

Ethics in the Workplace

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Ethical Conduct

Since 1977, Gallop polls have consistently ranked insurance agents among the lowest in terms of ethics. In a November 1999 poll; insurance agents were ranked at the very bottom of a long list of professionals, out ranking only telemarketers and car salesmen.

Many studies have indicated that insurance professionals look to different sources for ethical guidance. Some insurance agents watch and observe the behavior of their managers and colleagues to formulate their own opinions on insurance ethics; others rely on their own personal values. Since many insurance professionals rely on various sources of guidance, experts believe that it would be wise for insurance managers to modify the atmosphere of the workplace to one of high ethical standards. The professional manager should always strive for consistent ethical behavior on the part of his or her agents (Consistency has always been a major ingredient for success in any business). Very little time is spent on ethical training, but on the other hand, an enormous amount of training hours are spent on selling techniques. If managers would place ethical standards on the same plane as sales, they would send a very positive message to their workforce, clients, and the general public.

INSURANCE BASICS

Customarily, insurance is written by corporations which are intangible legal creations acting through real people operating under either a principal –agent relationship. Where general or specified authority to make contracts for the corporation is granted, the relationship is one of principal-agent.

For the most part, the marketing of insurance is conducted through representatives of insurers known as “agents.” An insurance agent is anyone authorized by an insurer to solicit, create, modify or terminate contracts of insurance between the insurers and the insured. Also involved in the marketing process are insurance brokers. An insurance broker is a person who, for a consideration, solicits and negotiates contracts of insurance for an insured and is the agent of the insured and not the insurer.

Creation of an agency relationship

An agency relationship may be established between principal and agents by mutual assent. This assent usually is given in an express agreement known as an agency contract. Most insurance agency relationships are based on expressed agreements. Mutual assent, however, can be reached after a transaction has occurred by one party sanctioning the actions of another as those of one’s own, creating an agency by ratification.

While an agency relationship between principal and agent usually may be created only with the consent of the principal by agreement or ratification, special circumstances are construed to deny the principal the right to claim that no agency relationship existed. These circumstances established an agency by estoppels. Thus, if the insurer's behavior causes a reasonable person to believe that a particular individual is an agent of the company, a court is likely to hold that a presumption of agency exists.

Agent's powers and authorities

The power of an agent rests primarily on the authority granted in the agency contract. However the power to bind the principal extends beyond the contractual authority specifically granted. Insurance agents have three kinds of authority.

1. The agent has the stipulated or expressed authority bestowed by the terms of the contract with the insurer.
2. The agent has implied authority. The law gives agents that power which the public reasonably may believe them to have.
3. The agent has apparent authority-that authority which the agent has exercised and in which the insurer has acquired by failure to protect.

Responsibility of principals

The acts of the insurance agent operating within the scope of expressed or apparent authority are viewed as acts of the insurers. The law considers the agent and the insurer as one and the same. Thus, the insurer is legally responsible for the actions of its agents

while performing their prescribed duties, even if such agents make fraudulent assertions unknown to or unauthorized by the insurer.

While the insurer may limit the agent's authority and such limitations are binding on the agent, they are not always binding on third parties. Third parties may rely on a "normal" agency relationship. Therefore, "unreasonable" limitations on the agent's authority are not binding on insured's unless effectively communicated to them.

Warranty, Representation, and Concealment

In insurance, the use of warranties and representation is to protect the insurer from the insured. The basic principal arose under the common-law doctrine that insurance is a contract of utmost good faith. Insurers rely on information furnished by prospective buyers in deciding whether or not to write the insurance and in determining the premium. If the information is false or incomplete the insurer may be able to void the contract on the grounds of warranty violations, misrepresentation, or concealment.

The common-law doctrine of warranty

A warranty in insurance is defined as a stipulation in the policy relating to the nature of risk insured which conditions the insurer's liability. Thus, in a theft insurance contract, if the insured agree to keep the doors locked while the house is unattended, that promise is a warranty. Noncompliance with a warranty may be grounds for the insurer to void the contract. To void the contract, the insurer need only to prove that a warranty has been violated. Breach of a warranty may void a policy even if the insured gave information to the best of his knowledge.

The common –law doctrine of representation

Representations are statements made by the applicant to the insurance company in the process of obtaining a policy. Representation may be oral or included in a written application. Oral representations, however, are difficult to prove in a court of law.

The agent’s fiduciary responsibility to the principal

An agent is an individual who has the responsibility to look out for the best interest of the principal. This entails the highest degree of trust and confidence. When an agent under takes employment with an insurer, he will be held to a high degree of trust, fair play, and responsibility while performing his duties.

An agent must always act on behalf of the insurer’s best interest and must put the insurer’s interest ahead of his own. This is the role a fiduciary takes when he enters into a contract with a principal.

The agent, if authorized, can represent the interest of more than one principal. An independent insurance agent or broker can represent the interest of several insurers as long as there is full knowledge and consent of all parties.

An agent must stay within the confines and conditions of his agency contract with the insurer. An agent cannot receive personal financial gain other than what is specified in the agency agreement.

It is the agent’s responsibility to make sure that all questions on the applications are answered truthfully and completely. The agent

must use every skill at his or her disposal to make sure that the insurer's goals are obtained in the most effective and efficient manner possible.

When conducting insurance transactions, the agent must avoid any potential conflict of interest between himself, the insurer or the insured. The agent must represent insurance products and services in a skillful and honest manner to the insured. If the agent misrepresents the insurer or its products and services, the agent would be liable for losses to either the insurer or the insured or both. This is true even if the misrepresentation was not intentional.

Ethically in the insurance industry, it is accepted practice that when the subject of a competing insurer is brought up that it is in the best interest of the industry for the agent to not defame the competing insurer. The agent should stick to the issue at hand and avoid causing any ill feelings towards the other insurance company.

Captive insurance agents

A captive insurance agent is an individual who has an exclusive contract with one or more insurance companies. He is the insurer's fiduciary and therefore must represent the insurer in the highest and most reputable manner possible.

It is unethical for captive agents who represent one or more insurance companies to sell the same or similar policies to potential clients.

The agent has an obligation to disclose to the insurer his or her interest in any similar business or service that he renders regardless of whether he receives compensation. It is then up to the principal to determine whether or not a conflict of interest exists.

Unfair Trade Practices

Twisting

Twisting is the practice of inducing a policyholder to lapse or cancel a policy of one insurer in order to replace it with the policy of another insurer in a way which would operate to the prejudice of the interest of the policyholder.

Rebating

Rebating consists of directly or indirectly giving or offering to give any portion of premium or any other consideration to an insurance buyer as an inducement to the purchase of insurance. An example of unlawful rebating would be an offer by an insurance agent to give a part of his commissions to a prospective insured. Only licensed insurance agents can receive commissions from the sale of insurance policies.

Misrepresentation

A representation is a written or oral statement made by the applicant prior to the creation of an insurance contract. If the statement is false or misleading, a misrepresentation exists that could provide grounds for the insurer to void the contract at a later date. In order for misrepresentation to be grounds for voiding the contract, it must be of a “material fact”. A material fact is information that would have caused the insurance company to reject the application or caused the insurer to issue the policy on substantially different terms had the truth been known.

Usually, misrepresentation must be made with fraudulent intent before it can be used by the insurance company as grounds for voiding the contract.

This application of the principle is based on the assumption that the subject matter of the insurance can be inspected by the insurer. The company is not obligated to depend solely on the information provided by the insured, and therefore doesn't have grounds to void the contract, unless it can prove a willful intent on the part of the insured to defraud the insurance company. For example, a provision in the basic fire insurance policy states:

“This entire policy shall be void if, whether before or after a loss, the insured has willfully concealed or misrepresented any material fact or circumstance concerning this insurance or the subject matter thereof...”

Typically, fire policies require a willful intent on the part of the insured to defraud the insurer. In the past, many insurance applicants have misrepresented important facts. Naturally, the reason for this is to obtain insurance where otherwise no insurance company would issue a policy at all, or to obtain the insurance at a lower cost.

State Insurance regulations

Claims and complaints handling

One of the goals of State Regulators is to ensure policyholders are treated fairly and can have confidence that their valid claims will be paid. Complaints from policyholders can arise from all aspects of the placing and servicing of a risk, but most complaints stem from the decision to deny claims or because of inadequacies in the claims handling process.

Principals should ensure that documentation clearly identifies the steps to be taken in the event of a personal lines claim and that in-house procedures facilitate the prompt handling and payment of valid claims. A well-defined claims handling process setting out clear levels of staff responsibility should be in place, supported by a policy of open communication with claimants. It should be emphasized that where authority to settle personal lines claims is delegated to intermediaries, principals still retain overall responsibility and should therefore ensure that the guidance set out is in compliance with State Insurance Laws.

Documentation

The insurance policy is the primary source of information available when a policyholder wishes to file a claim. Accordingly, policies issued to policyholders should clearly state the initial point of contact in the event that there is a claim and make it clear what action the policyholder should take.

Procedures

The principal should ensure there are written procedures in place setting out the process for handling claims from policyholders. These procedures should be designed to ensure that

- a. an individual is nominated as having overall responsibility for the claims handling function;
- b. an individual's level of authority for claims settlement is based on his knowledge and experience;
- c. the person who originally underwrote the risk does not have sole responsibility for handling a claim;
- d. each individual dealing with a claim is aware of and understand the procedures (and their own limits of authority);
- e. there is a clear delineation of responsibility and clear reporting lines;
- f. all claims are dealt with promptly and appropriate action is taken in line with in-house service standards;
- g. claims files are properly documented with a copy of the claim any reports commissioned. A record of relevant telephone conversations/meetings and the action taken, together with details of the final outcome.
- h. there is a system for regularly monitoring the effectiveness of the claims handling process; and identifying common causes of complaints;

- i. any appropriate remedial action is promptly taken.

Communication with claimant

As the primary source of complaints relates to claims, principals should have in place a policy of keeping policyholders (or their agents) informed of the progress of their claims and provide an explanation of the reason for the outcome of a claim in the event that a claimant's claim is not being met in full. Accordingly, procedures should ensure that:

1. policyholders (or their agents) are kept regularly advised of developments on the progress of the claim and, where appropriate, of the responsibilities of the parties involved,
2. where a claim is denied in whole or in part, the policyholder is given a clear written explanation of the reason.
3. the policyholder (or his agent) receives a clear explanation of how claim payments were calculated (with supporting evidence where appropriate).

Standard Services

The principal should ensure in-house services are included as part of the procedures for the prompt handling of personal lines claims and complaints and that they are kept under review. The service should be realistic, in writing and set out reasonable expectations in respect of such issues as for example:

1. time limits on acknowledging written complaints and other mail including time frames for providing interim updates to complainants and policyholders;
2. time limits on answering and returning calls;
3. responsibilities of others appointed to assist the complaints/claims handling process such as adjusters/repairers;
4. guidance on dealing with complaints against those acting on underwriters' behalf e.g. approved repairers' adjusters' etc;
5. guidance on dealing with complaints that include against unlicensed producers/ agents;
6. guidance on the use of standard letters/explanations of insurance principles;
7. guidance on dealing with claims complaints from third parties;
8. time frames within which payments representing settlement of valid claims will be made to policyholders.

In order to prevent the escalation of a complaint, the complainant must be kept informed of progress in clear and open manner, for example:

1. where it is decided additional medical reports are necessary in order to assess a claimant's disputed demand for continuing benefits under a Personal Accident Policy, that the complainant is told why this is deemed necessary, of the co-operation required and the next steps to be followed,
2. where the policyholder remains dissatisfied, new or outstanding issues raised by the policyholder or points not previously covered should be communicated, relevant insurance principles explained in plain language and any final proposal to conclude matter made.
3. where in-house procedures are exhausted all options available in circumstances where/if the policy allows for this or referral of the complaint to the State Insurance Department, should be outlined. Policyholders should not be coerced into following one course of action in preference to another.

Filing a complaint with the State Insurance Administration

The primary role of each State Insurance Administration is to protect consumers from illegal insurance practices by ensuring that insurance companies and producers that operate in their state act in accordance with State insurance laws.

What the Insurance Administration will do once a complaint has been received from a consumer:

- forward a copy of the complaint to the insurance company, appropriate;
- obtain information or explanations on the consumer's behalf from the insurance company or their representatives. This may involve written and verbal contact with such companies or persons;
- review in detail the information obtained from the company for compliance with statutes, regulations and policy contracts;
- explain the provisions of the consumer's insurance policy, as appropriate;
- suggest to the consumer actions or procedures that he may take which could aid in resolving the insurance problem;
- if it is determined that the actions of an insurance company in violation of a statute, regulation or policy that the Insurance Administration enforces, they will take corrective action against that insurer.

State Insurance Administrations have the authority to make decisions as to disputes between the consumers and insurance companies or their representatives which involve deciding matters as to;

1. Who is negligent or at fault;
2. The facts surrounding the claim

3. The value of a claim or the amount of money owed to the consumer; or
4. Any other factual disagreements between the consumer and another party, unless the dispute involves a violation of law.

How to file a complaint

All complaints must be received in writing. Some States allow consumers to file complaints on-line, but most complaints are filed by sending a written letter. If the consumer sends a letter then he must provide the following information to the Insurance Department:

1. name, address and daytime and evening phone number
2. name of the person's insurance company, type of insurance (auto, homeowners, fire, etc.), policy number and claim number (if applicable)
3. name of any other insurance company, agent, adjustor, etc. involved in the problem
4. a detailed explanation of the problem or situation
5. copies of any documents that may be important for the investigator to review

Each State Insurance Administration has the authority to regulate all insurance companies, producers, premium finance companies, motor clubs and HMOs that are licensed to conduct business in their state.

Generally, State insurance laws do not apply to insurance contracts (or policies) issued in other states. For example, if a person's policy was issued in Virginia, then Virginia law and not Maryland law applies to his coverage. In these instances,

the person will need to contact the Regulator in that state of assistance.

Regulation of the Insurance Industry

The basic danger of competition in the insurance industry is the possibility that, in their attempt to compete, insurers may underestimate their costs and fail as a result. **The primary purpose of government regulation of insurance companies is to assure the solvency of the insurers.**

Insurance contracts are uncertain promises made by the insurer to the insured. In return for the insured's premiums, the insurance company promises to pay a specified sum in the event the insured suffered a loss that is covered in the policy. Because the insurer's ability to fulfill its promise is based on the financial soundness of the company, the public welfare requires the regulation of insurers.

The complicated nature of most insurance contracts makes them difficult for the insured to understand. Regulators are charged with the responsibility of assuring that the contracts offered by insurers are fair and complete.

History of insurance regulations

Paul vs Virginia

The case of Paul vs Virginia was an important Supreme Court decision concerning the regulation of insurance. Samuel Paul was a native of Virginia who represented New York insurance companies in his state. Paul challenged Virginia's right to regulate insurance by selling insurance policies without

obtaining a license from the state of Virginia. The state of Virginia required all insurers that sold insurance policies in its state to post a security deposit. Paul's insurers refused to post a deposit, and therefore the state of Virginia denied both Paul and his insurers an insurance license. In defiance of their actions, Paul continued to sell insurance in Virginia and later arrested and fined \$ 50. the case was carried to the United States Supreme Court, where it was finally decided in 1869. **In rendering its decision, the Supreme Court ruled that insurance was not interstate commerce:**

Issuing a policy of insurance is not a transaction of commerce. The policies are simply contracts of indemnity against loss by fire entered into between the corporations and the insured for a consideration paid by the latter. These contracts are not articles of commerce in any proper meaning of the word. They are not commodities to be shipped or forwarded from one state to another and then put up for sale. They are like other personal contracts between parties which are completed by their signature and the transfer of considerations. Such contracts are not interstate transactions, though the parties may be domiciled in different states. The policies do not take effect – are not executed contracts – until delivered by the agent in Virginia. They do not constitute a part of the commerce between the states any more than a contract for the purchase and sale of goods in Virginia by a citizen of New York, whilst in Virginia, would constitute a portion of such commerce.

The decision of the United States Supreme Court that insurance was not interstate commerce, and, therefore, was not subject to regulation by the federal government stood for 75 years.

The South-Eastern Underwriters Association Case

After a period of 75 years, another test of the authority of the federal government to regulate insurance was made. In 1942, the Attorney General of the United States filed a brief under the Sherman Act against the South-Eastern Underwriters Association (SEUA), a cooperative rating bureau, alleging that

the bureau constituted a combination in restraint of trade. In its decision of the SEUA case in 1944, the Supreme Court reversed its decision of **Paul vs Virginia**, stating that insurance is interstate commerce and as such is subject to regulation by the federal government. **This decision still stands today.**

Public Law 15

Congress insisted that it was the right of the federal government to regulate the insurance industry, but stated in the **McCarran – Ferguson Act of 1945** that the federal government would not regulate insurance as long as the states did an adequate job of regulating the industry. Following the enactment of Public Law 15, the states attempted to put their houses in order, enacting rating laws, fair trade practices, and extending the licensing and solvency requirements.

Regulation Today

Insurance is presently regulated by the states, through the three basic branches of our state government; legislative, judicial, and the executive.

Regulation by the Legislative Branch

Each state enacts laws that govern the conduct of the insurance industry within its boundaries. These laws spell out the requirements that must be met by persons wishing to organize an insurance company in the state. A company domiciled within the state is called a domestic insurer. The laws also specify certain requirements that a company domiciled in another state (called a foreign insurer) must meet in order to obtain a license to do business in the state. In addition, the insurance code sets

forth the standards of solvency that is to be enforced and provides for the regulation of rates and investments. It also provides for the licensing of agents.

Regulation by the Judicial Branch

The judicial branch exercises control over the insurance industry through the courts by rendering decisions on the meaning of policy terms and ruling on the constitutionality of laws of the state and the actions of those administering the law.

Regulation by the Executive Branch – the Commissioner of Insurance

The central figure in the regulation of the insurance industry in each state is the Commissioner of Insurance. In most states the Commissioner of Insurance is appointed by the governor of the state and is charged with the administration of the insurance laws and the general supervision of the business. Few people understand the complicated nature of the position or the tremendous power the commissioner of insurance wields. Although he is a part of the executive branch of the state government, the commissioner frequently makes rulings which

have the binding force of law and exercises judicial power in his interpretation and enforcement of the Insurance Code.

The National Association of Insurance Commissioners

The National Association of Insurance Commissioners (NAIC) has been an active force in the regulation of insurance since it was founded in 1871. Although it has absolutely no legal power over insurance regulation, it is an important force. Through it, the fifty state commissioners exchange information and idea and coordinate regulatory activities. On the basis of the information exchanged at its two annual meetings, the NAIC makes recommendations for legislation and policy. The individual commissioners are free to accept or reject these recommendations, but in past the majority of the commissioners have seen fit to accept the recommendations appropriate for their states.

Areas of Regulated

The Commissioner of Insurance has the power to license insurance companies and revoke those licenses. Before licensing an insurer to conduct business in the state, the commissioner must satisfy himself that the company to be licensed meets the financial requirements specified in the insurance code of the state. In order to qualify for a license, the insurance company making application must have a certain amount of capital and/or surplus. The exact amount required varies from state to state, being relatively small in some states and substantial in others.

In addition to the capital and surplus requirement, the commissioner normally reviews the personal characteristics of the organizers, promoters, and incorporators of the company in order to determine their competence and experience. **The commissioner may deny the application for a license if the organizers or incorporators prove to be unworthy of public trust.**

Examination of Companies

The insurance code requires every licensed company, domestic and foreign, to submit an annual report to the Commissioner of Insurance. This report includes information regarding the assets and liabilities of the company, its investments, its income, loss payments, and expenses, and any other information desired by the commissioner. In addition to the annual report, a periodic inspection of each company conducting business in the state is made by the commissioner's office. In the state of Maryland, all domestic and foreign insurers records are audited at least once every five years. The insurance commissioner may examine or inquire into the affairs of any insurer transacting business in the state at any time.

In order to eliminate duplication of effort, it is becoming a practice for the commissioner to examine only those companies that are domiciled in his state. **To provide for the examination of foreign companies, "zone" examinations are conducted, wherein each state in a zone (there are six zones) accepts the examination of the zone for its foreign insurance companies.**

INSURANCE RATES

All state insurance codes provide for the regulation of insurance rates, requiring that the rates be:

1. Not unfairly discriminatory
2. not excessive in nature
3. Adequate

Insurers may not charge a significantly different rate for two clients with approximately the same degree of risk, doing so would be a violation of unfair discrimination laws. **Any difference in rates charged must have an actuarial basis.**

Life insurance rates constitute a special case in the area of rate regulation. Apart from making certain that the insurance companies do not engage in price discrimination, the state regulatory authorities do not directly control life insurance rates. Life insurance companies do not engage in cooperative rate-making, as do the property and liability companies. However, the companies generally begin with the same mortality table and the dictates of competition generally force them to use realistic interest assumptions. In addition, legal restrictions on the expense portion of the premium help to control the cost of life insurance. Some states limit the amount of commission payable in the first year of a life insurance policy to 55% of the premium. Other states have no such limitations on commissions earned in the first year of the insurance contract.

The main reason why regulators have not in the past strictly regulated life insurance rates is because they believed that competition was an effective regulator itself. But a study by Joseph Belth has shown that assumption to be in questioned. In Belth's study, he showed that there are wide differences in costs for identical insurance contracts. He also indicated that the consumer is generally not aware of the price he pays when he buys life insurance. Belth maintains that the pricing complexities in life insurance place analysis of the price beyond the reach of even the sophisticated buyer, and he advocates more extensive disclosure by life insurance companies.

In the area of property and liability insurance, most states follow the pattern of the "All-Industry Model Law," which was proposed in 1946 following the SEUA case. Under the provision of this law, the insurance company must file the rates they intend to charge with the Commissioner of Insurance for his approval. These rates cannot be used until the commissioner has approved them, or until a certain period has expired without his approval. The commissioner retains the right to disapprove the rates after they have become effective.

But in many cases, the commissioner has a limited staff to review rate filing, and as a result, the approval process may take a considerable amount of time. This often leads to a lag in the time between the need for a rate increase and its approval. Now there is a growing interest among industry leaders and insurance regulators in replacing the "prior approval" rate regulatory statutes with state laws under which property and liability rates

would be set by the insurance companies themselves, subject to insurer competition.

Rates must not be excessive

Insurance has come to be regarded as a product that is essential to the well being of society. Insurers may not take advantage of the needs of society to realize unreasonable gains.

Rates must be adequate to cover losses

Insurance rates, together with the interest income from investments, must be sufficient to pay all losses as they occur and all expenses in connection with the production and servicing of the business.

The Reinsurance Market

Through the transfer and spread of insurance risk, reinsurance companies help to protect insurance companies and their consumers from unprofitable or catastrophic results, and provide the capacity to offer coverage to all who need it. On the other hand, inadequate or poor quality reinsurance can contribute to insurers becoming insolvent.

Because of the critical role reinsurance plays in the ability of insurers to keep their commitments to policyholders, a number of state insurance laws, regulations and accounting rules have been adopted to establish requirements for the conduct of reinsurance business and the conditions under which a ceding insurer may take credit for reinsurance in statutory financial statements. This accounting credit takes the form of the establishment of an asset for amounts that a ceding insurer is entitled to recover from a reinsurer or the reduction in the ceding insurer's liabilities or reserves for losses that it has reinsured.

The United States insurance industry has suffered a number of insolvencies of major commercial property/casualty insurers over recent years, and state regulators and industry analysts continue to be concerned about the adequacy of the amount of loss reserves being held by property/casualty insurers transacting business in the U.S. Commercial property/casualty insurers are the insurers the nation relies on for coverage of the risks involved in the provision of vital business and human services. Both federal and state regulators are constantly trying to find ways of helping insurers to improve their financial soundness and industry's image.

Insurers Investments

The ability of insurers to fulfill promises made to insureds will greatly depend on the value of the insurers' investments.

Therefore, state regulators must be sure that these investments are sound. If it were not for outside regulation, insurers might turn to investments which entail a greater degree of risk than is desirable in an attempt to increase their investment performance. In general, property and casualty insurance companies are granted greater latitude in their investments than life insurance companies. Each state's insurance code spells out the particular type of investments permitted to each type of insurance company in the state.

The investments permitted are usually the following:

1. United States government obligations
2. State municipal bonds
3. Territorial bonds
4. Canadian bonds
5. Mortgage loans
6. High-grade corporate bonds
7. Preferred and common stocks (on a limited basis)

Life insurance companies are generally permitted to invest only a small percentage of their assets in common stocks. Stocks represents less than 5% of the total investment holdings of life insurance companies, while approximately one-third of the assets of property and casualty companies are invested in common stocks.

Unfair Trade Practices

Rebating

An insurer might be sound financially and yet indulge in practices that are detrimental to the public, such as unfairly discriminating against an insured or engaging in “sharp” claim practices. The commissioner attempts to control such activities. Rebating and twisting are two unfair practices that are specifically forbidden by many insurance codes. Rebating consist of directly or indirectly giving or offering to give any portion of the premium or any other consideration to an insurance buyer as an inducement to purchase an insurance policy.

Twisting

Twisting is the practice of inducing a policyholder to lapse or cancel a policy of one insurer in order to replace it with the policy of another insurer in a way which would be detrimental to the insured.

Misrepresentations

It is illegal for any person to make issue or circulate any statement or estimate that:

- * Misrepresents the benefits, advantages, conditions, or terms of any insurance policy

- * Misrepresents the dividends or share of surplus to be received on any policy
- * Makes a false or misleading statement about the dividends or share of surplus previously paid on similar policies
- * Makes a misleading representation or misrepresentation about the financial condition of any insurer, or about the legal reserve system upon which any insurer operates
- * Uses any name or title of an insurance policy or class of policies that misrepresents the true nature of the policies.

Defamation

No one may publish, disseminate, or circulate any oral or written statement that is false, maliciously critical of, or derogatory to the financial condition of any insurer, and that is calculated to injure any person engaged in the insurance business.

STATE VERSUS FEDERAL REGULATION

The prospect of federal regulation of the insurance industry has existed since the SEUA case of 1944. While the McCarran-Ferguson Act left regulation in the hands of the states, it did so with the implicit condition that the federal government would not regulate insurance as long as the states did a good job. In effect, the federal government permitted the states to continue to regulate insurance, but it stands ready to take over the regulation if state regulation proves inadequate

Supporters of Federal Regulation

Those who advocate federal regulation of insurance do so on two basic grounds: that the past regulation by the states has been inadequate, and that federal regulation would bring a desired uniformity. The chief criticism of state regulation has been the lack of uniformity. While it is true that some states have done an outstanding job in their regulatory activities, the quality of the regulation has varied markedly. Some states have imposed rigid financial standards on the insurance companies licensed in the state, but others have been relatively lax. The result in some cases has been the failure of insurers and public suffering.

In addition to the inadequacy in some jurisdictions, the lack of uniformity has caused some inconvenience, waste, and duplication of effort. There are 51 different insurance codes, each of which imposes restrictions and limitations on the insurers. An insurance company seeking a rate adjustment or a change in policy form must obtain approval from each of the jurisdictions. This lack of uniformity has been a leading consideration in the pressure for federal regulations.

Supporter of State Regulation

The opponents of federal regulation argue that the individual states have the experience and expertise necessary to meet and solve the critical issues, and that state regulatory authorities, being more familiar with local conditions and problems, are more responsive to local needs. Advocates of state regulation maintain that the NAIC already provides a vehicle for uniformity of regulations to the extent that such uniformity is desirable. Finally, they point out that a system of federal regulation would of necessity be superimposed on the system of state regulation, for many regional insures not subject to federal regulation (since they do not engage in interstate commerce) would continue to exist.

Confidentiality

Title V of the Gramm-Leach-Bliley Act "GLBA" (15 U.S.C. 6801 et seq.) sets forth requirements for protecting the privacy of the non-public personal information of consumers. Federal and State agencies designated as functional regulators in GLBA are directed to implement the Act's consumer privacy requirements.

Under Section 501(b) of GLBA, federal regulatory agencies and state insurance departments are instructed to establish standards for the financial institutions subject to their respective jurisdictions to safeguard such information. Sections 501(b) and 505(a)(6) specifically designate "the applicable State insurance authority of the State" as the agency that "shall establish appropriate standards" covering "any person engaged in providing insurance" under State law. Section 505(a)(6) provides that the state insurance authority will enforce those standards with respect to the financial institutions and other persons subject to its jurisdiction.

The effective date of GLBA's privacy requirements is November 13, 2000. In May of 2000, the designated federal agencies adopted rules to implement the provisions of GLBA. In those rules, the federal agencies extended the time for compliance with the rules until July 1, 2001, in order to provide sufficient time for banks and securities entities to comply with the rules' requirements. The agencies explained their rationale in the Preamble to the federal rules:

New Mortality Tables for Life Insurance

For the first time in 20 years, the National Association of Insurance Commissioners has introduced new mortality tables for life insurance. The new charts-the Commissioners Standard Ordinary, or SCO, mortality tables-are used to determine how long people are expected to live.

Insurers use these tables to determine the amount they must put into their loss reserve account. This account is used to pay future death claims; cash surrender values etc., associated with a life insurance policy.

The new tables were approved in 2002 by the National Association of Insurance Commissioners to replace the 1980 actuarial tables. The NAIC is working vigorously to get the new mortality tables adopted in all 50 states, including the District of Columbia.

The new charts go up to age 120, compared with age 100 for the old charts. The average male life expectancy has risen from age 70 to age 74, and age 77 to age 79 for females.

Experts believe that premiums on new life insurance policies will go down, because as people live longer, insurers will be able to hold and invest the premiums they collect for longer periods of time.

The Gramm-Leach-Bliley Act

Privacy of Consumer Financial Information

Subtitle A of Title V of the Gramm-Leach-Bliley Act ("GLB Act") has privacy provisions relating to consumers' financial information. Under these provisions, financial institutions have restrictions on when they may disclose a consumer's personal financial information to nonaffiliated third parties. Financial institutions are required to provide notices to their customers about their information-collection and information-sharing practices. Consumers may decide to "opt out" if they do not want their information shared with nonaffiliated third parties. The GLB Act provides specific exceptions under which a financial institution may share customer information with a third party and the consumer may not opt out. All financial institutions are required to provide consumers with a notice and opt-out opportunity before they may disclose information to nonaffiliated third parties outside of what is permitted under the exceptions.

Subtitle A of Title V of the GLB Act and the Federal Trade Commission regulation can be found on the Gramm-Leach-Bliley Act web page which can be reached directly from the FTC home page at www.ftc.gov.

* The views expressed in this presentation are not the official views of the Federal Trade Commission or of any individual Commissioner. June 18, 2001.

I. Important Dates and Citations about the Gramm-Leach-Bliley Act

Statute (Public Law 106-102, 15 U.S.C. § 6801, et seq.)

- enacted November 12, 1999

Regulations (16 C.F.R. § 313, 65 Fed. Reg. 33646 (May 24, 2000))

- effective date: November 13, 2000
- compliance date: July 1, 2001

Other Agencies' Rules

- Federal Reserve Board: 12 C.F.R. § 216
- OTS: 12 C.F.R. § 573
- OCC: 12 C.F.R. § 40
- FDIC: 12 C.F.R. § 332
- NCUA: 12 C.F.R. § 716
- SEC: 17 C.F.R. § 248
- CFTC: 17 C.F.R. § 160

II. Overview

A. Key Definitions

- Financial Institution
- Consumers and Customers
- Nonpublic Personal Information

B. Notices

C. Exceptions

D. Limits on Reuse and Redisclosure

III. Financial Institution

Definition: Any institution the business of which is engaging in *financial activities* as described in *section 4(k) of the Bank Holding Company Act* (12 U.S.C. § 1843(k)). Under the Final Rule promulgated by the Federal Trade Commission (FTC), an institution must be *significantly engaged* in financial activities to be considered a "financial institution."

A. Financial Activities:

- Lending, exchanging, transferring, investing for others, or safeguarding money or securities; insuring, guaranteeing, or indemnifying against loss, harm, damage, illness, disability, or death; providing financial investment or economic advisory services; underwriting or dealing with securities. [§ 4(k)(4)(A-E)]
- Engaging in an activity that the Federal Reserve Board has determined to be closely related to banking. [§ 4(k)(4)(F); 12 C.F.R. § 225.28]. For example:
 - Extending credit and servicing loans
 - Collection agency services
 - Real estate and personal property appraising
 - Check guaranty services
 - Credit bureau services
 - Real estate settlement services
 - Leasing real or personal property (on a no operating basis for an initial lease term of at least 90 days)
- Engaging in an activity that a bank holding company may engage in outside of the United States. [§ 4(k)(4)(G); 12 C.F.R. § 211.5(d)]. For example:
 - Operating a travel agency in connection with financial services
 - Only those activities determined to be financial activities under § 4(k)(1-3) as of November 12, 1999, are covered by the FTC

Privacy Rule. While the Federal Reserve Board and the Department of Treasury have authority to add activities that are "incidental" or "complementary" to financial activities, the FTC will review those determinations before proposing to extend coverage of its Rule to such new activities.

B. Examples of businesses that engage in "financial activities" and are "financial institutions" for purposes of the GLB Act:

- Mortgage lender or broker
- Check casher
- Pay-day lender
- Credit counseling service and other financial advisors
- Medical-services provider that establishes for a significant number of its patients long-term payment plans that involve interest charges
- Financial or investment advisory services including tax planning, tax preparation, and instruction on individual financial management
- Retailer that issues its own credit card
- Auto dealers that lease and/or finance
- Collection agency services
- Relocation service that assists individuals with financing for moving expenses and/or mortgages
- Sale of money orders, savings bonds, or traveler's checks
- Government entities that provide financial products such as student loans or mortgages

C. "Significantly Engaged" in Financial Activities:

- Whether a financial institution is "significantly engaged" in financial activities is a flexible standard that takes into account all the facts and circumstances.
- Examples of businesses that are not "significantly engaged" for purposes of the GLB Act:
 - Retailer that does not issue its own credit card (even if it accepts other credit cards)
 - Grocery store that allows consumers to get cash back by writing a check in an amount higher than the actual purchase price
 - Merchant who allows an individual to "run a tab"
 - Retailer that provides occasional "lay-away" and deferred payment plans or accepting payment by means of credit cards issued by others as its only means of extending credit

IV. Consumers and Customers

A. Consumers

Definition: A "consumer" is an individual who obtains or has obtained a financial product or service from a financial institution that is to be used primarily for personal, family, or household purposes, or that individual's legal representative.

Examples of Consumer Relationships:

- Applying for a loan
- Obtaining cash from a foreign ATM, even if it occurs on a regular basis
- Cashing a check with a check-cashing company
- Arranging for a wire transfer

General Obligations to Consumers:

- Provide an initial (or "short-form") notice about the availability of the privacy policy if the financial institution shares information outside the permitted exceptions.
- Provide an opt-out notice, with the initial notice or separately, prior to a financial institution sharing nonpublic personal information with nonaffiliated third parties.
- Provide consumers with a "reasonable opportunity" to opt out before disclosing nonpublic personal information about them to nonaffiliated third parties, such as 30 days from the date the notice is mailed.
- If a consumer elects to opt out of all or certain disclosures, a financial institution must honor that opt-out direction as soon as is reasonably practicable after the opt-out is received.
- If you change your privacy practices such that the most recent privacy notice you provided to a consumer is no longer accurate (e.g., you disclose a new category of NPI to a new nonaffiliated third party outside of specific exceptions and those changes are not adequately described in your prior notice), you must provide new revised privacy and opt-out notices.

B. Customers

Definition: A "customer" is a consumer who has a "customer relationship" with a financial institution. A "customer relationship" is a continuing relationship with a consumer.

Examples of Establishing a Customer Relationship:

- Opening a credit card account with a financial institution
- Entering into an automobile lease (on a non-operating basis for an initial lease term of at least 90 days) with an automobile dealer
- Providing personally identifiable financial information to a broker in order to obtain a mortgage loan
- Obtaining a loan from a mortgage lender
- Agreeing to obtain tax preparation or credit counseling services

"Special Rule" for Loans: The customer relationship travels with ownership of the servicing rights.

- A financial institution establishes a customer relationship with a consumer when it originates a loan.
- If it subsequently sells the loan and retains the servicing rights, it continues to have a customer relationship with the consumers.
- If it subsequently transfers the servicing rights, the entity that acquires servicing has a customer relationship with the consumer.
- Those with an ownership interest in the loan but without servicing rights have consumers.

General Obligations to Customers

- Provide an initial privacy notice not later than when the customer relationship is established.
- Provide, with the initial privacy notice or separately, an opt-out notice prior to sharing nonpublic personal information with nonaffiliated third parties outside of specific exceptions.
- Provide an annual privacy notice annually for the duration of the customer relationship.
- Provide customers with a "reasonable opportunity" to opt out before disclosing nonpublic personal information about them to nonaffiliated third parties, such as 30 days from the date the notice is mailed.
- NOTE: If a customer elects to opt out of all or certain disclosures, a financial institution must honor that opt-out direction as soon as reasonably practicable after the opt-out is received.
- If you change your privacy practices such that the most recent privacy notice you provided to a consumer is no longer accurate (e.g., you disclose a new category of NPI or to a new nonaffiliated third party outside of specific exceptions and those changes are not adequately described in your prior notice), you must provide new revised privacy and opt-out notices.

V. Nonpublic Personal Information ("NPI")

NPI Includes:

- Nonpublic personally identifiable financial information; and
- Any list, description, or other grouping of consumers (and publicly available information pertaining to them) derived using any personally identifiable financial information that is not publicly available.

NPI Excludes:

- Publicly available information; and
- Any list, description or other grouping of consumers (including publicly available information pertaining to them) that is derived without using personally identifiable financial information that is not publicly available.

"Personally Identifiable Financial Information" is any information:

- A consumer provides to obtain a financial product or service;
- About a consumer resulting from any transaction involving a financial product or service; or
- Otherwise obtained about a consumer in connection with providing a financial product or service.

"Publicly Available Information" is:

- Any information that a financial institution has a *reasonable basis to believe* is lawfully made available to the general public from:
- Federal, State, or local government records;
- Widely distributed media; or
- Disclosures to the general public required by Federal, State, or local law.

"Reasonable Basis to Believe" means the financial institution:

- Cannot assume information is publicly available.
- Must take steps to determine if:
 - the information is of the type generally made available to the public;
 - whether an individual can direct that it not be made available; and
 - if so, whether that particular consumer has directed that it not be disclosed.

Examples of Publicly Available Information:

- Fact that an individual is a mortgage customer of a particular financial institution where that fact is recorded in public real estate records
- Telephone number listed in the phone book
- Information lawfully available to the general public on a website (including a website that requires a password or fee for access)

Examples of NPI (assuming such information is not publicly available):

- Fact that an individual is the customer of a particular financial institution
- Consumer's name, address, social security number, account number
- Any information a consumer provides on an application
- Information from a "cookie" obtained in using a website
- Information on a consumer report obtained by a financial institution (NOTE: Such information may also be covered by the Fair Credit Reporting Act)

NPI and Lists: Always consider how the list is derived.

- List of a finance company's mortgage customers with their outstanding mortgage balance and account numbers is NPI
- List of a retailer's credit card customers is NPI
- List of a retailer's credit card customers that is combined with a list of magazine subscribers is NPI
- List of all individuals who purchased washing machines from a retailer is NOT NPI where the information is not derived from information obtained in providing a financial product or service

VI. Notices

A. Types of Notices:

1. *Initial*: To customers not later than when relationship is established; To consumers prior to sharing nonpublic personal information
2. *Opt-Out*: To consumers and customers prior to sharing information
3. *Short-Form*: To consumers who are not customers, in lieu of full initial notice, prior to sharing nonpublic personal information about them
4. *Simplified*: To customers if don't share NPI about current or former customers with affiliates or nonaffiliated third parties outside exceptions 313.14 and 313.15
5. *Annual*: To customers for duration of the relationship
6. *Revised*: To consumers, customers, and former customers

B. Format of Notices: Notices Must Be "Clear and Conspicuous"

1. "Clear and conspicuous" means that a notice must be reasonably understandable *and* designed to call attention to the nature and significance of the information in the notice.
2. "Reasonably understandable" means clear and concise sentences, plain language, active voice.
3. "Designed to call attention" means using headings, easily read typeface and type size, wide margins. On website: use text or visual cues to encourage scrolling down the page to view the entire notice; place notice on a frequently accessed page or via a clearly labeled link; ensure that there are no distracting graphics or sound.

C. Content of Initial and Annual Notices:

[for purposes of this section, "consumers" includes "customers"]

1. Categories of nonpublic personal information that the financial institution collects, for example:
 - information obtained from the consumer
 - information obtained from the consumer's transactions with a financial institution or its affiliate
 - information obtained from nonaffiliated third parties about the consumer's transactions with them

- information obtained from a consumer reporting agency
2. Categories of nonpublic personal information that the financial institution discloses. Must provide illustrative examples, such as:
- information from the consumer on applications or other forms, such as name, address, and social security number
 - information from transactions with the consumer: account number and balances, payment history, parties to transactions, credit card usage
 - information from a consumer reporting agency: creditworthiness and credit history
3. Categories of affiliates and nonaffiliated third parties to whom the financial institution discloses nonpublic personal information. Must provide illustrative examples, such as:
- Financial service providers, such as mortgage brokers and insurance companies
 - Non-financial companies, such as magazine publishers, retailers, and direct marketers
 - Others, such as nonprofit organizations
4. If the financial institution discloses nonpublic personal information about former customers:
- Categories of nonpublic personal information disclosed; and
 - Categories of affiliates and nonaffiliated third parties to whom nonpublic personal information is disclosed (other than what is permitted under exceptions 313.14 and 313.15).
5. If the financial institution discloses nonpublic personal information to a nonaffiliated third-party under exception 313.13 (for service providers and joint marketing partners):
- Separate statement of the categories of nonpublic personal information disclosed (including illustrative examples); and
 - Statement about whether the third party is:
 - a service provider that performs marketing services on behalf of the financial institution itself or on behalf of products or services jointly marketed between two financial institutions; or
 - another financial institution with whom the financial institution has entered into a joint marketing agreement.
6. An explanation of the consumer's right to opt out.

7. Any disclosures that the financial institution is required to make under the Fair Credit Reporting Act.

8. The financial institution's policies and practices with respect to protecting the confidentiality and security of nonpublic personal information.

9. If the financial institution discloses nonpublic personal information to a nonaffiliated third party under exceptions 313.14 and 313.15, state that disclosures to nonaffiliated third parties are made as permitted by law.

10. The financial institution may also reserve the right to disclose categories of nonpublic personal information that it does not currently disclose or categories of nonaffiliated third parties to which it does not currently disclose nonpublic personal information.

D. Content of Opt-out Notice

[for purposes of this section, "consumers" includes "customers"]

1. Fact that the financial institution discloses (or reserves the right to disclose) nonpublic personal information about a consumer to nonaffiliated third parties.

2. The consumer's right to opt out of those disclosures.

3. A description of a "reasonable means" by which the consumer can opt out, for example:

- Toll-free telephone number
- Detachable form with mailing information
- If the consumer has agreed to receive notices electronically, an electronic means such as a form that can be sent via e-mail or through the financial institution's website
- NOTE: It is NOT a reasonable means to require a consumer to write her own letter as the ONLY option

Remember: A financial institution must allow a "reasonable opportunity" for the consumer to opt out before sharing information.

E. Content of the Short-Form Notice

1. State that the financial institution's full privacy policy is available on request.

2. Explain a reasonable means by which the consumer may obtain the full notice, for example:

- Toll-free telephone number
- On-site for in-person transactions

F. Content of Simplified Notice

1. List the categories of NPI collected.
2. Provide statement explaining that the institution does not share NPI with affiliates and nonaffiliated third parties, except as permitted by law (if applicable).
3. Provide statement explaining the institution's policies and practices with respect to safeguarding NPI.

G. Revised Notice

If a financial institution changes its policies and practices regarding disclosure of nonpublic personal information to nonaffiliated third parties outside of specific exceptions, it must:

- Provide a new notice that accurately reflects its policies; and
- Provide a new opt-out notice and a reasonable means to opt out.

H. Timing of Annual Notice

- Financial institution must provide an accurate privacy policy to its customers at least annually during the continuation of the customer relationship.
- Annually means at least once in a period of twelve consecutive months which the financial institution can define but must apply consistently. A financial institution can send annual notices to all its customers at the same time each year.
 - Customer opens account in January of 2004. Financial institution must send its first annual notice to that customer by December 2005.

I. Delivery of Notices

- Consumer or customer must be reasonably expected to receive actual notice in writing or, if the customer agrees, electronically. Examples of appropriate delivery include:
 - Hand delivery
 - Mail to last known address
 - For a consumer using an ATM, post the notice on the screen and require acknowledgment of receipt of the notice as a necessary part of the transaction.
 - For the consumer who conducts transactions electronically, post the notice on the website and require acknowledgment of receipt of the notice as a necessary part of the transaction.
 - For the customer who uses a website for electronic financial transactions and agrees to receive an annual notice at that website, post the current privacy notice continuously in a clear and conspicuous manner on that website.
 - The notice CANNOT just be posted in a branch or on a website.
- Customers must be provided notice in a form that can be retained or accessed at a later time.

VII. Exceptions

A financial institution may disclose nonpublic personal information to nonaffiliated third parties under several exceptions where consumers and customers do not have the right to opt out of such sharing and, in some cases, will get no notice of the disclosure.

A. Exception to Opt-Out Requirements: Section 313.13

- Financial institution must provide notice but not the right to opt out when it provides nonpublic personal information to:
 - Third party service provider that provides services for the financial institution; or
 - Other financial institution(s) with whom the financial institution has entered into a joint marketing agreement.
- Third party service provider may market the financial institution's own products and services or the financial products or services offered under a "joint marketing agreement" between the financial institution and one or more other financial institutions.

- Joint marketing agreement with other financial institution(s) means a written contract pursuant to which those institutions jointly offer, endorse, or sponsor a financial product or service.
- To take advantage of this exception the financial institution must:
 - Provide the initial notice as required to consumers and customers; and
 - Enter into a contract with the third party service provider or financial institution under a joint marketing agreement that prohibits the disclosure or use of the information other than for the purpose for which it was disclosed.

B. Exceptions to Notice and Opt-Out Requirements: Sections 313.14 and 313.15

Exception 313.14:

- Disclosures *necessary to effect, administer, or enforce a transaction* that a consumer requests or authorizes (see section 313.14(b)); or
- Disclosures made in connection with:
 - Servicing or processing a financial product or service that a consumer requests or authorizes
 - Maintaining or servicing a consumer's account
 - A proposed or actual securitization, secondary market sale (including the sale of servicing rights) or similar transactions

Exception 313.15:

- With consumer consent
- To protect the confidentiality or security of records
- To protect against or prevent actual or potential fraud
- For required institutional risk control or for resolving consumer disputes or inquires
- To persons holding a legal or beneficial interest relating to the consumer
- To persons acting in a fiduciary or representative capacity on behalf of the consumer (i.e., the consumer's attorney)
- To provide information to insurance rate advisory organizations, persons assessing compliance with industry standards, the financial institution's attorneys, accountants or auditors
- To law enforcement entities or self-regulatory groups (to the extent permitted or required by law)
- To comply with Federal, State, or local laws
- To comply with subpoena or other judicial process

- To respond to summons or other requests from authorized government authorities
- Pursuant to the Fair Credit Reporting Act, to a consumer reporting agency or from a consumer report reported by consumer reporting agency
- In connection with a proposed or actual sale, merger, transfer or exchange of all or a portion of a business or operating unit

VIII. Limits on Reuse and Redisclosure by a Third Party

These restrictions apply to a third party that receives nonpublic personal information from a nonaffiliated financial institution.

A. Reuse and Redisclosure Under Exception 313.13: Information received under section 313.13 is restricted by the confidentiality agreement required under that section and cannot be used except for the purpose for which it was disclosed.

B. Reuse and Redisclosure Under Exceptions 313.14 and 313.15:

When a third party receives nonpublic personal information from a nonaffiliated financial institution under exception 313.14 or 313.15, the third party may:

- Disclose the information to affiliates of the financial institution from whom it received the information; or
- Disclose the information to its own affiliates who are limited in their use and disclosure of the information to the same extent as the third party; or
- Disclose and use the information pursuant to exceptions 313.14 or 313.15 in the ordinary course of business to carry out the activity covered by the exception for which it was received.

C. Reuse and Redisclosure Outside of Exceptions 313.14 and 313.15:

Where a third party receives nonpublic personal information from a financial institution outside of an exception (after the financial institution has provided notice and opts out and the consumer has not opted-out), the third party may:

- Disclose the information to the affiliates of the financial institution from whom it received the information; or
- Disclose the information to its own affiliates, who are limited in their use of information in the same manner as the third party; or

- Disclose the information to any other entity consistent with the privacy policy of the financial institution from which it received the information.

D. Examples of Limits on Reuse and Rediscovery:

A third party receives information from a financial institution to process account transactions authorized by consumers (pursuant to a section 313.14 exception):

- That third party may disclose that information to other nonaffiliated third parties in the ordinary course of business to carry out the servicing.
- It may also disclose it in response to a properly authorized subpoena.
- It *may not* use the information for its own marketing or sell it to another entity for marketing.

A magazine publisher purchases a list of a financial institution's customers (those who have not opted-out) where the disclosure falls outside the exceptions:

- It may use that list for its own purposes.
- It may disclose that list to other nonaffiliated third parties consistent with the financial institution's privacy policy.

IX. Other Issues

A. Prohibition on Sharing Account Numbers for Marketing Purposes

Financial institutions may not disclose, directly or through an affiliate, an account number of a consumer's credit card account, bank account, or transaction account to a nonaffiliated third party for use in marketing. A transaction account is an account to which a third party can initiate charges.

Exceptions:

- Disclosure to a consumer reporting agency.
- Disclosure to an agent or service provider to perform marketing of the financial institution's own products or services, provided that the agent or service provider is not authorized to directly initiate charges to the account.
- Disclosure to a participant in a private label credit card program or an affinity program where the participants are identified to the customer when the customer enters into the program.
- Disclosure of an encrypted account number to a nonaffiliated third party, provided that the financial institution does not give the third party the means to decode the number or code.

B. Effect on the Fair Credit Reporting Act

The FCRA is expressly not modified, limited, or superseded by Subtitle A of Title V of the GLB Act.

C. Relationship to State Laws:

State laws are not preempted except to the extent that they are "inconsistent" with this federal law. A state law is not "inconsistent" if it affords "greater protection" to consumers than provided for by this federal law, as determined by the FTC.

Endnotes:

1. Even if a business engages in one of these financial activities, it does not necessarily have to provide privacy notices. The notice obligations depend on whether the business is providing a financial product or service to customers or, if they share the information with nonaffiliated third parties outside of specific exceptions, to consumers.

Fraud at the Workplace

In the 1940's renowned criminologist Donald R. Cressey developed what has become one of the most widely respected theories on the conditions that lead to workplace fraud. His so called fraud triangle consists of several key elements.

The first is opportunity. For an employee to even consider fraud, the opportunity must be there to commit a fraud- and perhaps more important, believe he or she can get away with it.

Cressey's second factor is a financial problem that is non-shareable. Employees can run into financial difficulties through no fault of their own or for reasons such as a gambling addiction. The employee has a need he can't meet within his own financial means. Or the employee could simple be a person who is greedy!

The third factor is the ability to rationalize the fraud. They have to be able to convince themselves that what they're doing is ethical and not illegal. The amazing thing about people caught committing fraud is that few of them believe they were doing anything wrong.

Surprisingly, employees caught committing fraud are often the ones least suspected. While not always the case, they often work long hours, come in on weekends and will skip vacation. They may work on weekends to maintain a second book and will skip vacations because they're afraid that their replacement will discover what has been going on.

Take Control

The first and easiest step a business owner can take is to keep control of the checkbook. Write and reconcile all checks themselves. If the business is too big, have one employee write the checks and another reconciles the accounts.

The second thing to do is establish a clear separation of duties in the business. This ensures that several employees would have to collude before fraud can be committed, and odds against this happening are much greater.

Another possible option is to bring in an auditor. Tell employees that from time to time an auditor will be brought in to audit the books, with no warning.

Important Facts

1. It's estimated that 6 percent of revenue lost in 2000 was the result of occupational fraud. This translates to about \$600 billion or nearly \$4,500 per employee.
2. Small businesses will be the hardest hit. The average scheme will cost a small business \$127,000 in losses, compared with \$97,000 for larger companies.
3. Organization with fraud hotlines cut fraud losses in half. The most common method of detecting workplace fraud is tips from employees, customers, vendors and anonymous sources.
4. The typical business fraud perpetrator is a first time offender. Previous offenders commit only 7 percent of fraud.

5. More than 80 percent of occupational frauds involve asset-misappropriation with cash being the target asset 90 percent of the time.
6. The average fraud scheme lasts 18 months before being detected.

Credit Scoring

One of the hottest issues in the insurance market today is “credit scoring,” which means that an insurance company can or refuses to renew someone based on a poor credit history.

Some insurers claim that the credit score is a useful, accurate and fair measure of someone’s risk factor. Many legislators and consumer groups believe credit scoring unfairly discriminates against poor and lower income groups. Credit scoring is used in many states. In Maryland for example, credit scoring can be used as an underwriting tool for auto insurance but not for homeowner’s insurance. Insurers believe that credit scoring is a very good predictor of future loss. Consumer groups are concerned that it is a surrogate for discriminating against race and the poor.

Insurance companies have sampled people and ranked them based on credit scores. When they compare claims of people with the same background, those with the worst credit filed the most claims.

Opponents of credit scoring state that the insurers have not shown evidence that establishes a relationship between scores and insurance risk. They also believe credit scoring would improve long-term penalties on those going through temporary hard times such as sickness, marital separation and divorce.

FICO SCORE

Most lenders and every credit agency calculate borrower's credit scores using the FICO software. FICO stands for Fair, Isaac and Company, a San Rafael California company. It was founded by Bill Fair and Earl Isaac in 1956. This complex rating system is used by lenders to predict the likelihood of the borrower to successfully repay the loan. It takes into consideration account inquires, payment history, credit balances, and other important factors in determining a person's 3-digit credit score. Once the score has been determined, the borrower is then placed in one of 3 main categories. A person with a credit score of 680 and above is considered a category I. Borrowers in this category will have no problem getting a good interest rate on a home loan, car loan, or credit card. Credit scores between 680 and 560 are considered to be a category II, and borrowers in this group will likely have to pay a much higher interest rate on a loan. Scores below 560 are category III. People in category III will most likely have to pay interest rates between 22 and 23% and may even have to pay more for insurance. A very low credit score can even prevent a person from getting a job with many companies.

Many insurers, healthcare providers, banks, credit card companies, telecommunication organizations, and government agencies rely on the FICO software. Consumers can get their FICO score and other credit information through www.myfico.com.

Fair Isaac has offices located in 9 countries. It services over 80% of the top personal lines insurers in the United States, and most of the major credit card companies in America. The FICO score is the most used credit bureau score in the world. More than 40 billion have been sold since 1985.

Checking the Credit Report

At least once a year, consumers should check their credit report with the three major reporting agencies, Equifax, Experian, and TransUnion. People can get a copy of their credit report by contacting the credit reporting agencies directly at:

- * Equifax 1-800-685-1111 www.equifax.com
- * Experian 1-888-397-3742 www.experian.com
- * TransUnion 1-800-888-4213 www.Transunion.com

If a person finds erroneous information on his credit report, he should notify that agency immediately. Credit reporting agencies must investigate the matter and respond within 30 days after receiving notification.

Clue Report

When considering a persons application for insurance, insurers will review claims filed against the home the person wants to insure. If the owners filed a lot of claims in the past five years, the person may be rejected, particularly if the claims were for water damage. Insurers view those as a harbinger of mold claims.

Insurance agents should tell their customers to get a copy of the home's Comprehensive Loss Underwriting Exchange (CLUE) report, which shows the history of claims against the property. Only the owners of a home can get its CLUE report. The buyer of the home should ask the seller to get a copy of the CLUE report.

When reviewing a home's CLUE report insurers try to determine whether the problem that caused a claim has been repaired. They also look for patterns that suggest a risk of future claims. A history of break-ins, for example, may indicate the home is in a high-crime area. Some insurers will charge higher premiums for that home, or refuse to cover it.

If the person can't get insurance, the agent should consider advising the person about looking into the state's Fair Access to Insurance Requirement Plan. Many states offer FAIR plans to homeowners who can't buy insurance from private insurers. The plans cost more than private insurance, and coverage may be limited.

A list of state FAIR plans, along with their phone numbers can be found at the Insurance Information Institute's internet site, www.iii.org.

What is Homeowner's Insurance?

Homeowner's insurance protects the policy owner from financial loss if his house is damaged by "perils" such as fire, water, hail, lightning, theft or lawsuits resulting from an injury on the property. Coverage comes in two basic forms, insurance on the structure only and coverage for the house and the valuables inside.

The basic policy, usually the only one required by lenders, covers only the house. It is often called fire insurance or hazard insurance. The policy is written to cover only replacement cost of the house at the time it is damaged or destroyed. It does not include valuables inside the house. Basically, the fire policy protects the lender from losing its investment in the house.

Most homeowners pay for additional coverage to replace valuables such as jewelry, art, satellite dishes, computers, furniture and expensive collections. In the past, replacement insurance has been very affordable.

Most of the time, insurers figure the replacement cost of the valuables as a percentage of the home's value, typically 70 to 75 percent. So an insurer would pay \$70,000 to \$75,000 to replace possessions in a \$100,000 home. Most standard policies (above the basic-structure policy) also include \$100,000 of liability coverage.

Agents should warn their clients to watch for exclusions, which are more common in today's market. Two common exclusions are sewer and water backup in basements, toilets and other basement plumbing. For an extra \$25 or so, it's covered.

Hazard policies and the more extensive policies are designated "all peril". The policy will spell out what they cover-hail, lightning, wind, tree damage and fire damage and what they don't-normal wear and tear, earthquakes, nuclear disasters, terrorism, vermin, and acts of war.

Land is also excluded from most policies. Floods also are not covered by a standard homeowner's policy. The buyer of a house in a flood-prone area has to pay about \$400 for coverage through the Federal Emergency Management Agency. Regional hazards such as tornadoes and earthquakes usually require supplemental insurance that is sold by insurance companies. Premiums can vary sharply by region, right down to the zip code. Many factors go into the rating, but one of the most important is an area's risk of fire damage. Underwriters use a 1-10 scale based on the type, size and number of local fire departments.

An important factor today is the deductible – premium relationship. The more the deductible (what the policy owner pays before the insurer pays), the lower the monthly or annual premium. Many policy owners bump their policies from a \$250 deductible to a \$500 deductible to save 15 percent on their premiums.

Agents should remind clients that insurance is not a home warranty and should be used only when necessary to keep the insurance premiums down, policy owners should consider fixing it themselves if they can.

SURETY BONDS

SURETY BONDS ARE USED TODAY IN SITUATIONS IN WHICH ONE OF THE PARTIES INSISTS ON A QUARANTEE OF INDEMNITY IN THE EVENT OF FAILURE OF THE SECOND PARTY TO PERFORM A SPECIFIED ACT. SUCH A REQUIREMENT MAY ARISE IN CONNECTION WITH CONSTRUCTION CONTRACTS, COURT PROCEDURES, OR OTHER SITUATIONS IN WHICH THERE MAY BE DOUBT CONCERNING ABILITY TO PERFORM.

Surety Distinguished from Insurance

Surety differs from insurance in a number of ways. The most frequently stated distinction is that a surety bond is a three-party contract, involving the surety, the principal, and the obligee, while the insurance contract is a two-party contract between the insured and the insurer. The most important distinction, however, is one of basic philosophy regarding losses. In the field of insurance, the insurer generally expects losses to occur. In the surety field, no losses are expected, primarily because the surety will not issue the bond if it appears that a loss is likely. For example, before issuing a bond for the completion of a construction project by a contractor, the surety will examine the financial resources of the contractor, his manner of operation, and past history. If it appears that the contractor has the financial ability and the technical skill required for the completion of the project, the surety will issue the bond. This bond is a certificate of character, ability, and financial worth of the principal. If there is any question about the ability of the principal to perform, the bond will not be issued.

In some cases, the surety may require the principal to put up collateral equal to the amount of the maximum possible loss under the bond.

It is important to note that although the purchaser of the bond is normally the principal; a surety bond is issued for the benefit of the obligee. The fact that a bond is for the benefit of the obligee and not the principal is illustrated by the fact that in the event of a loss under the bond, the surety has a right to collect from the principal any amount that the surety has been obligated to pay to the obligee. In other words, when a loss is paid by the surety, the surety obtains full rights of recovery against the principal.

**PERSONAL PROFILE
(PLEASE PRINT CLEARLY)**

COURSE NAME: ETHICS IN THE WORKPLACE

YOUR NAME.....

SOCIAL SECURITY.....

AGENT'S LICENSE #

TELEPHONE #.....FAX.....

ADDRESS.....

CITY.....STATE.....

COMPANY'S NAME.....

TELEPHONE.....

**AFFIDAVIT OF PERSONAL RESPONSIBILITY
(TO BE SIGNED BY AGENT)**

I AFFIRM THAT I PERSONALLY COMPLETED THE ENTIRE STUDY MATERIAL. I ALSO AFFIRM THAT I COMPLETED THE EXAMINATION WITHOUT ASSISTANCE FROM ANY COURSE MATERIAL, OTHER MATERIAL OR FROM ANY PERSON.

.....
SIGNATURE (SIGN IN INK ONLY)

.....
DATE

ETHICS IN THE WORKPLACE

AGENT'S NAME.....

- | | | |
|--------|--------|--------|
| 1.... | 21.... | 41... |
| 2.... | 22.... | 42.... |
| 3.... | 23.... | 43.... |
| 4.... | 24.... | 44.... |
| 5.... | 25.... | 45.... |
| 6.... | 26.... | 46.... |
| 7.... | 27.... | 47.... |
| 8.... | 28.... | 48.... |
| 9.... | 29.... | 49.... |
| 10... | 30.... | 50.... |
| 11.... | 31.... | 51.... |
| 12.... | 32.... | 52.... |
| 13.... | 33.... | 53.... |
| 14.... | 34.... | 54.... |
| 15.... | 35.... | 55.... |
| 16.... | 36.... | |
| 17.... | 37.... | |
| 18.... | 38.... | |
| 19.... | 39.... | |
| 20.... | 40.... | |

FAX YOUR PERSONAL PROFILE AND ANSWER SHEET TO 1-410-734-7966 OR 1-410-298-5239

ETHICS IN THE WORKPLACE

QUESTIONS

1. Where specified authority to make contracts for the insurer is granted, the relationship is called?
 - a. principal-agent
 - b. agent-broker
 - c. agent-insured
 - d. agent-client

2. The power of an agent rests primarily on the authority granted in the
 - a. policy
 - b. agency contract
 - c. client's application
 - d. none of the above

3. All of the following are correct true about agent's authority **except**
 - a. The agent has stipulated and expressed authority.
 - b. The agent has implied authority.
 - c. The agent has apparent authority.
 - d. The agent has unlimited authority.

4. The law considers the agent and the principal as.....
- a. one and same
 - b. individuals
 - c. partners
 - d. clients
5. The principal is legally responsible for the action of its.....
- a. agents
 - b. clients
 - c. insureds
 - d. none of the above
6. If the information on an application is false or incomplete, the insurer may be able to do what?
- a. void the contract
 - b. ask the agent to have the application fully completed
 - c. reject the application
 - d. all of the above are true
7. Which of the following is false?
- a. Oral representations are difficult to prove in court.
 - b. An insurance policy is a contract.
 - c. Written contract are difficult to prove in court.
 - d. Representation may be oral or in writing.

8. It is whose responsibility to make sure that all questions on the application are answered truthfully and completely?

- a. the applicant
- b. the agent
- c. the insured
- d. policyholder

9. The primary role of State Insurance Commissioners is the protection of whom?

- a. consumers
- b. criminals
- c. agents
- d. insurers

10. State Commissioners have the authority to regulate all the following **except**

- a. insurers
- b. agents
- c. premium finance companies
- d. retail merchants

11. In the case of Paul vs Virginia, who did the Supreme Court ruled had the legal right to regulate the insurance industry?

- a. the courts
- b. the federal government
- c. the states
- d. the Attorney General

12. The Supreme Court's decision in Paul vs Virginia stood for how many years?

- a. 10
- b. 25
- c. 50
- d. 75

13. The National Association of Insurance Commissioners has legal power over which of the following states?

- a. Maryland
- b. New York
- c. Virginia
- d. none of the above

14. All states insurance codes provide for the regulation of insurance rates, requiring that the rates be:

- a. Not unfairly discriminatory
- b. Not excessive in nature
- c. Adequate
- d. all of the above

15. Common stocks traditionally represent what percentage of a life insurance company's assets?

- a. 5%
- b. 10%
- c. 20%
- d. 25%

16. Common stocks traditionally represents what percentage of property and casualty companies' assets?

- a. 10%
- b. 20%
- c. 33 ½ %
- d. 50%

17. Life insurers are allowed to invest in which of the following securities?

- a. Canadian bonds
- b. Territorial bonds
- c. High-grade corporate bonds
- d. all of the above

18. What has been the chief criticism of state regulation?

- a. Lack of uniformity
- b. Insufficient staff
- c. Corrupted commissioners
- d. States being able to quickly to response to consumer's needs

19. The United States has how many different state insurance codes?

- a. 25
- b. 35
- c. 50
- d. 51

20. Which of the following institution(s) are examples of businesses that engage in financial activities and are financial institutions for purposes of the Gramm-Leach-Bliley Act?

- a. Collection agency services
- b. Auto dealers that lease and/or finance
- c. Check cashiers
- d. all of the above

21. Under the Gramm-Leach-Bliley Act, financial institutions must provide its customers their privacy policy at least how often?

- a. Once a year
- b. twice a year
- c. Once every other year
- d. never

22. Organizations that provide fraud hotlines can cut their losses by how much?

- a. 10%
- b. 20%
- c. 50%
- d. 90%

23. How long does the average fraud scheme lasts?

- a. 12 months
- b. 18 months
- c. 36 months
- d. 48 months

24. Which of the following institution(s) rely on FICO software?

- a. Insurers
- b. Healthcare providers
- c. Banks
- d. Credit Card companies
- e. all the above

25. FICO is located in which state?

- a. Maryland
- b. Texas
- c. Virginia
- d. California

26. The **primary** purpose of government regulation of insurance companies is to assure

- a. solvency of the insurers
- b. insurers that the state is a good place to do business
- c. consumers that they are buying insurance from good insurers
- d. agents that the insurers will pay all commissions

27. How many branches of state governments regulate insurance companies?

- a. one
- b. two
- c. three
- d. four

28. Which branch of state government renders decisions on the meaning of policy terms?

- a. Judicial
- b. Executive
- c. legislative
- d. Insurance Administration

29. Which branch of state government enacts insurance laws?

- a. Judicial
- b. Executive
- c. Legislative
- d. Insurance Administration

30. Which branch of state government specifies certain requirements that a company domiciled in another state must meet in order to obtain a license to do business in the state?

- a. Judicial
- b. Executive
- c. Legislative
- d. Insurance Administration

31. Which law grants states the right to regulate insurance companies?

- a. Public Law 11
- b. Public Law 12
- c. Public Law 13
- d. Public Law 15

32. The Insurance Commissioner is part of what branch of state government?

- a. Judicial
- b. Executive
- c. Legislative
- d. none of the above

33. Who do insurance brokers represent?

- a. agents
- b. insurers
- c. insureds
- d. Insurance Commissioners

34. Polls have ranked insurance agents among.....in terms of ethics.

- a. highest
- b. lowest
- c. top three
- d. no ranking

35. How much time do insurance managers devote to ethical training?

- a. none
- b. very little
- c. a lot
- d. unknown

36. The professional manager should always strive for consistent ethical behavior on whose part?

- a. the clients
- b. the agents
- c. the public
- d. none of the above

37. One way of improving the ethical behavior of his agents is for the manager to.....

- a. increase sells training
- b. devote more serious time to ethics during training secessions
- c. read more sells books and magazines
- d. go to more seminars on closing the sell

38. Some insurance agents rely on what sources for ethical guidance?

- a. the behavior of their managers
- b. the behavior of their co-workers
- c. the own personal values
- d. all of the above

39. An agent must always act on behalf of thebest interest.

- a. insurer's
- b. co-workers'
- c. his own
- d. none of the above

40. The agent should avoid causing any ill feelings towards

- a. the other insurance company
- b. the other insurance agent
- c. the other insurance broker
- d. all the above

41. Misrepresentation may be grounds for the insurer to.....

- a. extend the contract
- b. void the contract
- c. add a rider to the contract
- d. pay the claim

42. Misrepresentation must be a

- a. material fact
- b. insignificant fact
- c. verbal statement
- d. none of the above

43. Misrepresentation must be made

- a. in writing
- b. with fraudulent intent
- c. orally
- d. none of the above

44. What were the reason(s) why applicants have made false statements on the application?

- a. to get insurance at a lower cost
- b. to get insurance
- c. to qualify for certain types of insurance
- d. all of the above

45. Rebating is illegal because.....

- a. anyone can earn insurance commissions
- b. only licensed insurance agents can receive insurance commissions
- c. most states approve the practice
- d. none of the above

46. The surety bond is a

- a. one contract
- b. two-party contract
- c. three-party contract
- d. four-party contract

47. In the surety field, does the surety expects losses?

- a. Yes
- b. No

48. If the surety believes that the contractor has the financial ability and the technical skill required for the completion of the project, the surety will do which of the following?

- a. not issue a bond
- b. issue a bond
- c. void the contract
- d. none of the above

49. The surety bond is issued for the benefit of who?

- a. the surety
- b. the principal
- c. obligee
- d. none of the above

50. When a loss is paid by the surety, the surety has full rights of recovery against whom?

- a. the principal
- b. the obligee
- c. the suppliers
- d. the vendors

51. The 2002 mortality tables go up to which age?

- a. 80
- b. 90
- c. 100
- d. 120

52. Based on the new mortality tables, what is the life expectancy for males?

- a. age 70
- b. age 74
- c. age 79
- d. age 83

53. Based on the new mortality tables, what is the life expectancy for females?

- a. age 70
- b. age 74
- c. age 77
- d. age 79

54. Based on the 1980 CSO, what is the life expectancy for males?

- a. age 70
- b. age 74
- c. age 77
- d. age 79

55. Based on the 1980 CSO, what is the life expectancy for females?

- a. age 70
- b. age 74
- c. age 77
- d. age 79

