance outside the scope of your license

D. Rebating

Rebating means you use a sales inducement to get a prospective customer to buy an insurance policy. This could

involve guaranteeing a dividend, splitting commissions with the client, or paying premiums for the client.

E. Illegal Inducement

This is a nice way of saying bribing somebody. It could mean giving gifts to prospective clients, offering them money, or even buying them nice dinners. Offering special contracts or changes to a contract or policy is also illegal, as well as offering prospective clients foot massages or a free phrenological assessment. Illegal, illegal, illegal.

F. Concealment

Concealment involves intentionally withholding facts or information to gain an advantage in an insurance transaction.

G. Twisting

Twisting means any situation where the truth is twisted or bent to get someone to drop an existing policy for a new policy. For example, if a producer could get a commission by convincing a client to drop their existing life policy, which takes care of all their needs, for a new policy they might not necessary need, the producer is engaging in twisting.

H. Defamation

The official definition of defamation is the malicious discrediting or slandering of an insurance company or its agents. Basically, it's saying/writing/implying something mean that could hurt a company/individual's reputation or cost them money. For example: "Buy from us, because unlike our competitors, we

don't reek of day old cheese!" Usually it's harsher than that, but you get the general idea.

I. Controlled Business

You can't get a license just to write controlled business, which means you're only selling to friends and family. You can write some controlled business, but there are guidelines regarding controlled business:

- In a **2**-year period no more than twice the amount of a producer's premiums can be from controlled business
- A producer can't have twice the amount of controlled Life and Health policies, than they have for noncontrolled premiums

J. Free Insurance

This would fall under "inducement," but the CIC specifies that Free Insurance is a no-no. Basically, someone would offer free insurance as a benefit of buying an annuity or a property. Agents/producers/insurers aren't allowed to do this.

Note: The prohibitions of free insurance doesn't include insurance written in connection with newspaper subscriptions or general circulation. It also doesn't include insurance issued to credit unions or members of credit unions.

2. Misrepresenting Policy Provisions

It's considered a misrepresentation of policy provisions if an insurance company or producer:

- Fails to disclose policy benefits during a claim

- Denies a claim because the insured fails to exhibit property without proof of demand
- Denies a claim because the insured didn't act within time frames that weren't in the policy
- Requires a release beyond the scope of claim for the payment of the claim
- Issues payment checks for partial settlement that releases the insurance company of it's total liability
- Makes payments to the insured that requires reimbursement if the company doesn't tell the insured about that policy

3. Unfair Claims Settlement practices

The following are considered specific unfair claim settlement practices. An insurance company can't:

- Misrepresent facts or policy provisions
- Fail to respond promptly to a claim
- Fail to properly investigate a claim
- Refuse to pay a claim without an investigation
- Fail to affirm or deny coverage after Proof of Loss is provided
- Refuse to act in good faith when payment is reasonably clear
- Fail to offer reasonable settlement amounts, forcing the insured to resort to litigation or arbitration
- Delay processing a claim with excessive paperwork
- Delay settlement under one coverage as leverage to effect the settlement under another coverage for that policy
- Deny a claim without providing the insured with a clear explanation
- Discriminate against claimants who are represented by a public adjuster

- Fail to honor checks paid to claimants
- Fail to pay a claim promptly after settlement
- Fail to promptly deliver a release or settlement document to the insured of claimant
- Delay or add to the cost of Property/Casualty appraisals
- Fail to make a good faith effort to settle and force the insured into a Property and Casualty appraisal
- Settle directly with a claimant who's represented by an attorney without the attorney's consent
- Delaying the payment or provision of hospital, medical, or surgical benefits for services provided with respect to acquired immune deficiency syndrome or AIDS-related complex for more than **60** days after the insurer has received a claim for those benefits, where the delay in claim payment is for the purpose of investigating whether the condition preexisted the coverage.

Note: This **60**-day period doesn't include any time during which the insurer is awaiting a response for relevant medical information from a health care provider.

3. Prompt, Fair, and Equitable Settlements Definitions

Claimant

The claimant is any person who asserts a right of recovery under a surety bond, an attorney, any person authorized by operation of law to represent the claimant.

Notice of legal action

means notice of an action commenced against the insurer with respect to a claim, or notice of action against the insured

received by the insurer, or notice of action against the principal under a bond, and includes any arbitration proceeding.

Proof of claim

means any evidence or documentation in the possession of the insurer, whether as a result of its having been submitted by the claimant or obtained by the insurer in the course of its investigation, that provides any evidence of the claim and that reasonably supports the magnitude or the amount of the claimed loss.

D. File and Record Documentation

Every licensee's claim files shall be subject to examination by the Commissioner or by his or her duly appointed designees. These files shall contain all documents, notes and work papers (including copies of all correspondence) which reasonably pertain to each claim in such detail that pertinent events and the dates of the events can be reconstructed and the licensee's actions pertaining to the claim can be determined.

E. Duties upon Receipt of Communications

Upon receiving any written or oral inquiry from the Department of Insurance concerning a claim, every licensee shall immediately, but in no event more than twenty-one (21) calendar days of receipt of that inquiry, furnish the Department of Insurance with a complete written response based on the facts as then known by the licensee. A complete written response addresses all issues raised by the Department of Insurance in its inquiry and includes copies of any

documentation and claim files requested.

Upon receiving any communication from a claimant, regarding a claim, that reasonably suggests that a response is expected, every licensee shall immediately, but in no event more than fifteen (15) calendar days after receipt of that communication, furnish the claimant with a complete response based on the facts as then known by the licensee. This subsection shall not apply to require communication with a claimant subsequent to receipt by the licensee of a notice of legal action by that claimant.

4. Standards for Prompt, Fair and Equitable Settlements

These are the standards for prompt, fair, and equitable settlements by insurance companies.

No insurer shall discriminate in its claims settlement practices based upon the claimant's:

- Age
- Race
- Gender
- Income
- Religion
- Language
- Sexual orientation
- Ancestry
- National origin
- Physical disability
- Address or location

After receiving proof of claim, every insurer has to:

- Accept or deny the claim as quickly as possible, and no later than **40** calendar days
- Notify the claimant if more time is required to determine whether a claim is going to be accepted or denied, either partially or wholly. The claimant needs to be notified every 30 days if more time is needed
- Settle the claim by making a reasonable offer—insurers can't make an offer that's unfair or unreasonably low

Note: If someone thinks they have received an offer that's too low, they can file a complaint with the Commissioner. The Commissioner shall consider any admissible evidence offered in determining whether or not a settlement offer is unreasonably low.

- Pay any approved claims no later than **30** calendar days

5. Insurance Information and Privacy Protection Act

An insurance institution or agent has to provide a notice of information practices to all applicants or policyholders in connection with insurance transactions as provided below:

- At the **time of the delivery** of the insurance policy when personal information is collected only from the applicant, an insured under the policy, or from public records
- At the **time of the collection** of personal information is initiated when personal information is collected from a source other than the applicant, an insured under the policy, or public records.

The written notice has to include the following:

- Whether personal information may be collected from persons other than the individual or individuals proposed for coverage
- 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
- The types of disclosures and the circumstances under which the disclosures may be made without prior authorization
- A description of the rights established and the manner in which the rights may be exercised.
- That information obtained from a report prepared by an insurance-support organization may be retained by the insurance-support organization and disclosed to other persons

Disclosure forms must be:

- In plain language
- Dated
- Include the nature of information, as well as to whom it may be disclosed
- The name of the agent or insurer
- How long the authorization is valid.

Penalties for violation could include a fine of up to **$50,000** and any court awarded damages.

Privacy Legislation

The Gramm-Leach-Bliley Act (1999) concerns consumer financial privacy and financial safeguards: ***Financial Privacy --*** Requires financial institution to provide each consumer with a privacy notice explaining what information is collected about the consumer, where the information is used and how it is protected. Any changes must be disclosed. Prohibits the sharing of nonpublic information with a non-

affiliated third party unless consumers are given an opportunity to opt-out. ***Financial Safeguards --*** Requires financial institutions to develop a written security plan describing how the company is prepared for and plans to protect consumer nonpublic information, even if the consumer is no longer with the financial institution.

The California Financial Information Privacy Act (2003) adds to the financial privacy provisions of Gramm-Leach Bliley by requiring that consumers ***opt-in*** PRIOR to any sharing of nonpublic information among financial institution non-affiliates. Consumers can ***opt-out*** for any sharing of information among affiliates of the financial institution.

Insurance Information and Privacy Protection Act (2003) provides that personally identifiable information supplied to an insurance agent or broker in order to apply for insurance must be protected. Agents must provide consumers with a privacy Notice explaining how and with whom this information will be shared and the consumer right to ***opt-out*** from having personal information shared.

Health Insurance Portability and Accountability Act (HIPPA) assures that an individual's health information (medical records) by establishing national standards for health providers, billing services and health information companies. Requires covered entities to take reasonable steps to ensure confidentiality of communications, notification of record use and document privacy policies and procedures.

Note: In California, marketing life, annuities, or disability to seniors who are **65** years or older, has specific regulations. Policies have to include a **30**-day free look period, a written comparison of any existing health coverage, and the person has to receive advice concerning HICAP's free services to seniors (the Health Insurance Counseling and Advocacy Program).

6. The Insurance License

It is illegal to sell any insurance product without an official state-granted license to do so. Also, selling insurance that is outside the scope of one's license is illegal. If an agent is licensed to sell

Automobile and Home insurance, they cannot sell or write a Health insurance policy without being licensed for that line. It is also illegal to obtain any insurance license by fraudulent means.

Every licensee shall prominently affix or be printed on business cards, written price quotations for insurance products, and print advertisements distributed exclusively in this state for insurance products, its license number in type, the same size as any indicated telephone number, address, or fax number, as well as the word "insurance".

If someone violates these rules, the person could receive a fine of up to:

- **$200** for the first offense
- **$500** for the second offense
- **$1,000** for the third offense, or any other offenses afterwards

Note: The penalty can't exceed **$1,000** for any one offense.

7. Unfair Discrimination

Insurance companies can't deny insurance coverage based solely on the basis of race, religion, or national origin. Coverage also can't be denied because of a physical or mental disability.

Law and regulations regarding unfair discrimination state that:

- Insurance companies have to treat all applicants equally
- Insurance companies can discriminate as long as the discrimination is based on **Risk Selection and Sound Actuarial Principles**

Note: **Risk Selection and Sound Actuarial Principles** are methods for determining whether a person or a group of people are desirable insurance risks. This takes into account their age, occupation, gender, lifestyle, and history, but it also looks at a statistical model of certain demographics. Actuarial principles help companies deduce how much money in claims they could end up spending on claims based on morbidity rates, mortality rates, etc.

Companies are allowed to use the following characteristics only if those characteristics increase the risk of insurance:

- Age
- Sex
- Marital status
- Race
- Creed
- National origin
- Ancestry
- Lawful occupation
- Change of occupation
- Change of domicile
- Previous insurance rejection
- Cancellations/nonrenewals of insurance
- A previous lack of insurance

8. HIV

California has established mandatory and uniform minimum standards for insurers to avoid making or permitting unfair distinctions between individuals of the same class in the underwriting of life or disability income insurance for the risks of

acquired immune deficiency syndrome (AIDS)and AIDS-related conditions (ARC), for assessing AIDS and ARC risks for determining insurability which are deemed to be sufficiently reliable to be used for life and disability income insurance risk classification and underwriting purposes, and to require the maintenance of strict confidentiality of personal information obtained through testing as well as require informed consent before any insurer tests for HIV.

9. Commissions and Fees

Only licensed producers can receive commissions or fees, or any other valuable considerations from insurance transactions. It's illegal for anyone who isn't licensed to accept a commission. Someone can accept renewals and deferred commissions if they were licensed at the time of the sale.

A service fee is a charge the insurance producer makes that isn't part of premium payments.

Note: Service fees aren't allowed in Personal lines of insurance: Auto, Property, and Liability.

Service fees can be charged in Commercial lines of insurance if the producer provided additional services above and beyond customary practice. In these instances, the producer would have to provide a written explanation for the charge.

You can't accept compensation from the insurance company unless you have done the following, prior to the insured's purchase of a policy:

- Obtained the insured's documented acknowledgement

- Disclosed the amount of reimbursement or provided a reasonable estimate of what that reimbursement might be
- Disclosed the nature of the work that will be done on behalf of the insured

10. Advertising

False advertising is illegal. Here are some guidelines concerning advertising:

- Advertising has to be clear and not misleading
- If a company advertises their assets, those assets have to match the last verified statement filed with the Commissioner
- You can't infer or suggest you're an insurer unless you're an insurer
- All advertising has to be true and accurate no matter what form it's in: media, newspapers, magazines, online, and etc.

Note: Advertisements for term life insurance aimed at people who are **55** years or older will:

- Clearly and prominently distinguish basic life insurance benefits from supplemental benefits such as accidental death benefits
- Prominently disclose any limitations, exceptions, or reductions affecting each benefit
- Prominently disclose any condition affecting the policy or certificate holder's continued insurability. If term coverage terminates at a stated age, or at the end of any designated period, that fact and the specified age or designated period shall be disclosed
- Prominently disclose any change in benefits resulting from the aging of the insured, policy duration, or any other factor

- Prominently disclose any change in premium resulting from the aging of the insured, policy duration, or any other factor. If the insurer retains any right to modify premiums in the future, that fact shall be disclosed

A. Internet Advertising

A person licensed in this state as an insurance agent or broker, who advertises on the Internet, and transacts insurance in this state, must identify all of the following information on the Internet:

- Name as it appears on his or her insurance license, and any fictitious name approved by the commissioner
- The state of his or her domicile and principal place of business
- License number

If someone who advertises on the Internet does any of the following, the California Code considers them to be “transacting” insurance:

- Gives an insurance premium quote to a California resident
- Accepts an application for coverage from a California resident
- Communicates with a California resident regarding terms of an agreement to provide insurance or an insurance policy

11. Fiduciary Responsibilities

Producers have certain financial responsibilities. If they receive premium payments on behalf of an insurance company, they have

to report the exact amount of the payment and records must be kept on all received/refunded premiums.

Any refunded or returned premium has to be delivered promptly to the insured.

If the producer accepts a premium payment, they have to provide the insured with a receipt for the payment of premium no later than the next business day.

The producer has to deposit premium payments within **7** days of receipt, and if the payment is a check that's made out to the insurance company, the producer has to forward the check directly to the insurance company.

Note: Insurance producers have to keep client records for Property and Casualty insurance for **3** years past the policy's expiration.

If premiums are paid in cash, the insured has to get a receipt, which includes:

- The date
- The name of the agent/producer
- The name of the policyowner/insured
- The amount received
- The insurance company's name
- The policy number

Okay, so some of that is ultra-obvious. Don't roll your eyes at us, we're just being thorough.

Note: Just a quick aside—if there are extra charges relating to someone's policy or application, the insured needs an explanation in writing for those charges.

12. Policy Retention

> Policy retention benefits everyone. A producer who keeps an open line of communication with his/her clients will have the opportunity for more sales, as well as be able to provide the maximum protection for that client.

It benefits the client because they always have the insurance protection they need. And, obviously, if a producer has a lot of happy clients, this is going to benefit the producer and the insurer financially.

13. Code of Ethics

The California Insurance Code and other California laws may identify unethical or illegal practices, but they are NOT a complete guide to ethical behavior. Following are acceptable codes of behavior found in major industries that can be adapted to insurance agents:

- Place the customer's interest first.
- Know your job and continue to increase your level of competence.
- Identify customer's needs and recommend products and services that will meet those needs.
- Accurately and truthfully represent products and services.
- Use simple language

- Stay in touch with customers and conduct periodic coverage reviews.
- Protect your confidential relationship with your client.
- Keep informed of and obey all insurance laws and regulations.
- Provide exemplary service to your clients.
- Avoid unfair or inaccurate remarks about the competition.

14. A Special Note About Seniors

The insurance commissioner has special ethical concerns when insurance agents do business with senior citizens. Specifically, the use of pretext interviews (whereby an agent misrepresents the purpose of a meeting as a free seminar when it is really a ploy to collect financial information and "sell" a product) are prohibited. With certain insurance products, seniors must also be given 24 hours notice before simply stopping by their home. And, state that the purpose of in-home meetings is to discuss insurance.

Section CE 5

CALIFORNIA INSURANCE GUARANTEE ASSOCIATION

Objectives

Guarantee associations are the safety nets of the insurance industry. This unit includes:

- What are Guarantee Associations?
- The California Life and Health Guarantee Association
- The California Insurance Guarantee Association (CIGA)

1. What are Guarantee Associations?

Guarantee associations protect the public from insolvent insurance companies. “Insolvent” means an individual or company can’t pay their debt. The company might even be going through bankruptcy. The Commissioner determines if a company is insolvent, which means the company can’t fulfill any future financial obligation.

Here’s the core of the issue: just because a company becomes insolvent doesn’t mean it can stop paying claims. If an insurance company becomes insolvent, and then its clients experience covered losses, those clients still have settlements coming to them.

Obviously, once a company is bankrupt, it doesn’t really have the money to pay insureds’ claims. Guarantee associations pay

insurance claims that an insolvent company isn't able to pay. This protects claimants and policyowners.

Any insurance company that wants to do business in California is required to belong to one or both of the following guarantee associations:

A. California Life and Health Guarantee Association

The **California Life and Health Guarantee Association** is under the Commissioner's authority, and protects annuity policyholders, beneficiaries, and payees of Life and Health policies.

The California Life and Health Guarantee Association guarantees any payments of benefits and continued coverage if an insurance company becomes insolvent. This association guarantees the following:

- **80%** of contractual limitations
- Up to **$250,000** for Life insurance Death benefits
- Up to **$100,000** for cash surrender value
- Up to **$100,000** for the present value of annuities
- Up to **$200,000** for Health benefits

Note: The maximum amount an individual can receive for all policies is **$250,000**.

The maximum amount a firm or corporation can receive for all policies is **$5 million**.

The **California Life and Health Guarantee Association** doesn't cover:

- Variable Life or Variable annuities that aren't guaranteed by the insurer
- Risks the policyholder accepted
- Any part of the policy that's reinsured
- Policies issued by a health care service contract
- Anyone that's self-funded or uninsured
- Parts of a policy subject to dividends or experience credits
- Policies issued by an insurer that doesn't have a Certificate of Authority in California
- Any coverage issued by the California Medical Insurance Pool

B. California Insurance Guarantee Association for Property and Casualty

The **California Insurance Guarantee Association for Property and Casualty** protects Property and Casualty policyowners from insolvent insurance companies.

Every California insurance company that transacts Property and Casualty insurance has to be a member of the California Insurance Guarantee Association for Property and Casualty.

The limits of coverage for all Fire and Casualty (excluding Workers Compensation) are:

- A minimum of **$100**
- A maximum of **$500,000**

The California Insurance Guarantee Association for Property and Casualty pays claims for most types of Property and Casualty policies, including Workers Compensation.

Alert!
There is no limit on Workers Compensation claims. The California Insurance Guarantee Association for Property and Casualty doesn't put any limits on Workers Compensation claims. We're drawing attention to this fact, because we've seen this actual question on the test.

Claims are paid if they are filed within **30** days of a company becoming insolvent. Once the Commissioner receives notification that a company is insolvent, the Commissioner notifies the CIGA within **3** days.

The Commissioner could request that the policyowners also be informed of the insolvency and their rights regarding the insolvency. Claims are paid up to **$500,000**.

Note: Before a company can receive a Certificate of Authority in California, they have to belong to one or both of the CIGA. They won't be able to transact insurance business or appoint any producers until they've done so.

Section CE 6

INSURANCE

TERMS & CONCEPTS

Objectives

Insurance has a language of its own: in Life insurance, Health insurance, Property insurance, and in Casualty insurance, as well as Individual or Group. We'll look at some of the common terms in this unit, but refer to the glossary for additional information.

This unit includes:

- General Terms and Concepts (no big mystery there)
- More Terms and Concepts

1. General Terms and Concepts

Just so you know, In California, the word:

- "Shall" means mandatory
- "May" means permissive
- "Person" means any individual, association, organization, partnership, business trust, limited liability company, or corporation.

Note: Any provision of the code can be sent out by mail.

Here are some general terms and concepts you're going to frequently run into when dealing with insurance:

A. Insured

In Life insurance, the **insured** is the person on whose life an insurance company writes a policy. The insured and the policyowner may not be the same person.

In Property or Casualty insurance, it usually means the "named insured," or the one(s) named on the policy.

B. Insurable Interest

Insurable interest is required in the purchase of insurance to protect against an economic loss.

In **Life insurance**, the insurable interest has to exist when someone first applies for the policy.

In **Property** and **Casualty** insurance, insurable interest has to exist at the time of loss.

B. Insurable Events

Insurable Events are any contingent or unknown event, which may indemnify a person having an insurable interest, or create a liability against him, may be insured against.

C. The necessary Elements in a Policy

All insurance policies must contain:

1) Information about the parties involved in the contract
2) Description of the property or the life insured
3) The insured's insurable interest
4) Information about the risks the insurance covers
5) The policy period
6) Premium rates

Note: The financial rating of the insurer is not required.

D. Principle of Indemnity

The Principle of Indemnity is the restoration to the approximate financial position occupied prior to the loss, in whole, or in part, by payment, repair, or replacement.

E. The Law of Large Numbers

The Law of Large Numbers is a theory regarding probability. The Law of Large Numbers states that:

1) If you take a random sample from a larger population, it's more likely to represent the whole, than if you took a random sample from a smaller population.
2) The more people there are, the more the chance of risk increases.

F. Loss Exposure

Loss Exposure is defined as someone's potential for loss, or their loss exposure/exposure to loss. For example, a homeowner in a particular region of the country will have different kinds of exposures than a homeowner in another region. They may be more vulnerable to hail, tornadoes, or forest fires, so they have a higher exposure to loss to those particular perils.

Exposure is measured in **exposure units**, for which the price of insurance is the rate.

G. Adverse Selection

Adverse Selection is selection against an insurer by insuring more poor than good or average risks, and the tendency of poorer risks to buy and maintain insurance.

H. Concealment

Concealment is the withholding of facts or information by an applicant or insured that may materially affect the decision regarding an insurance risk.

I. Risk

Risk is the chance of loss. The term "risk" is often used in a general way to designate the entire subject matter of insurance covered under a policy or upon which an application for insurance has been received. Risk is also sometimes used to designate a policyholder (e.g. poor, standard, etc.).

There are **2** categories of risk:

1) **Pure Risk** is defined as the uncertainty as to whether or not a possible loss will actually happen. There could be a loss, but no one knows when or how. A pure risk is the chance of loss only.
2) **Speculative Risk** is a loss that's more predictable, such as gambling, business ventures, or playing the stock market. Speculative risk assumes that, based on the person's actions/decisions, a loss is inevitable. A speculative risk also has the chance of gain.

Note: Insurance only protects against pure risks.

J. Ideally Insurable Risks

The following criteria describes an ideally insurable risk:

- The loss must be **measurable**
- The loss must be **accidental**
- The loss must be **predictable**
- The **law of large numbers** has to apply
- The loss must create **financial hardship**
- Insurance must be **affordable and practical**
- The loss must not be **catastrophic**

K. Risk Management Methods

There are **4** Risk Management methods used to deal with the uncertainty of loss:

1) **Avoid** the risk
2) **Reduce** or control the risk
3) **Retain** the risk
4) **Transfer** the risk (insurance)

L. Hazard

Hazard is any factor that creates or increases the chance of loss. There are different types of **hazards**:

- A **physical hazard** is created by the condition, occupancy, or use of the property itself. Examples include faulty breaks that increase the chance of collision, and faulty electrical wiring that increases the chance of fire.
- A **moral hazard** is a characteristic of the insured that increases the chance of loss. Examples include arranging an accident to collect the insurance, or inflating the amount of a claim.

- A **morale hazard** is carelessness or indifference to a loss because of the existence of insurance. One example is leaving the car keys in an unlocked car.
- A **Legal Hazard** is created by decisions or actions of the courts. If something could result in big, expensive lawsuits, this is considered a legal hazard.

M. Peril

Peril refers to the specific event causing a loss, such as fire, windstorm or collision.

N. Fraud

Fraud is the intentional and fraudulent omission, or the communication of information of matters, proving or tending to prove false, and entitles the insurer to rescind.

O. Concealment

Concealment is the neglect to communicate that which a party knows, and ought to communicate, and whether intentional or unintentional, entitles the injured party to rescind.

Information you aren't required to communicate includes information that is:

- Already known or should be known
- Waived by the other party
- Not material to the risk

Concealment, whether intentional or unintentional, entitles the injured party to rescind insurance.

P. Rescission

Rescission means the same as revoke or remove. An insurer could legally rescind an insured's policy if:

- There's been intentional or unintentional concealment
- There's been an intentional and fraudulent omission
- A misrepresentation comes to light after a policy has gone into effect
- A material warranty or a material policy provision has been violated

Q. Materiality

Materiality has to do with facts and information relevant to an insurance policy. Materiality can be determined using **3** questions concerning the information:

1) Can the information convince or dissuade either party to enter a contract?
2) Does the information create a disadvantage for either party?
3) Does the information have any affect on the risk or insurability involved?

Materiality concerns both the insurer and the insured. Each party involved in the contract has to have all the relevant information that could have any positive or negative affect on the contract.

R. Representations

Representations are statements on an application that the applicant represents as true and accurate, to the best of their knowledge and belief. Representations may be considered to be an implied warranty.

A representation may be altered or withdrawn before the insurance is effected, but not after. A representation is considered false when the facts fail to correspond with its assertions or stipulations.

Misrepresentations are the false representation of the terms or benefits of a policy by an agent, or an applicant who falsely represents the health or other condition of the proposed insured.

S. Warranty

A **warranty** is a statement made by the applicant that becomes a condition of the contract. False warranties void the entire contract.

Alert!

Warranties do not apply to Life insurance. No statement made on a Life insurance policy is ever considered to be a warranty. The final exam will definitely try to trick you on that one (all you potential Life agents out there).

A warranty is either:

- **Expressed** warranties are in written form and attached to the policy.
- **Implied** warranties are not written but still exist under the law. Some representations may qualify as implied warranties.

T. The Law of Agency

The Law of Agency is the authority of one to act as the agent of another, the insurer, with one of **3** types of authority:

1) **Express Authority**, what is spelled out in the contract
2) **Implied Authority**, what is assumed to exist
3) **Apparent Authority**, what is by conduct or action

U. Loss

Loss may refer to the claim itself, the amount sought in a claim, the reduction in value of an insured's property, or the amount paid on behalf of an insured under an insurance policy.

The **2** categories of loss are:

1) **Direct loss**, which is a loss that is the direct result of an insured peril.
2) **Indirect loss**, which is a subsequent loss, such as being unable to use a building after a fire.

V. Liability

Liability is something for which you are legally responsible.

Liability insurance provides coverage and pays for losses to other people and their property caused by negligence.

W. Negligence

Negligence is the result of carelessness, thoughtlessness, or inaction, but it's never intentional.

Before a court will award any damages to an injured party due to another's negligence, the **4** elements of negligence must be present:

1) **Legal duty** means the person has a legal responsibility to take the necessary precautions to avoid being negligent.
2) **Breach of duty** means the person failed to uphold their legal duty.
3) **Damage or losses** occurred as a result.
4) **The breach of duty** caused the damages or losses.

Here's a surreal story to help you remember the **4** elements:

Bob decided to put quicksand outside his driveway. He thought to himself, "I should really tell people about this here quicksand." (Legal duty)

When Gwen was walking by, she said, "Is that safe?"
Bob forgot about the quicksand, and said, "Yep. Safe as safe can be!" (Breach of duty)

Trusting him, she went on her way, and was promptly sucked into the quicksand. Luckily, she just happened to have a copy of "How to Escape from Quicksand," so she survived, but she still lost one of her tennis shoes. (Damages or losses)

"Hey," she said, "I lost one of my tennis shoes because you said it was safe!" (Damages or losses caused by the breach of duty)

True, it's a weird story, but we're sure you'll remember the **4** elements of negligence long after you've developed senility and forgotten everything else.

Note: If these **4** elements of negligence are present, the injured party has a good chance of winning a lawsuit.

X. Accident

Accident is an unforeseen and unintentional act identifiable in time and place.

Y. Occurrence

Occurrence is an event that results in a loss.

Z. Reinsurance

Reinsurance is the transfer of risk between insurance companies. Used in both Life and Health, as well as Property and Casualty, it's an agreement or "treaty" between insurance companies where one company may transfer, and one company will accept, all or part of the risk of loss of the other.

1. From the Top!

You may have noticed that we've run out of letters of the alphabet. Well, we're too enterprising to let that stop us! We'll just start over again! (Problem-solving!)

A. Cancellation

Cancellation is the termination of coverage in the policy period by the insurer.

B. Lapse

Lapse is the termination of coverage for non-payment of premium. A policy will lapse at the end of the grace period.

C. Renewal

Renewal is the continuation of coverage from one policy period to the next. **Non-renewal** is termination of coverage at the end of the policy period.

D. Unearned versus Earned Premiums

Unearned versus earned premiums are based on whether or not someone has paid for future coverage.

If someone pays an annual premium, and six months have gone by, then they have six months of:

- **Unearned premium**, for the six future months that are prepaid
- **Earned premium**, for the six months that have already gone by

E. Binders

A **binder** gives the insured temporary coverage. An insured may have just requested or applied for the insurance, and he/she doesn't actually have the official documentation in hand, but the **binder** means the insurer has agreed to provide temporary coverage pending approval.

Someone can receive a binder and still be denied insurance. If the insurance company gives the person a binder while the insurance application is being processed, that binder doesn't guarantee a certificate of insurance. If the insurance company decides not to insure someone, the company has to issue a legal

notice of cancellation. Until then, the binder will continue to provide coverage.

Note: Binders are not used with Life insurance.

Section CE 7

CONTRACT LAW

Objectives

A contract is defined as: “a legal document between 2 or more parties, in which a certain performance is promised, in exchange for a valuable consideration.” In this unit we’ll discuss the elements of a contract, as well as other contractual terms that apply to insurance.

This unit includes:

- The Elements of a Legal Contract (C.L.O.C)
- Different Kinds of Contracts
- Legalities

1. The Elements of a Legal Contract (C.L.O.C)

There are certain elements that make a contract a legal contract, and therefore a legally binding contract. The term legally binding means that the terms of the contract will be upheld by a court of law.

There are **4** important elements to a legal contract:

1) **Competent Parties** means the people entering into the contract have to be considered “legally capable” (of age, mentally stable, etc.).
2) **Legal Purpose** means a contract has to have a lawful purpose. If it doesn’t have a lawful purpose, it’s not enforceable.

3) **Offer and Acceptance** means both parties agree on the terms of the contract and now the contract is considered legally binding.
4) **Consideration** means the physical return both parties get from the contract. In insurance terms, the consideration the insurer gets is premium payments, and the consideration the insured gets is insurance coverage.

The elements of a legal contract spell **C.L.O.C**.:
Competent parties
Legal Purpose
Offer and Acceptance
Consideration

The 6 Requirements for Insurance Policies

All insurance policies must contain:

7) Information about the parties involved in the contract
8) Description of the property or the life insured
9) The insured's insurable interest
10) Information about the risks the insurance covers
11) The policy period
12) Premium rates

Legal World: An insurer's financial rating (A+, B, C, etc) is not required to be specified in an insurance policy.

2. Different Kinds of Contracts

Insurance is a contract whereby one undertakes to indemnify another against loss, damage, or liability arising from a contingent or unknown event.

There are different characteristics of insurance contracts that can change the entire tone of the contract. These include the following:

A. Contract of Adhesion

This kind of contract means “take it or leave it.” In this type of contract, one party has all the bargaining power, and the other party has no bargaining power. This type of contract doesn’t allow for negotiation or quibbling over contract wording.

B. Aleatory Contract

This kind of contract means the amount of money paid by one party could be a lot more or less than the other party. Most insurance contracts are considered Aleatory contracts, because the insured could make premium payments for years for an occurrence that never happens, or the insurer could end up compensating an insured after only a few premium payments.

C. Unilateral Contract

This kind of contract means that someone promises to do or not do something in return for consideration. This is also referred to as a “one-sided contract.” A very simplified example of this would be: if you pay me $500, I’ll paint your house.

D. Conditional Contract

This type of contract depends entirely on an event actually happening. An easy example of this is if someone is selling their house, they won't get paid until the house actually sells.

E. Personal Contract

This type of contract insures the person, and not the property. This applies in Life and Health insurance.

Open vs. Valued Policy? An open policy is one in which the value of the subject matter is not agreed upon, but is left to be ascertained in case of loss. A valued policy is one which expresses on its face an agreement that the thing insured shall be valued at a specified sum, i.e. a predetermined value. If you owned a classic car or expensive artwork, you would want to know whether you were buying a valued or open policy.

3. Legalities

Here are some important legal characteristics affecting contracts:

A. Indemnity

This refers to a type of contract, such as insurance, that serves to restore the individual to the approximate financial position occupied prior to the loss.

B. Representations/Misrepresentations

Representations are statements made by the applicant for insurance before the policy is issued. These statements aren't considered set in stone: usually the wording is "true and correct to the best of my knowledge."

Legal World: A representation made by an applicant for insurance may be altered or withdrawn before the insurance goes into effect, but not afterwards. A representation is considered false when the facts fail to correspond with its assertions or stipulations.

If the information turns out to be incorrect, this is called a **misrepresentation**. Intentional **misrepresentations** can void an insurance policy, because it affects the determination of potential risks.

Putting it into Context:
Here's an example of intentional **misrepresentation**: Chris's Health insurance application asked if Chris has any family history of heart problems. Chris is completely healthy, but there is an extensive history of heart problems in Chris's immediate family. Worried that checking "yes," would affect her premiums, Chris checked "no." If the producer/agent finds out about Chris's intentional misrepresentation, it could keep Chris from being insured, or it could void Chris's policy.

C. Warranties

A **warranty** is a statement made by the applicant that becomes a condition of the contract. False warranties void the entire contract.

Alert!
Warranties do not apply to Life insurance. No statement made on a Life insurance policy is ever considered to be a warranty. The final exam will definitely try to trick you on that one (all you potential Life agents out there).

A warranty is either:

- **Expressed** warranties are in written form and attached to the policy.
- **Implied** warranties are not written but still exist under the law. Some representations may qualify as implied warranties.

Legal World:
A representation in an insurance contract qualifies as an ***implied warranty***.

D. Concealment

Concealment *means withholding important information regarding a loss or the events surrounding a loss. Concealment immediately voids coverage.*

An Insurance Contract Does NOT Need . . .
Information that DOES NOT need to be communicated in an insurance policy is:

- Known information
- Information that should have been known
- Information which the other party waivers
- Information not material to the risk

E. Insurable Interest

Insurable interest is required in the purchase of insurance to protect against an economic loss.

In **Life insurance**, the insurable interest has to exist when someone first applies for the policy.

In **Property** and **Casualty** insurance, insurable interest has to exist at the time of loss.

F. Waiver and Estoppel

Waiver is the giving up or surrendering of a known right or privilege.

Estoppel is the legal principle that holds that anyone whose words or actions have caused a waiver of a right or privilege, can't later reclaim the waived right or privilege if a third party has relied upon it.

For example, Angie's house burns down and she loses everything. Because she's having a really difficult time coming up with an inventory of items lost to submit her proof of loss form on time, her insurance company tells her they'll give her an extra 30 days to submit the form. Even though the insurance company has the legal right to demand the form by a certain date, they are **waiving** that right.

Estoppel is a court/judge blocks someone from asserting the original right they chose to **waive**. The exact definition of this can be along the lines of: If someone behaves in a manner that's inconsistent with their behavior in the past. This is a very circuitous way of saying, "if someone goes back on their word," but look out for that answer on the final exam.

An example of **estoppel** would be if Angie's insurance company suddenly changed their minds and said they wouldn't reimburse her loss because she didn't submit her Proof of Loss on time. Angie takes the company to court and the judge issues an **estoppel**, which forces the insurance company to honor the conditions of the **waiver**.

G. Rescission

Rescission means the same as revoke or remove. An insurer could legally rescind an insured's policy if:

- There's been intentional or unintentional concealment
- There's been an intentional and fraudulent omission
- A misrepresentation comes to light after a policy has gone into effect
- A material warranty or a material policy provision has been violated

Return of Premium: California has many codes devoted an insured's right to a return of premium (CIC 481 through 487). In a nutshell, a person insured is entitled to a return of premium if the policy is canceled, rejected, surrendered, or rescinded. Of course, there are many pro-ration rules to determine the exact amount that must be returned.

H. Utmost Good Faith

Insurance policies are considered contracts of **utmost good faith**, which basically means all parties involved were completely honest and disclosed any and all relevant information and facts.

Utmost good faith means mutual trust during the negotiation of a contract.

4. Tort Law

Tort means a civil wrong for which the law provides a remedy. A simple way of looking at this is that a tort has more moral than legal implications, but someone who has been wronged can still turn to the law for protection and compensation. There's such thing as an intentional tort, which means someone intentionally wronged someone else.

Note: Someone who commits a tort is called a **tortfeasor**.

The differences between tort law and contract law stem from the fact that tort law deals with civil wrongs, and contract law protects against and handles legal wrongs.

5. Fraud

This is a dishonest or deceptive act meant to cheat or gain an advantage.

For example, if an insured signs a claim form for a fraudulent claim, they would be committing a fraudulent act.

The California Department of Insurance has set up a Fraud Division to handle the possibility of insurance fraud.

An insurance claims analysis bureau is set up specifically to:

- Compile information and data concerning insurance claims

- Provide information to insurers/subscribers about insurance claims to avoid attempts to defraud the industry
- Help develop programs to further insurer fraud prevention, fraud investigation, and fraud prosecution
- Provide all California data and information regarding claims to the Commissioner

6. Materiality

Materiality has to do with facts and information relevant to an insurance policy. Materiality can be determined using three questions concerning the information:

1) Can the information convince or dissuade either party to enter a contract?
2) Does the information create a disadvantage for either party?
3) Does the information have any affect on the risk or insurability involved?

Materiality concerns both the insurer and the insured. Each party involved in the contract have to have all the relevant information that could have any positive or negative affect on the contract.

What is misrepresentation?
Materiality of concealment is the rule used to determine the importance of misrepresentation, i.e., someone is considered to have misrepresented an answer on an application if the concealment is considered material. A fact is said to be material is it has influenced someone, put them at a disadvantage or affected the risk being insured or insurability.

Section CE 8

LIFE INSURANCE

NOTE: If you signed up for Accident and Health or Fire & Casualty, you still need to complete this section.

Objectives

This section will cover the many important **Laws and Regulations** associated with **Life Insurance** in California, including:

- Required Provisions
- Required Individual Policy Provisions
- Required Group Policy Provisions
- Conversion Rights
- Termination of Group Life
- Reduction of Indebtedness
- Blanket Life Insurance
- Disclosures
- Policy Replacement
- Policy Loans
- Insurable Interest, Beneficiaries, and Consent
- Accelerated Benefits
- Policy Illustrations
- Backdating

1. Required Provisions

In California, Life Insurance polices are required to have certain Provisions in policies. These Required Provisions are further broken down into those for Individual policies and for Group policies.

2. Required Individual Policy Provisions

The following is a list of the Required Provisions in Individual Life Insurance policies in the state of California:

A. Free Look Provision

Every policy of individual life insurance with a face value of less than ten thousand dollars ($10,000) which is delivered or issued shall have printed thereon or attached thereto a notice stating that, after receipt of the policy by the owner, the policy may be returned by the owner for cancellation by delivering it or mailing it to the insurer or to the agent through whom it was purchased. The period of time set forth by the insurer for return of the policy by the insured shall be clearly stated on the notice and this period shall be not less than 10 days nor more than 30 days. The insured may return the policy to the insurer at any time during the period specified in the notice.

This Provision must allow the customer a Free Look period of at least **10** days, **30** days if it's a **Senior**, age 60 and over.

The policyowner may examine the policy, and retains the option of refusing it or right to cancel, and receiving a full refund of any premiums paid. If the policy is a Replacement policy, however, the policyowner has a Free Look Provision of at least **30** days with the option of refusing the policy and receiving a full refund of any premiums paid.

During the **30**-day period, the premium for a variable annuity may be invested only in fixed-income investments and money-market funds, unless the investor specifically directs that the

premium be invested in the mutual funds underlying the variable annuity contract.

Illustration Basics: If an illustration is used by an insurance producer in the sale of a life insurance policy and the policy is applied for as illustrated, a copy of that illustration shall be submitted to the insurer at the time of the policy application. A copy also shall be provided to the applicant. If the policy is issued other than as applied for, a revised basic illustration conforming to the policy as issued shall be sent with the policy. The revised illustration shall be labeled "Revised Illustration" and shall be signed and dated by the applicant or policy owner and producer or other authorized representative of the insurer no later than the time the policy is delivered. A copy shall be provided to the insurer and the policy owner.

If no illustration is used by an insurance producer the producer or representative shall certify to that effect in writing on a form provided by the insurer. On the same form the applicant shall acknowledge that no illustration conforming to the policy applied for was provided and shall further acknowledge an understanding that an illustration conforming to the policy as issued will be provided no later than at the time of policy delivery. This form shall be submitted to the insurer at the time of policy application.

Senior Illustrations: Illustrations for policies and annuities delivered to seniors (age 60 and over) shall have the following printed on the cover in bold 12 point text or larger: "**THIS IS AN ILLUSTRATION ONLY. AN ILLUSTRATION IS NOT INTENDED TO PREDICT**

ACTUAL PERFORMANCE. INTEREST RATES, DIVIDENDS, OR VALUES THAT ARE SET FORTH IN THE ILLUSTRATION ARE NOT GUARANTEED, EXCEPT FOR THOSE ITEMS CLEARLY LABELED AS GUARANTEED."

Advertisements for term life insurance directed to individuals 55 years of age or older shall:

(1) Clearly and prominently distinguish basic life insurance benefits from suppplemental benefits such as accidental death benefits.
(2) Prominently disclose any limitations, exceptions, or reductions affecting each benefit.
(3) Prominently disclose any condition affecting the policy or certificate holder's continued insurability. If term coverage terminates at a stated age, or at the end of any designated period, that fact and the specified age or designated period shall be disclosed.
(4) Prominently disclose any change in benefits resulting from the aging of the insured, policy duration, or any other factor.
(5) Prominently disclose any change in premium resulting from the aging of the insured, policy duration, or any other factor. If the insurer retains any right to modify premiums in the future, that fact shall be disclosed.

B. Payment of Premium
States the amount, time and place premium payments are to be made.

C. Grace Period
There is a **Grace Period** for every premium that will be paid after the initial premium payment. A policyowner must be

permitted to make a late premium payment so long as it is within **30** days of the due date. During the **Grace Period**, the policy will still be in force and coverage will not be effected. However, the insurance company can charge up to **6%** interest on late premium amounts. If a claim is made on the policy during the **Grace Period**, the late premium is deducted from any amount paid.

D. Incontestability

The **Incontestability Provision** states that after a Life Insurance policy has been in force for **2** years, the policy cannot be cancelled or voided except for the failure to pay premiums.

E. Incontestability and Reinstatement

A policy that has been **reinstated** for less than **2** years may be contested for fraud and misrepresentation. The fraud or misrepresentation must be of some relevance to the reinstatement.

F. Entire Contract

When a policy is issued to a policyowner, they must receive the **Entire Contract**, including the policy, application and any additional riders or provisions. Any verbal agreements or unattached documents are not considered to be part of the Entire Contract.

G. Misstatement of Age

When a claim is being settled, if the insurance company discovers that the insured misstated their age when they applied

for the policy, the insurance company has the right to adjust the premiums or benefits to properly reflect the insured's true age. This could result in either the insurance company or the insured receiving a credit. **Misstatement of Age** is not necessarily fraud, as it could be a genuine mistake on the part of the insured.

H. Dividends

This Provision concerns any participating policies and the distribution of shares, sums, or profits to be distributed to policyowners. Dividends can be paid annually in cash or taken as other forms of benefit.

3. Required Group Policy Provisions

The following is a list of Required Provisions for all Group Life Insurance policies in the state of California.

An Eligible group means an employer, association, trustee, union, or other entity to whom a group policy is issued, formed and operating for reasons other than obtaining insurance.

Putting it into Context:
That sounds weird, so we'll simplify it for you:
Group Insurance has advantages over Individual insurance, the main advantage being it's usually cheaper. Therefore, insurance companies have to set up guidelines for what constitutes a "group."

A group isn't just a bunch of people who decided to get together and call themselves a group in order to qualify for Group Insurance.

A Group Policy could exclude coverage for deaths relating to:

- War or act of war
- Military or naval service
- Aviation

A. Nonforfeiture Provisions

This provision is for any permanent plan Group Life policies that have lapsed, been declined, or have expired for some other reason and have a cash value.

B. Grace Period

The policyowner may make a late premium payment up to **31** days after the original due date. During the **Grace Period**, the policy stays in full effect.

C. Incontestability

After a life insurance policy has been in force for **2** years, it cannot be cancelled throughout the lifetime of the insured, except in cases of failure to pay premiums.

D. Application and Representations

This Provision states that any statements made by the **policyowner/insured** cannot be used against them by the insurance company unless it is part of the official written application for insurance.

E. Evidence of Insurability

These are the conditions under which an insurance company can require a person to furnish **proof of insurability**.

F. Misstatement of Age

When a claim is being settled, if the insurance company discovers that the insured misstated their age when they applied for the policy, the company has the right to adjust the premiums or benefits to properly reflect the insured's true age. This could result in either the insurance company or the insured receiving a credit. **Misstatement of Age** is not necessarily fraud, as it could be a genuine mistake on the part of the insured.

G. Payments under Policy and Payment of Interest

This important Provision states that the insurance company must pay any death benefits to appropriate beneficiaries within **30** days of receiving proof of death. If the insurance company fails to pay the death benefit within **30** days and the policy states the payment must be made in a lump sum, then the insurance company must pay interest on any payments due to the beneficiary and unpaid after **30** days.

The interest is computed from the date of the insured's death to the date of payment. After **30** days, the insurance company must notify the beneficiary (in writing to their last known address) that interest will be paid in addition to the lump sum death benefit.

H. Issuance of Certificates

A Group Life Provision that states that the insurance company must issue an individual certificate of insurance to each participating member of the group. The purpose of the certificate

is to state the insurance protection, the benefits available to the insured and the individual's rights under California law.

4. Conversion Rights

A person may lose their **Group Life** insurance policy if they are terminated or otherwise no longer eligible for coverage under a Group Life policy.

However, that individual is eligible to apply for an **Individual Life** policy and may do so without evidence of insurability. The individual must apply for this new policy and make the first premium payment to the insurance company within **31** days of being terminated.

This converted **Individual Life** policy must:

- Be a Permanent Life policy and not a Term Life policy
- The premium must meet the insurance company's customary rates for that person's age and amount of insurance applied for
- Not exceed the amount of Life Insurance it is replacing, with a notice of at least **15** days prior to the expiration of the Conversion period, or the employee shall have an additional **25** days

5. Termination of Group Life

If a Group Life policy issued in this state is terminated by an employer or by an insurer, Conversion Rights to an individual policy apply to all employees, including those who became totally disabled while insured under the policy. If an insured individual dies during the conversion period of a Group Life policy, the amount of insurance is payable as a claim under the

Group policy, regardless if the person had not already applied for the Individual policy or made the first premium.

6. Reduction of Indebtedness

A Group Credit Life policy must provide the policyowner with a form stating that the person has life insurance, and any death benefit paid will go to reducing or paying off the debt owed by the policyowner.

7. Blanket Life Insurance

Any life insurer may issue policies of blanket life insurance for a term not exceeding one year with premium rates less than the usual rates for such insurance. Such policies may thereafter be renewed.

Blanket life insurance is written under a policy issued to a newspaper, farm paper, magazine, or other publication and insuring independent contractors, such as newspaperboys, dealers, distributors, wholesalers, or other personnel, engaged in the sale, distribution, collecting for, or other activities pertaining to the marketing and delivery of publications. This includes attending coaching school or while participating in a trip organized, supervised, and sponsored as a reward for meritorious service.

Amounts of insurance are based upon a plan precluding individual selection:

- For the benefit of persons other than the policyholder
- Where the premium is remitted by the policyholder;

- Insuring persons without any requirement for individual enrollment and with either the policyholder or the insured to pay all or part of the premium

8. Disclosures

In California, insurance companies are required to provide certain **Disclosures** to potential buyers of insurance. The purpose of these Disclosures is to avoid any confusion or misrepresentations on the part of the insurance company or it's representatives. The buyer must be made fully aware of what type of insurance they are considering and the type of policy they might buy. In order to make sure this happens, an insurance company must provide a prospective buyer with:

- **A Buyer's Guide** is an informative booklet that helps the potential customer make good decisions about what type of insurance they need, how much insurance they need, and allows them to compare the costs of the different types of policies they are considering. The Buyer's Guide also clearly defines Whole, Term and Universal Life policies. The insurance company must provide the potential customer with a Buyer's Guide when requested.
- **A Policy Summary** is a separate written document that describes the specific elements of the insurance policy. Like a Buyer's Guide, a Policy Summary must be provided to any prospective customer upon their request.

  The Policy Summary must contain the following **8** items:

  1) A clearly placed title such as "STATEMENT OF POLICY COST AND BENEFIT INFORMATION"

2) The name and address of the agent and the insurance company
3) The generic name of the type of policy (e.g. term, whole life, etc.)
4) With respect to the first **5** years of the policy, the annual premiums, guaranteed amount payable upon death, the total guaranteed face value, the guaranteed cash surrender value, the cash dividends due to the policyowner annually, and any guaranteed endowment amounts
5) The annual percentage rate that would be charged on any Policy Loans
6) The Surrender Cost and Insurance Net Payment Cost Indexes for 10 and 20 years
7) A statement to the effect that an explanation of the intended use of these indexes is provided in the **Buyer's Guide**
8) The date the **Policy Summary** was prepared

- **Cost Comparison Indexes** show the cost of the benefits provided in an insurance policy. These indexes factor in the concept of the **time value of money**. For instance, a lower cost index would be a sign of lower costs for the benefits being paid for. These indexes are useful when comparing similar policies. Generally, there are **2** types of indexes used:
    1) A **Net Cost Comparison Index** is useful if the buyer's main concern for the policy is the benefits paid at the time of death. The level of the policy's cash value is of secondary importance. This index helps compare costs at a future time, usually 10 or 20 years ahead. These

predicted amounts are based on the premiums being paid and no cash values being taken from the policy.

2) A **Surrender Cost Comparison Index** is useful if the level of the cash value of the policy is the more important concern. This index helps the buyer compare costs if in the future (again, 10 or 20 years) the policy was surrendered for some reason and the cash value of the policy taken.

9. Policy Replacement

Policy Replacement is defined as a new life insurance policy or annuity is purchased and a current in-force policy or annuity is going to be:

- Lapsed, surrendered, partially surrendered, forfeited, or otherwise terminated
- Changed to lower the policy's term or benefits
- Reissued with a reduced policy cash value
- Converted to a nonforfeiture benefit
- Used in a purchase with money withdrawn, borrowed or obtained from the surrender of an existing policy

Any insurance company that is replacing the policy of another must notify the existing insurance company of the **Policy Replacement** within 3 working days of receiving the new application for insurance. The new insurance company must also keep the notice of replacement for at least **3** years.

Here are some exemptions when policy replacement doesn’t apply:

- Credit Life Insurance
- Group Life Insurance or annuities
- When the existing policy is being replaced by the same insurance company
- A policy that is a contractual change or conversion

Policy Replacement regulations are in place to ensure that insurance consumers are protected during transactions that involve the Replacement of a life insurance policy or annuity. Policy Replacement refers to any transaction involving a policy being lapsed, surrendered, or converted.

The purpose of the regulations involving Policy Replacement is meant to regulate the activities of insurance companies and their representatives. These regulations also protect the interests of insurance consumers by establishing codes of conduct and assure that an insurance consumer receives timely and accurate information so they can make a good decision about the insurance they buy.

Policy Replacement regulations also reduce any misrepresentation or incomplete disclosure. Finally, these regulations establish the penalties for failure to comply.

Every agent who accepts an application for life insurance or annuity, shall submit to the insurer both of the following:

- A statement signed by the applicant as to whether replacement of existing life insurance or annuity is involved in the transaction.

- A signed statement as to whether or not the agent knows replacement is or may be involved in the transaction.

Where a replacement is involved, the agent has to do all of the following:

- Present to the applicant at the time of application, a "Notice Regarding Replacement of Life Insurance" signed by both the applicant and the agent and left with the applicant.
- Obtain a list of all existing life insurance or annuities to be replaced, identified by name of insurer, the insured and contract number.
- Leave with the applicant the original or a copy of all printed communications used for presentation to the applicant.
- Submit to the replacing insurer with the application a copy of the replacement notice.
- Every agent who uses written or printed communications in conservation shall leave with the applicant the originals of any materials used.

Each agent or broker shall present to an applicant the following notice:

<u>Notice Regarding Replacement: Replacing your Life Insurance Policy or Annuity?</u>

Are you thinking about buying a new life insurance policy or annuity and discontinuing or changing an existing one? If you are, your decision could be a good one--or a mistake. You will not know for sure unless you make a careful comparison of your

existing benefits and the proposed benefits. Make sure you understand the facts.

You should ask the company or agent that sold you your existing policy to give you information about it. Hear both sides before you decide. This way you can be sure you are making a decision that is in your best interest.

We are required by law to notify your existing company that you may be replacing their policy.

10. Policy Loans

A **Policy Loan** on a permanent policy must have a cash surrender value and be available to a policyowner after **3** years of premium payments have been paid. The company must grant the policy loan within **6** months of a written request to do so.

The maximum fixed interest rate on a policy loan may not exceed **6%**. However, if the interest rate is variable, it may change between 4% and 8%. Variable rates can be changed no more than once per year. The insured must be made aware of the interest rate when the loan is made, and must be notified in advance of any increases in the interest rate on their policy loan.

It is important to note that if the indebtedness of the loan amount plus interest ever exceeds the cash surrender value of the policy, then the policy would be terminated. Any existing indebtedness can be subtracted from the total loan amount.

The repayment of a policy loan may occur at any time. While repayment is not required during the lifetime of the insured, if the insured dies before the policy loan is repaid, than the insurance company simply deducts the loan balance plus interest from the death benefit paid out. Also, if the policy were allowed to lapse, the outstanding loan and interest amount would be deducted from any surrender value.

11. Insurable Interest, Beneficiaries, Consent

California insurance Code and Ethics provide that an individual can purchase a Life Insurance policy insuring themselves, while also having the right to name anyone the beneficiary of that policy.

However, in order to take out a Life Insurance policy on another person, an individual must have an **Insurable Interest** in the life of that person. This is to prevent Life Insurance policies from being used to profit in illegal and immoral ways.

Accepted forms of Insurable Interest are:

- Between Spouses
- The parent or legal guardian of a minor who is being insured
- An individual who is responsible for the final expenses of an adult they provide support and care for
- Immediate family members who take out policies on each other and are the beneficiary

Note: There are exceptions to insurable interest, including beneficiaries that are educational, religious, or charitable institutions.

If a beneficiary or payee without insurable interest receives any payment on the death, disablement, or injury of the insured, their executor may seek to recover from whoever received payment. A company is allowed to rely on all statements made by an applicant for insurance regarding insurable interest, and may not held be liable for any untrue statements relied on in good faith.

A. Consent

Consent of the insured is always required for life insurance with the following exceptions:

- A spouse may obtain insurance upon the other
- A person having an insurable interest in the life of a minor, or any person upon whom a minor is dependent for support and maintenance, may obtain insurance upon the life of the minor
- Family policies may be issued insuring any two or more members on an application signed by either parent, stepparent, husband, or wife
- A person may obtain insurance that provides for the final expenses of an adult who is dependent on that person for support and maintenance
- Whenever a business has insured the life of a director, officer, agent, or employee, a written statement approved by the board of directors, signed by the president, protects the insurance company regarding the validity of the policy.

12. Accelerated Benefits

Accelerated Death Benefits may be payable to the policyowner or beneficiary while the insured is still alive. These benefits are paid in anticipation of the insured's imminent death or other catastrophic occurrence. Accelerated Death Benefits also reduce the benefit amount that would otherwise be payable under the policy, and they are also payable upon the occurrence of a single qualifying event that results in the payment of a benefit amount that is established and fixed at the time of acceleration.

Accelerated Death Benefits may be used in the following situations:

- A current medical condition that limits the insured's life to less than **2** years
- A current medical condition that involves an organ transplant, artificial life support or other drastic medical procedure that keeps the insured alive
- A current medical condition that will confine the insured to an eligible health care facility for the rest of their life
- Any medical condition that requires crucial treatment, that if not done will result in the death or shortened life of the insured, such as emergency surgery, treatment for AIDS, or other similar drastic medical procedure
- Any medical condition that the Director deems to be life-threatening to the insured and is thus eligible for **Accelerated Death Benefits**

It is important to note that an Accelerated Death Benefit option may have a probationary period of up to **30** days for an illness. However, there cannot be a probationary period for an accident.

This benefit also must include a lump sum payment option, and the use of the payment amount cannot be limited in any way.

Insurance companies cannot define or sell these benefits as 'long-term care insurance'. The company may not discriminate in any way among those who choose or elect to use Accelerated Death Benefits.

13. Policy Illustrations

The purpose of the Law and Regulation concerning Policy Illustrations is to make sure any illustrations used by insurance companies are understandable and do not mislead consumers in any way. An insurance company must notify the Commissioner if a policy is to be marketed or sold using policy illustrations.

A. The 3 Types of Illustrations

Policy Illustrations may be of **3** types:

1) A **Basic Illustration** is a proposal that shows the both the policy's guaranteed and non-guaranteed elements.
2) An **In Force Illustration** is provided to the policyowner at any time the policy has been in force for more than one year.
3) A **Supplemental Illustration** is usually provided in addition to the Basic Illustration. It can only show non-guaranteed policy elements that are similar to the Basic Illustration.

Note: **Guaranteed elements** include the premiums, death benefits, cash values and riders that are established and guaranteed when the policy is issued.

Non-guaranteed elements include the premiums, death benefits, cash values and riders that are shown by illustration over a number of years and are not guaranteed when the policy is issued.

All Policy Illustrations must be clearly labeled 'Life Insurance Illustration' and must include:

- The name of the insurance company/provider
- The name and address of the insurance company/provider
- The name, sex, and age of the proposed insured
- The rate classification under which the illustration is based (e.g., smoker, non-smoker)
- The generic name of the policy, form number and company product name
- The initial death benefit
- Any dividend option if applicable

Life insurance policies that use illustrations must also include annual reports that show the following:

- Annual premiums
- Current dividends
- Current death benefits
- Outstanding loan amounts
- Current cash surrender values
- Application of current dividends

Note: Any interest rates used in an illustration can’t be higher than rates currently being offered by the insurance company. If a Policy Illustration is used, the insurance company must keep copies,

including any revisions or updates, for at least **3** years after the policyowner terminates the policy.

When a **Policy Illustration** is to be used during any sales presentation of a Life Insurance policy, the insurance company, or it's representative, may not:

- Claim or mention that the policy is anything but a Life Insurance policy. Prohibited are claims of it being an 'investment' or a 'retirement savings account'
- Mislead or describe that any non-guaranteed elements in the policy are actually guaranteed
- Use or make reference to any **Policy Illustration** that does not comply with state laws and regulations
- Provide or show any incomplete illustrations
- Use the term 'vanishing' or 'vanishing premium', or any term that implies the policy becomes paid up or that future premiums can be paid by non-guaranteed elements
- Use a **Policy Illustration** that shows policy performance as more favorable to the policyowner than the insurance company's illustrated scale
- Use a higher interest rate to increase cash value or other non-guaranteed elements than the insurance company's underlying rate scale

Every insurer and agent offering for sale individual life insurance policies or individual annuity contracts with the use of nonpreprinted illustrations of nonguaranteed values has to emphasize those illustrations on an attached cover sheet, using:

- Bold or underlined capitalized print

- A contrasting color sticker
- Bright highlighter pen
- Any manner that makes it more prominent than the surrounding material, with at least one-half inch space on all four sides

The illustration should come with the following statement:
"This is an illustration only. An illustration is not intended to predict actual performance. Interest rates, dividends, or values that are set forth in the illustration are not guaranteed, except for those items clearly labeled as guaranteed."

B. Illustration Exceptions

The Law and Regulations concerning Policy Illustrations applies to all life insurance policies except for the following:

- Variable life insurance
- Group term life insurance
- Credit life insurance
- Individual and group annuity contracts
- Any life insurance policy with a face value of less than **$10,000**

Any **Policy Illustration** used in a sales or marketing presentation must also be signed and dated by the potential insurance consumer to indicate that the illustration has been explained to them and they understand it.

14. Backdating

While a Life Insurance policy may be legally backdated for the purpose of "saving age" or eligibility, it cannot be issued or take

effect more than **6** months before the application date of the insurance.

Section CE 9

HEALTH INSURANCE

NOTE: If you signed up for Life Only or Fire & Casualty, you still need to complete this section.

Objectives

Unit 9 will cover the Laws and Regulations concerning Health Insurance in California.

1. Law and Regulations Pertinent to Health Insurance

A. Post Claims Underwriting

No insurer in California who issues Disability policies that cover hospital, medical, or surgical expenses, can engage in what is known as “postclaims” underwriting. Postclaims underwriting means the rescinding, canceling, or limiting of a policy due to the insurer's failure to complete medical underwriting and resolve all reasonable questions from written information submitted on or with an application before issuing the policy.

B. HIV

Testing for the **HIV** virus can only be done with the written consent of the potential insured party. This consent includes the party to which the results of the test are to be reported to: a physician, the county health department in which the insured

resides, or the insured directly. This consent is valid for **6** months and is obtained by the insurance company during the underwriting process, so long as it is prior to any testing for the virus. It must be made known to the potential insured that the test for HIV will be used in the determination of the individual's insurability.

Alert!
When we took the final licensure exam, we ran into this question: "The HIV written consent is valid for ____ months:" We always like to point out the questions we had, just so you can be extra-special prepared.

Any positive test results are to be reported as indicated on the consent form. Any direct disclosure of positive test results has to include information on the California AIDS Hotline telephone numbers to help the person find a doctor or with any questions.

The insurance company may report any positive test result to the **Medical Insurance Bureau**. This report is made in the form of *a* nonspecific abnormality determined by a blood, urine or saliva test.

C. Incontestability Clause

A Health Insurance policy is considered to be Incontestable after **2**- years from the date of issue. After a **2**-year period, no claims can be denied and the policy can't be canceled for any reason. The only exception to this would be for fraudulent misrepresentation on the individual's application.

2. Group Health Insurance

The following are also required in California Group Health policies:

A. Coordination of Benefits (COB)

This provision limits the total benefits payable to **100%** of all covered expenses when more than one insurance plan is providing coverage. It also establishes the priority of plans for coverage: one plan will be the Primary plan, the other will be the Secondary plan.

The Primary plan will cover all expenses up to the plan's limits. Then, the Secondary Plan will cover all expenses in excess of the Primary plan. A rule of thumb for Coordination of Benefits is that when a plan covers an individual who is an employee or qualified member, that plan is Primary over a plan that covers the same individual as a dependent.

When two plans cover the same dependant (common when parents are divorced), the COB provision outlines which policy will be primary and which will be secondary. The primary plan may be decided by which parent has an earlier birthday in the year or it may also be decided by which parent has more custody over the child. In either case, coverage for the dependant will not exceed **100%** of the expenses incurred.

B. Continuation of Benefits

California state law requires **Continuation of Coverage** when an employer is not subject to COBRA requirements. When an employee or other participating member of a Group Health plan is terminated, they can continue coverage under the group policy for themselves and any eligible dependents, so long as the employee or participating member had been covered for at least **3** months prior to termination.

However, the employee would not be eligible for Continuation of Benefits if that person were eligible for Medicare or similar health coverage. This continued coverage has to include only medical and hospital expense benefits. It can exclude expenses for:

- Accidental death
- Dental
- Vision
- Prescription drugs

Continuation of Benefits must be requested in writing within **10** days of termination, or within **10** days of the employee being notified of the right to continued benefits by their employer. This includes any and all COBRA continuation of coverage.

Note: It's too late to make the request, if the person waits longer than **31** days after termination.

A surviving, divorced or separated spouse, who is **55** years or older, can continue the coverage for up to **6** months with

adequate payment of premiums. They can do so until they're eligible for Medicare.

Continuation of Benefits ends on the earliest of the following dates:

- End of the period for which the last premium was paid
- The date the group policy ends, unless replaced by another group policy by the employer
- **6** months after the date the group coverage would have ended
- The premium due date after the date the insured becomes eligible for Medicare benefits
- When COBRA policy provisions dictate coverage will end

C. Termination of Group Disability

If a state-issued Group Disability policy is terminated by an employer or by an insurer, **conversion rights** to an individual policy apply to all employees and dependents, including those who became totally disabled while insured under the policy.

If an insured person dies during the conversion period of a Group Life policy, the amount of insurance is payable as a claim under the Group policy. It is payable regardless if the person did or did not apply for Individual insurance or made the first premium.

3. Medical Supplement Insurance

California requires insurers to have a **6**-month enrollment period for **Medicare Supplement** policies. The **6**-month period begins after:

- Someone has turned 65
- On the 1st of the month
- The person has enrolled in Medicare Part B

Note: For **6**-months after enrollment, a person can't be denied **Medicare Supplement Insurance** due to a medical condition.

These Medicare benefits must be provided as one of the 10 standardized benefit plans (Medicare **A-J** plans). While all 10 plans don't have to be offered, Plan A and at least one other plan must be offered.

Note: A Medicare Supplement policy may not duplicate benefits provided by an actual Medicare plan.

In California, you can't advertise, solicit, or issue a Medicare Supplement Insurance policy without meeting the following requirements:

- No Medicare Supplement policy can contain waivers to exclude, limit or reduce coverage or benefits for specifically named or described preexisting conditions or sicknesses.
- A Medicare Supplement policy in California must not exclude or limit benefits for a loss incurred more than **6**-months after the effective date of coverage because the loss involved a preexisting condition.
- A Medicare Supplement policy in California that is a replacement policy, requires that all time periods regarding preexisting conditions, waiting periods, elimination periods, and probationary periods must be waived.

An insurer can't discriminate—beginning on the first day of the month— for the first **6** months against a 65-year old person if that person is enrolled under Medicare Part B, based on:

- Health status
- Claims experience
- Receipt of care
- Medical condition of an applicant for a policy or certificate that is submitted prior to or during the **6**-month period

In California, a Medicare Supplement policy can't define a preexisting condition more restrictively than: a condition for which medical advice was given or treatment was recommended or received from a doctor within **6** months of the effective date of coverage. This type of policy also cannot cover losses resulting from sicknesses in a different manner than it would cover losses resulting from accidents.

Insurance companies that offer these 'Medigap' policies have the responsibility of establishing marketing procedures to assure that any comparison of policies will be completely accurate and fair. Also, insurance companies must establish marketing procedures to make sure that excessive coverage of insurance is not mistakenly issued or purchased.

Insurance companies must also display prominently on the first page of a Medicare Supplement Insurance policy the following statement:

"Notice to buyer: This policy may not cover all of your medical expenses."

This is an important regulation, because it points out to the purchaser of a Medicare Supplement policy that it is a 'supplement policy' they're buying.

4. Long Term Care Insurance

A chronically ill person qualifies for LTC if one of the **2** following criteria is met:

1) Impairment in **2** out of 6 activities of daily living (ADLs), such as:
    - Bathing
    - Walking
    - Eating
    - Cooking
2) Impairment of cognitive ability

A. The 4 Levels of Care

There are **4** levels of care considered with respect to LTC policies:

1) **Skilled care** requires the treatment and skills of a licensed professional nurse.
2) **Intermediate care** is provided by skilled medical practitioners, but is obviously not continuous or permanent.
3) **Custodial care** is to help meet daily living requirements and does not require a licensed professional or qualified medical health practitioner.

4) **Home health care** includes skilled nursing care, therapeutic health providers and skilled and/or licensed nursing professionals. It is important to note that no Long-Term Care policy sold in California can only offer nursing home benefits. The LTC policy must be comprehensive.

B. Advertisements and Marketing LTC

Every insurer providing long-term care coverage in California shall provide a copy of any advertisement intended for use in California to the commissioner for review at least **30** days before dissemination. The advertisement shall comply with all laws in California. In addition, the insurer needs to keep records of the advertisement for at least **3** years.

California has certain requirements with respect to Long Term Care (LTC) insurance. Every insurer marketing long-term care insurance must:

- Develop and use suitability standards to determine whether the purchase or replacement of long-term care insurance is appropriate for the needs of the applicant
- Train its agents in the use of its suitability standards
- Maintain a copy of its suitability standards and make them available for inspection upon request by the commissioner

Long Term Care Replacement: If the premium on the replacement product is less than or equal to the premium for the product being replaced, the sales commission shall be limited to the percentage of sale normally paid for renewal of long-term care policies or certificates. Replacement is further contingent

upon the insurer's declaration that the replacement policy materially improves the position of the insured.

The agent and insurer shall develop procedures that take into consideration, when determining whether the applicant meets the standards developed by the insurer, the following:

- Can the person afford to pay for the proposed coverage?
- What are the person's unique goals or needs with LTC, and what are the disadvantages and advantages of insurance with regards to those goals and needs?
- If the applicant already has insurance, what is the value, benefit and costs of the existing insurance compared to the value, benefit, and costs of the recommended insurance for purchase or replacement?

Note: It's considered an unfair practice for any insurer, broker, or agent to encourage a policyholder to replace an LTC policy unnecessarily. It's also unfair to cause a policyholder to replace an LTC policy that results in a decrease in benefits and an increase in premium.

It's the Law! With regard to long-term care insurance, all insurers, brokers, agents, and others engaged in the business of insurance owe a policyholder or a prospective policyholder a duty of honesty, and a duty of good faith and fair dealing.

An agent, broker, or other person who contacts a consumer as a result of receiving information generated by a **cold lead device** (only a name, address and phone have been obtained through

advertising), shall immediately disclose that fact to the consumer.

Additionally, each insurer must:

- Establish marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate
- Establish marketing procedures to assure excessive insurance is not sold or issued
- Submit to the commissioner every six months a list of all agents or other insurer representatives authorized to solicit individual consumers for the sale of long-term care insurance
- Display prominently on page one of the policy or certificate and the outline of coverage: "Notice to buyer: This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations."

C. HICAP

HICAP trains volunteer counselors to help seniors with questions regarding Medicare and Long Term Care insurance. All volunteers receive **30** hours of initial training, and continuing education annually. HICAP counselors are there to provide a service only, and do not to sell or endorse any specific type of insurance or company.

HICAP's mission is to help seniors:

- Receive health care benefits
- Understand Medicare's coverage
- Compare Medicare Supplement plans
- Consider HMO options
- Review long-term care and financing choices
- File claims
- Organize their doctor and hospital bills
- Prepare Medicare/HMO appeals and challenge claim denials
- Clarify senior's rights as a health care consumer

Insurers have to give applicants for LTC, information regarding the Health Insurance Counseling and Advocacy Program (HICAP). HICAP provides Health insurance counseling to senior Californians for free. The agent needs to provide the name, address, and the local HICAP number, as well as the statewide HICAP number: 1-800-434-0222.

Note: Insurers have to also give the applicant a copy of the LTC insurance shoppers guide. The guide was developed by the California Department of Aging.

Note: If an LTC policy provides benefits for both institutional care and home care, than that LTC policy can be called "comprehensive long-term care" insurance.

D. California LTC Requirements

Long-term care policies must:

- Cover preexisting conditions that are disclosed on the application no later than **6** months following the effective

date of the coverage of an insured, regardless of the date the loss or confinement begins

- Provide a free look period of **30** days

E. California LTC Prohibitions

A long-term care policy can't:

- Be canceled, nonrenewed, or terminated on the grounds of the age or the deterioration of the mental or physical health of the insured
- Contain a provision establishing a new waiting period in the event existing coverage is replaced by a new insurer, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder
- Provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care
- Provide for payment of benefits based on a standard described as "usual and customary," "reasonable and customary," or words of similar meaning
- Terminate a policy, or contain a provision that allows the premium for an in-force policyto be increased due to the divorce of a policyholder
- Include an additional benefit for a service other than the statutorily required home- and community-based service benefits, the assisted living benefit, or a nursing facility benefit, unless the additional benefit provides for the payment of at least five times the daily benefit and the dollar value of the additional benefit is disclosed in the schedule page of the policy.

5. Disability and Workers Compensation

In California, Workers Compensation **coverage is mandatory,** even if the employer only has one employee. There are of course exemptions such as certain domestic employees, charity or volunteer workers, and certain other workers.

There are 3 ways an employer can obtain Workers Compensation coverage:

1) Obtain Workers Compensation from a private insurer
2) Obtain Workers Compensation from a state fund

Note: The California State Compensation Insurance Fund, which is also referred to as the state fund, is an insurer run by the state. The state fund competes with private insurers within the insurance marketplace, for Workers Compensation business. Sometimes, if someone can't obtain Workers Compensation insurance, they'll go to the state fund as a last resort. Despite that, the state fund is still considered competitive with the private insurers.

3) Self-insurance

Premium determination may be based on the job or job classification. The employer pays total payroll and premiums.

A. Workers Compensation Benefits

The types of benefits that are provided under Workers Compensation are:

- **Medical benefits** are provided without limiting the time or dollar amount for all necessary medical/surgical expenses.
- **Income benefits** are provided for employees who've suffered work-related disabilities. There is a **3**-day elimination period, and if the disability continues for **14** days, Workers Compensation benefits are then paid. The benefits are paid retroactively to cover the waiting period as well. For permanent total or temporary total disabilities, the maximum weekly benefit is **66 2/3%** of the worker's weekly income.
- **Death benefits** include burial expenses and these benefits provide income for the surviving dependents in **2** possible ways:
    1) **Lump Sum Burial Allowance**—this method is determined by the number of dependents and how financially dependent they were on the deceased.
    2) **Weekly Income Benefit**—the maximum weekly benefit is **66 2/3%** of the deceased's weekly income.

- **Rehabilitation Benefits**—this method helps to rehabilitate or retrain a disabled person to allow them to return to work as quickly as possible. This could include paying the expense of altering their lifestyle to incorporate the disability, or it could include vocational training, which trains the disabled person for a completely new job.

B. Workers Compensation Exclusions

The following exclusions apply to Workers Compensation:

- Intentional injuries, either self-inflicted, via prank, or otherwise
- Injuries resulting from intoxication
- Injuries resulting from the employee's failure to use provided safety equipment
- Pain and suffering

C. 24-Hour Coverage

24-hour coverage is the joint issuance of a workers' compensation policy with a disability insurance policy, health care service plan contract, or other medical insurance coverage for non-occupational injuries and illnesses.

A life agent is authorized to sell 24-hour coverage and has completed a course, or seminar of an approved continuing education provider, and proctored examination on Workers' Compensation and general principles of employer liability.

D. Employers Liability

Employers Liability protects the employer when injuries are not covered by Workers Compensation. Employers Liability insurance provides coverage for:

- Lawsuits brought by injured employees
- Lawsuits brought by the family/dependents of injured employees
- Legal defense expenses
- Employee's who aren't eligible for Workers Compensation
- Other supplemental benefits

Exclusions to Employers Liability:

- Contractual Liability
- Anything that's covered under Workers Compensation, Unemployment Compensation, or Disability
- If the employer intentionally caused the injuries
- If the injury happened outside the boundaries of the US, US territories, or Canada
- If a violation of employment laws caused the damages
- Any lawsuits brought by injured employees who were hired illegally
- Work-related injuries to an employee who was knowingly hired illegally

E. Common Law Duties

Employer/Employee relationships and employer obligations have changed since the time of the Industrial Revolution. Prior to the enactment of legislation, this relationship was based on common law, that is, case law as handed down by a court resulting from litigation.

Employers had to be negligent and were sued for any injury or death.

The Common Law **Duties** owed to employees included:

- A safe workplace
- Competent and trained workers
- Warning employees of any dangers or hazards
- Safety procedures

F. Employer Defenses

Employers raised some of the following defenses to prove they aren't liable:

- **Fellow Servant/Employee Rule** states that if one of the injured worker's fellow worker directly caused the injury, then the worker is liable, and not the employer.
- **Contributory Negligence** means if the injured worker was even a tiny bit responsible for the injury, the employer can't be held liable.
- **Assumption of Risk** means that the injured worker knew the rules or the possible dangers, and went ahead and did it anyway. Therefore, the injured worker is liable for their own injuries.

6. Advertising

Each insurance company must establish and maintain a demonstrable system of control over the content, form, presentation, distribution, and dissemination of all such **advertisements** of the policies they offer. All such **advertisements**, regardless who may have produced, created, or disseminated them, remains the responsibility of the insurance company whose policies are being **advertised**.

Alert!

The final exam may ask you who is responsible for the content in a commercial. The answer, as we discussed above, is the insurance company is responsible for the content in the commercial. We're drawing special attention to that point, because the exam wants to make sure you know that inaccurate advertising can't be blamed on anyone other than the company paying for the advertisement.

Advertisements have to be clear and complete in order to avoid outright deception, or unintentional confusion. The Commissioner can decide that an advertisement is misleading. This decision is based on the impression the advertisement is likely to make on any potential buyers.

√ **Search this section using CTRL+F**
√ **Please study required minutes before taking Section Quiz**
√ **CAUTION: 20-Minutes or more idle time (no study activity) will cause disconnection and loss of study session minutes A red flashing button will warn you.**

Section CE 10

PROPERTY INSURANCE

NOTE: If you signed up for Life Only or Accident and Health, you still need to complete this section.

Objectives

Section CE 10 discusses Law and Regulations relating to:

- The Fair Plan
- General Renewal, Nonrenewal and Contract Cancellation
- Rates
- Filings
- Unfair Discrimination
- Credit Scoring
- Claim Settlement

1. FAIR Plan

FAIR stands for Fair Access to Insurance Requirements. Most states have their own FAIR Plan, which acts as a safety net for people who may otherwise have trouble getting insurance.

If someone needs insurance for an insurable property and they've been denied normal insurance coverage, they then become eligible for the FAIR Plan.

All insurance producers in California have to participate in the **California Fair Plan Association (CFPA)**. The Fair Plan is important because:

- It keeps Property insurance stable
- It guarantees that Property insurance is available for anyone who needs it
- It guarantees that insurers always provide insurance for insurable properties

Insurable property that isn't insured under the normal insurance market has to be insured through the FAIR Plan. If the property is physically insurable, coverage can't be denied, even if the property has been previously declined because of its location or any environmental hazards.

Putting it into Context

Sal's dream of owning a hotel finally came true. After purchasing the Home Sweet Home Inn for next to nothing, he contacted his insurance agent to set up a policy. His agent told him that he qualified for the FAIR Plan because the gas station next to Sal's property had caused extensive pollution in the area. The pollution was out of Sal's control and he was legally bound to insure his property, so the insurance company was obligated to write him a policy.

FAIR Plan properties may be higher insurance risks, but insurers equitably distribute these risks.

A. Qualifying for the FAIR Plan

In order to obtain insurance through the FAIR Plan, the applicant has to have:

1) Physically insurable property

2) Made attempts to get insurance through normal insurance markets
3) Been categorized as a high risk by the normal insurance market

If all **3** conditions apply, then the applicant qualifies for the FAIR Plan.

B. Essential Property Insurance

Essential Property insurance falls under the FAIR Plan umbrella. Essential Property insurance is equal to a DP and provides coverage for:

- Fire
- Lightening
- W.H.A.R.V.V.E.S
- V&MM

2. General Renewal, Nonrenewal, and Contract Cancellation

If an insurer wants to renew a policy and raise the rates, the insured has to be notified within 45 days. The insured can take one of two steps:

1) The insured can accept the changes, and the policy becomes effective on the renewal date.
2) The insured can say, “No way, buster!” and then cancel the policy within **45** days of renewal. They’ll receive any paid premiums pro-rata, based on the old policy.

Note: Under no circumstances can an insurer re-rate an insured’s policy if there are changes in their credit history due to divorce or the death of a spouse.

If an insurer wants to cancel a policy or doesn't want to renew a policy, the insured has to notified within **30** days of the cancellation/nonrenewal. The notification has to be in writing and it has to explain why the insurance is being cancelled/nonrenewed.

An insurer can't cancel a policy before it expires, EXCEPT for the following reasons:

- The insured hasn't been paying their premiums. If the insured is canceling for nonpayment of premium and it's within the first **30** days of the policy, the insurer only has to give the insured **10** days notice
- Fraud, misrepresentation, or illegality relating to the policy or a claim

Note: If the insured wants to cancel their policy, the insurer needs to send a short-rate refund within **30** days.

A. Auto Insurance Cancellation/Nonrenewal

If an Auto policy has been in effect for **60** days or more, the insurer can only cancel the policy:

- For nonpayment of premium
- For fraud or violations of the policy
- If the insured loses their driver's license

If the above reasons apply, and the insurer is going to cancel an Auto policy, the insurer must:

- Send the insured written notice with the reasons for cancellation

- Compensate the insured for any unearned pro-rata premiums within **45** days

B. Commercial Policy Cancellation/Nonrenewal

If an insurer wants to renew a policy and raise the terms or rates, they have to notify the insured within **30** days. The insured can either:

1) The insured can accept the changes, and the policy becomes effective on the renewal date.
2) The insured can say, "Take a hike!" and then cancel the policy within **30** days of renewal. They receive any paid premiums at a pro-rata rate based on whichever is lower: the current year or the old policy.

The insurer can't refuse to renew a policy or decide to increase the premium for the term of that policy, IF:

- The policy is issued for longer than **1** year
- The premium is guaranteed

Normally, and insurer can't cancel a Commercial Insurance policy during the policy period. There are exceptions to this rule. An insurer can cancel a policy with only **10** days notice for any of the following reasons:

- Nonpayment of premium
- Fraud or violation of the policy
- If the insured becomes a higher insurance risk due to a court decision or new legislation
- If the insured doesn't comply with loss control recommendations

- If the insured violates contractual duties, conditions, or warranties
- If the Commissioner decides that it's too risky to insure a certain business or line of business
- If the Commissioner decides that insuring a certain business or line of business could put the insurer in violation of California law, or any other state law
- Loss or decrease in reinsurance covering the risk
- Any other reason the Commissioner approves

Note: If the Commercial policy includes fire coverage, the insurer has to give **30** days written notice.

In all situations involving involuntary cancellation, the following must be present:

- Reasons for cancellation
- The cancellation effective date
- Information about the insured's rights to a hearing

If the insured wants to request a hearing, they have to submit their request to the Commissioner within **30** days of receiving the cancellation notice.

Note: During the hearing the burden of proof is always on the insured.

C. Fire Policy Cancellation/Nonrenewal

The insured can cancel a Fire Insurance policy at any time. If the insured cancels the policy in the middle of the term, the insurer will refund any excess paid premiums on a short rate basis.

The insurer can also cancel a Fire Insurance policy at any time. Most of the time, insurers will give the insured **30** days written notice and then the excess premium is refunded on a pro-rata basis.

However, there are reasons that could result in only **10** days notice, such as:

- Nonpayment of premium
- If the building is unoccupied for more than **60** consecutive days
- If utilities have been turned off for more than **60** consecutive days
- If the dwelling might collapse, or it's generally unsafe
- If fire, safety, or building codes aren't maintained
- If the insured doesn't let the insurer inspect the building

Note: Mortgagee or other additional interests will be given **10** days written notice of cancellation.

There are some circumstances that could lead to the insurer not being liable for losses under a Fire policy, such as:

- The insured knew about the hazard and didn't take preventative measures
- The building was unoccupied for more than **60** consecutive days

D. HOP Cancellation/Nonrenewal

The insurer can't cancel an HOP during the policy term, UNLESS:

- Nonpayment of premium
- Any reason involving fraud

If an insurer wants to cancel a policy for nonpayment of premium, they have to give at least **10** days notice. If the insurer has any other reason to cancel the policy, the insurer has to give the insured at least **30** days notice.

Note: The insurer has to notify any mortgagees or other interested parties within **10** days, that the insured will no longer be receiving coverage.

If an insurer doesn't want to renew a policy, or is going to cancel a policy, they have to send the insured a notice of cancellation. The notice of cancellation should include:

- Reasons for the cancellation
- The amount of unearned premiums calculated on a pro-rata basis

If the insured doesn't want to renew a policy or wants to cancel the policy, they have to send the insurer written notice and return the policy or binder. Any remaining premiums are then short rated and owed by the insured for the rest of that policy's period.

E. A Note on Workers Compensation Cancellation/Nonrenewal

If an insured decides to renew a Workers Compensation that's been cancelled for more than **6** months, the insurer has to

submit employee work classifications. If the entire policy needs to be reclassified, the insurer can retroactively bill the insured.

If the insured submits employee work classifications that are inaccurate or purposefully misleading, the insurer will give the insured **60** days notice of cancellation.

3. Rates

Insurance rates shouldn't be too high or too low, and rates need to encourage fair competition between insurance companies.

Insurers determine the rates in California based on:

- The area's predictable, possible, and historical catastrophes
- Reasonable profit margins
- Dividends, savings, and paid premiums

Here are some other methods of determining rates:

- Fire insurance rates are based on how many claims the insured has filed in the past **5** years.
- Homeowners rates can include the cost of risk inspections.
- Workers Compensation rates include plans for rewarding employers for loss prevention and low incidents of loss.

A. Premium Errors

The insured has to be notified if the producer or company charged an incorrect premium. The insurer must also:

- Inform the insured about the error amount
- Offer to cancel on a pro-rata basis of the incorrect premium

- Offer to continue the policy and apply the incorrect premium to the policy, and then the insured has **20** days to pay the remaining balance

If the error is on the insured's end, the insurer can either retroactively apply the adjusted premium or accept the incorrect premium. However, the insurer may choose to cancel the policy, and then any unearned premiums will be pro-rata and based on the correct premium.

4. Filings

The Commissioner approves all forms before an insurance company can use them, including:

- Basic Property and Casualty forms
- Applications
- Riders
- Endorsements
- Renewal certificates

The Commissioner approves or rejects a form no later than **30** days after it's been filed. The Commissioner can also decide to suspend his/her decision for another **30** days. Either way, the insurer receives written notice.

5. Unfair Discrimination

Insureds are grouped by classifications to establish rates and premiums. These classifications are never discriminatory. Examples of unfair discrimination include:

- Class (tax bracket)

- Equal life expectancy
- Race
- Gender
- Physical/mental handicaps
- Victims of domestic violence
- Age

If an insurer is discriminating against clients, the following could apply:

- If the Commissioner believes the discrimination is accidental, the insurer will receive written notice within **10** days requiring a response and correction.
- If the Commissioner believes the discrimination was intentional, the insured will receive written notice no less than **10** days before any hearing.
- After the hearing, the Commissioner could decide that the violation is ongoing, and issue an order to suspend or remove the insurer's Certificate of Authority.

It's not considered unfair discrimination if an insurer chooses not to issue a policy based on location and the ratio of premiums at that location. That has nothing to do with the client; sometimes it's just too risky.

6. Credit Scoring

California statutes and rules protect consumers against unfair or illegal use of credit reports and credit scores as an underwriting factor. An insurer can't refuse insurance based solely on an individual's credit report or score.

The **Fair Credit Reporting Act of 1970** states that if an insurer denies an individual insurance coverage because of information contained in a credit report, that individual has to be notified and have access to their credit information from the reporting agency. If the information contains errors, the agency has **6** months to correct the report.

On an annual basis, the person can request that the insurer review the credit score and reevaluate the policy.

After coverage has been in effect for **60** days, the insurer can't cancel or refuse to renew a policy based on a credit score.

The insurer can't consider any of the following reasons regarding underwriting risks with credit scoring:

- If someone doesn't have a credit history
- If there are credit report inquiries that weren't initiated by the consumer and aren't relevant to insurance
- If there are more than one credit report inquiries due to mortgage or auto loans made within **30** days of each other
- If one person has more available credit than another

Putting it into Context:
Rachel and Wendy walk into an insurance company to apply for insurance. Taking all of Rachel's assets and liability into account, she has $5,000 of available credit. Taking all of Wendy's assets and liability into account, she has $50,000 of available credit. Their limit of

available credit has nothing to do with whether or not they're eligible for insurance.

7. Claims Settlement

The following are considered fair claim settlement practices:

- Provide true information
- Respond to or pay a claim within **30** days of receipt
- Respond to any inquiries from the Commissioner within **21** days
- Complete the investigation within **45** days of the notice of claim or request more time every **45** days until the investigation is complete
- Confirm or deny coverage within **30** days of notification
- Promptly settle any claims where liability is clear

Under no circumstances should the insurer ever:

- Negotiate a settlement with a claimant who isn't an attorney or represented by an attorney
- Offer less than the reasonable recovery amount
- Cause any delays in the settlement process
- Refuse to pay a claim without justification

A. Auto Claims

Auto insurance policies provide settlements based on the ACV or a replacement vehicle that's comparable to the one damaged. The insurer also pays for all applicable taxes and fees.

When settling a claim for Auto insurance, the insured needs to:

- Provide the insurer with all of the information and documentation relating to the accident
- Notify the insurer within **35** days of receipt if a replacement vehicle is more expensive than the claimed market value
- Give the insurer an estimate for the cost of repairs

Note: The insurance company can't specify which person or auto body shop will do the work.

Section CE 11

FIRE & CASUALTY

INSURANCE

NOTE: If you signed up for Life Only or Accident and Health, you still need to complete this section.

Objectives

This section will discuss:

- California Responsibility Law
- Required Coverages
- Assigned Risk Plans
- Workers Compensation

1. California Responsibility Law

Most states require drivers to prove that they can pay for liable bodily injury or property damage in the event of an auto accident. The driver satisfies this requirement by buying Auto insurance for at least the minimum liability required by state law.

California requires that all licensed drivers with a registered auto carry a minimum of **15/30/5**:

- **$15,000** per person for bodily injury
- **$30,000** maximum for bodily injury for all persons involved in the accident
- **$5,000** for property damage

California also requires licensed drivers to carry the same limits (**$15,000/$30,000**) for bodily injury damages caused by uninsured and underinsured drivers.

Note: If the car is regularly driven in more than one state, the driver's insurance has to meet the financial responsibility requirements in each of those states.

Proof of financial responsibility has to be carried in the vehicle. This proof can be:

- A valid Liability insurance policy (**15/30/5**)
- Documentation if someone is self-insured
- A bond of at least **$60,000**
- Cash or securities deposit of at least **$60,000**

California insurance companies issue Certificates of Insurance to prove the insureds met their financial responsibility. The Certificate of Insurance includes:

- The policy number
- The covered auto(s)
- The effective date
- The expiration date

If the insured lies to a police officer or falsifies their financial responsibility, the insured can be convicted of a **Class B misdemeanor.** Here are a few examples of this sort of falsification:

- Forging signatures
- Forging the actual financial responsibility document
- Intentionally giving false information
- Denying the insured has coverage

2. Required Coverages & Actions

Valid Driver License

If you're driving in California, a valid driver's license and valid insurance is mandatory. If you violate this law, you could be required to prove financial responsibility for **3** years—**3** years all at once. So, if a cop pulls you over, you have to prove that you can pay for any auto accident related expenses that happen in the next **3** years.

Insurance Card

Anyone who drives the car has to have a valid insurance card. If a police officer asks to see the insurance card, and the driver doesn't have it, the driver is committing a Class B traffic violation. This violation usually results in a fine, but it can also mean the insured has their car towed and they have to hoof it or take a cab.

Accident Reports

California law requires that all accidents be reported immediately. Within **72** hours of an auto accident, the driver has to:

- Report the accident to the DMV
- Provide a copy of their insurance card that verifies the driver's liability insurance
- Depending on the situation, the driver may also have to file a report with the city

If the person who owned the car wasn't in the car accident and learned about the accident after the fact, they also have to file an accident report with the DMV.

Note: If someone fails to report an accident to the DMV, or they file a false accident report, they'll be charged with a Class B misdemeanor.

Uninsured/Underinsured Motorist Coverage

The State of California does <u>not</u> currently require this coverage.

UM/UIM coverage limits are offered in the same limits the insured carries under Liability. The motorist can choose to lower UM and UIM limits, but they have to say in writing that limits equal to BI Liability were offered to them.

With UM and UIM coverage, the insured is covered for:

- BI caused by an accident involving an uninsured or underinsured vehicle
- BI from owning, maintaining, or using an uninsured vehicle

UM/UIM excludes:

- Anyone other than the insured, their spouse or children, or someone who has permission to use the insured's vehicle
- A vehicle owned or operated by a self-insurer
- State or federal vehicles (US or Canada)
- Any vehicle that operates on rails or crawler treads
- Farm equipment
- Any vehicle that is used regularly by the insured or their household
- An insured vehicle

You're not allowed to stack insurance. The Limit of Liability is the maximum limit for all damages from any one accident regardless of the number of vehicles involved.

Note: UM Property Damage is used in conjunction with BI. The maximum deductibles that a company can require are:

- **$300** deductible for a hit and run or phantom vehicle
- **$200** deductible for any other cause

No-Fault Insurance

California is a not no-fault state, so no-fault insurance is not required.

Personal Injury Protection (PIP)

The State of California current does not require drivers to carry PIP insurance.

PIP is an extension of car insurance that covers medical expenses and, in some cases, lost wages and other damage.

PIP benefits consist of:

- Coverage per person for all reasonable and necessary medical, hospital, dental, surgical, ambulance, and prosthetic services for up to **1** year
- **70%** of loss income up to **$1,250** per month for up to **1** year. Loss of income payment begins **14** days after the accident until the person can return to work, or up to **52** weeks if the disability continues
- Up to **$30** a day reimbursement for essential services that the insured would perform if they hadn't been disabled by the accident. The coverage begins **14** days after the accident and ends when the person can perform the services by themselves, up to **52** weeks, or upon the person's death
- **$2,500** for all reasonable and necessary funeral expenses within **1** year of the accident
- Up to **$450** (a maximum of **$15** a day) for childcare if the parent is hospitalized. Payment starts **24** hours after hospitalization and continues for up to **1** year, or until the parent can return to work

Note: PIP benefits may not apply if the insured is eligible for Workers Compensation, or disability benefits.

California SR-22 Requirements

California currently requires an SR-22 filing to reinstate a driver's license.

SR-22 is a document that is required to be filed with a state's DMV as proof that the minimum liability coverage for the state is being carried. Not everyone needs an SR-22 filing. SR-22s are typically required for a driver to reinstate their driving privileges after an offense such as a DUI conviction, uninsured auto accident, or driving without proof of insurance.

California DUI Laws

For the first DUI offense in the State of California, you will face the following maximum penalties:

- 4 days to 6 months imprisonment
- $390 to $1000 fine(s)
- 6-month license suspension
- Possible court-ordered installation ignition interlock device at the expense of the DUI offender
- Successful completion of Driving Under the Influence Program
- SR-22 required for restricted license

3. The California Automobile Assigned Risk Plan (CAARP)

Assigned Risk Plans, also called Auto Insurance Plans, are agreements between insurers in a particular state who share the poorer risks.

Poorer risks are people that have a hard time getting Auto insurance, because of bad driving records. They're still legally required to carry Auto insurance. Poorer risks are therefore distributed among insurers, and the insurers share the added risk of providing Auto insurance to poorer risks.

4. Additional Automobile Insurance Settlement & Repair Standards

In **settling or adjusting** automobile claims there are numerous standards contained in the California Code of Regulations #2695.8. While these standards apply mainly to insurers, agents should know the following:

Insurers may elect to make a cash settlement based on the actual cost of a comparable automobile (like kind and quality with similar options and mileage), minus any policy deductible. This amount shall include taxes, transfer fees, license and registration fees.

Insureds who decide to keep their vehicles shall receive a cash settlement of a comparable automobile, including the sales tax. Transfer fees and salvage value will also be part fo the final amount.

In the **repair of automobiles**, No insurer shall require that an automobile be repaired at a specific automotive repair dealer, unless either of the following applies:

(A) A referral is expressly requested by the claimant.
(B) The claimant has been informed in writing of the right to select the automotive repair dealer.

If the recommendation is accepted by the claimant, the insurer shall cause the damaged vehicle to be restored to its condition prior to the loss at no additional cost to the claimant other than as stated in the policy or as is otherwise allowed by law. If the recommendation of an automotive repair dealer is done orally, and if the oral recommendation is accepted by the claimant, the insurer shall provide the information contained in this paragraph, as noted in the statement below, to the claimant at the time the recommendation is made. The insurer shall send the written notice required by this paragraph within five calendar days from the oral recommendation. The written notice required by this paragraph shall include the following statement plainly printed in no less than 10-point type:

"WE ARE PROHIBITED BY LAW FROM REQUIRING THAT REPAIRS BE DONE AT A SPECIFIC AUTOMOTIVE REPAIR DEALER. YOU ARE ENTITLED TO SELECT THE AUTO BODY REPAIR SHOP TO REPAIR DAMAGE COVERED BY US. WE HAVE RECOMMENDED AN AUTOMOTIVE REPAIR DEALER THAT WILL REPAIR YOUR DAMAGED VEHICLE. IF YOU AGREE TO USE OUR RECOMMENDED AUTOMOTIVE REPAIR DEALER, WE WILL CAUSE THE DAMAGED VEHICLE TO BE RESTORED TO ITS CONDITION PRIOR TO THE LOSS AT NO ADDITIONAL COST TO YOU OTHER THAN AS STATED IN THE

INSURANCE POLICY OR AS OTHERWISE ALLOWED BY LAW. IF YOU EXPERIENCE A PROBLEM WITH THE REPAIR OF YOUR VEHICLE, PLEASE CONTACT US IMMEDIATELY FOR ASSISTANCE."

5. Workers Compensation

The **Workers Compensation Division (WCD)** is part of the State of California Department of Consumer and Business Services. The **WCD** regulates and administers California's Workers Compensation laws.

In the past, workers had to really fight for compensation for on the job injuries. Now workers don't need to fight for compensation if they're injured on the job.

A non-disabling injury only requires medical attention. A disabling injury entitles the employee to disability or death benefits.

Note: This should be obvious, but for all you H. Simpsons out there, you're not entitled to Workers Compensation benefits if you're injured off the job.

An employer is required to report any accident that might result in a claim within **5** days. Employers are also required to help their employees process any claims.

An insurer has to provide compensation for temporary disabilities **14** days after receiving notice of a claim, if the validity of the claim is verified by a physician or nurse practitioner.

Workers Compensation benefits include:

- **Medical Benefits** cover any necessary medical expenses.
- **Disability Income** assists the worker while they're disabled, either temporarily or permanently. The worker is entitled to **70%** of lost wages during this period. The disability can be:
    - o Temporary and totally incapacitating. Temporarily the worker can't perform their usual duties, and they'll receive no less than the state's minimum wage.
    - o Permanent and totally incapacitating. The worker won't ever be able to perform their usual duties, and they'll

receive no less than the state's minimum wage. They'll also have an opportunity to receive training for another position.

  - A temporary partial disability. The worker can do some of their usual duties at a lower wage. If the injury results in the loss of a limb, eye, or hearing in one or both ears, the worker will be compensated for the loss. They'll also receive a portion of their lost wages.
  - A permanent partial disability. The worker will only be able to perform certain duties for the rest of their life. They're entitled to receive a percentage of lost wages.

- **Death and Survivor Benefits** cover the costs to bury the worker in an amount up to 10 times the weekly wages. It also covers monthly benefits to surviving family members:
  - A surviving spouse will receive monthly benefits until they remarry or start living with another person. Once this happens, they'll receive a lump sum of 36 times the monthly wage.
  - A surviving child will receive monthly benefits, which is determined by the worker's income and the child's age.
- **Rehabilitation Benefits** cover the costs associated with medical rehabilitation to help the worker recover from their injuries. If the worker can't recover, they may be eligible for retraining.