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AGENTS' STUDY MANUAL

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COMMISSIONER OF INSURANCE

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HERBERT W. ANDERSON
COMMISSIONER

TO ALL AGENTS AND PROSPECTIVE AGENTS

GREETINGS:

This study manual has been prepared for use by persons who are licensed insurance agents in the State of Iowa, and for those who wish to become licensed.

Although the manual is not by any means all inclusive in respect to the insurance industry, it does, I believe, provide enough information necessary for a first-time applicant to evidence proof of competency as provided in Section 522.3 of the Code of Iowa.

The information contained herein has been prepared through a cooperative effort on the part of many people in the insurance industry and the staff in this Department. Our appreciation for the many hours of hard work is especially extended to the Independent Insurance Agents of Iowa and their officers and Executive Secretary; Dr. Emmett J. Vaughan of the University of Iowa; Iowa Insurance Institute; Iowa Insurance Association; Iowa Association of Mutual Insurance Agents; Iowa Association of Life Underwriters and Central Iowa Association of Health Underwriters.

Very truly yours,

HERBERT W. ANDERSON
Commissioner of Insurance

1979

IOWA

Agent's Study Manual

Independent Insurance Agents of Iowa, Inc.

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GENERAL SECTION

THE INSURANCE DEVICE

RISK: THE BASIC PROBLEM WITH WHICH INSURANCE DEALS

The Nature of Risk

A fire engine with its siren screaming roars down the street. A building in your neighborhood burns. You hear the crash of an automobile collision or see a wrecked car being towed to the garage. You see an ambulance racing to the hospital. All of these tragic events arouse your interest and emotions.

After the noise and excitement have died down, you are grateful that the loss was not yours, and you may even feel sorry for whoever suffered the loss. But you are glad that it wasn't you.

Losses like those described above happen to some people, while others go along happily, free from misfortune. The fact that these and other similar occurrences could happen to you; and the fact that you cannot tell for sure whether or not they will, is a condition we call risk.

Whenever someone states that there is risk in a given situation, the listener understands what is meant: that there is some uncertainty about the outcome, and the possibility exists that the outcome will be unfavorable. In the simplest terms possible, risk is a condition in which a possibility of loss exists.

In its broadest context, the term risk includes all situations in which there is a possibility of an undesirable outcome. In some cases the possible loss is financial, while in other cases it does not involve money. There is some element of risk in almost every human activity, and many of these risks have no financial consequences. Here, however, we are concerned with those risks which involve financial loss.

All forms of risk involve the possibility of some type of loss, but in some cases this possibility of loss is accompanied by a possibility of gain. For example, investment in common stocks or real estate are examples of situations in which the individual may have a loss or a gain. Wagering is still another example. In these situations, the individual voluntarily exposes himself to the possibility of loss, because that possibility of loss is accompanied by the possibility of gain. These instances in which there is a possibility of loss and gain are called speculative risks. Because speculative risks are voluntarily assumed, the individual can choose whether or not he wants to take the chance.

Other risks involve only the possibility of loss or no loss. The ownership of property is a good example of this type of risk. The minute a person buys a house, he is exposed to risk in connection with that house. Perhaps the house will be struck by lightning. Perhaps a windstorm will blow the roof off and damage the interior of the house. These risks, in which there is only a possibility of loss or no loss are called pure risks. In general, pure risk exists whether or not you want it to. Just by owning an automobile, you are confronted with the risk of having an accident. Just by owning a building, you face the possibility of loss by fire.

Speculative risks are attractive to many people. A gambler obviously enjoys the risk connected with wagering more than he enjoys the certainty of not gambling—otherwise he would not gamble. But it is the possibility of gain that makes speculative risk enjoyable. In the case of pure risk, where there is no compensating chance of gain, risk is distasteful.

Unfortunately, pure risk exists in practically every phase of human activity. It begins with one's first breath and continues persistently throughout life. Illustrations of the infinite variety and number of risks that the individual faces exist on every side. Fire destroys millions of dollars of property every year. Crime losses also amount to millions annually. The automobile produces literally billions of dollars in economic loss each year. Unemployment, disability, or death which leaves dependents without income are other examples.

Types of Pure Risk

In general, the individual is exposed to four classes of pure risk. At this point, it might be a good idea to take a look at these areas. We can classify the pure risks that the individual faces into

1. Personal risks
2. Property risks
3. Liability risks
4. Risks of loss resulting from the failure of others

Personal Risks. The term personal risk refers to those unfortunate things that can happen to individuals which affect their earning power. In general, there are four such perils:

1. premature death
2. dependent old age
3. disability
4. unemployment

As we shall see, private insurance may be used to provide protection against losses resulting from the first three of these perils, and government programs provide some protection against loss resulting from unemployment.

Property Risks. Property risks exist for anyone who owns property, simply because that property can be destroyed. Ownership of property may result in two distinct forms of loss: direct loss, and indirect or "con-

sequential" loss. Direct loss is the simplest to understand. If you own a house and that house is destroyed by fire, you lose the value of the house. But in addition to the value of the house, you no longer have a place to live; and during the period of time required to rebuild the house, it is likely that you will incur additional expenses living somewhere else. This loss of use of the asset that has been destroyed is an "indirect" or "consequential" loss. An even better example exists in the case of a business firm. When a firm's facilities are destroyed, it loses the value of those facilities; but it also loses the income that would have been earned through the use of the facilities. This loss of income during the period of shutdown is a form of indirect loss. Insurance coverage is available to protect against both direct and indirect losses.

Liability Risks. The basic peril in the liability risk is negligence. Although negligence is difficult to define precisely, a simple definition is "carelessness". Under our legal system, the laws provide that one who has injured another or property belonging to another through carelessness can be held responsible for the injury or damage caused. It is difficult to imagine anyone who is immune from the possibility of lawsuits. Liability insurance is available from private insurance companies to protect against losses arising out of legal liability. One great service provided by the insurance company in connection with a liability policy is the fact that the insurance company assumes the court costs in defending the policyholder.

Risks arising from failure of others. When another person agrees to perform a service for you, he creates an obligation which you hope he will meet. When his failure to meet this obligation would result in a financial loss to you, risk exists. Suppose, for example, that you engage a contractor to build a new home for you; and that he begins the job but quits half-way through. Such a situation could well cause financial loss. Surety bonds are instruments designed to protect the person to whom the obligation is owed.

The Impact of Risk

The greatest burden connected with pure risk is that some losses will occur. When a house burns or money is stolen or someone dies, there is a financial loss. When someone is careless, and that carelessness results in injury to a person or damage to property, there is a financial loss. These losses are the primary reason that individuals attempt to avoid pure risk or reduce its impact.

In addition to the losses themselves, there are other detrimental aspects of risk. Most people hope that misfortunes will not occur in their lives, and their present state of well-being will continue; but while they hope that no misfortunes will occur, they nevertheless realize that losses may take place. The mere uncertainty as to whether or not a loss will take place usually produces a feeling of frustration and mental unrest. In other words, it causes us to worry.

Methods of Handling Risk

Because there is no escape from the presence of risk, people seek other ways of dealing with it. Basically, we deal with the risks to which we are exposed in five ways: through avoidance, reduction, retention, sharing, and transfer.

Risk Avoidance. Risk is avoided when the individual refuses to accept the risk even for an instant. This is accomplished by not being involved in the activity that gives rise to the chance of loss. If you do not desire to risk losing your savings in a hazardous investment, pick one in which there is less risk. If you want to avoid the risks associated with the ownership of property, do not purchase the property, but rent or lease it instead. Risk avoidance is often used in the speculative risk area, but because it is a negative approach, it is not practical to deal with all of the pure risks which we face through avoidance.

Risk Reduction. In those instances where risk cannot be avoided, it may be possible to reduce it by reducing the chance of loss or the amount of loss that may occur. There is almost no source of loss where some efforts are not made to keep the loss from occurring. Police departments reduce the risk of crime losses. Levees reduce the threat of flood damage. Drivers education classes reduce the likelihood of automobile accidents. Safety programs and loss prevention measures, such as nightwatchmen, burglar alarms, and even locks, are all examples of attempts to deal with risk by preventing loss from occurring. In addition to our attempts to prevent losses from occurring, we also attempt to minimize the amount of loss if it should occur. Fire departments represent a good example. Perhaps the best example of an attempt to reduce the amount of loss is a sprinkler system. Although the sprinkler system will not prevent a fire from occurring, if one should occur, the amount of damage will be considerably less than would otherwise be the case.

Risk Retention. Risk retention is perhaps the most common method of dealing with risk. The individual faces an almost unlimited number of risks; in most cases he does nothing about them. When the individual does not take positive action to avoid, reduce, share, or transfer the risk, he retains the possibility of the loss in volved in that risk. Risk retention may be involuntary or voluntary. Voluntary risk retention is characterized by the recognition that the risk exists, and a decision to assume the possibility of loss involved. Involuntary risk retention takes place when the individual exposed to risk does not recognize the existence of that risk. In these cases the person so exposed assumes the financial consequences of the possible loss without realizing he does so.

Risk retention is a legitimate way of dealing with risk; in many cases it is the best way. Each person must make a decision as to which risks he will retain and which he will seek to avoid or transfer on the basis of his ability to bear the loss that might result. As a general rule, the risks that should be retained are those that involve relatively small certain losses.

Risk Sharing. The distribution of risk is accomplished in a number of ways in our society. One outstanding example of a device used for the sharing of speculative risk is the corporation. Under this form of business, the investments of a large number of persons may be pooled. As we shall see shortly, insurance is another device that may be used for sharing risk; except that in the case of insurance, it is pure risk rather than speculative risk that is shared.

Risk Transfer. When the risk is too great to be assumed and cannot be reduced to a level at which assumption is possible, the risk may be transferred to someone more willing to bear it. In the area of speculative risks, hedging is a technique that may be used to deal with risk through transfer. Pure risks may also be transferred. A hold-harmless agreement, in which one individual assumes the risk of liability loss for another, is an example of such a transfer. Finally, insurance, the most formal of the techniques by which risk is transferred, is also used for the transfer of pure risks.

THE NATURE AND FUNCTIONS OF INSURANCE

Insurance: What it is and How it Works

Insurance is a complicated and intricate mechanism, and it is consequently difficult to define. The reader will recall that in discussing the techniques that are used to deal with pure risks, we included insurance under both sharing and transfer. This is because in its simplest aspect, insurance has two fundamental characteristics:

1. The transferring or shifting of risk from one individual to a group.
2. The sharing of losses on some equitable basis by all members of the group.

The primary function of insurance is to relieve the individual of the burden of risk by transferring that risk. A simple example should serve to illustrate how it performs this function. Let us assume that there are 1,000 identical houses in a given city, each worth $10,000. If we know from past experience that two and only two of these houses will burn, and that the total amount of losses will be $20,000, we could promise to pay the owner of any house which burned $10,000 by dividing up the total losses ($20,000) and assessing the cost among the 1,000 property owners. Thus the maximum that any one property owner would be forced to pay would be $20.

On the basis of its characteristics and its primary function we may define insurance as follows:

> Insurance is an economic device whereby the individual substitutes a small certain cost (the premium) for a large uncertain loss (the contingency insured against) which would exist if it were not for the insurance contract.

Small amounts of money are collected from many people in order to pay the losses experienced by those few who suffer losses. For example, each of 1,000 homeowners incurs the small certain cost of $20 in exchange for a promise of indemnification in the amount of $10,000 if his house burns down. This $20 premium is in effect the individual's share of the total losses of the group.

The Law of Large Numbers

In addition to the elimination of risk at the level of the individual, the insurance mechanism involves a reduction of risk (and the uncertainty related to risk) for the economy as a whole. Winston Churchill once remarked in reference to insurance, "The essence of the business is bringing the magic of averages to the rescue of millions." The "small certain cost" in our definition of insurance was stated to be the insured's share of the total losses of the group. If this cost is to be assessed in advance, the insurer to which the risk is transferred or the members of the group must be able to predict what each insured's share of the losses will be. This is accomplished through the law of large numbers. The risk which the insurance company faces is not merely a summation of the risks transferred to it by individuals. The insurance company is able to do something that the individual cannot do, and that is predict the amount of losses that will occur. Insofar as its predictions are completely accurate, the insurance company is able to do something that the individual cannot do, and that is predict the amount of losses that will occur. Insofar as predictions are completely accurate, the insurance faces no possibility of loss, for it will collect each individual's share of the total losses and use these funds to pay the losses. On the other hand, if these predictions are not accurate, the premiums which the company has charged on the basis of these predictions will be inadequate to pay for the losses and expenses which the company experiences. The accuracy of the insurer's predictions are based on the law of large numbers. By combining a sufficiently large number of homogeneous exposure units, the insurer is able to make predictions for the group as a whole. This is accomplished through the theory of probability.

In the case of statistical probability, the requirement of a large number has dual application. In order to discover what the underlying probability is, the insurance company must have a sufficiently large sample. On the basis of past experience, actuaries can obtain a reasonable approximation of future events in certain

cases. In addition, once the estimate of probability has been determined, it must be applied to a sufficiently large number of units to permit the underlying probability to work itself out. In this sense, to the insurance company, the law of large numbers means that the larger the number of cases examined, the better the chance of making a good estimate of the probability; and the larger the number of exposures to which the estimate is applied, the better the chance that a good prediction will be reasonably accurate.

If the insurance company's actuary could be absolutely certain that his predictions would be 100% accurate, there would be no possibility of loss for the insurance company, for premium income would always be sufficient to pay losses and expenses. Obviously the actuaries cannot be absolutely certain, and insofar as the actual experience fluctuates from what is predicted, risk exists for the insurance company. The greater the fluctuation the greater the possibility of loss.

Thus, in addition to the elimination of risk for the individual through transfer, insurance reduces the amount of risk in the economy by substituting certain costs for uncertain losses. These costs are assessed on the basis of predictions made through the use of the law of large numbers.

Insurance does not prevent losses, nor does it reduce the cost of losses to the economy as a whole. As a matter of fact, it may very well have the opposite effect of causing losses and increasing the cost of losses for the economy as a whole. The existence of insurance encourages some losses for the purpose of defrauding the insurer; and, in addition, people are less careful and may exert less effort to prevent losses than they might if it were not for the existence of insurance contracts. In addition, the economy incurs certain additional costs in the operation of the insurance principle. Not only must the cost of the losses be borne, but the expense of distributing the losses on some equitable basis among members of the group adds to this cost.

The Economic Contribution of Insurance

Property that is destroyed by an insured contingency is not replaced through the existence of an insurance contract. True, the funds from the insurance company may be used to replace the property; but when a house or building burns, society has lost a want-satisfying good. Insurance as an economic device finds its justification in the certainty about the financial burden of losses it creates and in its function of spreading the losses that occur. In providing a mechanism through which losses can be shared and uncertainty reduced, insurance brings peace of mind to society's members and makes costs more certain.

Insurance also provides for a better use of capital. Without insurance, individuals and businesses would have to maintain large reserves to meet the risks they faced. These funds would be held in the form of idle cash, or would be invested in safe, liquid, and low-interest bearing securities. This would be an inefficient use of capital. When risk is transferred to an insurer, predictability is better; and insurers can maintain smaller reserves than would be the situation if all individuals and businesses maintained their own reserves. The released funds are then available for investment in more productive pursuits.

Insurance and Gambling

Perhaps we should make one final distinction regarding the nature of insurance. It is often claimed that insurance is a form of gambling. "You bet that you will die and the insurance company bets that you won't" or "I bet the insurance company $20 against $10,000 that my house will burn." The fallacy of these statements should be obvious. In the case of a wager, no chance of loss, and hence no risk, exists previous to the wager. In the case of insurance, the chance of loss exists whether or not there is an insurance contract in effect. In other words, the basic distinction between insurance and gambling is that gambling creates a risk, while insurance provides for the transfer of existent risk.

Elements of an Insurable Risk

Not all losses are insurable, and there are certain requirements that must be met before a risk is a proper subject for insurance.

1. **There must be a sufficiently large number of homogeneous exposure units to make the losses reasonably predictable.** Insurance as we have seen is based on the operation of the law of averages. Unless we are able to calculate the probability of loss, we cannot have a financially sound program.
2. **The loss produced by the risk must be definite.** It must be a type of loss that is relatively difficult to counterfeit, and it must be capable of financial measurement. We must be able to tell, in other words, when a loss has taken place; and we must be able to set some value on the extent of the loss.
3. **The loss must be fortuitous or accidental.** The loss must be the result of a contingency, i.e., it must be something that may or may not happen. It must not be something that is certain to happen. If the insurance company knows that an event in the future is certain to happen, it also knows that it must collect a premium equal to the certain loss that it must pay, plus an additional amount for the expenses of administering the operation. Depreciation, which is a certainty, cannot be insured; it is dealt with through a sinking fund.

   Furthermore, the loss must be beyond the control of the insured. The law of large numbers is useful in making predictions only if we can reasonably assume that future occurrences will ap-

proximate past experience. Since we assume that past experience was a result of chance occurrences, the predictions concerning the future will be valid only if future occurrences are also a result of chance.

4. **The loss must not be catastrophic.** It must be unlikely to produce loss to the majority of the exposure units at the same time. The entire idea of the insurance principle is based on a notion of sharing losses, and inherent in this idea is the assumption that only a small percentage of the group will suffer loss at any one time. Damage which results from enemy attack would be catastrophic in nature. There are additional perils, such as flood, which, while they would not affect everyone in the society, would effect those who had purchased insurance. The principle of randomness in selection is closely related to the requirement that the loss must not be catastrophic.

Randomness

The future experience of the group to which we apply our predictions will approximate the experience of the group upon which the predictions are based only if both groups have approximately the same characteristics. There must be a proportion of good risks and bad risks in the group equal to the proportion of good risks and bad risks of the group upon which the prediction is made. Yet human nature acts to interfere with the randomness which is necessary to permit the random composition of the current group. The losses that are predicted are based on the average experience of the old group, but there are always some individuals who are worse than average risks, and who realize that they are worse than average. Since the chance of loss for these worse than average risks is greater than the chance of loss of the oth r members of society, they have a tendency to desire insurance coverage to a greater extent than the remainder of the group. This tendency results in what is known as "adverse selection." Unless some provision is made to prevent it, predictions based on past experience would be useless in predicting future experience. Adverse selection works in the direction of accumulating bad risks. Since the predictions of future losses are based on the average loss of the past, in which both good risks and poor risks were involved, if the experience of the future is based on the experience of a larger proportion of bad risks, the experience of the future will be worse than that of the past and the predictions will be invalid.

Self-Insurance

The term "self-insurance" has become a well-established part of the terminology of the insurance field, despite disagreement as to whether or not such a mechanism is possible. From a purely semantic point of view, the term "self-insurance" represents a definitional impossibility. The insurance mechanism consists of transfer of risk or pooling of exposure units, and since one cannot pool with or transfer to him or herself, it can be argued that self-insurance is impossible. However, the term is widely used and we ought, therefore, to establish an acceptable operational definition, semantically incorrect though it may be.

Under some circumstances, it is possible for a business firm or other organization to engage in the same types of activities as a commercial insurer dealing with its own risks. When these activities involve the operation of the law of large numbers and predictions regarding future losses, they are commonly referred to as "self-insurance." To be operationally dependable, such programs must possess the following characteristics:

1. The organization should be big enough to permit the combination of a sufficiently large number of exposure units so as to make losses predictable. The program must be based on the operation of the law of large numbers.
2. The plan must be financially dependable. In most cases, this will require the accumulation of funds to meet losses that occur, with a sufficient accumulation to safeguard against unexpected deviations from predicted losses.
3. The individual units exposed to loss must be distributed geographically in such a manner as to prevent a catastrophe. A loss affecting enough units to resut in severe financial loss should be impossible.

Even apart from its semantic shortcomings, self-insurance is an overworked term. Few companies or organizations are large enough to engage in a sound program meeting the requirments outlined above. In the majority of cases, risks are simply retained without attempting to make estimates of future losses. In many cases, no fund is maintained to pay for losses. Furthermore, until the fund reaches the size where it is adequate to pay the largest loss possible, the possibility of loss is not eliminated for the individual exposure units.

THE FIELDS OF INSURANCE

Insurance is a broad generic term, including the entire array of institutions that deal with risk through the device of sharing and transfer of risk. Insurance may be divided and subdivided into certain classifications on the basis of perils insured against or the fundamental nature of the program. Basically we make a first distinction between Social Insurance and Commercial Insurance.

Social Insurance

Social Insurance differs from commercial insurance in a number of important respects. Such programs as Old-Age, Survivors and Disability Insurance and Unemployment Insurance Compensation are social insurance programs. They make use of the insurance mechanism for transferring and sharing risks, but they do so on a

somewhat different basis than does commercial insurance. They are based on the notion that there are some people in the economy who face risks which they cannot handle themselves, and that these risks should be borne by the economy as a whole. In many cases there is a lack of equity in social insurance programs; and in most cases, because the programs lack equity, they are made compulsory by the government.

Commercial Insurance

Commercial insurance consists for the most part of voluntary insurance programs which are available to the individual as a means of protecting himself against the possibility of financial loss due to a contingency. Commercial insurance is provided by private firms, but in some instances it is also offered by the government. The distinguishing characteristics of commercial insurance are the facts that it is voluntary, and that the transfer of risk is normally accomplished by means of a contract.

Commercial insurance may be further categorized and subdivided into personal insurance, which provides protection against financial loss in the areas of life and health, and property insurance, which provides protection against perils affecting assets. In general, we may speak of four distinct types of commercial insurance:

1. Life Insurance
2. Accident and Health Insurance
3. Fire and Marine Insurance
4. Casualty Insurance

Life Insurance. Life insurance is designed to provide protection against two distinct risks: premature death and superannuation. As a matter of personal preferences, death at any age is probably premature; and superannuation (living too long) does not normally strike the individual as an undesirable contingency. From a practical point of view, however, the individual can and sometimes does die before he has prepared for the financial requirements of his dependents. By the same token, a person can, and often does, outlive his income earning ability. Life insurance, endowments, and annuities are used to protect against the undesirable consequences for the individual and his dependents which result from premature death and superannuation.

Accident and Health Insurance. Accident and Health Insurance (or more simply, health insurance) is defined as "insurance against loss by sickness or accidental bodily injury." The "loss" may be the loss of wages which the sickness or accident causes, or it may be the expense involved in doctor bills, hospital bills, medicine, etc. Included within this definition of health insurance are those forms of insurance which provide lump-sum or periodic payments in the event of loss occasioned by sickness or accident, such as disability income insurance and accidental death and dismemberment insurance.

Fire and Marine Insurance. Fire Insurance is designed to indemnify the insured from loss of or damage to buildings, furniture, fixtures, or other personal property against loss as a result of fire, lightning, windstorm, hail, explosion, and a vast array of other perils. Coverage may be provided for both direct loss (i.e., the actual loss which the destruction of the asset represents) and indirect loss (defined as the loss of income and/or the extra expense which is the result of the loss of the use of the asset protected). Originally only fire was an insured peril, but the list of perils insured against has gradually been expanded until it reached the present status where "all risk coverage" can be provided.

Marine insurance, like fire insurance, is designed to protect against financial loss as a result of the loss of property. It is divided into two classifications: Ocean Marine and Inland Marine.

Ocean Marine provides coverage on all types of vessels, including liabilities connected with them, and on their cargoes. The cargo coverage has been expanded to protect the owners from warehouse to warehouse, including all intermediate transit by rail, truck, or other transportation means.

Inland marine insurance is designed to provide coverage on articles that may be transported from one place to another. At one time this form was simply an extension of the "warehouse to warehouse" coverage of ocean marine. It is now used to insure any goods in transit (except trans-ocean transit) or any goods which by their nature are subject to the perils of transportation.

Casualty Insurance. As it exists today, casualty insurance is virtually impossible to define. One commonly proposed definition states that, "If it isn't fire, marine, or life, it's casualty." Certainly what this definition lacks in precision, it makes up in scope.

Casualty insurance originally included accident and health and liability insurance. As new fields of insurance were developed, someone had to accept the underwriting responsibility; and more often than not, these new coverages were adopted and marketed by casualty companies. As a result, the following coverages, unrelated though they may be, are considered to be casualty insurance:

1. Health and accident insurance, including disabili ty.
2. Liability insurance.
3. Workmen's compensation insurance.
4. Plate glass insurance.
5. Boiler explosion insurance.
6. Burglary, robbery, and theft insurance.
7. Fidelity and surety bonds.

Some authorities question whether the last of these (bonds) are actually insurance at all; and as a matter of

fact, there are some technical distinctions which distinguish a bond from a contract of insurance. For our purposes here, we may ignore the distinctions. Insurance regulatory authorities normally include bonds within the framework of the contracts which they regulate. Furthermore, casualty insurance carriers sell these bonds. Since suretyship is normally considered to be a part of the casualty insurance business, we will ignore the distinctions between bonds and insurance at this point.

THE INSURANCE INDUSTRY

In spite of the great benefits which accrue to society as a result of the insurance mechanism, it is self-evident that such a complicated and intricate mechanism as insurance does not come into existence by itself. Someone must make the estimates of the probability of loss, collect the funds that are necessary to compensate those who suffer loss, make payment for the losses that occur, and provide for the general administration of the program. This is the task of the insurance companies. In addition, insurance is a product; it must be sold. Individuals in the economy must be made aware of their need for the product; this is the task of the insurance agent.

The insurance business in the United States is a tremendous industry, measured by any one of a number of standards. There are approximately 4,700 insurance companies conducting operations in the United States. These companies employ about 1,620,000 persons and have responsibility for assets of more than $347 billion.

We begin our examination of the insurance industry with insurance companies. Insurance carriers may be classified in a number of different ways, the most obvious being on the basis of the product which they sell, and their legal form of ownership.

TYPES OF INSURERS

For a considerable period of its history, the insurance industry in the United States was organized along a mono-line basis. Due to the nature of the development of business, insurance companies were restricted by law to writing a particular line of insurance. A company which wrote fire insurance was not permitted to write casualty insurance; a casualty carrier could not write fire insurance policies. Neither fire insurance companies nor casualty insurance companies could write life insurance and life insurance carriers were permitted to write nothing but life insurance. This system was unique to the United States, for the European insurance industry had developed along a multi-line basis, under which a carrier could write any and all types of insurance. Thus at one time, it was approximately accurate to classify insurance carriers as fire insurance companies, casualty companies, life insurance companies, or specialty companies, depending upon the type of business in which they engaged. The specialty companies were also mono-line organizations and were organized to insure only certain types of hazards, such as boiler explosion, or confined their activities to one aspect of the casualty business, such as health and accident insurance. Thus, until the period immediatelty following World War II, there were four distinct types of carriers:

1. Fire Insurance Companies.
2. Casualty Insurance Companies.
3. Life Insurance Companies.
4. Specialty Insurance Companies.

Following World War II, the distinction between property and casualty insurers gradually disappeared. Following the recommendations of the National Association of Insurance Commissioners,[1] the individual states began to permit insurance carriers in the property and casualty lines to engage in limited multiple line underwriting. In 1949 full multiple line laws were enacted which permitted a single insurance company to write all lines of fire and casualty insurance. As a matter of fact, under the multiple line laws a carrier could write all forms of insurance except life insurance, provided that it met the capital and surplus requirments of each individual line. The legal barriers which had divided property and casualty insurance carriers for over a century were ended.

Presently we may distinguish between three distinct types of insurance carriers:

1. **Life Insurance Companies,** which write life insurance contracts, annuities, and health and accident.
2. **Property and Casualty Insurance Companies,** which write all forms of property and casualty (including health and accident).
3. **Health and Accident Insurance Companies,** which are specialty companies, writing only health and accident insurance.

At the end of 1974, there were 1,810 life insurance companies in the United States, more than three times the number that were in existence at the end of World War II. In addition, there were 2,900 property and casualty insurers. In addition, there were a few companies selling health insurance only, making the total number of insurance companies in the country in excess of 4,700.

TYPES OF INSURERS BY FORM OF OWNERSHIP

In addition to being classified on the basis of the types of insurance they provide, insurers may also be grouped according to their legal form of ownership into the following six broad groups.

1. Capital stock insurance companies
2. Mutual insurance companies

[1] An explanation of the nature and functions of this organization will be made later.

3. Reciprocals or interinsurance exchanges
4. Lloyds associations
5. Health expense associations
6. Government insurers

Capital Stock Insurance Companies

Stock companies are organized as profit making ventures, with the stock holders assuming the risk that is transferred by the individual insured's. If the actuarial predictions prove accurate, the premiums collected are sufficient to pay losses and operating expenses and return a profit to the stockholders. The capital provided by the stockholders provides a fund for the operation of the company until premium income is sufficient to pay losses and operating expenses. In addition it provides a surplus fund which serves as a guarantee to the policy holders that the contracts will be fulfilled.

The distinguishing characteristics of a capital stock insurance company are the facts that:

(a) the premium charged by the company is final. There is no form of contingent liability for the policy holder.
(b) the board of directors is elected by the stock holders.
(c) earnings are distributed to shareholders as dividends on their stock.

Capital stock companies more or less dominate the field of property and casualty insurance, accounting for approximately two-thirds of the premium volume.

Mutual Insurance Companies

In contrast to a stock company, a mutual insurance company is owned by the policyholders. Mutual companies are organized for the purpose of providing insurance for its members. Normally a mutual company is incorporated, and in many states this is a legal requirement. The essential characteristic of the mutual carrier is its lack of capital stock and the distribution of earnings. Any money left after paying all costs of operation is returned to the policyholders in the form of a dividend. Included in the concept of "costs" which must be paid, is the addition to the surplus of the company. Unlike the capital stock company, the mutual company has no-paid in capital as a guarantee of solvency in the event of adverse experience. For this reason it is essential that a surplus be accumulated to protect against such adverse contingencies as excessive losses or a decline in investment return.

Pure Assessment Mutuals. Pure assessment mutuals operate on the basis of sharing the losses by members of the group. Under the pure assessment plan, no premium would be payable in advance; but assessments would be made of each member for his portion of losses which occur. The difficulty in making these assessments makes the operation of such a plan impractical.

Advance Premium Mutuals — Assessable Policies. The advance premium mutual, as the name indicates, charges a premium in advance, at the beginning of the policy period. If the original premiums are sufficient to pay all operating expenses and losses, any surplus is returned to the policyholders in the form of a dividend. If, on the other hand, the original assessment is insufficient to meet all contingencies, additional assessments may be levied against the members. Normally the amount of the assessment which may be made is limited, either by state law or simply as a provision in the bylaws and policies of the mutual. Under this limited assessment arrangements, the amount of an additional assessment normally may not be more than the advance premium, although at times it is specified as two, three, or some other multiple of the advance premium.

Under an assessment mutual plan, each member of the organization becomes both an insured and an insurer. In becoming a member of the organization, the individual makes himself liable for his share of all losses that occur to members of the group.

Advance Premium Non-Assessable Mutuals. Until a mutual company has established its financial stability through the accumulation of surplus, it must provide for assessment of its members. However, all states permit mutual carriers to issue non-assessable policies after they have established their financial responsibility. Normally, when a mutual company has the same financial strength required of a capital stock company writing the same type of business, it may be permitted to issue non-assessable policies. An advance premium mutual company issuing non-assessable policies is usually operated in about the same manner as a capital stock company. The advance premium which is collected is intended to be sufficient to cover all losses and expenses. If it is not, the additional costs are paid out of the accumulated surplus. All of the larger mutual carriers in the United States operate on this basis. However, unlike the capital stock companies, the premium is not fixed and definite, and any excess of premium income over costs may be returned to the policyholders in the form of dividends. In the field of property and casualty insurance this excess is predicted in advance and the "return" is made in the form of a lower initial premium.

In the last analysis, there are few practical differences between a mutual company operating on an advance premium basis and issuing non-assessable policies and a capital stock company. Although the policyholders own the mutual company in theory, there are no vested rights of ownership for these policyholders except in the case of liquidation. Furthermore, while the policyholders theoretically control the company, this control is equivalent to the theoretical control of the stockholders over the management in a large corporation with a large number of individual stockholders.

Fraternals. Fraternal societies are specialized forms of mutual insurers. Basically, fraternal societies are non-profit organizations which operate on the basis of a "lodge," with a representative form of government. Fraternals have primarily concentrated their activity in the field of life insurance although they sometimes sell sickness and accident insurance. Since fraternals are considered to be charitable institutions they do not pay federal income tax or the state premium tax.

Reciprocals

The reciprocal or interinsurance exchange is a relative newcomer to the insurance industry. It is a particularly American innovation, and while reciprocals are only a small segment of the insurance industry, they are a significant segment.

Reciprocal insurance exchanges are often confused with mutual carriers; and while there is a similarity, there is also a fundamental difference. A reciprocal is an unincorporated aggregation of individuals, called subscribers, who exchange insurance risks. Like mutuals, reciprocals are fundamentally cooperative organizations. Each member (or subscriber) is both an insured and an insurer; as a member of the group, the individual is insured by each of the other members, and he in turn insures each of them.

In a mutual organization, members of the group assume their liability collectively; in a reciprocal exchange each of the subscribers assumes his liability severally as an individual, and not as a member of the group. The advantage inherent in this arrangement is that the liability of each of the subscribers is limited. Although some reciprocals provide for a limited assessment of the members, one member cannot be called upon to assume the liability of a defaulting member. The premium paid by each subscriber is maintained in a separate account and the subscriber's share of each loss is paid from his account.

One of the chief characteristics which distinguishes the reciprocal is the chief administrator of the program who is called the "attorney in fact." The attorney in fact derives his authority through a power of attorney granted to him by each of the subscribers. The attorney in fact uses his power of attorney to commit the members as insurers of each other's property. The power of attorney which is granted by the members is unusually broad — as a matter of fact, the broad power of attorney, granted to the attorney in fact, can be one of the detrimental aspects of the reciprocal. An unscrupulous attorney in fact could conceivably exploit the subscribers for his own personal gain. The attorney in fact receives some percentage of the gross premiums paid by the subscribers (usually about 25 percent) to cover the expenses involved in operating the program.

With the exception of the compensation of the attorney in fact and the expense of operating the plan, the only expense involved for a subscriber is the amount of the losses that occur. If there are no losses, there is no cost. Profit is eliminated through a return of the unused premiums to the subscribers. In addition, since the insurers are also the insureds, the expense of commissions or other acquisition costs are also eliminated.

Reciprocals confine their operations to the property and casualty fields. The portion of the total premiums written through interinsurance exchanges is relatively small. In 1960, only about 3.5 percent of all property and casualty premiums were written through reciprocals.

Lloyd's Associations

Lloyd's of London. Lloyd's of London is the oldest and perhaps the most famous of all insurance organizations in the world. Generally speaking, Lloyd's is a corporation for marketing the services of a group of individuals. Lloyd's itself does not issue insurance policies or provide insurance protection. The actual insurance is underwritten by the 9,000 underwriting members of the association. Technically each of these members is a separate "insurance company," issuing policies and underwriting risks separately or collectively with other members. In a sense, Lloyd's is similar to the New York Stock Exchange, in which the actual physical facilities are owned by the stock exchange and made available to members for the transaction of business.

Each of the underwriters at Lloyds must conduct business as an individual proprietor or as a member of a syndicate. No corporations or other limitations on liability are permitted, and every member of Lloyd's exposes his entire personal fortune in addition to his business assets.

The fact that Lloyd's is a combination of a great many individual underwriters who assume their liability individually means that each member is liable only for his own commitments. Normally policies issued through Lloyd's are issued by a member of the individual underwriters. A single underwriter will not assume the total risk connected with a given policy, but will assume only a fraction. He will be liable only for his portion of the total policy if a loss should occur, and is under no obligation to assume the portion underwritten by another member. In the past, for public relations, solvent members have assumed the liabilities of defaulting members.

In addition to the individual liability that results from the severability of the underwriters, another problem arises. In the event of a dispute concerning coverage under the policy, it is technically necessary to sue each of the individual underwriters. As a matter of practice, however, if suit is brought against one of the underwriters under a contract and is successful, the remaining members pay their portion of the loss without the necessity of further litigation.

Although Lloyd's of London is famous throughout

the United States, it is licensed in only two states: Illinois and Kentucky. In each Lloyd's policy issued in the United States, there is a clause in which the underwriters agree to submit to the jurisdiction of either of these two states or any other court of competent jurisdiction in the United States. As a special guarantee to American policyholders, Lloyd's maintains a fund of approximately $1 billion in the United States.

In spite of the fact that Lloyd's is licensed in only two states, it provides insurance protection in many other areas. In order to service the need of clients who desire protection which is not available from carriers licensed in the state, it is permissable in many states for an agent to place coverage with non-admitted or non-licensed companies. The insurance obtained in this manner is known as "Surplus Lines Insurance." Basically, an agent may secure coverage for a client with Lloyd's (or any other non-admitted carrier) provided that he has made a diligent effort to place the coverage concerned with licensed carriers.

American Lloyd's. The American Lloyd's are an attempt to emulate the success of (and capitalize on the fame of) Lloyd's of London. An American Lloyd's is simply a group of individuals who operate an insurance mechanism using the same principals of individual liability of insurers that Lloyd's of London uses. In an American Lloyds, each individual underwriter assumes a part of each risk. Each of the individual insurers promises to pay a specified amount in the event that the contingency insured against occurs. Each member is liable only for his portion of the risk and is not bound to assume any portion of a defaulting member. In other words, American Lloyd's operate in essentially the same manner as Lloyd's of London, but without the strict regulation which the original Lloyds imposes upon its members. Most states have laws which prohibit the organization or licensing of American Lloyd's. Those American Lloyd's which do exist operate almost exclusively in the property insurance field.

Health Expense Associations

Unique to the field of health insurance are the hospital and medical expense associations: Blue Cross and Blue Shield, and the "independent" plans. The Blue Cross and Blue Shield plans are nonprofit associations usually organized under special state enabling legislation to provide for prepayment of hospital and surgical expenses. The Blue Cross plans were originally organized by individual hospitals to permit and encourage prepayment of hospital expenses. Blue Shield plans occupy approximately the same position in the surgical expense field as Blue Cross plans occupy in the hospitalization field. Both Blue Cross and Blue Shield market "service" contracts under which service benefits, rather than a dollar indemnity, are provided to insured members. Thus, while a commercial insurer's contract might, for example, provide for payment up to $50, $60, or $70 a day while the insured is confined to a hospital, a Blue Cross contract would provide a semiprivate room in a member hospital.

Independent plans have a longer history than do the Blue Cross and Blue Shield associations. However, they represent a very heterogeneous group and generalizations are difficult. The term "independent" has been used to denote a health insurance plan which neither is a conventional insurance company nor is affiliated with Blue Cross or Blue Shield. Most of the early independent plans were industrial plans instituted by an employer or a union, and with enrollment limited to employees and members. A smaller number were sponsored by communities or by clinics. Some of these independent plans pioneered the prepaid group practice approach to the provision of medical services, which is now known by the more popular term "Health Maintenance Organization" or HMO. Under the HMO plan, subscribers pay an annual membership fee in return for which they receive a wide range of health care services. The physicians practicing in these plans usually work for salaries paid by the group rather than for fees from the individual patients.

Government Insurers

Government at both the state and federal level is engaged in an extensive variety of insurance programs, including both social insurance coverages and voluntary or "private" forms of insurance. These programs have been established at various times in our history for various reasons. In some instances, they were established because the risks involved did not lend themselves to private insurance, because the hazards were too great or because private insurers were subject to adverse selection. In other instances, they have been set up because of the inability or reluctance of private insurers to meet society's need for some form of voluntary insurance. In a few cases, government insurance programs have been established as tools of social change, designed to provide a subsidy to a particular segment of our society or to help solve social ills. Finally — and regrettably — some government insurance programs have been established on the mistaken notion that such programs could somehow repeal the law of large numbers, providing insurance against a particular risk at lower rates that would be charged by private insurers.

Federal Social Insurance Programs. The United States government is the largest insurer in the world, through its administration of the federal social insurance programs. These include The Old-Age, Survivors, and Disability Insurance program (popularly known as social security) and the Medicare program, both administered by the Department of Health, Education, and Welfare.

State Social Insurance Programs. State governments also operate social insurance programs. Among

their major programs are unemployment compensation programs and state workers' compensation plans:

1. All of the states operate unemployment insurance plans, which provide for payment to certain unemployer workers who have qualified on the basis of previous employment.
2. Eighteen states offer workers' compensation insurance. In six of these states (Nevada, North Dakota, Ohio, Washington, and West Virginia) the government fund operates as a monopoly, and employers may purchase this coverage only from the state. In the remaining twelve states (Arizona, California, Colorado, Idaho, Maryland, Michigan, Montana, New York, Oklahoma, Oregon, Pennsylvania, and Utah) the government fund competes with private insurers.
3. Five states (California, New York, New Jersey, Hawaii, and Rhode Island) have established compulsory temporary disability plans which provide income to workers disabled from a nonoccupational cause.

Federal Private (Voluntary) Insurance Programs. The federal government is engaged in a wide variety of voluntary insurance fields. Although the extent of the national government's involvement in the field of insurance has increased recently, it is not exclusively a recent phenomenon. For example, war risk insurance programs existed in both World War I and World War II; and the U.S. Post Office has sold insurance on registered mail and parcel post for many years. The principal voluntary insurance programs conducted by the federal government include the following:

1. **Federal Crop Insurance.** The Federal Crop Insurance Corporation, established in 1939 provides all risk crop insurance to farmers. Although the program is theoretically self-supporting, with premiums sufficient to pay losses, there is an element of subsidy in the administrative costs, and loss payments frequently exceed premiums.
2. **Nuclear Energy Liability Insurance.** When atomic energy was released from government monopoly and turned over to private industry for development, Congress established a $560 million limit on the liability arising out of a nuclear accident. Pools organized by the insurance industry provided a part of the coverage necessary for those firms that obtained fissionable materials, and Congress authorized the Atomic Energy Commission to sell supplementary liability insurance up to the specified $560 million limit.
3. **Federal Riot Reinsurance.** Following the urban riots throughout the U.S. in the summer of 1967, Congress established the National Insurance Development Fund. This agency provides riot reinsurance, for which private insurers pay a premium, to those insurers participating in state supervised and federally approved FAIR plans.The FAIR Plans are special pools set up on a state by state basis and operated by the private insurance industry to provide insurance to property owners who find it difficult to obtain insurance because of the location of their property and hazards of location over which they have no control. (If an insured cannot obtain insurance through normal channels, he makes application to the plan. After an inspection of the property, the FAIR Plan will assign the property to an insurer or tell the property owner what physical hazards must be corrected before the property will be insured.)
4. **The Federal Flood Insurance Program.** Until the enactment of the Housing and Urban Development Act of 1968, which initiated the National Flood Insurance Program, flood insurance on fixed property was generally considered to be an uninsurable risk, and was not available at any price. The HUD Act of 1968 established a national flood insurance program, which makes flood insurance available in any community that pledges to adopt and enforce land control measures designed to guide future development of the community away from flood prone areas. The program was originally conducted as a partnership between the federal government and the private insurance industry. The National Flood Insurers Association, a group of about 100 insurance companies, entered into an argument with the government in 1969, under which these companies pledged risk capital and agreed to act as servicing agent for the program. When this contract expired in December of 1977, the Secretary of Housing and Urban Development decided to change the program to one in which the federal government itself acts as the insurer. A Texas computer operations and management firm, Electronic Data Systems, acts as the fiscal agent for the program, but the government itself is the risk bearer. The coverage is sold through property and liability insurance agents, who are paid commissions for the flood insurance they sell.
5. **The Federal Crime Insurance Program.** The Housing and Urban Development Act of 1970 authorized the federal government to determine those states in which the unavailability of crime insurance is a critical problem, and to write crime insurance in those areas at reasonable rates. Policy forms, rates, deductibles, and underwriting requirements are set by the office of the Federal Insurance Administration; and the coverage is sold through regular insurance agents in the state. Coverage under this program is now available in twenty-three states, including the state of Iowa.

6. **The Small Business Administration Surety Bond Program.** Because surety bonds guarantee that the individual or firm that is bonded will perform the specific function contracted, bonding companies generally look closely at the past performance of a bond applicant before granting a bond. Not surprisingly, smaller contractors who are underfinanced and have little experience usually have difficulty in obtaining bonds. In 1968, Congress authorized a study of the bonding field to determine if difficulties in obtaining surety bonds were preventing small contractors—particularly minority contractors—from competing for public and private housing contracts. As a result of this study, Congress established the Small Business Administration (SBA) Surety Bond Program in 1971. Under this program, the SBA is authorized to guarantee a surety company against 90% of the loss it sustains as a result of the failure of a small contractor who is reinsured under the program. In exchange for this 90% loss guarantee, the surety company pays the SBA 10% of the bond premium.

7. **The Federal Fidelity Bonding Program.** The Federal Fidelity Bonding program, operated by the U.S. Department of Labor, is designed to provide fidelity bonds to persons who have participated in federally financed work-training programs, and who are still unable to find work because of police, credit, or other records that prevent them from obtaining fidelity bonds required by their prospective employer. Coverage is available in $500 increments up to $10,000. The federal government contracts with a private insurer, selected through a bidding process, to furnish the bonds; and the Department of Labor pays the premiums.

State Private (Voluntary) Insurance Programs. With the exception of the 18 workers' compensation funds noted above, there are only a handful of state private insurance programs.

1. **State Crop Hail Funds.** At one time, six states operated crop hail insurance plans. Only two remain, in Colorado and Montana. The largest of these plans, which had existed in North Dakota, was abolished in 1967.

2. **The Wisconsin State Life Insurance Fund.** The state of Wisconsin sells life insurance to residents, in amounts ranging from $1,000 to $10,000. The rates are considerably lower than those charged by private insurers because there are no commissions and the state provides a subsidy in the form of office and administrative expenses. Although the fund has been in existence since 1911, the insurance in force represents less than 1% of all life insurance in the state.

3. **The Maryland State Automobile Insurance Fund.** The State of Maryland created a state run automobile insurance fund in 1973, promising lower rates for motorists who insured through the fund. Underwriting losses in the first two years exceeded $36 million, and by 1976 the fund was on the brink of insolvency. It now operates as a "partnership" with the private insurance industry, under an arrangement in which all private auto insurers in the state share the losses of the fund through a statewide reinsurance pool.

THE AGENT

From many points of view, the most important person in the entire insurance transaction is the agent. The marketing of insurance is a complicated operation, and yet it is an essential part of the insurance business; for without an effective marketing organization, insurance carriers could not obtain a sufficient number of exposure units to permit the spreading of the risk and the calculation of the probability of loss on an accurate basis. With few exceptions, the marketing mechanism in the insurance industry revolves around the agent. However, the role of the agent varies in different lines of insurance. In the field of property and casualty insurance, on one hand, the agent is "an individual authorized to create, terminate, and modify contracts of insurance." In the area of life insurance the agent's power is somewhat more limited. Life insurance agents are appointed with the authorization to solicit and deliver contracts of insurance; however, they cannot, as can the property and casualty agent, bind the company to a risk.

The agent derives his powers as an agent from two sources. He is given express powers by his company in the agency agreement or contract. This agreement gives the agent express authority to represent the company, and generally contains clauses dealing with such things as the specific and general powers of the agent, the scale of commissions, the ownership of the contracts that are sold, and a provision for cancellation of the contract.

In addition to those expressly granted powers which he derives from the agency contract, the agent has certain implied powers.

Under the doctrine of "ostensible authority," the courts have ruled that an agent has those powers which the public has come to expect agents to have. Since it is accepted by the public that property and casualty agents have the power to bind their company to a risk, they have this power, in spite of the fact that the company may not have granted this power expressly. Let us say for example that the insurance company has told a particular agent not to sell any insurance on match factories, but the agent binds coverage on such an establishment. In spite of the fact that the company has forbidden the agent to bind such coverage, it would

be liable for any loss that occurred. As far as the public is concerned, an act by the agent is an act by the company. He acts on behalf of the company in the insurance transaction; and under the laws of agency, his acts are deemed to be those of the company. If he binds the company to a risk, the company is bound to that risk until such time as it effects cancellation of the contract.

MARKETING SYSTEMS

As noted previously, the agent is the central figure in the insurance marketing process. While this is true, the relationship between the agent and the company which he represents can be and is often quite varied. Through a process of evolution several marketing forms have been developed. Each form has as its goal the attainment of efficiency in distribution and service.

The Life Insurance Distribution System

With the exception of a small amount of life insurance sold through the mail, life insurance companies are represented by agents. Most life insurance companies either insist that their company be the only one represented by the agent, or else attempt to encourage the agent to represent them exclusively. While there are agents who represent more than one life insurance company, these agents are the exception.

The chief differences between life insurance companies in their distribution techniques are centered around the supervision of the agent. Two systems are used: (1) the general agent and (2) the branch office.

A general agent is an independent businessman, empowered by the company which he represents to sell life insurance in a specified territory and to appoint subagents. At one time the general agent received no financial aid from the company which he represented, but received a commission on all business which his subagents produced. He in turn paid a part of this commission to his subagents and paid his expenses, with the balance representing his personal income. This has gradually changed and today most general agents receive some sort of financial assistance from their companies, in the form of a contribution toward the general agency expense.

The fact that the general agent hires, trains, and compensates his subagents makes the general agency a relatively inexpensive and riskless manner of starting in a new area. Unfortunately, however, there are certain disadvantages inherent in the general agency system. One major shortcoming is the lack of supervision and control which the company has over the subagents. For this reason the general agency operations have gradually been modified with more control from the home office.

The branch manager, in contrast to the general agent, is a salaried employee of the company. All expenses of the branch office are paid by the home office, for in reality the branch office is simply an extension of the home office. At one time, the branch manager received only a salary, but in recent years this has been modified and in many cases the branch manager now receives additional compensation on the basis of the production of the agents who he supervises or through exclusive or "captive agents" (as is the case with National Liberty Mutual Insurance Company).

The trend in the supervision of life insurance agents is toward an elimination of the differences between the general agent and the branch manager. Today the general agent has many of the characteristics of the branch manager and vice versa.

Property and Casualty Distribution Systems

In the field of property and casualty insurance, companies may be classified into two groups based on their distribution system: Those who operate through the American Agency System, and the "direct writers." The agents who operate through the American Agency System are known as "independent agents," while those who represent direct writers are called "captive agents."

The American Agency System. The independent agent normally represents several companies, dividing the policies which he sells among those companies according to his choice. He owns his expirations, which means that he may place the renewals of policies which he has sold with some other carrier if he chooses to do so. This alternative often gives the independent agent strategic power which he can use to the benefit of his clients. However, although the independent agent is first and foremost a representative of the company, he also has an obligation to the insured.

Direct Writers. Direct writing companies operate through salaried representatives (as in the case of Liberty Mutual Insurance Company), or through exclusive or "captive agents" (as is the case with Nationwide, State Farm, and Allstate). Technically, companies that operate through exclusive agents are not "direct writers," but rather "exclusive agent companies." However the term direct writer is commonly used in reference to both companies operating through salaried representatives and those operating through exclusive agents. The compensation of the salesman may be in the form of a salary, or it may be a commission based on the premium volume. In the case of the exclusive agent, it is normally in the form of commission. The important point is that the agent or the salaried employee does not own the expirations. He has no choice as to where the policy is to be renewed.

COOPERATION AND COMPETITION IN THE INDUSTRY

Cooperation in the Insurance Industry

Insurance by its very nature is cooperative. Despite the fact that insurance carriers and insurance agents

compete vigorously with each other, there are many areas in which both insurance companies and insurance agents cooperate. This cooperation arises out of economic necessity in some cases. Many cooperative organizations are organized and supported by groups of insurance companies to perform functions which would involve a duplication of effort if each company attempted to perform them individually. In other areas the objective of the organizations is public relations or education. The complicated nature of the insurance business requires cooperation in technical areas such as rate making and management, and cooperative organizations have been organized and are supported by insurance companies to serve this end. The extent and nature of the cooperation within the industry can best be shown by examining a number of the more important organizations.

Rating Organizations. One of the major areas of cooperation among insurance companies is in rate making. As we have seen, the accuracy of the predictions made by actuaries is increased as the number of exposures upon which these predictions are based increases. Numerous organizations called rating bureaus are supported by insurance companies who furnish their loss statistics to these organizations as the raw material for producing rates. Members of the bureau then use the rates that are published by the bureau. A full member of the bureau agrees to use all of the facilities of the bureau and to adhere to its rates and forms. In addition to the full bureau members, there are numerous companies that subscribe to the services of the bureau. While they do not belong to the bureau as members, they use the facilities of the bureau and purchase the right to use the rates published by the bureau as a basis for their rates. Subscribers to a bureau may write their coverages at full bureau rates; or, with the permission of the insurance regulatory authorities, they may "deviate" or depart from the bureau rates.

There are, of course, companies which do not belong to the major cooperative rating bodies. These companies pursue an independent course of action, using independently filed rates and forms. A small firm does not normally have a sufficiently large number of exposures to devise adequate rates, and as a result only larger companies make independent filings. Many people in the insurance business feel that the cooperative rating bureaus set the standard for the insurance industry. In other words, companies which deviate must have something to deviate from.

Some of the more important rating bureaus and rating organizations are:

1. **The Insurance Service Office (ISO).** The Insurance Service Office provides a wide range of advisory, rating and actuarial services relating to property and casualty insurance, including the development of policy forms, rates, premiums, and related services for multiple line coverages. This organization was created on January 21, 1971, through the consolidation of the Fire Insurance Research and Actuarial Association, the Inland Marine Insurance Bureau, the Insurance Rating Board, the Multi-Line Insurance Rating Bureau, the National Insurance Actuarial and Statistical Association and the Insurance Data Processing Center. It computes and publishes rates for general liability insurance, boiler and machinery insurance, theft insurance, plate glass and inland marine insurance, package policies such as the homeowners forms and automobile liability, medical payments, and physical damage.

2. **The Surety Association of America.** The Surety Association of America is a statistical and rating organization for surety companies.

3. **The National Council on Compensation Insurance.** The National Council on Compensation Insurance develops and administers rating plans and systems for workmen's compensation insurance.

There are no rate bureaus in the life insurance field; however, the Society of Actuaries, a voluntary association of insurance actuaries, holds periodical meetings for the exchange of information with the goal of improvement of premium determination.

Distressed and Residual Risk Pools

One of the most socially significant areas of cooperation among insurers is found in the techniques used to deal with certain classes of insureds that are unprofitable but which, for various reasons, must be insured. In some instances, applicants are shared on some predetermined basis; in others, the losses are shared. The following are a few of the more important programs that have been designed to deal with the problem of the high-risk insured.

1. **Automobile Assigned Risk Plans.** Some drivers, because of their past records and the likelihood of future losses are unacceptable to insurers in the normal course of business. However, because it is socially undesirable to permit such drivers on the road without any form of insurance, the insurance industry operates special mechanisms to provide the necessary coverage. The most widely used approach is the Automobile Insurance Plan (formerly called Assigned Risk Plan) which is currently in use in 42 states. Under this program, each automobile insurer operating in a given state accepts a share of the undesirable drivers, based on the percentage of the state's total auto insurance that it writes. Other states use a reinsurance plan or a joint underwriting association to accomplish the same goal.

2. **FAIR PLANS.** Twenty-six states operate property insurance pools, known as "FAIR Plans," which are designed to provide access to insurance for property owners who find it difficult to purchase insurance because of the location of their property. If a property

owner cannot obtain insurance through the normal market, he makes application to the FAIR Plan. After inspecting the property, the FAIR Plan assigns the property to a participating insurer or informs the owner what physical hazards must be corrected before the property will be insured.

Underwriting Syndicates

In addition to the other forms of cooperation, insurers sometimes join together in underwriting syndicates for the purpose of handling risks that would be beyond the capacity of an individual company. In these syndicates, which are found primarily in the property and liability field, insurers make use of the basic insurance principle of spreading risk and sharing losses. Unlike the pools discussed above, however, the syndicates are designed to provide some competitive advantage to the members, who voluntarily enter into the arrangement.

1. **The Associated Factory Mutual Insurance Companies.** The "Factory Mutuals" are a group of direct-writing mutual insurers that specialize in insuring highly protected exposures, usually involving large concentrations of value.

2. **The Industrial Risk Insurers.** The Industrial Risk Insurers (IRI) is a syndicate of about 100 capital stock companies organized to insure large concentrations of value. Like the factory mutuals, the IRI emphasizes loss prevention and specializes in large concentrations of value.

3. **Nuclear Energy Pools.** Three pools (The Nuclear Energy Liability-Property Insurance Association, the Mutual Atomic Energy Liability Underwriters, and the Mutual Atomic Energy Reinsurance Pool) provide $390 million in property and liability protection to owners and operators of nuclear facilities.

4. **The American Foreign Insurance Exchange.** The American Foreign Insurance Exchange (AFIA) represents its member companies in the transaction of insurance business in foreign countries.

In addition to these syndicates, there are a number of similar organizations designed to deal with specialized exposures or the needs of particular industries. There are syndicates for insuring aviation exposures (Associated Aviation Underwriters and the United States Aircraft Insurance Group) for ocean marine insurance (The American Hull Insurance Syndicate) and syndicates that specialize in a particular industry (the Cotton Insurance Association, the Underwriters Grain Association, and the Railroad Insurance Underwriters).

Public Relations Organizations

Each of the three major fields of insurance has its "information institute."

The Institute of Life Insurance is primarily a public relations organization financed by member life insurance companies. It prepares and distributes educational materials to teachers and schools, prepares news releases concerning developments in the field of life insurance which are of general interest to the public, and gathers and publishes statistics concerning life insurance.

The Health Insurance Institute performs the same functions in the area of health insurance for the health insurance companies that the Institute for Life Insurance performs for life insurance companies.

The property and liability insurance equivalent of the above two organizations is the Insurance Information Institute, which is supported by approximately 300 capital stock insurance companies.

Education Organizations

The field of insurance requires continuing education on a scale that is matched by few occupations. A large number of educational organizations exist for the agent or company employee who wishes to improve his knowledge and increase his professionalism.

The American College of Life Underwriters is the leading educational organization in the field of life insurance. It sponsors the course of instruction leading to the professional designation "Chartered Life Underwriter," or "C.L.U." This designation is a symbol of professional attainment which relatively few individuals achieve. The American College of Life Underwriters is supported by contributing life insurance companies.

The American Institute for Property and Liability Underwriters is the equivalent of the American College of Life Underwriters in the area of property and casualty insurance. The designation granted by the Institute is Chartered Property and Casualty Underwriter or the C.P.C.U. The C.P.C.U., like the C.L.U., is the highest symbol of attainment granted to a member of the insurance profession for educational development and professionalism.

In addition to the American Life College and the Institute for Property and Liability Underwriters, two other organizations exist with the purpose of sponsoring education. The Insurance Institute of America offers basic courses which are a preparation for the rigorous requirements of the C.P.C.U. study program. The Life Underwriters' Training Council offers similar instruction in the field of life insurance.

Agents Cooperative Organizations

Cooperation in the insurance business is not limited to insurance companies. There is also substantial degree of cooperation among agents.

In the area of property and casualty insurance, many agents belong to cooperative organizations at the local level known as local boards of insurance agents. These local boards in turn cooperate by affiliating with a state association of insurance agents, (e.g., The Independent

Insurance Agents of Iowa or The Professional Insurance Agents of Iowa). The state associations further cooperate by affiliating with the Independent Insurance Agents of America. A similar organization, known as the National Association of Professional Insurance Agents, deals primarily with agents representing mutual insurance companies.

In the area of life insurance, the basic cooperative organization is the local association of life underwriters. Each of the local associations of life underwriters affiliates with a state association (e.g., The Iowa Association of Life Underwriters). The national organization with which each of the state associations is affiliated is known as the National Association of Life Underwriters.

In the case of property and casualty and in life insurance, agents associations perform many valuable functions for member agents, particularly in the areas of supporting legislation which is of interest to the public and the insurance industry and guarding against unwise legislation. An equally important function provided by the agents associations is the promotion of agent education, helping agents to improve themselves and their operations.

Competition in the Insurance Industry

The competition within the insurance industry today is fierce; perhaps more so than at any time in history. Briefly, this competition takes place in three areas:

1. **Price competition**
2. **Quality competition**
3. **Service**

Price Competition. Insurance competes on the basis of price by offering a lower priced product than other companies dealing in the same line of insurance. It is often puzzling how insurance carriers can charge significantly different premiums for identically the same coverage. The price of insurance coverage, like most prices, is a function of the cost of production. The most obvious answer to the question of how various insurance carriers can charge significantly different premiums for identically the same insurance coverage is that their costs must also vary significantly. The following costs are common to all insurance companies:

1. Payment of losses
2. Loss adjustment expense
3. Cost of production (sales expense)
4. Administrative expenses
5. Taxes

If a company is successful in reducing any of these costs below those of its competitors, it stands to reason that that company will be able to offer its coverages at a lower premium.

The first of the listed costs, the payment of losses, can be an area of significant difference between companies. Since the hazards and perils involved in each exposure are different, the exposure units have varying degrees of risk. Some exposures are better than average and some are worse than the average. If a company can succeed in obtaining its customers from a better class of risks, not only will its loss experience be lower, but since the better risks are thus removed from the total of exposure units, the average risk in the remaining group will be worse than previously. So when one company or a group of companies succeeds in lowering its loss payments through the selection of better risks, the loss payments of the remaining companies rise.

If losses decline, then the expense of adjustment also declines. In this way, careful selection of the more desirable exposures results in an additional saving.

The third cost, the cost of production, can also be altered to reflect substantial premium savings. The bulk of production costs have traditionally been agents commissions. In addition to the original commission when the policy is first sold, some lines of insurance require commission payments at each renewal, equal to the original commission. Some companies, such as the direct writers, have been able to reduce premium costs by reducing the agent's renewal commission. Even in life insurance, where the agent's commission is a significant cost only for the first year, lower commission scales may permit lower premiums.

Closely connected with the costs of production are administrative costs. Efficiency in administration, through the use of mechanized billing and automatic renewal procedures, not only save administrative costs, but they give the company greater control over policy renewals and permit a reduction of renewal premiums.

While all savings in the cost of various companies have some effect on the price of their product, the most substantial variations in premium rates are due to the savings made in loss payments.

The price competition in the life insurance field is a complicated operation. In the area of life insurance most companies use the same mortality tables and the same assumption regarding the return on their investment. Yet the price for a given type of policy varies from company to company. One of the reasons that the premium varies from one company to the next in life insurance is the fact that the policies are not identical products.

In the area of property and casualty insurance, the price competition takes place between various types of companies. Thus bureau companies compete with stock companies, bureau companies compete with non-bureau companies, and companies operating through the American Agency System compete with the direct writers.

Quality Competition. In addition to the price competition, insurance companies also compete by offering

different forms of policies, with broader insuring agreements or additional provisions which are beneficial to the insured. One of the aspects of the competition which has been beneficial to insureds (and we might add detrimental to the companies in some cases), has been the continuous broadening of coverage under various policy forms.

Service. Essentially the insurance product is a promise of future performance. The individual seldom knows if the product which he has purchased is adequate until he has a loss, and this is a rather inconvenient time to find that it is inadequate. One of the major areas which certain types of carriers have stressed is the servicing and advice which the agent performs for the individual. Basically the service consists of advising the client regarding the proper types of insurance which he needs, making certain that there are no unprotected exposures, maintaining a constant check on the coverages in effect from time to time, and providing prompt and fair settlement of losses when they occur.

REGULATION OF THE INSURANCE INDUSTRY

THE "WHY OF GOVERNMENT REGULATION

The courts have long held that insurance is an industry which, like banking, is "vested in the public interest." This simply means that insurance is a business which affects many people, and the public welfare demands that the insurnace industry be regulated in its activities.

Classical economic theorists held that competition serves the consumer best by forcing the firms in an industry to reach the point of maximum efficiency. In an economy characterized by perfect competition, the inefficient firms would be forced out of the market. However, in the case of insurance, the public interest would not be served by forcing the inefficient producers out of the market. The public welfare requires the continued existence of insurance companies in which members of the economy have invested their funds. Individuals purchase insurance to protect against financial loss at a later time. In the interest of the public welfare, it is essential that the insurance firm making the promise remain in business so that it will be able to fulfill its promise.

While a good deal of government regulation is aimed at enforcing competition and preventing artificially high prices, government regulation of insurance is aimed in the opposite direction. In the absence of government regulation, the natural tendency in the insurance industry would be toward the keenest sort of competition. There are two basic reasons for this:

1. The cost of production is not known until the contract of insurance has run its full term.
2. There are classes of desirable and undesirable risks. There is a danger that in attempting to compete insurance companies might assume that their risks are from the better class and make unwarranted assumptions about their future costs.

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

In addition to the competitive nature of the industry, there are certain other reasons that the industry must be regulated. The complicated nature of most insurance contracts makes them difficult for the insured to understand if he attempts to do so. Few individuals read their insurance policies, and even if they did, even fewer would understand what they had read. The regulatory authority is charged with the responsibility of assuring that the contracts offered by insurance carriers are fair.

The function of insurance regulation then is quite simple. Insurance is regulated with the goal of promoting the welfare of the public by maintaining sound insurance companies, who offer fair contracts at fair prices.

A BRIEF HISTORY OF INSURANCE REGULATION

Although statutes had been enacted by the states as early as the beginning of the Nineteenth Century which dealt with insurance activities, the history of modern regulation of the insurance industry begins shortly before the Civil War when several states established bodies to supervise the operation of the insurance industry within their borders. The New Hampshire Board of Insurance Commissioners, which was established in 1851, was the first of these bodies. Massachusetts followed shortly thereafter, and New York established its board in 1859. The Panic of 1857, which had been precipitated by the failure of a New York branch of the Ohio Life Insurance and Trust Company of Cincinnati was probably one of the leading factors in the establishment of the New York commission, as well as those of other states which followed.

Paul vs. Virginia

The case of Paul vs. Virginia was an important precedent concerning the regulation of insurance. Samuel Paul was a native of Virginia who represented New York insurance companies in his state. Paul challenged the right of the state to regulate insurance by refusing to obtain a license from the state. When he continued to sell insurance without a license, he was arrested and fined $50. The case was carried all the way 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 subjects of trade and barter, offered in the market as something having an existence and value independently of the parties to them. 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 no take effect — are not executed contracts — until delivered by the agent in Virginia. They are then local transactions and are governed by the local law. 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, while in Virginia, would constitute a portion of such commerence.[2] 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 seventy-five 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, a cooperative rating bureau, alleging that the bureau constituted a combination in restraint of trade. In its decision of the S-EUA 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.[3] This decision stands today.

Public Law 15

During the period of time that the S-EUA case was being decided and appealed, the insurance industry arranged to have bills introduced into the Congress which would have exempted the insurance industry from the provisions of the antitrust laws. These bills were all defeated, but finally a bill was drafted by the National Association of Insurance Commissioners which could be passed. This bill was Public Law 15 or the McCarran Act, which became law on March 9, 1945. Congress insisted that it was the right of the federal government to regulate the insurance industry, but stated in the McCarran Act that the federal government would not regulate insurance as long as the states did an adequate job of regulating the industry. In addition the law declared a two-year moratorium on the regulation of insurance by the federal government and stated that the federal government would not regulate the industry until after January 1, 1948, at which time it would do so to the extent that the industry was not being regulated by the several states. Following the enactment of Public Law 15, the several states attempted to put their house in order, enacting rating laws, fair trade practices, and extending the licensing and solvency requirements.

INSURANCE REGULATION TODAY

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

Regulation by the Legislative Branch

Each state enacts laws which govern the conduct of the insurance industry within the state. These laws spell out the requirements that must be met by persons wishing to organize an insurance company in the state. A company which is domiciled within the state, (i.e., which has its home office in the state) is called a domestic company. The laws also specify the requirements which a company domiciled in another state (called a foreign company) must meet in order to obtain a license to do business in the state. A company which is domiciled in a foreign country is called an "alien company." In addition the Insurance Code sets forth the standards of solvency that are 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 the 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 which the commissioner of insurance wields. As one author has written:

> . . . sometimes the insurance commissioner is an official clerk, sometimes he is a judge, sometimes he is a jury, sometimes he is a lawgiver and sometimes he is both prosecuting attorney and hangman. He is partly executive, partly judicial and partly

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[2] **Paul vs. Virginia,** 231 U.S. 495 (1869).

[3] **U.S. vs. South-Eastern Underwriters Association** 322 U.S. 533 (1944).

legislative; and yet he is not confined within any of these categories.[4]

The NAIC

The National Association of Insurance Commissioners has been an active force in the regulation of insurance since it was founded in 1871. Although it has no legal power over insurance regulation, it is an important force. Through it the 50 Commissioners of the separate states exchange information and ideas 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 the past the majority of the commissioners have seen fit to accept the recommendations which are appropriate for their particular state.

AREAS REGULATED

Licensing of Companies

The power to license insurance companies (or revoke those licenses) is perhaps the greatest power which the Commissioner of insurance possesses. In effect, when a company is licensed, the Commissioner of insurance certifies the company with regard to its financial stability and soundness of methods of operation. Before licensing a company 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. The amount of capital and/or surplus which is required also depends on the type of business which the firm will conduct and whether the company is a stock or mutual carrier.

Examination of Companies

The insurance code requires every licensed company, foreign and domestic, 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. The insurance Commissioner may examine or inquire into the affairs of any company transacting business in the state at any time, but the insurance code requires him to examine domestic companies at least once every three years. The expense of the examination is paid by the insurance company being examined. The examination is a detailed operation, quite often lasting a considerable period of time, during which the examiners scrutinize every aspect of the firm's operation.

In order to eliminate duplication of effort, it is becoming a practice for the Commissioner to examine those companies which 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 6 zones) accepts the examination of the zone for its foreign companies.

Company Insolvencies

Although one of the major goals of insurance regulation is to avoid insolvencies, on occasion they do occur; and in such cases the commissioner of insurance must take steps to have the insurer's assets taken over by an official liquidator. In most cases, liquidation is a last resort, and the commissioner will often take steps to rehabilitate a company when an examination indicates that it is in a hazardous condition. Sometimes large portions of the business will be reinsured with another insurer. In some cases, the shaky firm may be merged with a stronger firm.

When insolvencies do occur, their impact is felt not only by the stockholders and policyholders, but by the claimants as well. In order to reduce the impact of insurer insolvencies, 45 states operate insolvency guarantee funds, which are designed to compensate the members of the public who suffer loss as a result of the failure of a property and liability insurer. Under these plans, all insurers operating in the state are assessed their proportionate share of losses when an insolvency occurs. Iowa is among the states operating an insolvency fund.

Rates

To the extent that the insurer's promises depend on the price which it charges for these promises, these rates must be subject to regulation. All state insurance codes provide for the regulation of insurance rates, requiring that the rates must be:

1. Adequate
2. Not excessive
3. Not unfairly discriminatory

Adequancy is the primary requirement. The 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. Competition between carriers on a price basis must be limited through regulation to insure that solvency of the carriers is maintained. As we have seen, much of the rating in certain lines of insurance is done on a cooperative basis. The regulatory authorities permit, but do not require, concerted rate making. companies pool their loss statistics in an attempt to

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[4]Patterson, Edwin W., **The Insurance Commisssioner in the United States**, (Cambridge: Harvard University Press, 1927), p. 5.

achieve greater accuracy in prediction, they agree to use the bureau rates which are published. Yet the practice does not constitute collusion. If a company wishes to deviate from the published rates, it must satisfy the insurance commissioner that there is a basis for the deviation, by presenting loss experience and expense information justifying the deviation.

In addition to the requirement of adequacy, the insurance rates must be reasonable. Insurance has come to be regarded as a product which is essential to the well-being of members of the society. Insurers may not take advantage of the need of the members of society in order to realize unreasonable returns.

Finally, insurance rates must not discriminate **unfairly.** The emphasis in this requirement is on "unfairly," for the very nature of insurance rates requires some degree of discrimination. By "unfairly" discriminatory we mean that the insurance company may not charge a significantly different rate for two risks with approximately the same degree of risk. Any difference in rates charged must have an actuarial basis.

Life insurance rates constitute a special case in rate making and price competition. Apart from making certain that the 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 casualty companies. However the companies are required to use the same mortality table and the dictates of competition force them to use realistic interest assumptions. In addition, legal restrictions on the expense portion of the premium restricts the cost of life insurance. New York state, for example, limits the amount of commission of life insurance policies payable the first year.

Reserves

If we recall that the insurance business operates on the somewhat unique plan of collecting in advance for a product that is to be delivered at some time in the future, it becomes obvious that the insurance company must make some provision for future obligations. The insurer's obligations under the insurance contract are, at the time the policies are issued, all in the future. If the insurer were permitted to continue operating as long as it had no matured obligations which it could not meet (which is the ordinary measure of solvency), it would in most cases be perpetrating a fraud on the policyholders by using the funds to secure future protection to meet already occurring obligations to others. The only way that the insurance business can be conducted on an advance premium basis is by making some provision in advance for obligations contracted to be met in the future. This is done by setting up the present value of these obligations as liabilities.

The dollars that are paid to the insurance company in the form of premiums do not belong to the insurance company until they have been earned. They belong to the policyholders who have paid them, and the law requires insurance companies to set up liabilities recognizing this. In the case of life insurance, the policyholder often pays more than the cost of the death protection under his policy during the early years of the policy. The overpayment which he makes represents a liability on the part of the company, and a "policy reserve" must be established. If the insured decides to drop his policy, he is entitled to a return of a portion of his overpayment.

In property and casualty insurance, the premium is earned only as time elapses. On a one-year policy, after six months the company must still have half of the premium set aside to cover losses which will occur during the second half of the year, or to return to the insured if he desires to cancel the policy. Thus the company cannot use premiums to pay losses until these premiums have been earned. In addition to the unearned premium reserve, there are various other reserves, such as the loss reserve, (which represents the obligation of the company for losses which have occurred but which have not yet been paid), that must be maintained.

The insurance code of most states specifies the manner in which the reserves must be computed. In addition, the insurance company is required to deposit cash or securities with the insurance commissioner equal to the value of these reserves.

Investments

To the extent that the insurer's promises to pay depend on the value of its investments, these investments must be sound. It is a basic principle of investment that the return on a given security is a function of the risk inherent in that security. In an attempt to increase their investment return, insurance companies might turn to investments which entailed a greater degree of risk than is desirable if it were not for regulation. The insurance code normally specifies in some detail the type of investments which insurance companies are permitted to make.

Policy Forms

Since the insurance product is a contract, by its very nature it is technical. In most cases the customer is asked to purchase a product in which he becomes a party to a contract which he has not read, and which he would not understand if he did read it. The complicated nature of most insurance contracts makes them appear to be formidable objects to the public, but this is so simply because as contracts, they must be precisely drawn. If the insurance company wishes to insure against loss by a specified peril, it must make certain that the contract limits coverage to that peril. In order to do this it is often necessary to devise a complicated document. Since the insurance contracts are complicated, these contracts must be approved by the regulatory authorities to insure that the insurance buy-

ing public will not be unfairly treated as a result of provisions in the contracts which are unfairly contrary to the public interest. In addition, the solvency of the insurers must be protected against unreasonable commitments which they might make in the interest of competition. In some states new policy forms and endorsements need only be filed with the commissioner's office before they are put into use; if the commissioner does not approve of the form, it is then withdrawn from use. In most states, however, the law requires the approval of a form before it is used.

Competence of Agents

Because of the technical complications in the insurance product, it is particularly important that those selling insurance understand the products which they propose to sell. The Commissioner of Insurance in the State of Iowa, sworn to enforce the Iowa Insurance laws, is required to satisfy himself that an applicant for an agent's license:

1. Intends to hold himself out in good faith as an insurance agent.
2. Is a respected and responsible resident of his community.
3. Understands the contracts he proposes to offer the public.
4. Understands the laws under which he will oprate.

In order to satisfy himself that the applicant does, in fact, understand the contracts which he proposes to sell and the laws under which he will operate, the Commissioner requires satisfactory performance on a written examination by each applicant.

Access to Insurance

One of the newest areas of government concern, and at the same time, one of the most significant issues facing the insurance industry today, is the availability of insurance and the difficulty that some classes have experienced in obtaining it at reasonable rates. Legislative enactments have reduced the insurers' rights to select the insureds with which it will do business, and in some instances have compelled insurers to accept high-risk applicants at less than the full rates that the risks involved would dictate.

For example, most states now restrict the right of an insurer to cancel or refuse to renew insurance because of age or sex, factors traditionally considered to be important in automobile underwriting. In the same way, "red-lining," which consists of designating sections of a city in which an insurer will not accept business, is also prohibited.

Unfair Insurance Trade Practices

An insurer might be financially sound, and yet still engage in practices that are detrimental to the public interest. Section 507B of the Iowa Code, as amended by the 1973 legislature, defines and prohibits certain unfair insurance trade practices of insurance companies and agents, and provides for the imposition of penalties for violations. The unfair trade practices specifically defined include:

1. **Misrepresentation and False Advertising.** It is unlawful to make written or oral misrepresentations about policies offered, dividends to be received, or the financial condition of an insurer, or to make advertising statements that are untrue or misleading. The prohibition includes misrepresentations for the purpose of inducing an insured to drop a policy of one insurer in order to replace it with a policy of another insurer (a practice known as "twisting").
2. **Defamation.** It is unlawful to make, aid in, or encourage the making of any statement which is false and maliciously critical or derogatory about an insurer or its representatives.
3. **Boycott, Coercion, and Intimidation.** Commission of (or agreements to commit) acts of boycott, intimidation or coercion that tend to result in unreasonable restraint or monopoly of the insurance business are defined as unlawful.
4. **False Statements and Entries.** It is unlawful to knowingly file false statements with any supervisory or public official or circulate any false statement as to the financial condition of an insurer, or to omit any entry from such statements which tends to mislead as to the financial condition of an insurer.
5. **Stock Operations and Advisory Board Contracts.** Issuing stock or other securities or other contracts promising returns and profits as an inducement to purchase insurance is forbidden.
6. **Unfair Discrimination.** Making or permitting unfair discrimination between persons with essentially the same hazards is specifically forbidden.
7. **Rebating.** It is unlawful to make or offer to make, directly or indirectly, any consideration or special favor not specified in the contract as an inducement to purchase insurance. An example of an illegal rebate would be an offer by an agent to give a part of his commission to a prospective insured.
8. **Unfair Claim Settlement Practices.** The code outlaws "sharp" claim practices, such as unreasonably delaying payment, or denying payment when there is no reasonable basis for such denial, or forcing the claimant to induce litigation where the liability is reasonbly clear.
9. **Misrepresentations in Insurance Applications.** It is unlawful to make misrepresentations in any application for insurance.
10. **Coercion of Debtors.** It is unlawful to require as a condition for a loan or an extension of credit that the borrower obtain insurance from a particular insurer or agent.
11. **Disclosure or Use of Information.** It is unlawful to disclose or to use information furnished to a lender in connection with insurance on property

pledged as security for a loan when such disclosure or use is to the detriment of the borrower or the agent furnishing such information. An example of a violation in this area would be solicitation of the renewal of a policy by an agent who had obtained the renewal data from the lender to whom the insurance policy was furnished.

In addition to the practices specifically defined above, the Code also provides that other practices not defined in the act may be declared to be unfair by the Commissioner of Insurance.

If the commissioner believes that a person is or has been engaging in any unfair practices, whether or not described in the Code, he is empowered to investigate and hold a hearing. Upon determination that the person charged has engaged in unfair practices, he may issue a cease and desist order. If the unfair practice is one of those specifically defined in the code, he may also order one or more of the following penalties:

(a) a fine of up to $1,000 for each act, with an aggregate of $10,000
(b) suspension of the license of the individual or firm
(c) if the person knew or should have known that he was violating the law, a fine of $5,000 for each act, with an aggregate of $50,000 for any six month period.

The individual subject to the cease and desist order may appeal through the courts; but unless the Commissioner is overruled, subsequent violations of the cease and desist order are punishable by a fine of up to $10,000 for each and every violation plus revocation of the individual's license.

While we are on the subject of unfair practices, it might be well to discuss the ethical responsibilities of the agent. The responsibility of the agent is somewhat complicated by the fact that he must serve two masters: his company and his clients. To his companies, he owes the obligation to generate a profitable volume of business. At the same time, he has a responsibility to do the best job possible for his clients. Above all, he owes both the company and the client complete honesty. In addition to this obligation of honesty, the agent has an obligation to be technically competent in order that he can serve both his company and his clients. The code of ethics to which the agent should subscribe is best summarized in the pledge of the Chartered Life Underwriter and the Chartered Property and Casualty Underwriter:

THE PLEDGE OF THE
CHARTERED LIFE UNDERWRITERS

"I shall, in the light of all the circumstances surrounding my client, which I shall make every conscientious effort to ascertain and to understand, give him that service which, had I been in the same circumstances, I would have applied to myself."

THE PLEDGE OF THE CHARTERED
PROPERTY
AND CASUALTY UNDERWRITER

"I shall strive at all times to ascertain and understand the needs of those whom I serve and act as if their interests were my own; and I shall do all in my power to maintain and uphold a standard of honor and integrity that will reflect credit on the business in which I am engaged."

THE LEGAL FRAMEWORK

The transfer of risk from the individual to the insurance company is accomplished through a contractual arrangement under which the insurance company, in consideration of the premium paid by the insured and his promise to abide by the provisions of the contract, promises to indemnify the insured in the event of the specified loss. The instrument through which this transfer of risk is accomplished is the insurance contract, which, as a contract, is enforceable by law. Every contract, insurance or otherwise, is subject to the general laws that govern contracts. In addition to these general laws, there are certain additional legal principles involved in the insurance contract.

General Requirements of An Enforceable Contract

A contract is defined as "an agreement enforceable by law." In order for a contract to be legally binding or enforceable by law, it must have certain essential elements. These elements of a contract are:

1. Offer and Acceptance
2. Consideration
3. Legal Object
4. Competent Parties

All of these elements are necessary for a binding contract of insurance.

1. **Offer and Acceptance.** In order to have a legally enforceable contract, there must be a definite unqualified offer by one party, and this offer must be accepted in its exact terms by the other party. In the case of life insurance the offer is normally made by the applicant when he submits his application for insurance. The acceptance takes place when the agent binds coverage or when the policy is issued. It is important to note that there is no requirement that the contract be in writing. An oral contract is just as binding on both parties as is a written contract. However, the difficulty of proving the terms of the oral contract, or even the existence of such a contract, makes it advisable to confine contractual agreements to those that are written whenever possible. In certain instances, however, the situation may arise in which it may be necessary to create an oral contract of insurance. When a prospective insured requests coverage from a property and casualty agent, the agent may effect a contract orally, accepting the offer of the prospective insured. In such instances

coverage begins immediately. If a loss occurs before a written "binder" is issued,[5] or before the policy is issued, the company which the agent bound to the risk will be liable for the loss. However the courts have ruled that the agent must specify the company with which coverage is bound if he represents more than one company. The life insurance agent cannot bind the insurance company to a risk.

2. **Consideration.** The binding force in any contract is the consideration. Consideration is the thing of value which each party gives to the other. In insurance contracts, the consideration on the part of the company is the promise to indemnify the insured in the event of a loss. The consideration on the part of the insured is the premium (or the promise to pay the premium) and an agreement to abide by the conditions of the contract.

3. **Legal Object.** A contract must be legal in its purpose. A contract in which one party agreed to commit murder for a specified amount would be unenforceable in court because the object of the contract is not legal. Likewise an insurance policy that is actually a gambling contract would be unenforceable as contrary to public policy. By the same token an insurance policy which promised to assume the consequences of the insured's criminal acts would also be contrary to public policy. Insurance on goods illegally held would not be valid in favor of the illegal holder. With the exception of the instances enumerated above and a few similar cases, insurance is considered to be a legal object.

4. **Competent Parties.** The parties to the contract must be capable of entering into a contract in the eyes of the law. In most cases the rules of competency are concerned with minors and the mentally incompetent. The basic principle involved is that some parties are not capable of understanding the contract that they would enter into; therefore the courts have ruled that they are not bound by such contracts.

In the case of minors, insurance represents something of a special case in many jurisdictions. According to the law, a minor is a competent party only in contracting for necessities, and courts have not considered insurance to be included within the group of necessities. Therefore, unless there is a statute to the contrary, a minor may enter into an insurance contract, but may disaffirm the contract at any time, demanding the return of the premiums that he has paid. If he does not disaffirm the contract before he turns 21, the minor affirms the contract when he makes a payment.

Void—Voidable

The terms "void" and "voidable" are sometimes incorrectly used interchangeably. A void contract is simply an agreement without legal effect. In essence it is not a contract at all, for it lacks one of the requirements specified by law for a valid contract. A void contract cannot be enforced by either party. For example, a contract having an illegal object is void and neither of the parties to the contract can enforce it. A voidable contract, on the other hand, is an agreement which, for a reason satisfactory to the court, may be set aside by one of the parties to the contract. It is binding unless the party with the right to void it wishes to do so. For example, let us say that a situation develops under which the insured has failed to comply with a condition of the contract. The company may elect, if it chooses to do so, to fulfill its part of the contract; or it may elect to avoid the contract and revoke coverage. Or, let us say that a 13-year-old purchases a life insurance contract. While this contract would be binding on the company, in most cases it would be voidable at the option of the insured. A contract may be held to be voidable for any one of a number of legal reasons. If one party was forced into the contract under duress, or if there is an element of fraud involved, the contract may be voided.

SPECIAL LEGAL CHARACTERISTICS OF INSURANCE CONTRACTS

In addition to those principles which apply to all contracts, there are special legal characteristics unique to insurance contracts.

Insurance is a Contract of Indemnity

This means that under the terms of the policy the insurance company promises to reimburse the insured only to the extent of his financial loss. The insured is permitted to collect only if he has suffered a financial loss, and only to the extent of that loss. Put in its simplest terms, an individual should not be permitted to make a profit through insurance. Human nature being what it is, the ability to make a profit from the existence of an insurance policy would lead to the intentional destruction of property or other more serious crimes. The princple of indemnity is enforced through legal doctrines and policy provisions which are designed to limit the amount which the insured may collect to the amount of his loss. There are four important doctrines which enforce the principle:

Insurable Interest. The doctrine of insurable interest is directly related to the principle of indemnity. The insurance contract is designed to protect the individual against financial loss which he himself suffers. It would be contrary to public welfare and policy to permit an individual to take out an insurance policy providing for payment if an event occurred which did not cause him to suffer financially. The probability of the event occurring would most certainly increase. When there is not an insurable interest, an insurance contract is nothing more than gambling, and as such is not enforceable in the courts. The application of the principle of insurance interest is somewhat different in the life insurance field

[5] A "binder" is a temporary contract, normally issued for 30 days, which an agent uses to give evidence that he has accepted the offer of the prospect. A binder is issued and accepted by the insured with the understanding that the binder provides the same coverage as the policy form in use by the company.

than it is in the property and liability field. One of the basic differences in the application of this principle between the two fields is that in the field of life insurance, an insurable interest must exist at the inception of the policy, but need not exist at the time of the loss. In the field of property and liability insurance the exact opposite is true. In property insurance an insurable interest may not be required at the inception of the policy, but the insured must prove that he had an insurable interest at the time of the loss in order to collect.

Actual Cash Value. No matter how much insurance the individual purchases, the amount that he may recover is limited to the amount of his actual loss in most cases. The basis on which most property losses are settled is that of "actual cash value". Actual cash value is a technical term which for all practical purposes means "replacement cost less depreciation".

There are, of course, certain cases in which it would be impossible to determine the amount of the loss after the loss has taken place, such as might exist in the case of a rare and valuable painting. What, for example, might we say the replacement cost of the Mona Lisa is? In such cases the insurance contract may be a **valued policy.** Under a valued policy, in the event of a total loss, the face amount of the policy must be paid, regardless of the actual amount of financial loss. Perhaps the best example of a valued policy is a life insurance contract.

The valued policy represents one exception to the principle of indemnity. Certain other exceptions exist, which will be examined later.

Apportionment. Following the principle of indemnity, most insurance contracts (with the exception of life, accident, and health) contain a clause called the pro-rata or apportionment clause. This clause is designed to prevent the insured from collecting more than the actual extent of his financial loss through the existence of more than one insurance contract. The wording of this provision states:

> This company shall not be liable for a greater proportion of any loss than the amount hereby insured shall bear to the whole insurance covering the property against the peril involved, whether collectible or not.

In some cases, the contract makes the insurance in a given contract "excess over all other valid and collectible insurance" rather than contributing or pro-rata coverage. In these policies the company will pay only after the coverage of all other policies has been exhausted, and will then pay only to the extent that the insured has not been indemnified for the full amount of his financial loss.

Subrogation. The final principle which is derived from the principle of indemnity is the doctrine of subrogation, which may be stated as follows: If the insured collects under an insurance contract for damage to his property which results from the negligence of a third party, he must relinquish his right to collect damage to the insurance company. The subrogation provision of the fire insurance policy states:

> The Company may require from the insured an assignment of all right of recovery against any party for loss to the extent that payment therefore is made by this company.

If the policy did not contain this provision, or if the principle of subrogation did not exist, the insured would in effect be able to collect twice: once from the insurance company and again from the negeligent third party. The subrogation clause eliminates this possibility.

Insurance is a Personal Contract

Although insurance may apply to property, the risk is transferred to the company from the individual. While we speak of "insuring a house" or some other piece of property, the contract is really between the company and a specifically named insured. If the insured should sell the property which is "insured", the insurance is not binding in favor of the new owner of the property. Since the company has a right to decide who it will and who it will not do business with, the insured cannot transfer his contract to someone else without the written consent of the insurance carrier.

Insurance is a Unilateral Contract

Only one of the parties to the contract is legally bound to do anything. The insured makes no promises that he can legally be required to keep. It is true that an insurance contract is a conditional contract, and if the insured violates certain conditions of the contract he may be prevented from collecting, but he cannot be required to keep any of the conditions.

Insurance is a Contract of Adhesion

This means that it is prepared by one of the parties (the company) and accepted or rejected by the other (the insured). It is not drawn up through negotiation, and the insured has little to say about the provisions.

Because the company has the right to draw up the contract, the courts have held that any ambiguity in the contract should be interpreted in favor of the insured.

The fact that the insurance policy is a contract of adhesion and the insured must accept or reject the terms as they are written, makes the doctrine of "presumption of intent" rather important in the area of insurance. Under the doctrine of "presumption of intent" the courts have ruled that a person is bound by the terms of a written contract which he signs or accepts, whether he reads the contract or not. In other words, the court assumes that the insured has read his contract and agrees with the terms thereof.

Insurance is an Aleatory Contract

Briefly, the term aleatory means that the contract is subject to chance, and that the obligation of one party (the insurer) will mature only upon the occurrence of a fortuitous event. In this sense, the values given up by the two parties are unequal; the premium paid by the insured is small in relation to the amount that will be paid by the insurer in the event that a loss occurs.

Insurance is a Contract of Utmost Good Faith

Partly due to the fact that it is an aleatory contract, the insurance policy is also a contract of utmost good faith. The legal principle of **uberrimae fidei** (utmost good faith) has deep historical roots in its application to insurance. In the early days of marine insurance, an underwriter was often called upon to insure a ship that was half-way around the world, and he had to accept the word of the applicant that the ship was still afloat if the transaction was to take place. The practical effect of the principle of utmost good faith today lies in the requirement that the applicant must make a full and fair disclosure of the risk to the agent and the company. The risk which the insured transfers must be the same risk that the company thinks it is assuming. Any information concerning the risk, if known to one party, should be known to the other. The company should have the same information about the risk and the hazards relating to it that the insured has. If the insured intentionally fails to inform the insurer of any facts which would influence the issue of the policy or the rate at which it is issued, the insurer may have ground for voiding the policy, for the courts have given meaning to the principle of "utmost good faith" through the evolution of the doctrines of concealment, representation, and warranty.

Concealment is the failure to disclose known facts. It is a passive act.

Misrepresentation is a false statement of fact.

A warranty is a part of the contract itself, and as such is stronger than a representation.

In practical application there is considerable difference between concealment and misrepresentation and between misrepresentation and a breach of warranty. In order to provide grounds for voiding the contract, both a misrepresentation and a concealment must involve a material fact. A material fact is one that would have changed the underwriting basis of the policy, (i.e., if the company had known, it would not have issued the policy or it would have issued it on some other basis). In addition, however, concealment must be intentional in order to void the policy. A misrepresentation of a material fact may provide ground for voiding the policy, even if the misrepresentation was unintentional.

A warranty is a part of the contract. Any falsity of a warranty, because it is a part of the contract, provides grounds for voiding the policy even though it may not be material. At one time, to avoid the necessity of showing that certain statements made by the insured were material, insurance companies frequently made it a stipulation of the contract that all statements made by the insured and included in the contract were considered to be warranties and not representations. The majority of contracts today do not contain warranties. Many states have enacted laws which provide that in regard to life insurance and health and accident insurance, in the absence of fraud, all statements of the insured will be deemed to be representations and not warranties.

Directly related to the doctrines of concealment and misrepresentation are the doctrines of waiver and estoppel. Waiver and estoppel also relates directly to the law of agency and to the power of the agent.

Waiver is the intentional relinquishment of a known right. If the agent issues a contract, knowing that the conditions are being violated, he is deemed to have waived the violation. For example, let us assume that the insured takes out an automobile liability policy, and in the application states that no male drivers under 25 years of age will be operating the auto, when the truth of the matter is, his 17 year old son operates the car almost exclusively (probably in stock car races). Let us assume further that the agent knows full well that this is the case. Since the knowledge of the agent is presumed to be knowledge of the company, the agent is deemed to have waived this violation when he issues the policy.

Estoppel prevents one from alleging or denying a fact the contrary of which by his own previous action he has admitted. The waiving of a violation of the contract by the agent **estopps** the company from denying liability on the basis of this violation at some time in the future.

THE INSURANCE CONTRACT AS A CONTRACT

The complicated nature of the insurance contract has made it the butt of many jokes. Why, people often ask, doesn't the insurance company make the policy simple enough for the layman to understand? Why not cut out some of the excess wordage? The answer to both questions is that the insurance policy is in fact a contract. As a contract it is enforceable by law and must set forth as clearly and as unambiguously as possible every condition and obligation of both parties. Many of the provisions found in insurance policies are for the protection of the insured. In addition the insurance company must attempt to protect itself against both the insureds and misinterpretation by the courts.

In the material that follows, we will examine a number of insurance contracts, and while all of these contracts are different, they are similar in that they are all composed of four basic sections. These sections are:

1. The declarations

2. The insuring agreements
3. The exclusions
4. The conditions

1. **The Declarations.** The declarations section contains the statements made by the insured. As we have seen, these statements are usually considered to be representations by the courts. Also included in the declarations section is information about the location of the property insured, the name of the insured, and other matters relating to the identification of the person or property insured.

2. **The Insuring Agreement.** In this section the company promises to pay for loss if it should result from the perils covered. Coverage may be provided in one of two principal ways. It is either on a **named peril** basis, in which case the policy lists the perils insured against, or it is on an **all risk** basis. **All risk** policies cover loss by any perils except those that are specifically excluded.

3. **The Exclusions.** In this section the company states what it will not do. The number of exclusions has a direct relationship to the broadness or narrowness of the insuring agreement. If the policy is written on a named peril basis, the exclusions may be few. On the other hand, the **all risk** policies require more exclusions in order to eliminate coverage for those perils which are uninsurable. The exclusions are a basic part of the contract and a thorough understanding of the contract requires a complete knowledge of the exclusions. Certain perils must be excluded in insurance contracts either because they are not insurable, or because the basic premium does not contemplate the exposure and the coverage that must be obtained through the payment of an additional premium or under another more specialized contract.

4. **The Conditions.** This section spells out in detail the duties and rights of both parties. Most of the clauses contained in the conditions section of the policy are fairly standard, and relate to the duties of the insured in the event of loss and protect the insurance company from adverse loss experience through increases in the hazard within the control of the insured.

The Insurance Contract and the Courts

When members of society who have entered into a contractual arrangement disagree about the terms of the contract, or one of the parties questions the very existence of the contract, either party has recourse to the courts. It is important to recognize that the courts play an important role in the operation of private insurance. Since private insurance is offered through contracts, it is sometimes necessary to turn to the courts.

Court decisions are important in the individual case, because they decide the issue in question, but more important, from our point of view, they set precedents which are applied in future instances. Court interpretation of insurance policies make policy interpretation difficult in one sense, in that there is always the distinct possibility that the court will interpret a contract in a way which the insurer had not considered. On the other hand, past decisions are useful in interpreting contracts, for they indicate the intent of the court with respect to certain terms.

Since the insurance contract is a contract of adhesion, the courts normally favor the insured in the event of ambiguity in the contract. Since the insurer has the option of changing future contracts, court decisions often influence the drawing of insurance contracts.

PERSONAL LINES

The study of insurance may be approached in various ways. The traditional approach has been the line method, in which each of the various lines of insurance is studied in its entirety. Under this approach, the student studies fire insurance for the home and contents, then fire insurance on farm property, fire insurance on commercial property, and so on, until the entire field of fire insurance has been covered. Next the student moves to the field of automobile insurance, studying insurance for the individual, then automobile insurance for the business firm, then fleet coverage and all of the specialized forms of automobile insurance. Then another line is selected, and so on until the entire field of insurance has been covered. This approach to the study of insurance was a natural outgrowth of the insurance industry, which, up until a generation ago, was divided into companies which wrote the various lines. It places emphasis on the company side, stressing knowledge of all of the coverages sold by a particular company or a particular department.

In this study guide, the emphasis is on the buying unit rather than on the selling unit. A logical division exists between the personal lines of insurance, (which are purchased by the individual or the family), and the commercial lines, (which are purchased by the business firm). In attempting to determine "What should the agent know?" it appears logical to require him to master those coverages which his clients will be buying rather than those coverages which the company he represents might be selling.

A thorough knowledge of the coverage listed below should be considered essential for any agent who is licensed to solicit for the sale insurance coverages for individuals and family units:

- The Standard Fire Policy
- The Dwelling and Contents Form
- The Extended Coverage Endorsement
- The Dwelling and Contents Broad Form
- The Dwelling Building Special Form
- The Homeowners Forms (HO - 1, 2, 3, 4, 5, 6)
- The Amendatory Endorsements to the Homeowners
- The Farmowners Forms
- The Personal Property Floater
- The Personal Articles Floater
- Personal Theft Coverages
- The Comprehensive Personal Liability Policy
- The Farmers Comprehensive Personal Liability Policy
- The Family Auto Policy
- The Special Auto Policy
- The Basic Auto Policy
- The Personal Auto Policy

This personal lines section of the manual describes all of these coverages. The treatment of the various coverages included in the guide must of necessity be brief. Therefore the reader is cautioned that the guide is intended only as an introduction to the subject matter. An annotated bibliography at the end of the study guide lists additional sources that should be consulted.

Reference will be made to the policy provisions of various insurance contracts. In order to obtain maximum benefit from the study guide, the student should obtain copies of the contracts that are discussed in the text, and refer to them along with the text. The policies discussed in this study guide are the so called "Bureau forms", which have been developed by the national rating bureaus. These bureaus are national organizations whose membership is composed of the major capital stock and mutual companies in the United States. It is important to recognize that many insurance companies use contracts that differ from the bureau forms, and that the forms discussed in this study guide are not the only ones available. Although the trend has been for the bureau and independent forms to become more and more alike, it is, nevertheless, important to bear in mind that there may be significant differences between the forms discussed in this study guide and those which are offered by independent companies which you may represent.

As a final note, it should be repeated that this study guide is inteded only as an introduction to your study of insurance. There is no field of endeavor where the need for continuing education is as great as in the field of insurance. The agent can never acquire enough knowledge and can never assume that he has completed his studies. The agent must continuously expand his knowledge of insurance and become familiar with the frequent revisions of forms, rules, procedures and practices of the profession.

FIRE INSURANCE

One of the risks to which every property owner is exposed is the possibility that his property may be destroyed by fire or some other peril. Fire insurance and coverage against additional perils which may be included in the fire insurance policy provide protection against such losses.

THE STANDARD FIRE POLICY

The 1943 New York Standard Fire Policy is now used in almost all states. Three states, Texas, Massachusetts, and Minnesota use different forms, and twelve states have minor variations from the New York Standard Form. The differences in the form in use in the twelve states that have modified the New York Standard form are so insignificant that it can be said that the form is used in all states except Texas, Massachusetts, and Minnesota.

The form is "standard" in two respects. First, its wording is prescribed by law. In each jurisdiction any carrier wishing to write fire insurance must use the form that has been approved by the regulatory authorities; and most jurisdictions, including Iowa, prescribe the New York Standard Policy. In addition, the widespread use of this form throughout the United States justifies the term "standard".

Not a Complete Contract

It is important to understand at the beginning that the Standard Fire Policy is not a complete contract in itself. In order to be made complete, it must have a form attached. The terms "Form" and "Endorsement" and "Rider" are used rather loosely in fire insurance terminology. A Form and an Endorsement are normally considered to be about the same: a printed form which tends to be uniform throughout a given jurisdiction. "Riders", in contrast with forms and endorsements, are usually typewritten and vary with the individual policy. The purpose of all three attachments to the basic policy is to tailor the insurance to the specific risk being insured. There are over 200 forms and endorsements designed for use with the Standard Fire Policy, giving it extreme flexibility. The form used to complete the contract describes the property insured and modifies the basic policy to meet the requirements of insuring that specific type of property. With one form the Standard Fire Policy may be used to insure a barn in western Iowa, while with another it may be used to insure a large industrial plant in Detroit. There are forms for insuring dwellings, household goods, apartment houses, mercantile buildings, schools, churches, warehouses, and practically every other type of insurable risk. Forms may also be used to provide additional coverage by adding perils insured against to the insuring agreement.

Policy Format

The face of the fire policy includes the declarations section and the insuring agreement. The declarations section includes such items as the name of the insured, the description of the property and its location, the amount of coverage, the amount of the premium, the term of the policy, and the inception and termination dates. Immediately following the declarations is the insuring agreement. The conditions and exclusions are on the second page of the contract in 165 numbered lines. These 165 lines set forth the obligations of the insured and the company, specify the requirements in the case of loss, exclude certian uninusred perils, and provide the general framework of the contract.

A copy of the Standard Fire Policy is included in this Study guide, and the reader is advised to refer to the policy provisions in that policy as they are discussed in the text.

The Insuring Agreement.

The insuring agreement of the SFP states the following:

IN CONSIDERATION OF THE PROVISIONS AND STIPULATIONS HEREIN OR ADDED HERETO AND OF the premium above specified, this Company, for the terms of years specified above from inception date shown above At Noon (Standard Time) the expiration date shown above At Noon (Standard Time) at location of property involved, to an amount not exceeding the amount(s) above specified, does insure the insured named above and legal representatives, to the extent of the actual cash value of the property at the time of loss, but not exceeding the amount which it would cost to repair or replace the property with material of like kind and quality within a reasonable time after such loss, without allowance for any increased cost of repair or reconstruction by reason of any ordinance or law regulating construction or repair, and without compensation for loss resulting from interruption of business or manufacture, nor in any event for more than the interest of the insured, against all DIRECT LOSS BY FIRE, LIGHTNING AND BY REMOVAL FROM PREMISES ENDANGERED BY THE PERILS INSURED AGAINST IN THIS POLICY, EXCEPT AS HEREINAFTER PROVIDED, to the property described herein while located or contained as described in this policy, or pro rata for five days at each proper place to which any of the property shall necessarily be removed for preservation from the perils insured against in this policy, but not elsewhere.

Assignment of this policy shall not be valid except with the written consent of this Company.

This policy is made and accepted subject to the foregoing provisions and stipulations and those hereinafter stated, which are hereby made a part of this policy, together with such other provisions stipulations and agreements as may be added hereto, as provided in this policy.

Consideration

The consideration on the part of the insured consists

of both the provisions and stipulations of the policy, and the premium. In addition to paying the premium, the insured agrees to abide by the conditions with respect to such things as furnishing proof of loss and cooperating with the company in certain other areas. Since the promise to abide by the conditions is considered to be a part of the insured's consideration, failure to abide by these conditions relieves the insurance company of the obligation to pay in the event of a loss.

Policy Term and Time Effective.

In most jurisdictions, policies may be written for one, two, or three years. For many years, the term of the policy began at "Noon (Standard Time)" at the location of the property. However, in 1977 the Insurance Services Office announced a revision of the inception and expiration of all property insurance policies (including the Standard Fire Policy) to 12:01 a.m.

Persons Insured

The insuring clause provides coverage for the insured named in the policy, but it also provides coverage for the legal representatives of the insured. If the insured should die, any loss covered under the policy would be payable to his estate.

Valuation

One of the most important portions of the insuring clause is that part which concerns the amount of money to be paid by the company in the event of a loss. The insuring agreement of the SFP imposes four limits on the amount payable by the company in the event of loss:

1. The face of the policy
2. The actual cash value of the property
3. The amount which it would cost to repair or replace
4. The interest of the insured.

The limitation of the face amount of the policy requires little explanation at this point.

The actual cash value of the property may be reduced to "replacement cost minus depreciation" in most cases.

The phrase "not exceeding the amount which it would cost to repair or replace . . ." is merely a limitation on the amount that may be collected. It is not a requirement to be met by either party.

The necessity for an insurable interest on the part of the insured is referred to by the provision" . . . nor in any event for more than the interest of the Insured". The insured can collect only to the extent of his insurable interest in the property, regardless of the amount of the damage. To illustrate the importance of this provision, let us say that White and Brown have a joint ownership in a building valued at $50,000, each having 50% interest. If White insures the building for $50,000 with himself as the only insured, the maximum he could collect in the event of a loss would be $25,000, for this is the extent of **his** insurable interest. For this reason it is important that all persons having an interest in the property be designated in the policy. It is a good rule to list the insureds in the policy as they are listed in the title to the property.

Other Restrictions

The insuring clause lists two restrictions which might otherwise increase the cost of a loss. First, the indemnity does not include "allowance for any increased cost of repair or construction by reason of any ordinance or law regulating construction or repair . . .". This is to protect the insurance company from an increase in the amount of a loss that might result from a change in the building code of the city in which the building is located. For example, let us say that the insured has a frame warehouse, and that the city fathers have enacted a statute that requires all new warehouses to be constructed of brick. In the event of a loss to the frame warehouse, the loss would be settled on the basis of the replacement cost minus depreciation of the frame warehouse, and not of the replacement cost of the brick building.

The second limitation, "without compensation for loss resulting from business or manufacture . . ." is inserted to indicate that the nature of the SFP is to provide for direct loss. Such indirect losses as business interruption may be provided for through business interruption insurance.

Perils Insured Against

The insuring agreement provides coverage against ". . . direct loss by fire, lightning, and by removal from premises endangered by perils insured against in this policy . . ."

1. **Fire.** The first of these three perils, fire, is the basic peril which the policy was originally designed to provide protection against. It is rather surprising that the term "Fire" is nowhere defined in the policy. Although the term is not defined, court decisions over many years have established the fact that the "fire" which is contemplated in the fire policy is a fire of a specific type. Fire, according to the courts, is "combustion proceeding at a rate rapid enough to generate flame, glow, or incandescence".[1] In other words, there must be light. Mere smoke, scorching, or charring is not sufficient to establish the presence of a fire.

Not all fires are covered under the fire policy. The courts have made a distinction between a "friendly fire" and a "hostile" or "unfriendly" fire. A friendly fire is one that is within the confines for which it was intended; the friendly fire was intentionally kindled and is where it is supposed to be. A "hostile fire", on the other hand, is a fire that has escaped the confines for which it

[1]Western Woolen Co. vs. Northern Assurance Co., 139 Fed. 637.

was intended. Only hostile or unfriendly fires are covered under the SFP.

One of the best illustrations of both the distinction between a friendly fire and a hostile fire, and the existence of a fire which produces "flame, glow, or incandescence", is the cigarette that is inadvertently left on the edge of a table. The glow at the end of the cigarette is a fire — there is no question about that. However the fire is exactly where it is supposed to be; on the end of the cigarette. If the cigarette chars the table, there has been damage, but it has been the result of a friendly fire. On the other hand, if the table itself begins to glow, a new fire, and this time an unfriendly fire has come into existence, and the damage would be covered.[2]

In addition to the damage by the actual fire itself, the "direct loss by fire" peril provides coverage for any damage that results from the smoke from a hostile fire, or damage caused by water or firemen in attempting to extinguish a hostile fire.

2. **Lightning.** Lightning may cause damage to property, and in addition it may cause fire which in turn will cause damage. At one time the fire policy did not include the peril of lightning, which caused considerable difficulty in the adjustment of fire losses which were caused by lightning. Since the insuring agreement promises to pay on the basis of the "actual cash value at the time of loss", when a house was struck by lightning and a fire ensued, the loss settlement became virtually impossible. It was necessary to estimate the actual cash value of the house after it had been struck by lightning, but before it burned. The inclusion of the lightning peril has simplified the process by making the damage covered regardless of whether it was the lightning or the fire that caused the damage.

3. **Removal.** Often property that is insured may be damaged while attempting to preserve it from destruction by removing it from a building that is threatened by an insured peril. For this reason the SFP provides coverage for damage to property that is being removed to protect it from one of the perils insured against. The coverage provided under this peril is quite broad, and provides protection for almost anything that results in a loss when the property is being removed under the described conditions.

Closely related to the removal coverage is the extension of coverage to each location to which the property is removed for preservation from the perils insured against. The SFP covers property while it is located or contained as described in the policy. It is specific location coverage and covers property elsewhere only as provided by endorsement or in this removal extension. The extension is effective for five days, covering the property at each location on the basis of the percentage of total values that the values at the location represent. Within five days the insured is expected to have the coverage transferred.

[2]Damage caused by cigarette burns have been a constant source of difficulty. Since the extent of the damage is normally slight, companies usually pay them even when no coverage exists, in order to prevent ill-will. One decision by a court, which appears to be the only decision on the matter, ruled that a lighted cigarette which had fallen on a rug was a hostile fire; the movement of the cigarette from the ashtray to the rug took the fire out of the confines for which it had been intended. **Swering vs. Connecticut Fire Insurance Company, 180 Atl. 343.**

Assignment Clause

Immediately following the removal extension is the Assignment Clause:

> "Assignment of this policy shall not be valid except with the written consent of the company."

While we often speak of the property as being insured, an insurance contract is a personal contract, agreeing to indemnify a specific insured in the event of loss. Coverage does not transfer to the new owner of property when it is sold, and moreover, through this clause, the insurance company reserves the right to decide if it wishes to continue the insurance for a new owner.

Conditions and Exclusions

Lines 1 through 6 state that the policy shall be void if the insured has willfully concealed or misrepresented any material fact concerning the insurance. In addition, provision is made for voiding the policy if the insured is fraudulent about the amount of the loss, other insurance, or the extent of his insurable interest, regardless of whether this false swearing takes place before or after the loss.

Lines 7 through 10 excepts certain property from coverage. Accounts, bills, currency, deeds, evidence of debt, money, or securities are excluded. In addition bullion and manuscripts are also excluded unless they have been specifically named as insured property in writing. The reason for this exclusion, of course, is to prevent fraudulent claims. In the absence of this exclusion, every fire loss would involve a considerable amount of money. In addition it is difficult to determine the actual value of documents and evidence of debt. Other contracts are available to provide coverage on all other property excluded in this section.

Lines 11 through 24 list certain perils which are not covered. If a fire or other peril insured against in the policy is a result of one of these excluded perils, there will be no coverage:

(a) Enemy attack by armed forces
(b) Invasion
(c) Insurrection
(d) Rebellion
(e) Revolution
(f) Civil War
(g) Usurped power
(h) Order of civil authority

(i) Neglect of the insured at or after loss
(j) Loss by theft

The first seven exclusion are relatively obvious. By their nature such losses are catastrophic and uninsurable.

The exclusion of damage by fire as a result of civil authority "except acts of destruction at the time of and for the purpose of preventing the spread of fire, provided that the fire did not originate from any of the perils excluded by this policy", requires some furfurther explanation. Fires may be ordered by civil authorities for a number of reasons. Slum destruction or clearance projects might be accomplished by burning the old buildings. Such fire losses would not be payable under the fire policy. On the other hand, if property is burned by order of civil authority in an attempt to prevent the spread of fire, (as might be done to create a fire-break), the loss would be paid, provided that the fire that was being prevented from spreading did not originate from one of the other excluded causes.

The reason for the exclusion of damage at or after a loss which results from the negligence of the insured should also be obvious. The insured cannot collect for damage which he has a reasonable chance to prevent. He is expected to take any steps which a reasonable man would take if he did not have the insurance and was going to be forced to suffer the loss himself.

Lines 25 through 27 deal with the subject of other insurance covering the property insured under the policy. The limitation in these lines do not constitute a prohibitation of other insurance, but merely reserve the right to prohibit other insurance to the insurance company.

Lines 28 through 37 set forth certain conditions which suspend or restrict the insurance coverage:

1. While the hazard is increased by any means within the knowledge or control of the insured
2. While the described building, whether intended for occupancy by owner or tenant, is vacant or unoccupied for over 60 days
3. As a result of explosion unless fire ensues, and then the company is liable for the damage by the fire only.

Note that these restrictions merely provide that the coverage is suspended during the period of time that the hazard is increased or while the building is vacant; once the increase in hazard has been removed and the building is again occupied, the suspension is lifted. As we will see, most modern dwelling forms permit vacancy and unoccupancy without limit of time and also modify the "increase hazard" restriction.

Lines 38 through 48 deal with the modification of the policy by endorsements and riders. This section provides that the policy may be expanded to provide coverage against additional perils by endorsement. It also provides that no provision of the policy may be waived, unless by the terms of the policy it is subject to change.

Lines 49 through 55 might just as well have been left out of the contract. These lines provide that no waiver affecting the policy is valid unless expressed in writing and attached to the policy. The courts have held that not only are oral waivers by the agent valid, but that the agent can waive the very clause that says that he cannot waive provisions of the policy.

Lines 56 through 67 provide for the cancellation of the contract by either party and provides the basis for the refund of premium in the event of cancellation. If the insurance company elects to cancel, the return premium is computed on a "pro-rata" basis, which means that the insured will be charged only for the protection which he has recieved. If the policy is written for one year and the company cancels six months after inception, the insured is entitled to a return of 50% of the premium. On the other hand, if the insured cancels, the return premium is computed on a "short rate" basis, and the insured receives a less than proportionate return of premium. For example, the short rate return of premium after six months of coverage would be only 40% of the annual premium.

The right of the company to cancel is based on its right to choose the insureds with which it will do business. Most carriers cancel by registered mail with a return receipt requested, for the policy requires that the company give the insured 5 days written notice of cancellation. The five days required begins at midnight following receipt of cancellation.

Lines 68 through 85 contain provisions that govern the rights and obligations of a mortgagee named in the policy. A mortgage occupies an unusual position in the fire insurance contract. Although the mortgage does not enter into the formation of the contract, any mortgagee listed in the policy becomes a party to the contract with certain rights distinct from those of the insured. When a mortgagee is named in the policy, a Standard Mortgage Clause Endorsement is added to the policy granting certain rights to the mortgagee and imposing certain obligations. (This clause is included in the Dwelling Forms). The rights of the Mortgagee are:

1. To receive any loss or damage payments to the extent of its interest in the property, regardless of any default of the property owner under the contract, and regardless of any charge in the occupancy or increase in the hazard.
2. To receive 10 days notice in the event of cancellation instead of the 5 days afforded to the insured.
3. To sue under the policy in its own name.

In addition to these rights, certain obligations are imposed on the mortgagee:

1. To notify the insurer of any change in occupancy or ownership or any increase in hazard.
2. To pay the premium if the owner fails to do so.
3. To render proof of loss to the insurer if the owner fails to do so.
4. To surrender to the insurer any claim it has against the mortgagor to the extent that it receives payment in those cases where the company has ruled that no coverage exists for the owner.

Not that these are conditional obligations. They must be met only if the mortgagee wishes to enjoy the coverage of the policy; they are not conditions which the mortgagee can be required to keep.

Lines 86 through 89 deal with the pro-rata liability of the insurer in the event that there is more than one policy covering on the property. If more than one policy covers the same property, the insured is limited in his recovery under each policy to its proportion of the loss, based on the percentage of all insurance that the insurance of each policy represents. For example, property valued at $20,000 is insured in Company A for $15,000 and Company B for $5,000. In the event of a $4,000 loss,

Company A would pay $\frac{\$15,000}{20,000} \times \$4,000 = \$3,000$

Company B would pay $\frac{5,000}{20,000} \times \$4,000 = \$1,000$

The pro-rata liability clause enforces the principle of indemnity by making certain that all insurance covering property shares only a percentage of the loss, and that this sharing is on an equitable basis.

Lines 90 through 122 should be read in their entirety. These lines list the obligations which the contract imposed on the insured in the event of loss. As an examination of the requirements will indicate, they appear to be dishearteningly burdensome and exacting. All that is required in most cases is reasonable compliance with three fundamental requirements:

1. The insured is required to give immediate notice of loss. Although the policy specifies that this notice is to be in writing, normally the insured gives notice of loss by calling his agent, and the courts have accepted this as meeting the requirement.
2. The insured is required to protect the property from further damage. This is a reasonable obligation. Any further damage would be due to the neglect of the insured and would not be covered.
3. Within 60 days, unless this time is extended by the company, the insured is required to file a "proof of loss". The "Proof of Loss" is a certified statement, signed and sworn to by the insured, which contains information concerning the loss, the interest of the insured in the property, the total amount of insurance, the actual cash value of the property, and the amount claimed by the insured.

Lines 123 through 140 provide a framework for the settlement of losses in those cases where the company and the insured cannot agree on the amount of loss. In this event, the policy provides that each party shall select a competent and disinterested appraiser. Together the two appraisers select any umpire. If the appraisers cannot agree on an umpire, one will be appointed by the court. The appraisers then appraise the loss, each appraiser stating what he estimates the actual cash value to be. Their differences are submitted to the umpire, and an agreement in writing of any of the three persons is binding on both parties. The cost of the appraisers are paid by the party that they represent and the cost of the umpire is paid by both parties.

It is important to note that this provision provides a means whereby the amount of a loss can be determined. It is not used when the company and the insured disagree as to whether a loss actually has occurred, or whether or not the loss is actually covered under the policy. Such disagreements can be settled through the courts.

Lines 141 through 147 specify the options which the company may exercise in settling the loss. The policy provides that the company may pay for the loss in cash, or, at its option, it may repair, rebuild, or replace the property destroyed or damaged with property of like kind and quality. The purpose of this condition is to protect the company against inflated loss claims. Normally the company exercises its cash option; however, the right to repair or replace the property operates as a safeguard against unreasonable cash claims.

In addition, the provisions of these lines give the company the option to take all or any part of the salvage at the agreed or appraised value.

Lines 148 through 149 relate to the practice of taking salvage. In loss adjustment, it is the practice to agree on the value of salvage. As we have seen, the company has the option to take the salvage at the agreed value, however the Abandonment clause of the policy states that the company cannot be forced to take salvage, and the insured cannot abandon the property to the insurance company.

Lines 150 through 156 required the insurance company to pay for any loss under the policy within 60 days after it has received the insured's proof of loss and the company and the insured have agreed on the amount of the loss.

Lines 157 through 161 place a limit upon the time within which the insured must bring suit in a court of law. The policy provides that no suit shall be sustain-

able in any court of law unless the requirements of the policy have been complied with, and unless the suit is brought within 12 months of the loss.

Lines 162 through 165 contain the suborgation provision. The company may require the insured to assign the right to sue a third party to it, to the extent that it has made payment for loss which was caused by the third party and for which the insured has a claim against the third party. If the insured decides to collect under his fire policy, he gives the insurance company the right to sue in his name and collect those sums which he would have been able to collect. If he decides not to collect under the fire policy, he may retain the right and sue the third party himself. If the amount of loss is greater than the amount of the insurance, the insured may assign a part of the right to sue to the insurance company and retain his right to sue for the remainder of his loss.

1 **Concealment,** This entire policy shall be void if, whether
2 **fraud,** before or after a loss, the insured has wil-
3 fully concealed or misrepresented any ma-
4 terial fact or circumstance concerning this insurance or the
5 subject thereof, or the interest of the insured therein, or in case
6 of any fraud or false swearing by the insured relating thereto.
7 **Uninsurable** This policy shall not cover accounts, bills,
8 **and** currency, deeds, evidences of debt, money or
9 **excepted property.** securities; nor, unless specifically named
10 hereon in writing, bullion or manuscripts.
11 **Perils not** This Company shall not be liable for loss by
12 **included.** fire or other perils insured against in this
13 policy caused, directly or indirectly, by: (a)
14 enemy attack by armed forces, including action taken by mili-
15 tary, naval or air forces in resisting an actual or an immediately
16 impending enemy attack; (b) invasion; (c) insurrection; (d)
17 rebellion; (e) revolution; (f) civil war; (g) usurped power; (h)
18 order of any civil authority except acts of destruction at the time
19 of and for the purpose of preventing the spread of fire, provided
20 that such fire did not originate from any of the perils excluded
21 by this policy; (i) neglect of the insured to use all reasonable
22 means to save and preserve the property at and after a loss, or
23 when the property is endangered by fire in neighboring prem-
24 ises; (j) nor shall this Company be liable for loss by theft.
25 **Other Insurance.** Other insurance may be prohibited or the
26 amount of insurance may be limited by en-
27 dorsement attached hereto.
28 **Conditions suspending or restricting insurance. Unless other-**
29 **wise provided in writing added hereto this Company shall not**
30 **be liable for loss occurring**
31 (a) while the hazard is increased by any means within the con-
32 trol or knowledge of the insured; or
33 (b) while a described building, whether intended for occupancy
34 by owner or tenant, is vacant or unoccupied beyond a period of
35 sixty consecutive days; or
36 (c) as a result of explosion or riot, unless fire ensue, and in
37 that event for loss by fire only.
38 **Other perils** Any other peril to be insured against or sub-
39 **or subjects.** ject of insurance to be covered in this policy
40 shall be by endorsement in writing hereon or
41 added hereto.
42 **Added provisions.** The extent of the application of insurance
43 under this policy and of the contribution to
44 be made by this Company in case of loss, and any other pro-
45 vision or agreement not inconsistent with the provisions of this
46 policy, may be provided for in writing added hereto, but no pro-
47 vision may be waived except such as by the terms of this policy
48 is subject to change.
49 **Waiver** No permission affecting this insurance shall
50 **provisions.** exist, or waiver of any provision be valid,
51 unless granted herein or expressed in writing
52 added hereto. No provision, stipulation or forfeiture shall be
53 held to be waived by any requirement or proceeding on the part
54 of this Company relating to appraisal or to any examination
55 provided for herein.
56 **Cancellation** This policy shall be cancelled at any time
57 **of policy.** at the request of the insured, in which case
58 this Company shall, upon demand and sur-
59 render of this policy, refund the excess of paid premium above
60 the customary short rates for the expired time. This pol-
61 icy may be cancelled at any time by this Company by giving
62 to the insured a five days' written notice of cancellation with
63 or without tender of the excess of paid premium above the pro
64 rata premium for the expired time, which excess, if not ten-
65 dered, shall be refunded on demand. Notice of cancellation shall
66 state that said excess premium (if not tendered) will be re-
67 funded on demand.
68 **Mortgagee** If loss hereunder is made payable, in whole
69 **interests and** or in part, to a designated mortgagee not
70 **obligations.** named herein as the insured, such interest in
71 this policy may be cancelled by giving to such
72 mortgagee a ten days' written notice of can-
73 cellation.
74 If the insured fails to render proof of loss such mortgagee, upon
75 notice, shall render proof of loss in the form herein specified
76 within sixty (60) days thereafter and shall be subject to the pro-
77 visions hereof relating to appraisal and time of payment and of
78 bringing suit. If this Company shall claim that no liability ex-
79 isted as to the mortgagor or owner, it shall, to the extent of pay-
80 ment of loss to the mortgagee, be subrogated to all the mort-
81 gagee's rights of recovery, but without impairing mortgagee's
82 right to sue; or it may pay off the mortgage debt and require
83 an assignment thereof and of the mortgage. Other provisions
84 relating to the interests and obligations of such mortgagee may
85 be added hereto by agreement in writing.
86 **Pro rata liability.** This Company shall not be liable for a greater
87 proportion of any loss than the amount
88 hereby insured shall bear to the whole insurance covering the
89 property against the peril involved, whether collectible or not.
90 **Requirements in** The insured shall give immediate written
91 **case loss occurs.** notice to this Company of any loss, protect
92 the property from further damage, forthwith
93 separate the damaged and undamaged personal property, put
94 it in the best possible order, furnish a complete inventory of
95 the destroyed, damaged and undamaged property, showing in
96 detail quantities, costs, actual cash value and amount of loss
97 claimed; **and within sixty days after the loss, unless such time**
98 **is extended in writing by this Company, the insured shall render**
99 **to this Company a proof of loss,** signed and sworn to by the
100 insured, stating the knowledge and belief of the insured as to
101 the following: the time and origin of the loss, the interest of the
102 insured and of all others in the property; the actual cash value of
103 each item thereof and the amount of loss thereto, all encum-
104 brances thereon, all other contracts of insurance, whether valid
105 or not, covering any of said property, any changes in the title,
106 use, occupation, location, possession or exposures of said prop-
107 erty since the issuing of this policy, by whom and for what
108 purpose any building herein described and the several parts
109 thereof were occupied at the time of loss and whether or not it
110 then stood on leased ground, and shall furnish a copy of all the
111 descriptions and schedules in all policies and, if required, verified
112 plans and specifications of any building, fixtures or machinery
113 destroyed or damaged. The insured, as often as may be reason-
114 ably required; shall exhibit to any person designated by this
115 Company all that remains of any property herein described, and
116 submit to examinations under oath by any person named by this
117 Company, and subscribe the same; and, as often as may be
118 reasonably required, shall produce for examination all books of
119 account, bills, invoices and other vouchers, or certified copies
120 thereof if originals be lost, at such reasonable time and place as
121 may be designated by this Company or its representative, and
122 shall permit extracts and copies thereof to be made.
123 **Appraisal.** In case the insured and this Company shall
124 fail to agree as to the actual cash value or
125 the amount of loss, then, on the written demand of either, each
126 shall select a competent and disinterested appraiser and notify
127 the other of the appraiser selected within twenty days of such
128 demand. The appraisers shall first select a competent and dis-
129 interested umpire; and failing for fifteen days to agree upon
130 such umpire, then, on request of the insured or this Company,
131 such umpire shall be selected by a judge of a court of record in
132 the state in which the property covered is located. The ap-
133 praisers shall then appraise the loss, stating separately actual
134 cash value and loss to each item; and, failing to agree, shall
135 submit their differences, only, to the umpire. An award in writ-
136 ing, so itemized, of any two when filed with this Company shall
137 determine the amount of actual cash value and loss. Each
138 appraiser shall be paid by the party selecting him and the ex-
139 penses of appraisal and umpire shall be paid by the parties
140 equally.
141 **Company's** It shall be optional with this Company to
142 **options.** take all, or any part, of the property at the
143 agreed or appraised value, and also to re-
144 pair, rebuild or replace the property destroyed or damaged with
145 other of like kind and quality within a reasonable time, on giv-
146 ing notice of its intention so to do within thirty days after the
147 receipt of the proof of loss herein required.
148 **Abandonment.** There can be no abandonment to this Com-
149 pany of any property.
150 **When loss** The amount of loss for which this Company
151 **payable.** may be liable shall be payable sixty days
152 after proof of loss, as herein provided, is
153 received by this Company and ascertainment of the loss is made
154 either by agreement between the insured and this Company ex-
155 pressed in writing or by the filing with this Company of an
156 award as herein provided.
157 **Suit.** No suit or action on this policy for the recov-
158 ery of any claim shall be sustainable in any-
159 court of law or equity unless all the requirements of this policy
160 shall have been complied with, and unless commenced within
161 twelve months next after inception of the loss.
162 **Subrogation.** This Company may require from the insured
163 an assignment of all right of recovery against
164 any party for loss to the extent that payment therefor is made
165 by this Company.

IN WITNESS WHEREOF, this Company has executed and attested these presents; but this policy shall not be valid unless countersigned by the duly authorized Agent of this Company at the agency hereinbefore mentioned.

THE MODERN DWELLING and CONTENTS FORMS

Different forms are required for different types of property, and there are often several forms available for insuring a single class of property. The various forms that are available to insure a given type of property usually differ from each other in terms of the perils against which they provide protection. The various forms used to insure dwelling property represent a good example of the manner in which several forms designed to insure one type of property may differ.

There are three forms available for use with the Standard Fire Policy that may be used to provide insurance on dwellings and their contents:

Form DF-1 (called the Dwelling Building(s) and Contents Basic Form)

Form DF-2 (called the Dwelling Building(s) and Contents Broad Form)

Form DF-3 (called the Dwelling Building(s) and Contents Special Form)

A fourth form, DF-4 (which is called the Tenant's Personal Property Form) is used when contents only is to be insured.

There are five insuring agreements used in these forms:

Coverage A—Dwellings
Coverage B—Appurtenant Structures
Coverage C—Household and Personal Property
Coverage D—Rental Value
Coverage E—Additional Living Expense

Forms DF-1, DF-2 and DF-3 are identical in their policy provisions defining the coverage under Coverages A, B, C, and D. Coverage E (Additional Living Expense) is included only in Forms DF-2 and DF-3, but is available by endorsement to Form DF-1. The Tenant's Form includes only Coverage C. In addition to these coverages, the forms also include certain extensions of coverage under a Supplementary Coverages section.

THE DWELLING BUILDING(S) AND CONTENTS BASIC FORM

The Dwelling Buildings and Contents Basic Form, DF-1, is the standard form that is used to modify and complete the fire policy when coverage is provided on dwelling property. It may be used to insure most dwellings, including those under construction, whether or not owner occupied. In general, only farm dwellings are not eligible.[3] Even trailer homes may be insured, provided they are used exclusively for dwelling purposes and are at a fixed location. As its title indicates, the form can be used to provide coverage on both the dwelling and the personal property of the insured. The dwelling may also be insured without any coverage on the contents. When coverge on contents only is desired, Form DF-4 is used. There are four insuring agreements under Form DF-1:

Coverage A—Dwelling
Coverage B—Appurtenant Structures
Coverage C—Household and Personal Property
Coverage D—Rental Value

Coverage A—Dwelling Coverage

Coverage A applies to the dwelling described in the policy, including any additions in contact with that dwelling. It also provides coverage on building equipment and fixtures, and outdoor equipment pertaining to the service of the premises. Coverage also applies to materials and supplies intended for use in construction, alteration or repair of the dwelling.

Coverage B—Appurtenant Structures

Coverage under the Appurtenant Structures item applies to buildings on the premises other than the dwelling, such as garages or similar structures. A limited amount of coverage is automatically provided on appurtenant structures under one of the Supplementary Coverages discussed below. Additional specific coverage on appurtenant structures may also be purchased.

Coverage C—Household and Personal Property

Coverage C provides coverage on household and personal property usual and incidental to the occupancy of a dwelling. The form specifically excludes animals, birds, fish, aircraft, motor vehicles (other than motorized vehicles used for the maintenance of the premises) and boats (other than rowboats and canoes). This means that items such as riding lawnmowers, garden tractors, and rowboats and canoes would all be covered.

Coverage D—Rental Value

When a dwelling is damaged by fire or some other peril, the owner faces not only the loss resulting directly from the damage, but he also faces an indirect loss. During the period of time required to restore the building to tenantable condition, he loses the use of the dwelling. Coverage D insures the fair rental value of the building insured, as furnished and equipped by the owner. "Rental value" is defined as the amount for

[3]Technically, the manual provides that a Dwelling policy may be used to insure a dwelling building used exclusively for dwelling purposes (except permitted incidental occupancies) with not more than 4 apartments and with not more than 5 roomers or boarders in total. Trailer homes and mobile homes used exclusively for dwelling purposes at a fixed location are also eligible. Dwellings in the course of construction are also eligible. Incidental occupancies permitted include Business or professional office occupancies, and other incidental occupancies such as barber shops, beauty parlors, photographers' studios, and similar service occupancies with not more than two persons at work at any one time.

which the building could have been rented at the time of the loss, whether or not it was rented. Thus, if the insured himself was living in the house at the time of a loss, he would still be entitled to collect the amount for which he could have rented the building for the period of time that is or would be required to restore the building to livable condition. An extension under the Supplementary Coverages (discussed below) provides that the insured may apply up to 10% of the amount of insurance on the dwelling to cover rental value. If this 10% is inadequate for the insured's needs, additional coverage may be scheduled.

Supplementary Coverages

The Dwelling Buildings and Contents Basic Form provides certain supplementary coverages which constitute an important part of the insured's protection. Two of these extensions (Appurtenant Structures and Rental Value) have already been noted. Altogether there are four extensions of coverage under the form, which extend the policy to cover additional property or additional types of losses.

The Appurtenant Structures Extension. As previously noted, the Supplementary Coverages section of the form provides some automatic coverage on appurtenant structures. The Appurtenant Structures extension provides up to 10% of the amount of coverage on the dwelling may be applied to cover other structures on the premises. The 10% is not, however, additional coverage. If the dwelling is insured for say, $10,000, and the garage burns, the loss would be covered up to $1,000. However, if both the dwelling and the garage are destroyed in a single loss, the maximum payable would be $10,000. The only restrictions under the extension are that the buildings cannot be used for mercantile, manufacturing, or farming purposes, and that they may not be rented to anyone except a tenant of the main dwelling. A private garage which is used for private garage purposes does not come under this exclusion of "rented property", and is covered even if it is rented to someone other than the occupant of the dwelling. Other rented buildings are not covered under the Supplementary Coverages extension, but may be specifically scheduled under Coverage B.

Rental Value Extension. The rental value extension stipulates that the insured may apply up to 10% of the amount of insurance on the dwelling to cover rental value, with 1/12 of this 10% applicable in any one month. The 10% is not additional insurance. The monthly limitation of 1/12 of the 10% imposes a maximum on the amount recoverable in a single month. Suppose the insured has a dwelling that would rent for $300. If the insurance on the dwelling is $24,000, the 10% extension provides $2,400 in coverage for rental value, but the 1/12 limitation permits only a $200 per month recovery. On the other hand, assuming the same insurance coverage, if the dwelling has a rental value of $150 per month, this is the maximum that the insured can collect, regardless of the fact that the policy provides up to $200 per month.

Away From Premises Coverage. In discussing the fire policy, it was noted that the coverage afforded under the fire policy is coverage at the location listed in the policy except in the case of removal or extensions under the forms that are attached to the fire policy. The "Away From Premises" coverage of the Supplementary Coverages section provides that up to 10% of the amount of insurance on contents may be applied to personal property of the insured and members of his household while such property is away from the premises. The off-premises coverage applies to property anywhere in the United States or Canada. Rowboats and canoes, which are covered while on premises, are not covered by this extension. Note also that this "Away From Premises" coverage does not provide additional insurance.

This extension is an important feature of the coverage and considerably broadens the coverage of the basic policy. It would even provide coverage on the property of members of the insured's household such as children who are away from home at school. While the extension also applies to personal property which is in the hands of repair shops, laundries, dry cleaners and other types of servicing firms, the form specifically stipulates that the coverage shall not apply to the benefit of any bailee. This means that the insured or his insurer would file a claim against any bailee or carrier in whose possession the property was at the time of a loss.

Improvements, Alterations, and Additions. If the insured is a tenant and installs improvements or betterments in the building at his own expense, he has an insurable interest in these expenditures, even though by law any property attached to the dwelling or any improvements made by the tenant become the property of the owner. The Improvements, Alterations and Additions extension provides that the insured, if a tenant, may apply up to 10% of the amount of coverage on contents to cover such improvements. As in the case of the other extensions of this form, the 10% is not an additional amount of insurance.

Perils Insured

Form DF-1 provides coverage against the same perils specified in the insuring agreement of the Standard Fire Policy (i.e., Fire, Lightning, and Removal) and one additional peril, "Inherent Explosion", which is discussed below. In addition, the insured has the option of including coverage against the "Perils of Extended Coverage" and Vandalism and Malicious Mischief. The provisions relating to these latter perils are printed in the form and when the insured has paid the required premium, the declarations page indicates that coverage against loss by these perils is afforded. When the additional premium required is not paid, coverage is provided against four perils in the basic form.

Fire and Lightning. The form restates the perils of the insuring agreement of the Standard Fire Policy. With respect to the perils of Fire, the form stipulates that loss by fire does not include loss resulting from electrical injury or disturbance to electric appliances, fixtures, or wiring caused by artificially generated electricity unless fire ensues, and then only the ensuing damage is covered.

Removal. The coverage afforded under the Removal Insuring agreement has already been discussed. Basically, it converts the coverage under the policy to an "all risk" basis on property which is being or has been removed from the premises for protection from the perils insured against. Such coverage continues for five days.

Inherent Explosion. The Dwelling Building(s) and Contents Form adds the peril of inherent explosion without additional premium. The inherent explosion insuring agreement provides coverage for direct loss to the property insured caused by explosion occurring in the described dwelling or other buildings on the premises, even if fire does not ensue. The inherent explosion insuring agreement specifically lists explosion of accumulated gases or unconsumed fuel within the firebox or combustion chamber of a furnace or other fired vessel, but excludes explosion of steam heating systems, machinery, bursting pipes, electric arcing, or water hammer. Although the peril specifically mentions explosions of accumulated gases or unconsumed fuel, there is no requirement that the explosion result from these causes; and virtually any explosion emanating from an insured buiding, other than those noted above as specifically excluded, would be covered.

Extended Coverage

The term "Extended Coverage" is commonly used to designate a combination of nine perils which are sold as a group, and which have come to be considered a more or less standard addition to the fire policy. The perils composing this group are WINDSTORM, HAIL, EXPLOSION, RIOT, RIOT ATTENDING A STRIKE, CIVIL COMMOTION, AIRCRAFT, VEHICLES, AND SMOKE.

In the early 1900's, it was the custom for insurance companies to offer windstorm damage insurance to the public as a separate coverage. As people became increasingly aware of the possibility of property damage resulting from windstorm and certain other perils, the Extended Coverage Endorsement was eventually developed, which provided protection against this entire package of perils for a single premium charge. The cost of providing the combination of these perils is considerably less than would be the cost of purchasing them separately. By selling all of the coverages as a combined unit, companies are able to avoid the adverse selection that would result if the individual were permitted to purchase only those perils which he felt he needed most.

At one time, it was usual to add the coverage against loss resulting from the perils of Extended Coverage to the fire policy through the use of a separate endorsement called "The Extended Coverage Endorsement". Today, many of the forms used to complete the fire policy (such as the Dwelling Building(s) and Contents Form under discussion here) include the provisions of the separate Extended Coverage Endorsement.[4] In such cases, the provisions pertaining to these perils are made effective by payment of the required premium and indication in the declarations that the coverage is afforded.

It should be clear that the purchase of Extended Coverage does not increase the amount of insurance under the policy, but merely expands the number of perils insured against. The insured who purchases $10,000 in coverage against loss by fire and Extended Coverage does not have $20,000 in insurance; he merely has $10,000 in protection against a wider range of perils. When Extended Coverage is added to the fire policy, it is written for the same amount as the fire insurance in the policy.

A brief discussion of each of the perils of Extended Coverage should serve to indicate the nature of the coverage afforded under the various perils included.

Windstorm and Hail. The first perils of Extended Coverage are windstorm and hail, and coverage is provided for damage caused by "direct action" of wind and hail. The majority of the courts have held the position that objects that are propelled by the wind and which cause damage are a result of "direct action by the wind". If the wind blows a tree branch through a window, or blows a tree over on the insured's dwelling, the resulting damage would be covered.

The provisions of the endorsement specifically exclude any damage caused by rain, snow, sand, or dust, to the interior of the building unless the exterior walls or the roof are first damaged by direct action of the wind or hail. Thus if the insured leaves a window open and the wind blows rain into the house damaging the furniture and rugs, such damage would not be covered. However, if the window had been broken by the wind, the damage would be covered.

Explosion. The explosion coverage of the extended coverage endorsement is consideringly broader than the inherent explosion coverage of the Dwelling and Contents Form. Explosions are covered whether they originate within the building or outside the building. The endorsement states that the following are not con-

[4]The reader should recognize that although the treatment of Extended Coverage appears in this section of the manual which deals with dwelling coverages, the provisions of the Extended Coverage Endorsement which is used in insuring other types of property are exactly the same as those explained here.

sidered to be explosions within the definition of the contract:

1. Shock waves caused by aircraft (Sonic Boom)
2. Rupture or bursting of steam boilers, steam turbines, steam engines if owned or operated by the insured
3. Rupture or bursting of rotating parts of machinery or electrical arcing
4. Rupture or bursting of water pipes or pressure relief devices
5. Rupture or bursting due to expansion or swelling of the contents of any building or structure caused by or resulting from water.

Riot, Riot Attending a Strike, Civil Commotion. Although "riots" and the related terms are not defined in the contract, a riot is generally considered to be "an assembly of individuals who commit a lawful or unlawful act in a violent or tumultuous manner, to the terror or disturbance of others." Damage caused by rioters is covered by the extended coverage endorsement with very few exceptions. Even "pillage and looting" is covered, if it occurs during and at the place of the riot, riot attending a strike, or civil commotion. The exception to the coverage is an exclusion of damage to or destruction of property that results from a change in temperature (consequential loss), even though such a loss would otherwise be covered by the policy as to other perils.

Aircraft. The aircraft peril of the extended coverage endorsement provides coverage against damage to property as a result of physical contact of an airplane or an object falling from an aircraft with the insured property. The requirement of physical contact eliminates coverage from damage caused by sonic boom.

Vehicles. "Vehicles" are defined in the policy as including those which run on land or tracks, but not aircraft. The provisions of the form (and of the Vehicle peril of the separate Extended Coverage Endorsement) provides coverage for damage that results from the actual physical contact of a vehicle with the insured property. However, there are two very important exclusions relating to the vehicle damage:

1. Vehicle damage caused by vehicles owned or operated by the insured or a tenant of the property is excluded.
2. Damage to any covered vehicles or to the contents of vehicles is excluded.

It should be recognized that these two exclusions represent a serious limitation to the coverage. The greatest likelihood of loss by vehicles involves the two areas dealt with in the exclusions: owned vehicles and the contents of vehicles.

Smoke. The standard fire policy provides coverage for damage caused by smoke from a hostile fire; and the Extended Coverage Endorsement broadens this slightly by providing coverage for smoke damage which results from the "sudden, unusual, and faulty operation of a heating or cooking unit." The form specifically requires that such heating or cooking unit be connected to a chimney by a smoke pipe or vent pipe, and that it be on the described premises. Smoke from fireplaces and from industrial apparatus are specifically excluded.

Vandalism and Malicious Mischief

When the appropriate additional premium has been paid and the declarations so indicate, the policy is extended to cover losses caused by Vandalism and Malicious Mischief, meaning the willful and malicious damage to or destruction of property. Damage to glass by vandalism is specifically excluded, along with loss resulting from pilferage, theft, burglary or larceny. In addition, loss by Vandalism and Malicious Mischief is not covered if the building has been vacant for over 30 days.

The Apportionment Clause

In examining the pro-rata liability clause of the SFP, it was determined that when more than one policy covers the property insured, each policy participates on the basis of the percentage of all insurance that it represents.

The apportionment clause of Form DF-1, like the separate Extended Coverage Endorsement, provides for settlement when the policies on the loss do not all cover against the same perils. Losses covered by the policy written with extended coverage are apportioned as if all policies were written with extended coverage. If all policies are not written alike, the insured may suffer a penalty in payment for the loss. This is accomplished through the simple device of apportioning losses covered by extended coverage on the basis of the percentage of all fire insurance which the extended coverage represents.

For the sake of illustration, let us suppose that the insured has purchased two policies, each in the amount of $10,000 to cover his $20,000 building. However, in order to save on his premiums, the insured purchases one policy with both fire and extended coverage and one policy with fire insurance only. (This would appear to be a logical approach, if it were not for the apportionment clause, for few windstorm losses would be total.) In the event of a loss, the insured will find that he will collect only 50% of the loss, for this is the proportion of all fire insurance that the policy written with extended coverage represents.

When all policies covering the same property are not written exactly alike, they are said to be "non-concurrent". Concurrency in property insurance policies is of the utmost importance, for virtually all policies with broader or extended coverage provide for the apportionment of losses with other insurance on the basis of the face amount of all policies covering against the peril of fire.

Other Important Provisions

In addition to the four extensions, there are certain other important provisions in the form that are of particular importance.

Debris Removal. Although this provision is not located in the Supplementary Coverages section of the policy, it represents another important extension of coverage. The Debris Removal provision stipulates that the policy will cover expenses incurred in removing debris of insured property which is damaged by any of the perils insured against in the policy. It does not increase the limits of the policy, and all expenses charged for the removal of the debris will apply against the face of the policy in the same manner as direct loss of property.

Property Removal Provision. A special provision in the definition of contents coverage provides that if the insured moves to another location within the state, and the new location is to be the residence of the insured, the insurance on the contents will cease to cover at the old location and will cover the property at the new location. During the period of removal the property at each location is covered on a pro-rata basis; the coverage applies at each location on the basis of the total amount which the values at that location represent to the total values at each location. For example, if the individual has $10,000 worth of contents, which is insured for $10,000, and he has moved $4,000 worth of furniture to the new location, he has $4,000 in coverage at the new location and $6,000 at the old one. Property in transit is covered only to the extent of the off premises extension.

The Loss Clauses. The Dwelling Building(s) and Contents Basic Form, like most other fire forms, states that any loss under the policy will not reduce the amount of the policy. Following a loss the insured still has the same amount of insurance coverage as he had before the loss, and the policy does not need to be reinstated in any manner.

Consequential Loss. Consequential loss, in contrast to direct loss, results in damage or loss which is a result of damage to other property. The best example of consequential loss as it applies to the dwelling risk is that of frozen food in a deep freeze. Suppose that as a result of a fire, the deep freeze is damaged. In all probability the damage to the deep freeze will represent only a part of the loss sustained by the insured. He may lose $200 or $300 worth of frozen food. The Dwelling Buildings and Contents Basic Form provides some coverage for this loss, in the form of an exception to an exclusion. Exclusion b states that loss due to a change in temperature will be covered, if the change in temperature is a result of actual physical damage to the building itself or equipment in the building. Of course the damage must be caused by an insured peril. Suppose that lightning strikes the house and destroys all of the wiring, with the result that the meat in the freezer is ruined. This loss would be covered. However if the lightning does not strike the house and damage the wiring, but instead knocks out the power plant two miles away, the loss would not be covered because of the requirement of damage to the building or equipment in the building.

Liberalization Clause. The liberalization clause provides that if, during the term of the policy, the fire rating organization of the state adopts any form or endorsement which would broaden the policy without an additional premium, such endorsement is made a part of the policy.

Alterations and Repairs Clause. This clause grants permission to the insured to make alterations, additions, and repairs to buildings and to complete buildings in the course of construction. This is an important concession in the form, since the basic SFP suspends coverage at any time during an increase in hazard within the knowledge or control of the insured. In the absence of the Alterations and Repairs clause, questions might arise concerning whether or not the hazards related to the buildings were increased through the process of making alterations and repairs.

Vacancy and Unoccupancy. The policy also grants permission for the premises to be vacant or unoccupied without limit of time. This provision supercedes the provision of the SFP suspending coverage when the building is vacant or unoccupied in excess of 60 days. However, the permission contains the qualifications ". . . except as otherwise provided in this policy for certain perils," and some restrictions with respect to vacancy or unoccupancy may apply to individual perils (e.g., vandalism and malicious mischief).

Waiver of Subrogation. Finally, the policy includes a provision stating that the insurance is not invalidated if the insured should waive right of recovery against another party for damage to the property, if such waiver is in writing and takes place prior to a loss. As the reader will recall, the subrogation provision of the SFP requires the insured to assign all right of recovery against a third party to the insurer, to the extent that payment is made for the loss. The waiver of subrogation provision permits a landlord, for example, to agree in writing prior to a loss to release the tenant from damage to the premises by fire. If this is done, the insured would collect from his fire insurance company; and the tenant would not be subject to subrogation from the insurer.

Exclusions Under the Basic Form

Because the coverage of the Basic Form is written on a Named Peril basis, the number of exclusions required in the form is minimal. In addition, the insuring agreements of many of the individual perils include specific exclusions relating to the specific perils. However, the form does contain a section of General Exclusions, containing specific exclusions of losses that are not considered insurable or which are not contemplated by the rate charged for the coverage.

The War Exclusion and Nuclear Exclusion. The form contains two exclusions contained in virtually all forms of property insurance: war and nuclear damage. The first of these restates the exclusion of the Standard Fire Policy, and excludes war in all its forms. The second provides that losses by nuclear reaction or nuclear radiation or radioactive contamination are not insured in the policy.

Water Damage. The policy specifically excludes losses caused by, resulting from, contributed to, or aggravated by certain forms of water. The types of water specifically noted in the form include

(1) flood, in all its forms

(2) water which backs up through sewers or drains

(3) water below the surface of the ground that seeps through basement walls, foundations, floors and so on.

An exception to the exclusion provides that coverage is afforded if loss by fire or explosion ensues, but such coverage applies only to the enusing loss.

Power Failure. This exclusion has already been noted. The policy provides that there is no coverage for damage which is caused by or results from power, heating or cooling failure, unless such failure is caused by damage to power, heating or cooling equipment on the premises by an insured peril. As we have noted earlier, the net effect of this exclusion is to provide coverage in those instances where heating or cooling equipment on the premises is damaged by an insured peril.

Building Code. The form also excludes loss caused by the enforcement of any ordinance or law regulating construction, repair or demolition of buildings. This means that if an insured dwelling does not comply with the provisions of the building code, the insurer will not be liable for the increased cost of construction necessary to bring a damaged or destroyed building up to code standard.

Deductible

The Dwelling Building(s) and Contents Basic Form contains a $50 all perils deductible, which applies to all coverages except rental value. If more than one dwelling is covered under the policy, the deductible applies separately to the amount of loss to each dwelling and its contents. If the insured desires, this deductible may be modified for an additional premium, making it apply only to losses by windstorm and hail.

THE DWELLING BUILDINGS AND CONTENTS BROAD FORM

Following the development of the Extended Coverage Endorsement, the quest for broader coverage proceded, especially in the dwelling field. In 1951, an endorsement known as "Additional Extended Coverage" was made available, which, when combined with the Extended Coverage Endorsement, provided protection against a wide range of perils. The next step was to combine this endorsement with the Extended Coverage endorsement into a single form applicable to dwellings; the result was the Dwelling Building(s) and Contents Broad Form, which is currently designated DF-2.

Because the coverage under Form DF-2 is considerably broader than that of form DF-1, the eligibility requirements are more exacting. In order to qualify for coverage under the Broad Form, the amount of insurance on the dwelling must be at least $8,000. The form may also be used to insure contents only (in the case of a tenant), in which case the minimum amount of insurance is $4,000.

Coverages Under the Broad Form

There are five coverages in the Broad Form; the first four are identical with those of the Basic Form. The fifth coverage which is added under the Broad Form is Additional Living Expense, designated Coverage E. The insuring agreements of Coverages A, B, C, and D of the Broad Form are identical with those of the Basic Form, so it is not necessary to repeat the discussion of their provisions. With the exception of Coverage E, discussed below, the important differences between the Basic Form and the Broad Form are in the perils insured against and in the Supplementary Coverages extensions.

Coverage E, Additional Living Expense. The Additional Living Expense coverage applies to the necessary increase in living expense incurred by the insured in order to continue as nearly as practicable the normal standard of living of his household following loss by an insured peril. The emphasis is on the "necessary increase", and coverage applies for the shorter of two periods:

1. The period required with the exercise of due diligence and dispatch to restore the insured property to tenantable condition.
2. The period required for the insured and his household to become settled in any permanent quarters.

Coverage E applies automatically under the terms of a Supplementary Coverages insuring agreement, which provides an extension of coverage for up to 10% of the amount on the dwelling for Rental Value and Additional Living Expense. (See discussion later in this section).

Perils Added under the Broad Form

One of the principal differences between the Basic Form and the Broad Form is the number of perils against which protection is provided. In addition to the perils covered by the standard fire policy, the perils of extended coverage, and vandalism and malicious mischief (all of which may be covered under the Basic Form) the Broad Form adds the following perils:

Breakage of Glass

Burglary Damage
Falling Objects
Weight of Ice, Snow or Sleet
Collapse of Buildings
Heating System Explosion
Water Damge
Freezing of Plumbing
Injury By Artifically Generated Electricity

Breakage of Glass. Breakage of glass constituting a part of the building, including glass in storm doors and windows is covered, regardless of the cause of the breakage. In a sense, this insuring agreement is not a peril, but rather coverage for a particular type of loss, regardless of the peril causing the loss. The only restriction is that glass breakage is not covered if the building has been vacant for 30 days or more prior to the loss.

Damage Caused by Burglars. Only the damage caused by the burglars is covered. There is no coverage for loss of property that is taken by the burglars. Also, like the glass breakage coverage above, there is no coverage for burglary damage if the dwelling has been vacant for over 30 days.

Damage by Falling Objects. This peril covers damage caused by falling objects such as tree limbs, but, of course, is not limited to this. There is an exclusion of damage to the interior of the buildings or to the contents unless the exterior of the building first sustains damage. In addition, damage to trees, plants, shrubs, TV and radio antenna, cloth awnings, gutters, and downspouts is excluded.

Weight of Ice, Snow, and Sleet. Damage which resuilts from the weight of ice, snow and sleet is covered; but the damage must actually be the result of such weight. For example, melting snow which leaks into the dwelling doing damage is not covered. Damage is excluded to trees, shrubs, plants, lawns, outdoor equipment, awnings, fences, and to pavement, patios, swimming pools and foundations.

Collapse of the Dwelling. Direct loss as a result of collapse of the building or any part of the building is covered. Settling, cracking, shrinking, bulging, or expansion are excluded.

Heating System Explosion. The full title of this peril, as given in the form, is "Sudden and Accidental tearing asunder, cracking, burning or bulging of a steam or hot water heating system or of appliances for heating water". Coverage is provided not only for explosion of such items, but also for damage to the item itself through burning, bulging or cracking.

Water Damage. Specific enumerated types of water damage are covered under the peril: "Accidental discharge, leakage or overflow of water or steam from within a plumbing, heating, or air conditioning system or domestic appliance . . .". The insuring agreement also provides coverage for the cost of tearing out and replacing part of the building to make repairs. Only the loss of the plumbing or appliance itself is excluded. Vacancy is limited to 30 days.

Freezing of Plumbing. Loss as a result of freezing of plumbing, heating, or air conditioning systems or domestic appliances is covered, provided that the building has not been left vacant or unoccupied for over four days unless the plumbing, heating or air conditioning system was drained and the water was shut off. If the insured was diligent in attempting to maintain heat, or if the system was drained and the freezing loss still occurred, the loss would be covered even if the building had been vacant or unoccupied for over four days.

Injury to Appliances by Artificially Generated Electricity. Sudden and accidental injury from artificially generated electric currents to wiring or appliances is covered as an insured peril. This is in contrast to Form DF-1, which specifically excludes such damage. The major exclusion with respect to artificial electricity is that tubes, transistors, and similar electronic components are excluded.

Perils Broadened Under the Broad Form

Not only does the Broad Form add perils not covered by the Basic Form, but several of the perils of the Basic Form are considerably broadened under the Broad Form.

The Smoke Peril. The smoke peril of the Basic Form is quite restrictive, covering only smoke from a heating or cooking unit connected to a chimney. Under the Broad Form, any sudden and accidental smoke damage is covered, except smoke from industrial operations or agricultural smudging. There is no exclusion of smoke from a fireplace as in the Basic Form.

Explosion. The explosion peril does not exclude explosion of a steam boiler as does the Basic Form. As a matter of fact, steam boiler explosion is specifically insured under another peril.

Aircraft. The aircraft peril of the Basic Form requires actual physical contact of the aircraft or an object falling from an aircraft with the insured property for coverage to apply. The Broad Form makes no such requirement; therefore, sonic boom would be covered under the aircraft peril of the Broad Form.

Vehicles, Form DF-1 provides no coverage whatsoever for damage caused by a vehicle owned or operated by the insured or a tenant of the property. Form DF-2 provides coverage for damage caused by such vehicles. Damage to trees, shrubs, plants, lawns, walks, and driveways is excluded if the damage is caused by an auto owned or operated by an insured or a tenant of the property; but otherwise all damage is covered. There is no exclusion of damage to an otherwise insured vehicle or to the contents of a vehicle. Thus, for example, if the insured has personal effects in his automobile, and these personal effects should be damaged in a collision, the

vehicle damage peril would cover the items, (under the off-premises extension).

While the examples given above are not exhaustive, they serve to illustrate the manner in which the perils of the Dwelling and Contents Form have been broadened under the Dwelling and Contents Broad Form.

Supplementary Coverages of the Broad Form

The Broad Form contains six supplementary coverages:

Away From Premises Coverage
Improvements, Alterations, and Additions
Appurtenant Structures
Rental Value and Additional Living Expense
Trees, Shrubs, Plants and Lawns
Replacement Cost

The first of those listed, the Away From Premises Extension, is identical with the same extension in the Basic Form. Each of the others either differs from the similar extension found in the Basic Form or does not appear in the Basic Form. The Improvements, Alterations and Additions extension and the Appurtenant Structures extension are both broadened considerably in the Broad Form. In addition, the Rental Value and Appurtenant Structures extension, which is the Broad Form equivalent of the Basic Form's Rental Value extension is also considerably broader than its counterpart under the Basic Form. Finally, the last two extensions listed above (Trees, Shrubs, Plants and Lawns and Replacement Cost) do not appear in the Basic Form. The differences between the extensions of the Broad Form and the Basic Form are discussed below.

Improvements, Alterations and Additions. The wording of the Improvements, Alterations, and Additions extension of the Supplementary Coverages is essentially the same under the Broad Form as under the Basic Form, with one important exception. Under the Broad Form the coverage is an additional amount of insurance, equal to 10% of the amount of coverage on contents.

Appurtenant Structures. The coverage on appurtenant structures under the Broad Form is also an additional amount of insurance, equal to 10% of the amount of insurance on the dwelling.

Rental Value and Additional Living Expense. The Rental Value and Additional Living Expense extension of the Broad Form is the equivalent of the rental value extension of the Basic Form, but differs in two important respects. First, it is an additional amount of insurance under the Broad Form. In addition, the 10% may be used to cover both loss or rental value and additional living expense. The rental value portion of the coverage applies to that part of the premises not occupied by the insured, and the additional living expense coverage applies to the portion of the premises occupied by the insured. Under the additional living expense coverage, the insured is entitled to collect the amount by which his living expenses increase as a result of untenantability of the insured premises. The coverage is on an indemnity basis, and provides for payment of additional expenses required for the insured to maintain as nearly as practicable his same standard of living as before the loss. Coverage applies for the period required with due diligence to restore the premises, or for the period required for the insured and his family to become settled in permanent quarters, whichever is less. Unlike the Basic Form, there is no monthly limitation on either rental value or additional living expense under the Broad Form.

Trees, Shrubs, Plants and Lawns Extension. The Broad Form also provides that the insured may apply up to 5% of the amount of insurance on the dwelling to cover trees, shrubs, lawns and plants against the perils of fire, lightning, riot, riot attending a strike, civil commotion, vandalism and malicious mischief, damage by burglars, aircraft, smoke, collapse of the building, and damage by vehicles not owned or operated by the insured or a tenant. Windstorm and hail are specifically excluded. There is a maximum of $250 on any one tree, shrub, or plant. The $250.00 limit does not apply to lawns, although the coverage on lawns is limited to 5% of the amount of coverage on the dwelling.

Replacement Cost Extension. If at the time of a loss the amount of insurance covering the dwelling is at least equal to 80% of the replacement cost value of the building, the loss will be paid on the basis of replacement cost (without any deduction for depreciation). This extension applies only to building structures, and contents are covered on an actual cash value basis. The form states that outdoor equipment, domestic appliances, cloth awnings, and roof surfacing are not covered under the replacement cost extension.

In its simplest aspect, the extension eliminates depreciation in settling losses, provided that the insured has maintained insurance equal to 80% of replacement cost. In effect, the replacement cost extension furnishes the insured with an option to purchase insurance equal to the amount of depreciation which the building has suffered.

If the amount of coverage on the dwelling is less than 80% of the replacement cost value, the company will pay the larger of the following two amounts:

1. The actual cash value;
2. The proportion of the replacement cost of the loss that the amount of insurance bears to 80% of the replacement cost value of the house.

If the loss is more than $1,000 or 5% of the amount of insurance, the building must actually be repaired or replaced before the insured can collect on the replacement cost basis.

While on the subject of replacement cost, it might be

well to discuss the problem of determining the insurable value of dwelling property. The fact that most insureds have a somewhat distorted notion of what is meant by insurable value often results in underinsurance. Quite often the insured considers insurable value to be one of the inappropriate measures of value such as loan value, book value or market value.

Normally, the mortgagee requires protection equal to his interest in the property, and as a result many insureds feel that the property should be insured for its market value. Yet there is no guarantee that market value will be the same as either actual cash value or replacement cost value; there is good reason to assume that it will not. Market value is based on the supply and demand for real estate of the particular type involved. It includes the value of the land on which the dwelling is located, yet the value of this land is not a part of insurable value.

There are two basic measures of insurable value in dwelling property: replacement cost and actual cash value. By this time we all have a reasonably good estimate on what is meant by actual cash value; it is the replacement cost less depreciation. It is based on the replacement cost value, and as a result is more difficult to compute. Replacement cost value, on the other hand, is simply the cost of replacing the building with materials of like kind and quality. If the individual cannot estimate the replacement cost value of the property, he certainly cannot estimate its actual cash value.

Let's take a simple example and examine some of the aspects of the "insurable value" problem. We will assume that the dwelling under consideration was built 30 years ago at a cost of $8,000. The individual has just purchased this dwelling for $12,000. On the basis of an average square foot construction cost appraisal and a construction cost index, he determines that it could cost about $20,000 to replace the building at today's prices Next we assume that the building had a 60-year life length when it was constructed. (For the sake of simplicity we are also going to assume that the depreciation is linear and amounts to 50%). Thus we have an original cost of $8,000, a replacement cost of $20,000, a market value of $12,000, and an actual cash value of $10,000.

If the insured decides to insure the building under the Dwelling and Contents Form, he insures it on the basis of actual cash value. In the event of a loss, there will be a deduction made for depreciation. Let us say that the amount of the loss is $1,000. Since the amount of depreciation has been at 50% in our example, his recovery will be limited to $500.

On the other hand, let us assume that instead of insuring on an actual cash value basis, the insured elects to insure on the basis of replacement cost, and purchases a policy with the Broad Form for $20,000. Loss adjustment in the event of the $1,000 loss is equally simple in this instance. Since he has purchased an additional amount to cover the depreciation the building has suffered, he will be paid the full cost of replacement or $1,000.

In very few instances do we find insureds who are sufficiently sophisticated to distinguish between the replacement cost basis of insuring and the actual cash value basis. As a matter of fact, in most instances, the dwelling is insured for neither of those. It is insured for its market value.

If the insured in this example insures the dwelling under the Dwelling Buildings and Contents Broad Form, but purchases insurance on the basis of the market value of the house rather than the replacement cost, he will collect only a portion of the cost of repairing the damage. Since he has not maintained insurance equal to 80% of the replacement cost value of the dwelling, he will collect that proportion of the replacement cost of the loss that the amount of insurance purchased bears to the amount that is required under the form. Since 80% of the replacement cost of this dwelling is $16,000 and he has purchased only $12,000, he will collect 12/16 of the loss or $750.

Of course he will probably be greatly upset by the deduction for depreciation that the company has made, but it is made because he did not purchase enough insurance to cover the depreciation that the dwelling has suffered. If the insured does not purchase insurance against depreciation, he could not expect to collect for that part of the loss that represents the depreciation the property has suffered.

Other Provisions of the Broad Form

Apart from the various provisions discussed above, the provisions of the Broad Form essentially parallel those of the Basic Form. The Broad Form includes each of the following provisions discussed in connection with the Basic Form:

- The Loss Clause
- Alterations and Additions Clause
- Vacancy and Unoccupancy Clause
- Consequential Loss Clause
- Apportionment Clause
- Debris Removal Clause
- Property Removal Clause
- Waiver of Subrogation Clause
- Liberalization Clause

Exclusions Under the Broad Form

The provisions of the General Exclusions section of the Broad Form are identical with those of the Basic Form, and contain the following general exclusions already discussed:

- War and Nuclear Damage
- Water Damage
- Power Failure
- Building Code

In addition, the Broad Form adds one more exclusion, designated the Earth Movement Exclusion, excluding coverage for losses caused by, contributed to or aggravated by any earth movement. Types of earth movement specifically mentioned in the exclusion include earthquake, volcanic eruption, landslide, mudflow, earth sinking, rising, or shifting.

Broad Form Deductible

The $50 deductible of the Broad Form operates in essentially the same manner as that of the Basic Form. It applies to all losses except those under Rental Value and Additional Living Expense; and when two or more dwellings are insured under the form, the deductible applies separately to each dwelling and its contents. As in the case of the Basic Form, the deductible of the Broad Form may be modified so it applies only to losses by windstorm and hail.

THE DWELLING BUILDING(S) AND CONTENTS SPECIAL FORM

The next step up in terms of coverage on dwellings under the Standard Fire Policy is the Dwelling Building(s) and Contents Special Form, DF-3. The eligibility requirements of the Special Form are the same as those for the Broad Form: it may be written only on dwellings valued at $8,000 or more.

The principal difference between the Special Form and the Broad Form is the coverage on the Dwelling. Contents are covered under the Special form against the same broad named perils as is contents under the Broad Form. However, under the Special Form, coverage on the dwelling, appurtenant structures, rental value and additional living expense is on an "All Risk" basis, with coverage provided against all physical loss from any cause, except those causes that are specifically excluded. Otherwise, the coverage under Form 3 is exactly the same as under Form 2—the Supplementary Coverages, the perils for which contents is insured, the definitions of property insured—are all identical under both forms. Since the coverage on contents is identical under the Broad Form and the Special form, it is unnecessary to discuss the provisions of the Special form relating to the contents coverage. The following brief discussion of the all risk coverage on Coverage A, B, D, and E should suffice to illustrate the nature of the all risk coverage provided.

Dwellings, Appurtenant Structures, Rental Value and Additional Living Expense

The insuring agreement of the Special Form with respect to Coverages, A, B, D, and E is simple and straightforward:

> This policy insures under Coverage A and Coverage B against all risks of physical loss to the property covered (and under Coverage D and Coverage E resulting from such loss) except as otherwise excluded or limited.

It is important to keep in mind the distinction between the "Named Peril" type of insuring agreement and the "All Risk" form of coverage. The Standard Fire Policy, Form DF-1, and Form DF-2 are all written on a Named Peril basis: a loss is not covered under the policy unless the occurrence falls within the definition of a peril insured against. Under the Special Form's all risk insuring agreement which applies to coverages, A, B, D, and E, a loss is covered unless it is specifically excluded.

The number of exclusions required in an all risk form is extensive, for all uninsurable perils must be excluded. As a result, the exclusions of the Special Form are one of the most important parts of the contract. In addition to the exclusions relating to War, Nuclear damage, Water, Power Failure, and Building Code provisions, which were discussed in connection with the Basic Form, and which appear in all of the dwelling forms. The Special Form also includes the following exclusions which apply to all coverages:

> Earthquake
>
> Freezing of pipes when the building is vacant or unoccupied for over four days
>
> to fences, pavements, patios, swimming pools and certain other similar structures caused by freezing, thawing, or pressure or weight of ice, snow or sleet, theft of any property that is not an integral part of a building, or theft from a dwelling in the process of construction
>
> Vandalism or malicious mischief, glass breakage, or theft if the building has been vacant for over 30 days.

The following additional exclusions apply to Coverages A, B, D, and E only.

> Wear and tear
>
> Deterioration
>
> Rust, mold, wet or dry rot
>
> Contamination
>
> Smog
>
> Smoke from industrial or agricultural operations
>
> Mechanical breakdown
>
> Settling, cracking, shrinkage, bulging or expansion of pavements, patios, foundations, walls, roof, floor or ceiling
>
> Damage by birds, insects, vermin, or domestic animals

Anything that is not excluded under the all risk insuring agreement is covered. For example, note that there is no exclusion of theft. If fixtures constituting a part of the house were stolen, there would be coverage.

The Special Form includes all of the extensions and provisions of the Broad Form, including the replacement cost extension and the extension of coverage to trees, shrubs, plants, and lawns.

THE HOUSEHOLD AND PERSONAL PROPERTY FORM

The Household and Personal Property Form, designated DF-4, is intended for use by tenants, and provides coverage on contents only. Basically, the coverage follows that of the Dwelling Building(s) and Contents Basic form, DF-1, but omits those items relating to the dwelling and appurtenant structures. Only one coverage is included in the form, Coverage C, which defines the household and personal property in exactly the same terms as does Form DF-1. In addition, the property is insured against the same perils as provided under Form DF-1: fire, lightning, removal and inherent explosion. When the appropriate additional premiums are paid, the form is extended to include the coverage of the extended coverage perils and vandalism and malicious mischief.

There are only two extensions of coverage included under the Supplementary Coverages section of the form: the "Away from Premises" coverage, and the coverage on Improvements, Alterations and Additions. Each provides up to 10% of the amount of insurance on contents to cover the loss as defined in the form, but neither provides additional insurance. If the insured desires additional coverage on Improvements, Alterations and Additions, specific coverage may be added.

It should be noted that this form does not provide either rental value or additional living expense coverage. However, it does provide for automatic transfer of the insurance when the property insured is moved to a new residence within the same state. It also provides the same Debris Removal coverage and the Consequential Damage coverage afforded under the Basic Dwelling Form. The conditions, exclusions, and deductible are also similar to those of form DF-1.

THE HOMEOWNERS POLICIES

One of the most significant results of the removal of the legal barriers that impeded multiple line development was the introduction of the package policy. The outstanding example of the success of the package policy approach is the Homeowners program. The Homeowners policies, which combine insurance on the property of the insured with personal liability insurance, are the most widely sold and by far the best known of the package policies.

The Homeowners program was developed in 1958 by the Multi Peril Insurance Conference, an advisory and rating organization. The program was revised slightly in 1962 and then more extensively in November of 1968.

There are six standard Homeowners forms, designated HO-1, HO-2, HO-3, HO-4, HO-5 and HO-6. Four of these forms are designated for those individuals who own their own homes (Forms 1, 2, 3 and 5), one (Form 4) is designed for tenants, and one (Form 6) is designed for condominium unit owners. Each of the six forms is composed of two sections: Section I, which provides coverage on the insured's own property, and Section II, which provides liability insurance. The main distinctions between the various forms are in the Section I coverages (i.e., the coverage on the insured's own property). Section II of the forms are identical. Here we are concerned only with the Section I coverages.[5] In addition to the standard Homeowners forms (HO-1 through HO-6), there is a Modified Homeowners form (Form HO-8) designed for certain property owners who are not eligible for one of the standard forms.

The basic philosophy of the Homeowners program is to require some minimum amount of coverage on both the dwelling and its contents. Under Section I of each of the forms there are certain minimum amounts of coverage provided under four coverage items which are designated Coverages A, B, C, and D.

Coverage A provides coverage on the dwelling. A minimum of $8,000 is required on the dwelling under Forms 1, 2, and 3.
Form 5 requires a minimum of $15,000 on the dwelling. Forms 4 and 6 do not cover the dwelling.

Coverage B provides a specific amount of insurance equal to 10% of the amount on the dwelling to cover the garage and other appurtenant private structures on the premises.

[5]The Section II coverage will be treated later.

Coverage C provides a specific amount of insurance to cover the contents. Under Forms 4 and 6 the minimum coverage on contents is $4,000. Under the other forms it is 50% of the amount on the dwelling.

Coverage D provides a specific amount of insurance to cover additional living expense and loss of rental, similar to the additional living expense extension under the separate dwelling and contents forms. The amount of this coverage is 10% of the amount on the dwelling under Form 1, and 20% of the amount on the dwelling under Forms, 2, 3, and 5. The limit on Coverage D under Form 4 is 20% of the amounts on the contents, and under Form 6, it is 40%.

Coverages E and F, which constitute Section II of the policy, are Liability and Medical Payments coverages.

In a sense, each of the forms is comparable to one of the dwelling and contents forms that have just been examined. Homeowners Form 1 is the approximate equivalent of Dwelling Form DF-1, but with the additional perils of glass breakage and theft added. Homeowners Form 2 and Homeowners Form 3 parallel dwelling forms DF-2 and DF-3, but with the additional peril of theft. Forms 4 and 6 provide the same broad form perils as Form 2 on the contents only. Form 5 is a luxury type contract, which provides "all risk coverage" on both the dwelling and the contents. It is the equivalent of the Dwelling Building(s) and Contents Special Form on buildings, with a Personal Property Floater covering contents.[6] Form 6 covers the same named perils on contents as Form 4, and includes special provisions relating to the condominium exposure which will be discussed later.

For the convenience of the reader, the coverages of each of the six Homeowners forms, the minimum amounts of coverage, and the perils covered under each form are summarized in the table on the following page.

[6]There are rather strict eligibility requirements for the Homowners. Homeowners Forms 1, 2, 3, and 5 may be written only for the owner occupant of a dwelling which is used exclusively for private residential purposes (although the rules permit incidental office or professional occupancy), and which contain not more than two families and not more than two boarders or roomers per family. Homeowners Form 4 may be written for a tenant who does not own his own home, or for a homeowner who owns a dwelling which does not meet the eligibility requirements for one of the other forms. Form 6 may be written only for condominium unit owners.

Coverage	Homeowners Form 1	Homeowners Form 2	Homeowners Form 3	Homeowners Form 4	Homeowners Form 5	Homeowners Form 6
A: Dwelling	$8,000 min.	$8,000 min.	$8,000 min.	Not covered	$15,000 min.	Not covered
B: Appurtenant Structures	10% of A	10% of A	10% of A	Not covered	10% of A	Not covered
C: Contents	50% of A	50% of A	50% of A	$4,000 min.	50% of A	$4,000 min.
D: Additional Living Expense	10% of A	20% of A	20% of A	20% of C	20% of A	40% of C
	Fire Lightning Removal Windstorm Hail Explosion Riot Civil Commotion Smoke Aircraft Vehicles Vandalism Glass breakage Theft	Fire Lightning Removal Windstorm Hail Explosion Riot Civil Commotion Smoke Aircraft Vehicles Vandalism Glass breakage Theft Steam boiler explosion Falling objects Weight of ice, snow, sleet Collapse Freezing of pipes Damage to appliances artificial electricity	ALL RISK on buildings Same perils as Form 2 on contents but does not include glass breakage.	Same perils as Form 2 but does not include glass breakage.	ALL RISK on buildings. ALL RISK on contents.	Same perils as Form 2 but does not include glass breakage.

Coverage on the Dwelling and Appurtenant Structures

The dwelling coverage (designated Coverage A) of the various Homeowners forms is almost identical with equivalent dwelling forms. The definition of the dwelling includes building equipment, fixtures and outdoor equipment which pertain to the service of the premises, if the property of the insured and not otherwise covered. In addition the definition of structures includes materials and supplies located on the premises or adjacent to the premises which are intended for use in construction, alteration or repair of the dwelling.

As in the case of the separate dwelling forms, the appurtenant structures coverage (Coverage B) excludes any buildings which are used for business purposes or which are rented to anyone except a tenant. Again an exception is made in the case of rental of a garage to be used exclusively for garage purposes.

Replacement Cost Coverage. The coverage on the dwelling and the appurtenant private structures may be written on a replacement cost basis under all of the Homeowners forms. Each of the forms which includes coverage on buildings contains a condition which is quite similar to the replacement cost extension of the Broad Form, discussed in the previous section. There are some points of difference however. The Homeowners replacement cost condition specifically excludes outdoor radio and TV antennas and aerials, carpeting, awnings, domestic appliances and outdoor equipment.

In connection with the replacement cost condition of the Homeowners, a new endorsement called the "Inflation Guard Endorsement" was adopted in many states in 1969. Under the provisions of this endorsement the amount of insurance under the policy is automatically increased by 1 percent of the original amount every three months, for a total of 4 percent annually. The intent of the endorsement is to help the insured to meet the provisions of the replacement cost condition and protect against underinsurance which might result from inflation and increasing costs of construction. The increase applies not only to the building but also to the other items of coverage as well.

The Contents Coverage

The insured is permitted little choice with regard to

the minimum amount of coverage which he may purchase on contents. The basic amount of contents coverage under the Homeowners Forms 1, 2, 3, and 5 is 50 percent of the amount of coverage on the dwelling. Thus for a homeowner with the minimum $8,000 coverage on the dwelling, the automatic amount of contents coverage is $4,000. This amount may be decreased to 40 percent of the amount on the dwelling if the insured does not own personal property equal to 50 percent of the value of his dwelling; but it cannot be decreased below 40 percent. Under Forms 4 and 6 the minimum amount of coverge provided on the contents is $4,000. Form 5 provides 50 percent of the amount of coverage on the dwelling on contents; and since the minimum on the dwelling under this form is $15,000, the minimum on contents is $7,500. Of course, the amount of contents coverage may be increased under any of the forms if the need exists.

The contents coverage of the Homeowners Forms is considerably more liberal than that of the separate Dwelling Building(s) and Contents Forms. Certain items of property which are excluded under the separate forms are covered under the Homeowners. The basic definition of contents provides coverage on ". . . property usual or incidental to the occupancy of the premises as a dwelling and owned or used by an insured. . ." Coverage is provided on both owned and borrowed property. For example, if the insured or a member of his family should borrow property from a friend, and that property is damaged or lost as a result of an insured peril, the Homeowners policy will cover the loss as if it had been property owned by the insured.

Classes of property specifically excluded include animals, birds, fish, motorized vehicles (except vehicles used in the maintenance of the premises and not licensed for road use), aircraft, property of roomers not related to the insured, property carried or held as samples for sale, any property which is separately described and specifically insured under the Homeowners or any other insurance and tape or wire recorders (and their tapes) which may be operated by power from the electrical system of an automobile while in such an automobile. In addition, business personal property is excluded while away from the described premises.

Most of these excluded classes are self explanatory, but three may require explanation. First, the exclusion of motorized vehicles excludes not only automobiles, motorcycles, motorscooters, and the like, but also go-carts, golf carts, and snowmobiles. The exception to the exclusion of vehicles used in the maintenance of the premises affords coverage for vehicles such as riding lawn mowers or garden tractors, as long as they are not licensed.

The exclusion of property which is specifically described and insured is of special importance. The coverage for personal property is entitled "Unscheduled Personal Property" and is intended to provide coverage on the insured's personal effects on a blanket basis, insuring all items except those that are specifically excluded. In addition, the insured may desire to insure some items of high value specifically by listing them individually in a separate contract. Examples of items that may be specifically scheduled include boats, furs, and jewelry. The Homeowners Form states that if property is insured under another contract, or if it is listed as a specific item in a schedule under the Homeowners, the blanket personal property coverage provided under "Unscheduled Personal Property" will not apply to that item at all.

Theft of automobile tape players and tapes for use with such players has long been a source of difficulty for insurers. The difficulty arises not only because such players and their tapes are a source of frequent loss, but also because of the question of which policy should cover these items, the Homeowners policy or the auto policy. The current edition of the Homeowners forms specifically excludes from coverage:

> any device or instrument for the recording, reproduction or recording and reproduction of sound which may be operated from the electrical system of a motor vehicle, or any tape, wire, record disc or other medium for use with any such device or instrument while any of said property is in or upon a motor vehicle.

A careful analysis of this exclusion indicates that the critical point in coverage on such recorders or players revolves around the power source. If the tape player **may** be operated by the electrical system of the motor vehicle, coverage is excluded. In other words, the exclusion would apply not only to built-in players and their tapes, but also to portable players and their tapes, if such portable players can be plugged into the cigarette lighter or otherwise operated from the automobile's electrical system. Note that the exclusion applies not only to the player itself, but also to the tapes or other media that are used with the player.

The exclusion of business personal property while away from the premises also deserves comment, primarily because of misinterpretation in the past. Although the Homeowners was designed primarily to provide coverage on the personal effects of the insured and the family, it does provide some coverage on business property, as long as that property is on the described premises.

Unlike the other forms that have been examined, there is no exclusion of money, bills, manuscripts or boats under the Homeowners forms. As a matter of fact, the Homeowners forms provide coverage on these items, but with a dollar maximum listed for each:

There is a $100 limit on money and bullion

There is a $500 limit on bills, deeds, and valuabe papers

There is a $1,000 limit on manuscripts

There is a $500 limit on boats and their equipment

There is a $500 limit on trailers

The coverage on money may be increased to $500 for an additional premium. The coverage on boats is not limited to rowboats and canoes under the Homeowners as it is under the separate dwelling forms, but applies to any boat and its equipment (including a trailer) up to $500. Under a special exclusion the policies provide that windstorm and hail losses to boats (other than rowboats and canoes on premises) are covered only if the boat is in a fully enclosed building.

The off premises coverage of the Homeowners forms is also somewhat broader than that of the separate dwelling forms. Under Forms 1, 2, 3, 4, and 6, the off-premises coverage is 10% of the amount on the contents or $1,000, whichever is greater. This is an additional amount of insurance and coverage applies anywhere in the world. This limit may be increased by as much as $5,000 for an additional premium if the insured has need for more coverage off-premises than the amount automatically provided. Under Form 5 the entire contents coverage applies on a world-wide basis, so there is no need for an off-premises extension.

Theft Coverage Under the Homeowners

The fact that most of the perils included in the Homeowners forms are also included in the separate dwelling forms already treated eliminates the need to discuss them in detail. However, the peril of theft is covered under only one of the separate dwelling forms (the Special Form), and since that form applies only to the dwelling item the coverage is not particularly extensive.

The major difference between the separate dwelling forms and the coverage provided under Section I of the various Homeowners forms is the theft coverage of the latter. All of the Homeowners forms include coverage for theft as an insured peril applicable to both the building and contents. Under Form 1 theft is defined as any act or attempt of stealing. Under Forms 2, 3 and 4 this definition is expanded to include "loss of property from a known place under circumstances where a probability of theft exists", a provision which is intended to reduce the burden on the insured of proving that the loss actually resulted from theft. The wording in Forms 2, 3, 4, and 6 provides coverage where there is a strong presumption of theft, but no conclusive proof. Although the theft coverage is quite broad, it is subject to a number of exclusions that should be noted. There are three sets of exclusions under Forms 1, 2, 3, 4, and 6: a set of general theft exclusions, a set of exclusions which apply if the insured rents to someone else that portion of the dwelling which he customarily occupies, and a set of exclusions which apply to property while away from the premises.

General Theft Exclusions. There are four general theft exclusions:

1. Theft committed by an insured.
2. Theft in or to a dwelling under construction or material or supplies for such a building until it is completed and occupied.
3. Theft arising out of or resulting from the theft of a credit card or forgery or alteration of a check or draft.
4. Theft of a precious or semi-precious stone from its setting.

Most of these exclusions are self explanatory. With respect to the first, if Jones Jr., hard pressed financially on the night of the Junior-Senior prom steals $20 from his father's wallet, there is no coverage. Lumber, materials, equipment and appliances in a building under construction or on the premises intended for construction are covered as insured property under the definition of the Dwelling Coverage, but this exclusion deletes the theft coverage on such materials. With respect to the theft of a precious or semi-precious stone from its setting, the intent is to eliminate controversy over whether such a missing stone was lost or stolen. The exclusion makes it immaterial, since such losses are excluded whether the loss results from theft or merely a loose setting.

The exclusion with respect to credit cards and forgery may require additional comment. The widespread use of credit cards in the American economy is a fact of life, and at one time the loss potential in connection with theft and unauthorized use of credit cards was catastrophic. However, federal legislation, effective since October of 1970, provides a maximum of $50 for a credit card holder's liability in the event of unauthorized use of the card. This limitation on losses resulting from credit cards has reduced the impact of the credit card exclusion; but in view of the fact that the limitation applies to each card, substantial losses may still result. Coverage for loss resulting from loss in connection with credit cards may be added to the Homeowners policy by endorsement. Under the Credit Card and Depositors Forgery Endorsement, the insured and members of his family are protected up to a specified limit of liability against loss in four areas: credit cards, depositors' forgery, counterfeit paper money, and court costs and attorney's fees. The credit card coverage covers loss which results from "unauthorized use of a credit card that has been lost or stolen." The depositors' forgery coverage protects against loss resulting from forgery or alteration of any check, draft, promissory note or similar written promise, drawn on the insured. The counterfeit coverage protects against loss through the acceptance of counterfeit money, with a limit of $50 for

any one transaction and a $100 aggregate.[7] The Court Costs and Attorneys' fees coverage covers the legal costs that may be imposed on the insured in defending a suit with respect to an obligation in connection with credit cards or forged checks. The cost of the credit card endorsement is nominal, and coverage limits from $1,000 up to $10,000 are available. It should be noted that regardless of the deductible provision of the Homeowners policy to which it is attached, the deductible does not apply to loss covered by the Credit Card and Depositors Forgery Endorsement.

Theft Exclusions While the Dwelling is Rented. The second set of exclusions applies only in the event that the insured rents to someone else that portion of the dwelling which he customarily occupies. Such a situation might arise if the insured were leaving town for an extended period of time. When the situation does exist, the policy excludes theft of money, bullion, numismatic property and bank notes, securities and other valuable papers, jewelry, and furs, plus theft of any other property committed by a tenant or members of his household.

Theft Exclusions Applicable to Property Away from the Premises. There are five exclusions applicable to property while away from the described premises. First, property at any location owned, rented, or occupied by an insured is not covered for theft, except while an insured is temporarily residing at that location. For example, if the insured has a summer cottage, the contents of that cottage are covered under the off-premises extension of his Homeowners; but the theft coverage does not apply except while the insured is actually residing at the cottage. This exclusion may be of particular importance to students. A dormitory, sorority, or fraternity is a location occupied by an insured, which means that the theft coverage of their parents' Homeowners policy does not cover the student's property except while the student is actually residing in that location. Obviously, there would be no coverage on property at the dormitory during the summer while the student is at home. Other situations, such as Christmas vacation, Thanksgiving, Easter, when students leave the campus may or may not result in an exclusion of theft losses. Interpretation varies from company to company, but in general we should conclude that there is probably no coverage.

The second and third off-premises theft exclusions are related, so we may discuss them together. There is no coverage for theft of property while unattended in any motor vehicle or trailer, unless there is evidence of forcible entry into the vehicle. In addition, there is no coverage for theft of property while in or on watercraft unless the loss is a result of forcible entry into a securely locked compartment. In either case, the forcible entry must be evidenced by visible marks of forcible entry.

Both of these exclusions may be deleted under Forms 2, 3, 4, and 6 through the use of the Theft Coverage Extension Endorsement which requires an additional premium. This endorsement cannot be used with Form 1, and it is not needed with Form 5 since Form 5 does not exclude theft from unlocked unattached vehicles or watercraft. The Theft Coverage Extension Endorsement simply deletes the exclusions of theft from unlocked unattended vehicles and boats.

The fourth off-premises theft exclusion excludes theft of watercraft, their furnishings, their equipment and outboard motors; and the fifth excludes trailers, whether licensed or not.

The theft coverage on Form 5 is subject to only two exclusions: theft of materials and supplies in connection with a building under construction and loss arising out of the theft of a credit card, both of which were discussed above. Since none of the other exclusions discussed above are contained in this form losses arising from such thefts would be covered.

Limitation on Jewelry and Furs Under the Theft Coverage. One of the most important provisions relating to theft coverage under all of the Homeowners Forms is a limitation on loss by theft of jewelry and furs. Recovery for loss of jewelry and furs is limited to $500 per loss, regardless of the number of items that are stolen. This makes it essential that valuable items of jewelry and furs be scheduled.

Scheduled Items — When an item is scheduled under the Homeowners forms, the insured purchases specific insurance on the item scheduled through an Inland Marine supplement to the policy. This supplement is, in effect, a separate inland marine policy with its own insuring agreement and premium. The most attractive feature of the coverage afforded to scheduled items is the fact that this coverage is on an "All Risk" basis.

The Scheduled Personal Property Endorsement is such a supplemental policy, and it is frequently attached to the Homeowners policy to protect valuable items on an all risk basis. The provisions of this endorsement are discussed in the section on inland marine coverages for the individual.

The most important consideration in connection with scheduling under the Homeowners is the amount of coverage that must be obtained when an item is scheduled; the coverage of the basic homeowners form no longer applies to that item. The Homeowners excludes property which is "separately described and specifically insured in whole or in part by this or any other insur-

[7] In addition to the limitation on the card holder's liability of $50, the federal statute also requires the issuer of the card to provide the card holder with a prestamped mailer with which to report a lost or stolen card, and to provide the legitimate user of a credit card with some means of identifying himself as such. In view of the strictness of these regulations, many authorities feel that credit card issuers will choose not to comply with the provisions of the law, thereby relieving the card holder of even the $50 liability.

ance." Some agents mistakenly schedule valuable furs or jewelry for less than the full value, expecting the basic coverage to provide a part of the protection. If the insured has a valuable ring worth $2,000, it must be scheduled for $2,000, for the contents coverage of the Homeowners policy will not apply to the ring at all after it is scheduled.

The Homeowners Deductible

All Homeowners forms contain a $100 flat loss deductible clause which applies to loss under Section I except Additional Living Expense, Rental Value, or the Fire Department Service clause.

Under forms HO-1, HO-2, HO-3, HO-4, and HO-6, this deductible may be reduced to $50 by payment of an additional premium. The deductible may also be converted to a $50 flat deductible applicable only to the perils of windstorm and hail.

Higher optional deductibles are also available. The insured may elect an optional $250 or $500 deductible. In addition, there is also an optional $250 theft deductible. Premium credits are granted for the selection of these higher deductibles.

Other Provisions

In addition to the provisions already discussed, the various Homeowners forms include all of the extensions which were discussed in connection with the Dwelling Building(s) and Contents Broad Form, including the provision for automatic transfer of contents coverage to a new residence. However, the Homeowners forms provide coverage at the new location only for 30 days, and do not restrict coverage to a new residence in the same state. The extensions in the Homeowners Forms include:

The trees, shrubs, plants and lawns extension

The replacement cost extension

The Debris Removal extension

The Improvements, alterations and additions extension (in Forms 4, 5, and 6)

In general, these extensions in the Homeowners forms parallel those in the Dwelling Building(s) and Contents Broad Form. The only new provisions from the point of view of the student are those contained in Form 6, which relate to the special exposures of a condominium owner.

Homeowners Form 6. The somewhat unique exposures of the condominium unit owner are insured under Homeowners Form 6, and the special provisions of that form require some additional comment.

Basically, a condominium is a multiple occupancy building in which individuals own single units of living space. In other words, it is something like an apartment building, but differs in that the residents each own their "apartment". It is common in the case of condominiums for the individual owners to grant the right to purchase insurance on the building to a central authority (such as a condominium association) in order to avoid difficulties that might result from nonconcurrency, rebuilding of the damaged premises, and so on, that might result if each owner attempted to insure his particular unit separately. This means that the purchase of insurance coverage on the building by the condominium association still leaves the individual owners' needs for contents coverage unsatisfied. It was to meet this need that the Homeowners Form 6 was developed.

As we have already noted, HO-6, which is designed to cover the personal property of a condominium unit owner, generally parallels the coverage of Homeowners Form 4, the Tenant's Form, but with certain additional provisions tailoring it to the needs of the condominium unit owner. These special provisions, which deal with the condominium exposure, and which make this form different from the other homeowners forms are as follows:

1. The form provides a basic limit of $1,000 to cover any alterations and additions added to the unit by the condominium unit owner. This limit may be increased for an additional premium.

2. The limit of liability for additional living expense is 40% of the amount of coverage on the contents. This limit may also be increased for an additional premium.

3. The coverage on alterations and additions, like coverage on contents, is on the same broad named peril basis as Form 4. However, for an additional premium, the coverage on alterations and additions may be changed to an all risk basis. When this option is selected, the coverage on alterations and additions is modified to essentially the same coverage as that provided on the dwelling under Homeowners Form 3.

4. Special provision is made for those situations in which the condominium unit is rented by the owner to someone else. In such instances, the premium is surcharged 25%, and an amendatory endorsement provides three changes in the coverage:

(a) rental value coverage is added to the additional living expense insuring agreement, providing coverage for loss of rents in the event of untenantability caused by an insured peril.

(b) the definition of "personal property" is amended to provide coverage on rented property. (The basic form covers personal property only if "occasionally, rented to others)

(c) coverage is provided for theft of personal property by a tenant, an exposure that is excluded under the basic form without the endorsement.

5. Coverage may also be provided by endorsement on Appurtenant structures which are owned solely by the insured and located on the premises. This would provide for optional coverage in the case where the insured might own a tool shed or a garage on the premises in

which the condominium association does not have an interest.

6. Coverage is also available on an optional basis to cover assessments against the insured made by the condominium association against unit owners in cases where damage to the condominium building is not covered by insurance. Coverage is available in amounts from $1,000 up to $50,000. The coverage is subject to a $250 deductible. A special limit of liability under this coverage limits the insured's liability to $1,000 when the assessment results from a deductible under the property insurance on the building carried by the condominium association.

Homeowners Form 8

The Homeowners forms were originally conceived as a program for superior exposures in the dwelling field. The discount offered for packaging of coverages contemplates high insurance to value and reduction of adverse selection by the fixed relationships among the property coverages. While this concept has operated satisfactorily in most instances, there have always been some insureds who, for one reason or another, were not able to obtain coverage under the Homeowners package. One major class of insurance buyers who could not obtain coverage under the homeowners forms consisted of owners of certain types of older property. Some dwellings, for example, were built many years ago, when labor intensive techniques characterized the home-building industry. These dwellings often involve obsolete types of construction, or are too large in relation to the insured's needs. In virtually all instances, the replacement cost of such structures far exceeds their market value. It is not unusual for an older obsolete dwelling to have a replacement cost of $100,000 or $200,000, while the market value is $40,000 or $50,000. Owners of such property often do not see any sense in insuring the building for twice its purchase price. In addition, many insurers are reluctant to provide replacement cost coverage on such buildings. This meant that the owners of such property had no alternative but to secure coverage under individual monoline policies, purchasing a fire policy with one of the dwelling forms attached, a separate Comprehensive Personal Liability Policy, and perhaps some form of personal theft coverage.

In order to meet this dilemma, the Insurance Services Office introduced a new Homeowners form in 1978, the Homeowners Modified Coverage Form 8. In most respects, the coverage of Form 8 is similar to that of Form HO-1, but there are several important limitations. The two most important differences between Form 8 and the other Homeowners forms are the following:

1. There is no replacement cost provision in Form 8, and the insured is not required to purchase coverage equal to 80% of the replacement cost value of the dwelling. The insurance is on an actual cash value basis.
2. Theft coverage applies on premises only, and is limited to $1,000 per occurrence. A $250 deductible applies to theft losses.

Although the coverage of Form 8 is more limited than that of the other homeowners forms, the introduction of this form has made package buying available to a wide range of personal insurance buyers that previously were forced to purchase individual packages. In spite of the limitations of the form, the Homeowners Form 8 represents a more attractive alternative than the separate contracts that would otherwise be required to provide the same coverage.

MISCELLANEOUS FORMS OF PROPERTY INSURANCE FOR PERSONAL RISKS

Although the Homeowners forms provide broad protection against loss for those individuals who are eligible for these policies, there are certain additional forms of protection available to individuals which should be discussed. These include the inland marine coverages designed for the individual, insurance coverage for mobile homes, and the federal flood insurance program as it relates to the residential exposure.

INDIVIDUAL PERSONAL THEFT POLICIES

Individual personal theft policies have been replaced, for the most part, by the Homeowners forms. However, there are still individual theft policies available for the individual who desires to purchase theft coverage on his personal property and for some reason or another cannot qualify for a homeowners policy.

There are two important personal theft policies available from private insurance companies for the individual: The Personal Theft Policy (Limited Form) and the Broad Form Personal Theft Policy. The major distinction between the Broad Form and the Limited Form is that neither mysterious disappearance nor theft from an unlocked unattended vehicle is covered under the Limited Form, while both are covered under the Broad Form. In addition, the Broad Form Policy provides for separate amounts of coverage on premises and off premises, while the Limited Form has a single limit that applies both on and off premises.

INLAND MARINE COVERAGES FOR THE INDIVIDUAL

Scheduled Personal Property Endorsement Coverages

Although the Homeowners Forms do a reasonably adequate job of insuring the personal property of the average individual, in some cases it may be desirable to insure specifically certain items of personal property under Inland Marine Forms. Obvious examples would include items of property that are specifically excluded under the Homeowners, such as automobiles and recreational motor vehicles or items on which the coverage afforded under the Homeowners policy is limited. For example, coverage on boats and trailers is limited to $500, and the theft peril does not apply away from the premises. Theft coverage on jewelry and furs under the Homeowners is limited to $500 per loss. Perhaps not so obvious is the need for broader coverage on certain classes of property than that afforded under the named peril coverage of the Homeowners or for valued coverage in the case of fine arts or antiques.

Coverage on such property is provided under Inland Marine Forms purchased either as a separate contract or by endorsement to the Homeowners. The Homeowners "Scheduled Personal Property Endorsement," which may be attached to the Homeowners policy, provides all risk coverage on nine classes of property under the same terms as if separate contracts were purchased for each type of property[8]. Regardless of whether the coverage is purchased as a separate floater policy or by endorsement to the Homeowners, it is extremely broad and provides an attractive means of insuring valuable types of personal property. We shall not attempt to discuss all the personal floater policies available but shall limit our discussion primarily to those coverages which may be included in the Homeowners "Scheduled Personal Property Endorsement."

Personal Furs Floater

The Fur Floater policy was one of the earliest of the all-risk personal contracts. The extreme broadness of this policy and its equivalent coverage afforded under the Scheduled Personal Property Endorsement, is attested to by the fact that there are only three exclusions. The first excludes loss caused by wear and tear, gradual deterioration, insects, vermin, or inherent vice; the second excludes loss by nuclear radiation or radioactive contamination; and the last excludes war. The garment must be a fur garment; i.e., it must be the dressed pelt of some animal and not a man-made fabric, or it must be a garment trimmed with fur. Each item must be scheduled and an amount of insurance applicable to each. The insurance company generally will require an appraisal of each item before it can be insured; however, the sales slip on a recently purchased item is sufficient to establish a value. The coverage is on a world-wide basis.

Personal Jewelry Floater

Personal jewelry also may be scheduled under the Homeowners providing the same coverage as is available under a separate Jewlery Floater. The Personal Jewelry policy is also an all-risks contract. Each item must be scheduled with an amount of insurance applicable to each, and the indemnity may be on a valued or an actual cash value basis. Here again, an appraisal is mandatory, or at least some verification of the cost price must be established. In addition to the normal exclusions, this contract has a "pairs and sets" clause which is an important condition. This clause prevents the assured from collecting for a total loss if one item in a pair or set is lost or destroyed. The loss payable then becomes a fair proportion of the total value of the set, giving consideration to the importance of the article or articles. This coverage is also world-wide.

[8]Jewelry, furs, cameras, musical instruments, silverware, golfers' equipment, fine arts (including antiques), stamp collections, and coin collections.

Silverware Floater

Another class of property which may be insured under the Homeowners Scheduled Personal Property Endorsement or under a separate Inland Marine Floater is silverware. Coverage is provided on valuable silverware, silverplated ware, and the like. The coverage is essentially the same as that provided for jewelry as described above.

Golfer's Equipment

Golfer's equipment may also be insured under a separate policy, or it may be covered under the Homeowners Scheduled Personal Property Endorsement. Either form provides coverage for golfing equipment, including clubs, golf clothing (but excluding watches and jewelry), and other clothing which is contained in a locker in a club or other building used in connection with the game of golf. The description of eligible property is quite broad and could even inlcude a motor drive golf cart. The coverage is on an all-risk basis for most items of property and most generally is written on a blanket basis. However, the coverage for golf balls is definitely not all-risk but is limited to the perils of fire and burglary.

Camera Floater

Cameras and all the appropriate equipment used therewith such as projection machines, moveable sound equipment, films, binoculars, telescopes, and the like may be insured on an all-risks basis under the Camera Floater or the Homeowners endorsement. As usual, the various items are scheduled and a blanket item may be included to provide coverage for miscellaneous articles such as sunshades, filters, etc. Additionally acquired property is insured automatically but subject to a limitation of 25 percent of the amount of insurance or $10,000, whichever is less, and with the requirement that the acquisitions be reported within thirty days and the additional premium paid. The only exclusions are those of the wear and tear variety, war, and radioactive contamination.

Fine Arts and Antiques

A Fine Arts Floater is written to cover objects of art such as paintings, statuary, rare manuscripts and antiques.

The coverage is all-risks with the usual exceptions. It is customary to issue the policy on a valued rather than an actual cash value basis. Since this means that the insurance company agrees to the value of each item insured and that this is the value paid in the event of a loss, the greatest care must be used in determining these values. Appraisals normally are mandatory, and some insurance companies even have art appraisers who advise them on the values. Each insured item is scheduled with an amount of insurance automatically but subject to a percentage limitation relative to the aggregate amount of the schedule. However, reports of additional items must be made within ninety days and the proper pro rata additional premium paid.

Stamp and Coin Collection Floater

A stamp and coin collection may be an extremely valuable item of property. The appropriate all-risk coverage is provided in the stamp and coin collection floater or the Homeowners schedule endorsement.

The property eligible involves postage stamps including due, envelope, official, revenue, match and medicine, covers, locals, reprints, essays, proofs and other philatelic property owned by or in the custody or control of the assured, including the books, pages, and/or mountings. The eligible coins include rare and current coins, medals, paper money, bank notes, tokens of money, and other numismatic property owned by or in the custody or control of the assured, including coin albums, containers, frames, cards, and display cabinets in use with such collection. The property in both cases may be insured on a schedule or on a blanket basis. There is no automatic coverages of newly acquired property. In addition to the customary exclusions, there are several unique to this contract. For example, damage resulting from fading, creasing, denting, scratching, tearing, thinning, transfer of colors, or damage arising while the property is being worked upon is excluded. The policy also excludes mysterious disappearance of individual stamps unless the item has been specifically scheduled or unless mounted in a volume and the page to which the stamp is attached is also lost. Loss by theft from an unattended automobile is also excluded except while being shipped by registered mail. The policy also contains a limit of no more than $250 on any one stamp or any one pair, block, or series, and $1,000 on unscheduled numismatic property.

Musical Instruments Floater

The owner of expensive musical instruments needs the broad type of coverage that can be provided under an inland marine contract. Musical instruments may be scheduled under the Homeowners Scheduled Personal Property Endorsement or insured under a separate contract, either approach providing all risk coverage. The only unusual condition in this coverage involves an agreement on the part of the insured that none of the instruments insured will be played for remuneration during the term of the policy unless permitted by endorsement and the payment of an additional premium. Loss experience indicates that the loss experience of professional musicians is worse than that of individuals who are not engaged in performing for hire. The intent of this condition is to separate the two classes for rating purposes.

Other Floater Policies

In addition to those classes of property discussed above, thre are other classes for which the individual may desire the broad coverage of an inland marine form. For example, the owner of valuable gun collection might desire such coverage, or an avid fisherman with a

large investment in his equipment would both be interested in such coverage. A very specialized exposure may exist in connection with newlyweds who have accumulated valuable gifts. Floater coverages are available to cover each of these classes. Separate gun floaters and fishing tackle floaters, or sporting good floaters are available. In addition, the Wedding Present Floater provides coverage on presents during the temporary period in which they are accumulated before the bride and husband became permanently settled.

The Personal Property Floater

As we have seen, named perils coverage is available for tenants under the Homeowners Form 4. In some instances, however, the individual who does not own his own home may desire all risk coverage on all of his personal property rather than only on the classes of property which can be scheduled. The Personal Property Floater is designed to provide such all risk coverage. It covers all personal property owned, used, or worn by the insured. Under certain circumstances, it is also extended to cover the property of guests on the premises of the insured. In addition, it may even provide some coverage on real property. It may be written to cover unscheduled property only, or it may be written to cover both unscheduled and scheduled property. The scheduled property consists of those items of property that are specifically described and insured for a specific amount (such as a diamond ring or a valuable fur). The unscheduled property, on the other hand, includes everything else that the insured owns except those things specifically excluded from the coverage and real property.

There is some coverage provided for real property. The policy covers **any** property owned by the insured and not specifically excluded against loss by theft or attempted theft. Thus, loss by theft or damage by attempted theft to trees, shrubbery, or fixtures attached to the building would be covered. Damage caused by burglars or thieves to the building would also be covered.

The insuring agreement provides coverage against:

> "All risk of loss of or damage to property covered, except as hereinafter provided . . ."

This is a perfect example of an all-risk insuring agreement. The policy provides for a single amount of insurance to cover all of the insured's unscheduled personal property, subject to three important limitations:

1. There is a limit of 10% of the amount of insurance applicable to unscheduled personal property on property located at a secondary residence of the insured.
2. The maximum collectible for any loss of jewelry or furs is $250 (Note that this is for any loss and not for any item. The intent is to require the insured to schedule valuable items.)
3. There is a limit of $100 for loss of money including coin collections. There is a $500 limit of liability on accounts, bills, deeds, evidences of debt, and other valuable papers.

Since this is an all risk form, the most important provisions in the contract are the exclusions. The following are the more noteworthy exclusions in the contract.

Breakage of fragile articles — there is no coverage for breakage of fragile articles unless such breakage results from fire, windstorm, explosion, falling aircraft, riot, earthquake, collapse of buildings, flood, accident to conveyances, theft, attempted theft, or vandalism and malicious mischief.

Damage due to Processing — There is no coverage for loss which results from work on property in the course of refinishing, renovating, or repairing the property. (This exclusion does **not** apply to jewelry or furs).

Wear and Tear, Mechanical Breakdown are excluded.

Damage caused by Insects and Vermin is excluded.

Damage caused by atmosphere or extremes of temperature — excluded.

Flood or underground water seepage — are excluded, but damage to fragile articles caused by flood may be covered.

Damage by Pets — excludes damage caused by animals or pets owned by or kept by the insured or a resident employee of the insured.

Property on Exhibition — excluded unless the premises are described in the policy.

In addition to the exclusions, the policy is always written with a deductible, which may vary in amount from $15 to $50. The deductible is considered necessary because of the extreme broadness of the coverage.

The Personal Property Floater is a luxury contract, and is used primarily for wealthy individuals who desire the ultimate in protection and who do not own their own homes. If the individual does own his own home, the Homeowners Form 5 will provide the same all risk coverage on the contents as does the Personal Property Floater, plus all risk coverage on the dwelling.

Insurance for Boats

Since there are 40 million people who engage in the sport of boating, the question of insurance coverage on boats is of some importance. As we have seen, the Homeowners policy provides coverage up to $500 on boats and their equipment, but excludes coverage for loss of theft away from the premises. Because of the dollar limitation, and to a lesser degree because of the theft exclusion, it may be necessary for boat owners to purchase specific insurance on boats. Although the policies marketed to insure boats are not standard

forms, in general they may be subdivided into two classes: Yacht Insurance policies, which are designed for sailing vessels and inboards, and Outboard Motorboat policies. The basic distinction between the two has become somewhat clouded; but yacht policies are considered to be ocean marine coverages, while the Outboard Motorboat policies are considered to be inland marine. Our discussion here will focus primarily on the outboard motorboat program.

Under the most popular outboard motorboat program, the physical damage coverage provides all-risk protection on the hull, the motor or motors, the trailer, and the boat's equipment. The contract is written on an actual cash value basis, usually with a deductible. Even the deductibles are not standards, but range upward from $25. Since the coverage is on an actual cash value basis, it may be necessary to adjust the coverage downward as the boat ages. Market value is a reasonable approximation of the actual cash value in the case of boats and motors.

When the coverage is not all-risk, it is usually issued on a broad named perils basis. At one time, a very limited form was also used (which covered against fire and lightning, collision or overturn during transportation, windstorm on land, and theft of the entire boat or motor). This limited form has virtually disappeared. The broad named perils form adds "perils of the sea" to those listed above for the limited form. The "perils of the sea" include high winds, flood, collision with another vessel, striking of submerged objects, and sinking which results from one of the covered perils.

THE MOBILEHOME POLICY PROGRAM

It has been estimated that one half of the new homes being sold today are mobilehomes. Furthermore, in the class of homes sold at $15,000 or less, fully 95% are mobile homes. In view of the increasing popularity of this type of dwelling, it is not surprising that a special program has been developed to meet the special insurance needs of mobilehome owners.

The Mobilehome Policy Program was designed to provide, in a single insurance package, coverage for the basic exposures of the owner-occupant of a mobilehome, similar to that provided under the Homeowners program. The program consists of a single form, but with optional endorsements available to adapt the policy to the needs of the individual insured.

Eligiblity under the program is restricted to mobilehomes that are at least 10 feet wide and 40 feet long, and that have a minimum price when new of $4,000. These requirements are imposed to eliminate from eligiblity the small trailers of a "camper type" that may be pulled by private passenger automobiles. Such trailers are insured under the auto policy. In order to be eligible for coverage under the Mobilehome policy, the unit must be a trailer — that is, it must be a portable unit, designed and built to be towed on its own chasis, comprised of a frame and wheels, and must be designed for year-around living.

Policy Format

Like the Homeowners policy form which the Mobilehome program was copied, the policy consists of a policy jacket, declarations page, and a form. While the Homeowners program offers the insured a selection of several forms with differing coverage from which to choose, the Mobilehome program offers only one form, designated MP-1, which is roughly the equivalent of the Homeowners Broad Form HO-2. The form follows the Homeowners system of providing coverage on the insured's property under Section I, with Comprehensive Personal Liability coverage afforded under Section II.

Section I Coverages

The Mobilehome policy with form MP-1 attached provides coverage on the insured's property under four coverages, three of which are mandatory.

Coverage A. Mobilehome Coverage. Coverage A, the Mobilehome coverage, applies to the basic structure and includes all equipment, accessories, appliances and furniture originally built in or furnished by the dealer at the time of purchase. Coverage is on an "actual cash value" basis, and there is no provision for replacement cost coverage. The most important point to be noted is that furniture, equipment, and appliances need not be built in to be covered under the Mobilhome item of coverage. Manufacturers of mobilehomes usually sell the units equipped with furniture, and such furniture is included in the coverage on the mobilehome itself. The only requirement is that the items must have been furnished by the manufacturer or dealer at the time of sale. Replacements for original equipment are also covered under Coverage A. On the other hand, awnings, shelters, porches, and other additions, waterpumps, and airconditioners which were not part of the original equipment are not insured under Coverage A, even though they may be permanently attached. Such items must be insured under Coverage C, discussed below.

Coverage B. Unscheduled Personal Property. Unscheduled personal property is insured under Coverage B for a minimum of $2,000, and this limit may be increased. The definition of personal property is very similar to that of the Homeowners forms, but there are differences. The contents coverage applies to property usual and incidental to the occupancy of the unit as a dwelling, which is "owned or used by an insured". As is the case with the Homeowners forms, coverage applies at the option of the insured to the property of others on the premises. A few of the more noteworthy differences between the contents coverage of the Homeowners forms and that of the Mobilehome policy are the following:

1. Personal property away from the premises is covered up to 10% of the limit for Coverage B, but

the minimum under the Mobilehome policy is $300.

2. Boats and trailers, which are covered under the Homeowners subject to a $500 maximum are completely excluded under the Mobilehome policy.
3. Business Personal Property, which is excluded while away from the premises under the Homeowners policy, is excluded both on and off premises under the Mobilehome policy.
4. The Homeowners policy excludes motorized vehicles. The Mobilehome policy also excludes motorized vehicles, but adds an additional exclusion of equipment and accessories of motorized vehicles.
5. There is a $500 limit for loss of silverware by theft under the Mobilehome policy. The Homeowners policy contains no such limitation.

Coverage C. Additions to Mobile Home. Coverage C, which provides coverage on additions to the mobilehome which were not original equipment (such as awnings, shelters, carpets, waterpumps and airconditioners) is an optional coverage. Coverage applies only to those items listed on the declarations page of the policy for which a premium charge has been made.

Coverage D. Additional Living Expense. The Additional Living Expense Coverage of the Mobilehome policy, designated Coverage D, is considerably more limited under the Mobilehome policy than is the same coverage under the Homeowners policy. The Mobilehome policy provides for payment of additional living expenses up to $15 a day when the mobilehome is rendered untenantable by an insured peril, for up to 45 days. Coverage applies until the mobilehome is repaired or replaced, or until the insured's family becomes settled in permanent quarters. Manual rules provide that the $15 day limit may be increased to $20, $25, or $30 a day for an additional premium.

Perils Insured Against.

As previously noted, the Mobilehome form generally follows the pattern of the Homeowners Broad Form (HO-2), however, there are certain exceptions. The two most important differences involve the vehicle damage peril and theft of tires and wheels.

With respect to the first, the Mobilehome form excludes all damage caused by an owned vehicle. In this sense, it follows the coverage of Homeowners Form 1, which also excludes damage caused by owned vehicles. In addition, the Mobilehome form adds an exclusion for theft of tires and wheels unless they are attached to the trailer or unless they are within a fully enclosed building.

Optional Coverages

There are numerous optional coverages available under the Mobilehome policy, including Credit Card and Depositors Forgery Coverage, Extended Theft Coverage, Earthquake Coverage, and Scheduled Coverage on valuable items. All of these coverages have been discussed previously in connection with the Homeowners forms. In addition, the Mobilehome policy includes two additional options pertinent to the exposures of a mobilehome.

Collison Coverage. A special Collision Endorsement may be used to provide collision coverage on the mobilehome while it is in transit, subject to a deductible. The standard collision deductible is $100, but higher options may be elected. The endorsement provides coverage for damage to the mobilehome by collision of the mobilehome with another object and upset of the mobilehome while in transit. The coverage of the endorsement applies for 30 days, and the premium for the endorsement is fully earned upon attachment of the coverage.

Vendor's Single Interest Coverage. When the Mobilehome is financed by a dealer on a time payment basis or when there is a lienholder interested in the unit, special coverage protecting the interest of such parties may be provided under the Vendor's Single Interest Endorsement (MP-85). This endorsement, which insures the interest of the vendor or lienholder only, provides protection against loss resulting from collision, conversion, embezzlement, or secretion of the Mobilehome by the insured.

THE NATIONAL FLOOD INSURANCE PROGRAM

Thousands of property owners in coastal and inland communities are faced with the threat of losses from destructive and possibly devastating floods each year. Hundreds of millions of dollars worth of property losses are suffered annually. While flood insurance coverage on fixed location property was virtually non-existent for many years, it is now available in eligible communities in the form a federally subsidized insurance under the National Flood Insurance Program, which is administered by the Federal Insurance Administration of the U.S. Department of Housing and Urban Development (HUD). The program was conducted as a partnership between the federal government and the private insurance industry from 1969 until December of 1977, at which time the federal government eliminated the private insurers participation. Up until December of 1977, the private insurance industry participated in the program through an association of insurers, called the National Flood Insurance Association (NFIA).

Background

The National Flood Insurance Program was established under the National Flood Insurance Act of 1968, to make limited amounts of flood insurance available to property owners at federally subsidized rates. Under this original or "Regular" program, HUD was required to establish actuarial rates for flood insurance in each community, based on a study of the probability of losses conducted by the U.S. Corps of Engineers. Originally, a community could not become eligible for flood

insurance until this rate-making study had been completed. However, because of the time required to conduct these actuarial studies, progress in implementing the program was so slow that only eight areas qualified under the program during its first year of operation. This slow progress led Congress to amend the Act in 1969, creating an "Emergency Program", under which the NFIA and HUD were given permission to provide flood insurance in communities prior to the time that the rate-making studies were completed.

In addition to this expansion of the original concept, the scope of the program has also been expanded considerably since its inception. The program was originally intended only for residential properties, but the 1969 amendment expanded eligibility to include small businesses. In March of 1972, the definition of eligible property was again expanded, this time to include virtually all types of residential, commercial, industrial, agricultural, and institutional properties. In addition, the definition of "flood" has been expanded to include mudslide.

A second flood insurance law, the Flood Disaster Protection Act of 1973 was enacted in December of 1973. This most recent act increased the amount of flood insurance available to each property owner, amended several provisions of the earlier law relating to eligibility, and made flood insurance a requirement for certain types of federal financing in flood prone areas. These current provisions of the program are discussed below.

How the Program Works

Although the flood insurance program is directed by the Federal Insurance Administrator of the U.S. Department of Housing and Urban Development, a Texas computer and Management firm, Electronic Data Systems, acts as the fiscal agent for the program. However, the government itself is the risk-bearer. Residents in eligible communities can purchase flood insurance through licensed property and liability insurance agents or brokers in the state.

Eligible Communities

Cities, counties, or other governmental units seeking approval for the sale of flood insurance must take the initiative and submit an official statement to HUD indicating a need for the insurance and a desire to participate in the program. In order to become eligible for the insurance, the community must agree to adopt certain land-use and flood control measures, including zoning ordinances that prohibit new construction in areas where there is more than a 1% chance of serious flooding each year.

Once the community has agreed to adopt the specified controls, it becomes eligible for the "Emergency Program" . Under this program, coverage is available, at subsidized rates, for up to $35,000 on single family dwellings and up to $100,000 on other eligible structures, and up to $10,000 on residential contents and $100,000 on nonresidential contents.

When the community actually implements the controls, it becomes eligible for the "Regular Program". Under the Regular program, a property owner may purchase additional amounts of coverage, but on an unsubsidized basis. The amount of unsubsidized coverage available under the program has been increased several times, most recently in 1977. Prior to the most recent increase, unsubsidized coverage was available in an amount equal to the subsidized coverage. Under the new provisions, unsubsidized coverage is available on residential buildings for up to $150,000, making a total of $185,000 in coverage possible. In addition, the amount of unsubsidized coverage on contents was increased to $50,000, making a total of $60,000 in contents coverage available for residential property. The additional amounts of insurance available under the Regular program are not at subsidized rates, but are actuarial rates calculated to consider the probability of loss in the community.

Coverage of the Flood Insurance Policy

The insuring agreements, conditions, and exclusions of the federal flood insurance policy are rather simple and straightforward. The policy covers losses resulting from the general inundation of normally dry lands resulting from:

(1) overflow of inland or tidal waters

(2) Unusual and rapid accumulation or runoff of surface waters from any source

(3) Mudslides caused by accumulations of water on or under the ground.

The policy does not cover water damage stemming from sources on the insured's property or within his control, or from a condition that does not cause general flooding in the area.

Property Covered. Coverage may be purchased on buildings and/or contracts. When insurance is purchased on the dwelling, the policy provides an extension of up to 10% for enclosed appurtenant structures. The contents item excludes pets, aircraft, watercraft, motor vehicles (other than those pertaining to the service of the premises and not licensed), wheeled trailers, and business property. There is a $500 limit on fine arts and a $500 limit on jewelry and furs. Money and valuable papers are specifically excluded, and the policy does not provide coverage on land, trees, shrubs, plants or lawns.

Deductible. The coverage is subject to a deductible of 2% of the amount of insurance or $200, whichever is greater. The deductible applies to both building and contents.

Inception and Termination. Due to the nature of the peril insured, the inception and termination provisions of the policy are unique. Policies that are purchased

within 30 days after a community becomes eligible take effect immediately. Those policies purchased after the 30 day period are subject to a 15 day waiting period before the coverage becomes effective. The policy may be cancelled by the insurer only for nonpayment of premium, and the company must give the insured 20 days' written notice of the cancellation. The policy may be cancelled by the insured at any time, but if the insured retains title to the property, the premium for the current policy term is considered fully earned. If the insured disposes of the property, the return premium is calculated on a short rate basis.

Rates

The cost of flood insurance under the "Emergency Program" is identical for all eligible cities and towns, and the rates for the additional coverage under the Regular Program vary with the loss probability of the particular area. The following table summarizes the current subsidized premium rates for various structures and their contents:

TYPE OF STRUCTURE	Amount of Subsidized Coverage on Building	Rate for Building Coverage Per $100	Amount of Subsidized Coverage on Contents	Rate for Building Coverage Per $100
Single Family Residential	$ 35,000	.25	$10,000	.35
Other Residential	100,000	.25	10,000	.35

Other Important Provisions

The 1973 law amended several provisions of the original law in an attempt to make flood insurance more available and more desirable. The most important amendment requires the purchase of flood insurance in "Special Flood Hazard Areas" as a condition to receiving any form of federal financial assistance for acquisition or construction purposes. This means that property owners in those communities where flood insurance is available and whose property is located in a "Special Flood Hazard Area", must purchase the flood insurance in order to qualify for Federal loans or Federally assisted loans (VA, FHA, S & L, FDIC, FSLIC, and so on). A "Special Flood Hazard Area" is specifically designated land within a community in the flood plain which is most likely to be subjected to severe flooding. If the property is not in a "Special Flood Hazard Area", the flood insurance is not a prerequisite to obtaining a loan.

The 1973 legislation also eliminates the possibility of receiving federal disaster funds following a flood in any area identified as having a special flood hazard, unless the property owner has purchased Flood Insurance. The law specifically prohibits any Federal agency from approving financial assistance to victims for reconstruction following a flood, if the individual did not purchase flood insurance. This prohibition applies regardless of whether or not the community has become eligible for the flood insurance program.

LEGAL LIABILITY AND GENERAL LIABILITY INSURANCE

The importance of the liability exposure rests on the possible severity of the loss. The extent of the possible loss to one's own property is normally limited by the value of that property. If an individual owns a $10,000 house and does not insure it, he may lose $10,000. In the case of the liability exposure, the amount of loss is almost unlimited. The size of a judgment levied in a court may not only cause a loss of existing assets, but in addition it may place a serious drain on future assets.

Before we examine the role of insurance in protecting the individual or the business firm from the legal liability hazard, we will examine the principles of negligence and legal liability.

NEGLIGENCE AND LEGAL LIABILITY

Most people have a responsibility to behave in the same manner as would a reasonable and prudent individual. Failure to behave in this manner constitutes negligence; and if this negligence leads to an injury to another, or to the damage of property belonging to another, the negligent party may be held liable for the damage.

Legal liability is imposed by the courts when it has been established that:

1. There was negligence
2. The negligence was the proximate cause of the damage
3. There was actual damage or loss.
4. The person injured was free from fault.

There must be Negligence

The basic concept of our law holds that unless a party is at fault — unless he has unreasonably and unlawfully invaded the rights of another — he is not liable. The basic question in all cases concerning liability must be "Has there been negligence?". Negligence is defined as the failure of a person to exercise the proper degree of care required by the circumstances. To be held **legally** negligent, it must be established that the individual had a duty to act and that he acted incorrectly or that he failed to act.

Who May Be Held Liable?

At the beginning of this discussion, we stated that "Most people have a responsibility to behave in the same manner as would a reasonable and prudent individual". The question arises, "what persons do not have this obligation?". There are certain classes of individuals and certain institutions which are excepted from the obligation.

1. **Infants.** In order to be bound by the obligation to behave in the reasonable and prudent manner, the individual must be capable of determining what is reasonable. The person must have, in the terms of the law, reached the "age of reason". In some states this has been set by law at seven years of age; in other jurisdictions the court determines what constitutes the age at which the individual can distinguish between right and wrong.

There is a popular misconception regarding the legal liability of minors, arising from confusion between the terms "infant" and "minor". While infants are immune from legal liability, a minor who has attained the age of reason may be held legally liable for his own negligent acts. Although minors can be held legally liable, the degree of care required of a child is often different than that required of an adult.

2. **Mentally incompetent.** For obvious reasons, certain mentally incompetent persons are not expected to exercise the care required of the sane. In the eyes of the law, a mentally incompetent person is approximately the same as an "infant." However, if it can be shown that the deficient person could have been expected to exercise some degree of care, the courts will hold the individual to that degree of caution.

3. **Government bodies.** At common law, soverign powers can be sued only with their permission. Any government unit that shares in the soverignty is immune from liability. When performing strictly government functions, this government immunity is based on the old common law maxim that "the king can do no wrong." The doctrine is being modified significantly today—both by statute and by court decision. One of the most important qualification is the Federal Tort Claims Act, which provides that the United States shall be liable for money damages to the same extent as a private individual. Government immunity also has been modified at the state level in many jurisdictions by similar state statutes. Finally, the courts, in a growing number of instances, have attempted to find exceptions to the doctrine of government immunity; and a few courts have rejected it entirely.

4. **Charitable institutions.** Formerly there was a distinct difference between the liability exposure of a charitable institution and that of a profit-making one, but this distinction has gradually disappeared. The recent trend has been to treat them in the same manner as profitmaking institutions.

What Constitutes Negligence. As we noted previously, negligence is defined as the failure of a person to exercise the proper degree of care required by the circumstances. The duty to use care is owed to all persons. As a general rule, it is owed to anyone who might suffer injuries as a result of a person's breach of duty, even if the negligent party could not have forseen a risk of harm to someone because of the behavior.

One of the major problems is to determine what constitutes correct action in any given situation. In order to make this determination, the courts apply what is known as "the prudent man rule", which seeks to determine what would have been a reasonable course of action under the circumstances. The mere fact that some other course of action might have avoided the accident does not make the individual liable. The negligent person is entitled to have his actions judged on the basis of this "prudent man standard" rather than hindsight. The judge and jury are not permitted to look back at the situation in light of what happened and judge liability on the basis of whether some other course of action would have prevented the accident. The action must be judged on the basis of what a reasonable and prudent individual, confronted with the same situation, might normally and properly have done.

Normally the burden of proof is on the injured party to prove that the other party was negligent. However, there are also certain doctrines which impose liability by statute or which shift the burden of proof from the injured party to the defendant.

Negligence Per Se. In many circumstances, what constitutes the standard of care required of an individual is set arbitrarily by statute. For example, speed limits in most states set the rate of speed at which an automobile may be operated. These speed limits amount to the establishment of a rule that no reasonable man should violate. If the law is violated, it is referred to as "negligence per se" (negligence of itself) and the injured party is relieved of the obligation to prove that the speed was unreasonable.

Res Ipsa Loquitur (The thing speaks for itself). Under the doctrine of **resp ipsa loquitur,** the law reverses the burden of proof. When the instrumentality which causes the damage was under the exclusive control of the defendant, and the accident is of the type that would not ordinarily happen if it were not for negligence on the part of the person exercising control over that instrumentality, the law says that the very fact that the accident happened is proof that there was negligence on the part of the defendant. For example, if Mr. Brown walks down the sidewalk and a 2,000 pound safe which was being lowered by a rope falls on him, he is not required to show that the person or persons lowering the safe failed to exercise due care. The fact that the safe fell on him is evidence of this. The burden of proof is shifted and the defendants must prove that due care was exercised.

Workers' Compensation.

In the case of injury to a worker and the liability of the employer for this injury, there is a departure from the basic laws of negligence. Laws have been enacted which impose absolute liability on the employer, and there is no need for the injured worker to prove negligence on the part of the employer. As a matter of fact, workmen's compensation represents an exception to the rule that there can be no liability without fault. Negligence is not a factor in the case of the injured worker; he is entitled to an indemnity regardless of the negligence or lack of negligence on the part of the employer.

There Must Be Actual Damage or Loss

The mere fact that carelessness existed is not sufficient cause for legal liability. Actual injury or damage must have been suffered by the party seeking recovery. In most cases it is not difficult to prove that injury or damage has occurred, but the establishment of the amount of damages may be difficult indeed.

A tort may result in two forms of injury to another: bodily injury and property damage. In the case of property damage, the extent of the loss is usually simple to determine; it is measured by the actual monetary loss the injured party suffered, measured by the value of the property damaged or destroyed and the loss of the use of that asset.

In the case of bodily injury, it is more difficult to determine the loss monetarily. Bodily injury may lead to claims by the injured party not only for medical expenses and lost wages, but also for disfigurement, pain and suffering, mental anguish, and loss of consortium (the companionship of a husband or wife). Three classes of damages may be awarded:

1. **Specific Damages.** Specific damages compensate the injured person for actual expenses incurred for medical expenses, and for lost income, both present and future.
2. **General Damages.** General damages compensate the injured person for pain and suffering, mental anguish, disfigurement, and other similar types of losses. Determination of the amount of general damages is highly subjective, and can amount to whatever a judge or jury feels is "right."
3. **Punitive Damages.** Punitive damages are amounts assessed in addition to specific and general damages, and are intended as a form of punishment of the negligent party. In general, punitive damages are awarded when the injury resulted from outrageous behavior, gross negligence, or willful intent.

The Collateral Source Rule. It should be noted that damages for bodily injury can be assessed against the negligent party even when the injured person recovers the amount of his or her loss from other sources. A basic principle of common law, the "collateral source rule," holds that the damages assessed against a tort feasor should not be reduced by the existence of other sources of recovery available to the injured party. Thus, if X is injured by Y and X has full insurance to compensate for a bodily injury, he or she can still sue Y for the full amount of medical expense and lost income that would have been suffered without the insurance.

Proximate Cause

The negligence must have been the proximate cause of the damage if the injured party is to collect for the damage. This means that there must have been an unbroken chain of events beginning with the negligence and leading to the injury or damage. The negligence must have been the cause without which the accident would not have happened.

The negligent person is usually held to be responsible not only for the direct consequences of his action, but for the consequences which follow naturally and directly from the negligent conduct. Even if an intervening force arises, the negligent party may still be held responsible for the damage. For example, let us say that Mr. Brown decides to burn his leaves, but takes no precautions to confine the fire. The wind begins to blow (an intervening cause), which causes the burning leaves to set Brown's neighbor's house on fire. The negligence began the direct chain of events and in spite of the intervening cause Brown could be held liable.

Vicarious Liability

There are circumstances in which one person may become legally liable for the negligent behavior of another person. This type of liability is known as "imputed" or "vicarious" liability and is based on the common law principle of **respondeat superior** (let the master answer). For example, the principal is liable for the negligent actions of his agent. The employer is liable for the negligent actions of his employees when they are acting within their capacity of employees. In some instances, vicarious liability is imposed by law. For example, in many states the owner of an automobile is held liable for the negligent acts of anyone operating his automobile with his permission.

Note that this does not involve liability without negligence; there is negligence; the negligence of one person makes another person liable. The principle is known as the doctrine of **Respondeat Superior,** (Let the master answer). The purpose of the doctrine of **respondeat superior** is to transfer the liability to those parties which would probably have a greater ability to pay for the injury.

In addition to the liability of children itself, the liability of a parent for the acts of his children is often misunderstood. Fundamentally a parent is not liable for the acts of his children. Although a parent may feel a moral obligation, at common law he does not have a legal one. In other words, the parent is not **vicariously** liable for the acts of his minor children. While this is true as a basic principle, the courts have evolved certain principles which may make the parent liable.

1. If it can be shown that the parent himself was negligent in the supervision of the child, he may be held legally liable for the damage caused by the child. For instance, if the parent knew that the child made a habit out of breaking picture windows and did not at least tell him to stop, the courts would probably consider this to be negligence on the part of the parents.
2. If the child was acting as an agent of the father, the father could be held liable under the doctrine of **respondeat superior.**
3. Some states impose parental liability by statute. Under one type of law, parents are made legally liable for the "willful and malicious acts of their minor and unemancipated children". Under other laws parents are held to be legally liable if they permit the child to have a dangerous weapon.[9]

With the exception of these three instances, parents are not basically liable for the acts of their children. In addition, when parents are held liable for the acts of minor children, the children themselves can be held jointly liable.

Obligation of Property Owners to Others

The property owner or the person occupying the property has an obligation to persons who come onto the land. The care that must be exercised with regard to the other party depends on the status of that party. The law generally recognizes four classes of persons and the degree of care which must be shown to them as follows:

1. **Trespasser.** This is a person who comes onto the property without right and without consent. The property owner is obliged only to abstain from doing him intentional harm.
2. **Licensee:** This is a person who comes onto the property with the knowledge of the toleration of the owner, but for no purpose of or benefit to the owner. In addition to the duty to avoid intentional harm, the owner must warn the licensee of any hidden dangers.
3. **Social Guest:** Several states distinguish between the Social Guest and the Invitee, described below. The majority of the courts hold that a social guest is the same as a licensee. Other courts hold that a social guest is the same as an invitee.
4. **Invitee:** The invitee is a person who has been invited in or onto the property for some purpose of the owner. The best example of an invitee is a customer in a store. In addition to the obligation to refrain from intentional harm and warning of any hidden dangers, the owner must keep the premises safe so that no harm will come to the invitee.

The distinction between the above classes is not always clear cut and it is often difficult to determine if a person is an invitee or a licensee, or whether a person is

[9]Surprisingly enough, the automobile is not considered to be a "dangerous weapon" within the meaning of these laws. The entire question of legal liability arising out of the ownership and use of automobiles will be discussed later.

a trespasser or a licensee. The current trend is toward making the property owner more responsible.

Children: The law imposes a greater responsibility with regard to the degree of care which must be exercised with regard to children. It is an accepted fact that children do not always act prudently; and this being the case, the law requires property owners to protect the children from themselves. The doctrine of **"The Attractive Nuisance Hazard"** holds the property owner liable for injury to any child by an attractive hazard. An attractive hazard is anything that would attract and injure a child of tender years. Examples are piles of lumber, animals, or even trees. The doctrine is applied in the case of construction equipment more frequently than any other item.

Animals

In many jurisdictions the principles involved in liability with respect to animals represent a separate case. Obviously an animal cannot be held legally liable; but if the animal causes damage to a person or property, the law may hold the owner or keeper of the animal liable. For example, in the case of a wild animal, the law imposes absolute liability on the owner or keeper for injury or damage caused by such an animal.

Pets represent a special case. One of the most interesting principles of the old English common law was the doctrine which permitted a dog "one free bite". Under the legal doctrine of **scienter** (knowledge), the owner of the animal is held to be liable for injuries by that animal only if the animal is known to be vicious; hence the one "free bite" — how can the owner know that his dog bites people until he has bitten one? In many jurisdictions, however, this common law principle has been superceded by specific statutes which make the owner of a dog liable for injuries caused by the dog. For example, Section 351.28 of the Iowa Code provides that "... The owner of the any dog, whether licensed or unlicensed, shall be liable to the party injured for all damages done by said dog, except where the party damaged is doing any unlawful act, directly contributing to said injury."

Defenses to Negligence

An individual's negligent behavior does not necessarily mean that the person will be held legally liable. There are certain defenses that may be interposed by the negligent party in order to defeat a claim.

Assumption of Risk. One defense to tort actions is assumption of risk by the injured party. If a person recognizes and understands that there is danger involved in an activity and voluntarily chooses to encounter it, this assumption of risk may bar recovery for injury caused by negligence. One common application of this doctrine is attendance at certain types of sporting events such as baseball and hockey. Courts have held that in seeking admission, a spectator must be considered to have chosen to undergo the well-known risk of having his or her face smashed by a baseball or hockey puck. Another common example is the guest passenger in an automobile. In some jurisdictions, a guest is assumed to have assumed the risk of injury while riding in an automobile. Even if the car is driven in a grossly negligent manner, he or she may be considered to have assumed the risk of injury if the guest fails to protest the dangerous driving.

Contributory Negligence. As an outgrowth of the idea that every person has an obligation to look out for his or her own safety, the common law doctrine of "contributory negligence" developed. Under this doctrine, the injured party must come into court with "clean hands" in order to collect. Under the doctrine of contributory negligence, any negligence on the part of the injured party which contributed to the injury, even though slight, will normally defeat the claim.

Comparative Negligence. Because of the harshness of the contributory negligence doctrine, the majority of the states have adopted a somewhat more lenient doctrine, that of "comparative negligence."[10] Here contributory negligence on the part of the injured party will not necessarily defeat the claim, but will be used in some manner to mitigate the damages payable by the other party. For example, under the "contributory negligence" doctrine, an injured party who was 25% to blame for the loss would collect nothing. Under the "comparative negligence" rule, he or she would collect 75% of the damages suffered.

Last Clear Chance. The doctrine of "last clear chance" is an additional modification of the doctrine of contributory negligence. Under this rule, as used in almost all jurisdictions, it is recognized that the contributory negligence of the injured party should not bar recovery if the other party had an opportunity immediately prior to the accident—a "last clear chance"—to prevent the accident and failed to seize that chance. The logic seems obvious. If one can avoid an accident and does nothing to prevent its occurrence, he or she should be held legally liable, regardless of the contributory negligence of the other party.

Legal Liability and Bankruptcy

The risk of legal liability is one fraught with potential catastrophic losses. With all the various factors used in determining damages in a legal action added together, the loss can be astounding. Naturally the question must arise as to whether the guilty party, confronted

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[10]By mid-1978, the following 32 states had some form of comparative negligence law: Alaska, Arkansas, California, Colorado, Connecticut, Florida, Georgia, Hawaii, Idaho, Kansas, Maine, Massachusetts, Michigan, Montana, Minnesota, Mississippi, Nebraska, Nevada, New Hampshire, New Jersey, New York, North Dakota, Oklahoma, Oregon, Rhode Island, South Dakota, Texas, Utah, Vermont, Washington, Wisconsin, and Wyoming.

with a large judgment has any alternative but to pay. Bankruptcy is, of course, one alternative; and in some instances it will be the only possible course of action. However, judgments for liability arising out of a willful or malicious tort cannot be discharged by bankruptcy, and here the guilty party will be obligated to pay the judgment if it takes the rest of his or her life.

Although we have surveyed only the more fundamental aspects of legal liability, the tremendous exposure which the individual faces should be evident. Liability judgements have been high in the recent past and promise to become even higher.

LIABILITY INSURANCE

Liability insurance is designed to provide protection for the individual or business firm against the financial loss which might result from legal liability. In its simplest form, the liability insurance policy undertakes to pay all sums which the insured becomes legally obligated to pay, up to the limit of the policy. It is commonly referred to as "Third party coverage", since it undertakes to compensate someone who is not a party to the contract, the injured party to whom the insured is liable. It is important to recognize that this "third party" is not an insured, and that he has no direct claim against the insurance company. Under the contract, the company is bound to pay only when the insured has become **legally obligated** to pay, and the insured becomes so obligated only when a judgment has been granted in court.

In addition to the promise to pay all sums which the insured becomes legally obligated to pay, most liability policies include a promise to defend the insured in any law suit involving the type of liability insured under the contract. Thus, automobile liability insurance will pay for defense in connection with law suits involving the ownership, operation, or maintenance of an automobile; a premises liability policy will pay defense costs connected with suits alleging liability in connection with the premises. It is important to note that the insurance company is obligated to pay the defense costs even if the grounds of the suit are false or fraudulent. The basic principle is that the company must pay defense costs if it would be obligated to pay the damages should the insured be found liable.

As a practical matter, very few liability claims ever reach trial. The insurance companies realize that the interest of all concerned will best be served if a settlement can be reached without litigation, and the company normally attempts to reach an out of court settlement with the injured party. Most liability policies reserve this right to the insurer. In spite of the fact that the insurance company often deals directly with the injured party, it should be remembered that the injured party's claim is against the negligent insured and not the company. Technically, the company is not bound to make payment until actual liability has been determined in a court of law.

Types of Liability Insurance

Most people recognize the liability exposure in connection with the operation of an automobile. The size of the judgments we see in the newspapers act as a constant reminder of this exposure. Recognizing the exposure, most individuals purchase automobile liability insurance to protect themselves against the tremendous losses that can result from legal liability arising out of the automobile. Yet at the same time, many fail to recognize that the basis of the liability exposure, i.e., the negligent act, is also the basis for liability for acts which have no connection with an automobile. The individual needs protection against the consequences of any negligent act, not just those connected with the automobile. There are various forms of liability insurance available to meet the liability exposure from various sources.

For our purposes, we will divide liability insurance into three classifications:

1. Automobile Liability Insurance
2. Employer's Liability and Workmen's Compensation
3. General Liability

In general, these three classes of liability insurance are provided under separate contracts. Most general liability policies exclude liability to employees, benefits which are required to be paid by a workmen's compensation law, or liability which arises out of the operation of an automobile.[11] By the same token, the employer's liability and workmen's compensation, or the automobile liability policy cover only these exposures. In this discussion, we will be primarily concerned with the third of these classifications, general liability. The remaining two will be treated separately.

The Insured's Duties

Most liability policies impose three obligations on the insured under the conditions of the policy:

1. Notice of Accident
   The insured is required to notify the insurance company or the agent of any accident which would be covered under the policy as soon as practical. In giving notice of an accident the insured should include information concerning the time, place, and circumstances of the accident and the names of any witnesses.
2. Notice of Suit or Claim
   If a suit is brought against the insured or an injured party makes claim against the insured, the insured is required to forward any demand, notice or summons to the company immediately.

[11]There are exceptions to this statement. Some policies issued to business firms include liability coverage for general liability and automobile liability, but these policies are really package policies which combine two policies into one. In addition some liability policies cover liability to workers if the workers are not required to be covered under workmen's compensation by law.

3. Cooperation
   The insured is required to cooperate with the company in attempting to investigate, defend, or settle the claim. He can be required to attend hearings or trials, and the company will reimburse him for his expense in doing so. Some policies provide for reimbursement of wages lost by the insured in attending hearings or trials, while some do not.

The Comprehensive Personal Liability Policy

The Comprehensive Personal Liability Policy, or, as we will refer to it from this point on, the CPL, is designed to provide protection for the individual against claims arising out of his premises and his and his family's actions. The coverage of the CPL can be purchased in one of three ways:

1. It may be purchased as a separate CPL policy.
2. It is a basic part of the Homeowners policy. Section II of the Homeowners policy provides the individual with essentially the same coverage that he could purchase through a separate CPL policy.
3. It may be added to other casualty contracts by endorsement. For example, the individual's auto policy may be endorsed to provide the coverage.

In most cases, the coverage is purchased as a part of the Homeowners contract. Since the most widely used means of purchasing the contract is the Homeowners policy, we will use the provisions of Section II of the Homeowners as the basis for our discussion.

The CPL is designed to provide much of the necessary liability insurance for a homeowner or for a tenant in an apartment or in a rented dwelling. Insurance protection exists for legal liability arising in connection with the dwelling premises and also from that arising as a result of the personal activities of the insured, both on and away from the insured premises.

There are three separate coverages in Section II of the Homeowners policy, with three separate insuring agreements.

Coverage E. Liability. Under the insuring agreement of this coverage, the company promises to pay all sums which the insured becomes legally obligated to pay either because of bodily injury or property damage. There is a single limit of liability for both property damage and bodily injury. The minimum limit of liability, which may be increased, is $25,000. Under the separate CPL policy this coverage is designated Coverage L.

Coverage F. Medical Payments. The Medical Payments insuring agreement requires the insurer to pay all reasonable medical expenses (defined as including funeral expenses) incurred within one year from the date of an accident to or for anyone who is injured while on the premises with the permission of the insured or who is injured away from the premises if the injury results from an activity of the insured or a member of his family. The basic limit under the Homeowners for this coverage is $500 per person, which may be increased. (Under the separate CPL policy this coverage is designated Coverage M.)

Supplementary Coverages, Coverage 1. Damage to Property of Others. The Damage to Property of Others coverage contained in the supplementary coverages section of the policy provides some coverage for damage to the property of others which is caused by an insured but for which the insured may not be legally liable. It is intended to provide some coverage for damage for which the insured feels a moral obligation, even though there is no legal one. The limit of this coverage is $250, and the limit **cannot be increased.** (Under the separate CPL this coverage is designated Coverage N.)

The Liability Insuring Agreement

The liability insuring agreement is simple and straightforward:

> **Coverage E. Personal Liability.** This Company agrees to pay on behalf of the Insured all sums which the Insured shall become legally obligated to pay as damages because of bodily injury or property damage, to which this insurance applies, caused by an occurrence. This Company shall have the right and duty, at its own expense, to defend any suit against the Insured seeking damages on account of such bodily injury or property damage, even if any of the allegations of the suit are groundless, false or fraudulent, but may make such investigation and settlement of any claim or suit as it deems expedient. This Company shall not be obligated to pay any claim or judgment or to defend any suit after the applicable limit of this Company's liability has been exhausted by payment of judgments or settlements.

The agreement to defend, which is included with the agreement to pay damages, is an important element of the coverage. Most liability policies agree to defend the insured against suits which are brought against him alleging negligence. However, the policy will provide defense coverage only if the damages will be payable under the policy if the insured is held to be liable. For example, since this policy is not designed to cover liability arising out of the use of automobiles, if the insured is involved in a suit which involves the operation of an automobile, the CPL will not provide defense.

Persons Insured. One of the most important parts of any liability policy is the definition of "persons insured", for the promise of the company is to pay those sums the "insured becomes legally obligated to pay . . ." As is the case in many liability policies, coverage is provided under this contract for certain individuals other than the person listed in the declarations of the policy.

The definition of "Insured" in the liability section of the Homeowners is as follows:

> "Insured" means:
>
> (1) The Named Insured stated in the Declarations of this policy,
>
> (2) if residents of the Named Insured's household, his spouse, the relatives of either, and any other person under the age of twenty-one in the care of any Insured; and
>
> (3) Under Coverage E — Personal Liability and Coverage F — Medical Payments to Others;
> (a) with respect to animals or watercraft to which this insurance applies, owned by any Insured, any person or organization legally responsible therefor, except a person or organization using or having custody or possession of any such animal or watercraft in the course of his business or without the permission of the owner; and (b) with respect to any vehicle to which this insurance applies, any employee of any Insured while engaged in the employment of the Insured.

This definition is quite broad. It includes the named insured listed in the declarations, his or her spouse, any relatives of the husband or wife who are residents of the household, and anyone else under 21 in the care of the insured. There are only a few problems of interpretation that may arise. Obviously, the parents are insureds. The children living at home are also insureds; even a great aunt or grandparents will be insured, if they are residents of the named insured's household. But what about a son or daughter away attending college? Do such persons have to be actually living under the same roof in order to qualify as residents of the named insured's household? In general the answer is "No." There have been a number of court decisions in which a child who is in residence at a college or university and who expects to return during vacations and weekend visits is to be considered as residing in the same household as the named insured.

The definition of the insured also includes any other person under the age of 21 in the care of an insured. This refers to some person other than a resident relative who has become established in the household. It could include, for example, a child whose parents have gone on an extended vacation, a ward, a foreign-exchange student, a foster child, and persons in similar situations.

Severability of Insureds. One of the conditions in the policy states that: "The insurance afforded under Section I applies separately to each insured against whom claim is made or suit is brought, except with respect to this company's limit of liability." This is known as the severability of insureds clause. Since the insurance is stated to apply separately to each insured, it is possible for one insured to bring suit against another insured, with any resulting judgment payable under the policy. For the sake of example, let us say that the insured has a gardener. As the definition of "Insured" states, such an employee would be covered as an insured while operating a tractor for the insured. Suppose the gardner runs over the insured. In this case the insured could bring suit against the gardener and, if the suit were successful, he could collect under his own policy.

Liability Exclusions

Obviously exclusions will be applicable to the liability coverage, and these exclusions will include those normally applicable to liability insurance in general. There are four sets of exclusions under Section II of the Homeowners: one set of six exclusions which applies to both liability and medical payments; one set of five which applies to liability coverage only; one set of two, which applies to medical payments only; and one set of four, which applies to the damage to property of others coverage.

Aircraft, Motor Vehicles, and Recreational Motor Vehicles. The first major exclusion involves aircraft and motor vehicles. Generally, there is an exclusion (l.a.) for liability arising out of the ownership, maintenance, use, loading or unloading of any aircraft, motor vehicle, or recreational motor vehicle. Each aspect of the exclusion will require some explanation.

First, legal liability arising from the ownership, maintenance, or use of **aircraft** is excluded in all respects. Naturally the relatively nominal premium charged for the CPL does not contemplate the assumption by the insurer of a risk of this magnitude. If the insured owns or rents a private airplane, then he must purchase aircraft insurance specifically designed for this purpose.

Second, liability arising out of motor vehicles is excluded. "Motor vehicle" is specifically defined and means a vehicle designed for travel on public roads. It does not include vehicles which are not subject to motor vehicle registration and which are designed for use principally off public roads.

The exclusion of recreational motor vehicles was added in 1968. A recreational motor vehicle is defined as a golf cart, snowmobile, or, if not subject to motor vehicle registration, any other land motor vehicle designed for use off public roads. While "motor vehicles" are excluded both on and off premises, the exclusion of "recreational motor vehicles" applies only away from the premises. In addition, an exception states that the exclusion does not apply (and coverage is afforded) for a golf cart away from the premises being used for golfing purposes. The exclusion may be deleted with respect to snowmobiles by attaching endorsement HO-164, the Snowmobile Endorsement. Snowmobiles to be covered are listed, with a specific premium charge made for each.

Boats. Exclusion 1.b. excludes liability arising out of certain types of boats while away from the premises.

First, inboard or inboard-outboard motorboats over 50 horsepower or any sailing vessel over 26 feet in length which are owned by or rented to the insured are excluded. In addition, a boat powered by an outboard motor or motors in excess of 25 horsepower is excluded if the motor or motors were owned by the insured at the inception of the policy and not listed. Note that the exclusions with respect to outboard motors, unlike that with respect to inboards or sailing vessels, does not apply to rented motors. Coverage applies to all boats below these limits, and the exclusion with respect to larger units may be removed for an additional premium.

Business and Professional Pursuits. The CPL is designed to provide coverage for legal liability arising from the dwelling and personal activities of the insured. It is not intended to cover business activities. Two exclusions (l.c. and l.d.) make this clear. Coverage does not apply

> to bodily injury or property damage arising out of the rendering or failing to render professional services
>
> to bodily injury or property damage arising out of business pursuits of any Insured except activities therein which are ordinarily incident to non-business pursuits.

It is perfectly clear that the policy will not provide coverage for legal liability arising in the process of conducting the operations of a grocery store, a drug store, or the professional activities of a lawyer, medical practitioner, or real estate agent. These exposures may be insured under separate business and professional liability policies.

Considerable difficulty may arise in cases involving part-time remunerated activities, particularly of minors who are insureds under the policy. Are newspaper delivery, lawn cutting, baby-sitting, and part-time after-school and vacation jobs to be considered business pursuits? As is usual, the answer must "depend on the circumstances." It is intended that normal part-time activities of minors shall not be considered business pursuits. These may include newspaper delivery, lawn cutting, snow removal, baby-sitting, after-school jobs, and the like. On the other hand, if a minor is employed full time, the activity must be considered a business pursuit. Thus, if the insured's son has a paper route and should heave a newspaper negligently through a customer's glass door, the property damage would be paid because this part-time activity is not considered a business pursuit. At some point, however, the part-time activities may be sufficiently extensive to become business activities, probably when the income from the part-time activity becomes substantial.

It is possible, under certain circumstances, to endorse liability arising from business pursuits to the CPL. Provision is made specifically for clerical office employees, salesmen, collectors, messengers, and teachers. Thus, if the insured is engaged in any of these pursuits and desires liability insurance, it is available by endorsement to his CPL under the "Business Pursuits Endorsement."

The liability of a teacher is an excellent example of a business pursuit which can be added to the CPL. Here the insurance provided under the personal-liability and the medical-payments coverages of the CPL will apply to acts or omissions of the insured in connection with his business pursuits as a member of the faculty or teaching staff of any school or college. Consequently, legal liability for injuries to pupils or members of the general public arising from activities as a teacher would be covered. The endorsement could even include bodily injury to any pupil arising out of corporal punishment administered by or at the direction of the insured, for the administration of corporal punishment is not to be deemed to be injury caused intentionally by or at the direction of such insured.

The endorsement does not provide coverage, however, for acts of the insured in connection with a business owned or financially controlled by the insured or by a partnership or joint venture of which the insured is a partner or a member. A regular business liability policy should be purchased for this type of risk.

This coverage obviously is intended to be applicable to an employee in a business firm who desires liability insurance for legal liability that could arise in his business activities for his employer. But why would an employee want this insurance? The answer is quite simple. In many and perhaps most instances the employer does not include his employees as additional insureds in his general liability insurance. The only exclusions in the endorsement involves bodily injury to a fellow employee of the same employer in the course of the employment, and liability in connections with a business owned by the insured.

Uninsured Premises. As long as the insured has disclosed the ownership and location of all premises that he owns and paid the appropriate premium, coverage is afforded for liability arising out of such premises. However, a specific exclusion (l.e.) excludes liability arising out of any premises other than "insured prmeises" which are owned, rented, or controlled by an insured. The definition of "insured premises" found in the general conditions states that insured premises means:

(1) the residence premises described in the Declartions of this policy; and

(2) Under Section II only;

- (a) any other residence premises specifically named in this policy;
- (b) any residence premises acquired by the Named Insured or his spouse during the term of this policy;

(c) any residence premises which are not owned by any Insured but where an Insured may be temporarily residing;

(d) vacant land, other than farm land, owned by or rented to any Insured; and

(e) individual or family cemetary plots or burial vaults.

The definition in the policy includes, first, the named residence premises and all **other** residence premises listed in the policy. This portion of the definition needs little analysis. The definition next includes any other residential premises the named insured may acquire during the policy term. Coverage on additional residential premises is automatic in the policy. However, a small additional premium must be paid by the insured for each premises.

Perhaps the most interesting aspect of the definition of insured premises is that part of that includes premises in which an insured is temporarily residing but which are not owned by the insured. This would include a hotel or motel room. Legal liability obviously could arise with respect to some condition of the premises over which the insured has some control; and in addition, the medical-payments coverage could be made applicable to guests injured because of some condition involving the temporary premises.

The definition also includes vacant land, other than farm land, owned by or rented to any insured. Thus legal liability arising in connection with a vacant lot owned by the insured would be covered automatically in the policy. An example could involve injuries to children playing on the vacant lot, particularly if the situation involved an attractive nuisance. Coverage is also provided under the supplmentary coverages in connection with vacant land following the commencement of construction operations thereon of a one or two-family dwelling if the dwelling is intended as a residence for an insured. If a child were injured and a suit followed, everybody in sight would be named, including the owner and the contractor. The insurance carrier, under the CPL, would be obligated to defend the owner; and if a judgment were levied against the owner, it would be paid, up to the limits of the policy.

The final portion of the definition includes individual or family cemetary plots or burial vaults. This is interesting and may seem somewhat unusual. However, since the plot is owned by the insured, if somebody should be injured there, the insured could have a legal liability.

Intentional Injury. As noted in our discussion of intentional torts, it would be contrary to public policy to protect an individual from the consequences of intentional injury which he causes another. For this reason the policy also excludes bodily injury which is either expected or intended from the standpoint of the insured.

Contractual Liability. In addition to the imposition of liability because of negligence, liability may also be incurred as a result of contractual agreements. For example, a common clause in many leases shifts the liability in connection with the premises from the landlord to the tenant or from the tenant to the landlord. Such agreements are called "hold-harmless agreements" because one party agrees to hold the other harmless from liability arising out of the premises. To illustrate the operation of such agreements, assume that Brown, the tenant, has agreed to hold Smith, the landlord, harmless from liability arising out of the premises. Jones is injured as a result of a defect in the premises and brings suit against Smith as the owner. Smith is held liable and required to pay a judgment in the amount of $25,000. Under the terms of the hold-harmless agreement, Brown will be required to reimburse Smith. The CPL excludes liability assumed under any contract not in writing or any contract in connection with the insured's business. Since only non-written contracts and business connected contracts are excluded, the CPL would provide coverage for liability assumed under a lease agreement of the type discussed above.

Workmen's Compensation. There is no intention of providing coverage under the CPL for legal liability of an employer for injuries to domestic servants if these domestic servants are covered under the state workmen's compensation law. In a special exclusion (2.b.), liability for bodily injury to any person, including a residence employee, is excluded if the insured has a policy providing workmen's compensation or occupational disease benefits for such bodily injury or if benefits for such bodily injury are payable under any workmen's compensation or occupational disease law. In other words, if the insured has **or should have** workmen's compensation coverage on his employees, the CPL will not pay for their injuries. Under Iowa law, domestic employees are excluded from the Workmen's Compensation law only if they earn less than $200 during the thirteen consecutive weeks immediately preceding an injury. This means that domestic employees earning over $200 during any thirteen week period come under the provisions of the law and are subject to this exclusion in the CPL. However, coverage is afforded for injuries to those domestic employees who are not covered under the compensation law. In the case of employees not covered under the compensation law, an employer may still be held liable in a suit at common law, and although the CPL does not cover workmen's compensation benefits, it does provide coverage if the insured is sued by an employee who is not subject to the provisions of the workmen's compensation act. Coverage is provided automatically for up to two such employees, and an additional premium is charged for each employee in excess of two. In addition, another exclusion excludes liability for injuries to covered employees unless claim is made or suit is brought within 36

months after the end of the policy term. It should be obvious that this is merely to provide reasonable protection for the company in investigation and preparation of a defense.

Property Owned By, Rented To, or in the Care of the Insured. The CPL, similar to most liability contracts, excludes property damage to property owned by the insured (exclusion 2.c.) and to property occupied or used by the insured or rented to or in the care, custody or control of the insured (exclusion 2.d.). Although the first of these two exclusions is easily understood, the rationale of the second is frequently difficult to grasp.

Remember, this is a liability contract. An individual cannot be liable to himself, so the exclusion of property owned seems logical. Because it is difficult to separate interest and because the policy is not designed to promote carelessness, the policy also excludes damage to property which the insured may not own but which he has in his care. If the insured should borrow an outboard motor from a friend and allow it to drop into 600 feet of water, legal liability would exist but without the benefit of liability insurance coverage. Or, if the insured should borrow a neighbor's lawn mower and ruin the shaft by hitting a rock, even though the neighbor might sue and obtain a judgment, the policy would not cover the loss because of the care, custody, and control exclusion.

This exclusion does have one important qualification, however, with respect to property damage included within the fire hazard. Under the supplementary coverages section of the policy, the policy affords what is known as "Fire Legal Liability." Fire Legal Liability covers damage to premises rented to the insured and to house furnishings therein if such damage arises out of fire, or explosion, smoke, or smudge caused by sudden, unusual and faulty operation of a heating or cooking unit. The care, custody, and control exclusion does not apply to this coverage, and this qualification could be important to an insured who has rented a dwelling or apartment.

Medical Payments to Others

In addition to the rather broad coverage for liability, the CPL includes medical-payments coverage that applies to injuries to others even in those cases in which the insured is not legally liable. The insuring agreement provides that medical payments will be paid under a variety of circumstances:

> Coverage F—Medical Payments to Others
> This Company agrees to pay all reasonable medical expenses, incurred within one year from the date of the accident, to or for each person who sustains bodily injury to which this insurance applies caused by an accident, while such person is:
>
> 1. on an insured premises with the permission of any Insured; or
> 2. elsewhere, if such bodily injury
>   a. arises out of a condition in the insured premises or the ways immediately adjoining,
>   b. is caused by the activities of any Insured, or by a residence employee in the course of his employment by an Insured,
>   c. is caused by an animal owned by or in the care of any Insured, or
>   d. is sustained by any residence employee and arises out of and in the course of his employment by any Insured.

The definition of medical payments is quite liberal, and includes medical, surgical, X-Ray, and dental services, including prosthetic devices, ambulance, hospital, and nursing services. The definition even includes payment for funeral expenses, but of course the expenses again must be reasonable.

It is important to stress that medical payments is not a liability coverage. The medical payments portion of the policy provides payment even though the insured is not legally liable. As a matter of fact, the policy specifies that the benefits are payable "to or for each person who sustains bodily injury." This means that anyone injured within the scope of the coverage may claim directly under the policy. They do not have to have the consent of the named insured to enter a claim.

In addition, since the medical is a separate coverage, the injured party can technically collect benefits under the medical payments portion of the policy and in addition bring suit against the insured.

Medical Payments Exclusions

The liability exclusions discussed above relating to aircraft, motor vehicles, recreational motor vehicles, boats, business pursuits, uninsured premises and intentional injury also apply to the medical-payments coverage. In addition there are two more exclusions which apply to the medical payments coverage.

Workmen's Compensation. Just as liability imposed under any workmen's compensation law is excluded under the liability section of the policy, medical benefits payable or required to be paid under any workmen's compensation or occupational disease law are excluded. In addition, the policy excludes bodily injury to any person if there is a workmen's compensation policy in effect which would cover the injury. This excludes, for example, injuries to workmen who come on the premises and who are covered under a workmen's compensation policy purchased by their employer.

Certain Persons Excluded. One of the most important of the exclusions dealing with medical payments (3.b.) provides that medical payments are not applicable to certain classes of individuals. There are three classes of excluded individuals. The coverage is inapplicable to

the named insured, and to the residents of the insured's household. In addition, the policy provides that medical payments are not applicable to any other persons, other than a residence employee, who is regularly residing on any part of the insured premises. An example would be a college student to whom a room has been rented.[12] The final class of individuals excluded under medical payments are persons on the premises because a business is conducted or professional services are rendered thereon. For example, some individuals maintain an office in their dwelling, from which they conduct business. Business visitors would not be covered for medical payments.

Physical Damage to Property Coverage

Physical Damage to Property, like Medical Payments, is a non-liability coverage. It pays for damage to the property of others that is caused by an insured, regardless of whether the insured is legally liable. The insuring agreement for this coverage is worth examining in detail.

> Damage to Property of Others: This Company will, at its option, either pay for the actual cash value of property damaged or destroyed during the policy period by an Insured, or repair or replace such property with other property of like quality and kind, but in no event shall this Company's limit of liability exceed $250 in any one occurrence.

Note that the damage must have been caused by an insured, and that the property must have actually been damaged. If the insured borrows his neighbor's golf clubs and loses one, the loss would not be covered.

Damage of Property to Others Exclusions

There are four exclusions relating to this coverage.

Intentional Damage. The coverage does not apply to damage to or destruction of property that is caused intentionally by any insured who has attained the age of 13. The intentional damage exclusion under the liability coverage does not specify any age limit, thus excluding all intentionally caused damage. Under the damage to property of others coverage there is coverage up to the limit ($250) for intentional damage caused by insureds under the age of 13.

Owned and Rented Property. Damage to property owned or rented to any insured, any tenant of the insured, or any resident of the insured's household is also excluded. This exclusion is less restrictive than the exclusion of damage to property in the care, custody, or control of the insured which applies to the liability coverage. The physical damage to the property of others exclusion, like the liability coverage exclusion, excludes damage to property owned or rented, but it does not mention property in the care, custody, or control of the insured. This means that coverage would exist for damage to borrowed property under the physical damage to property of others coverage up to $250.

Business Pursuits and Vehicles. The third exclusion relating to this insuring agreement excludes completely any damage arising out of business pursuits or professional services, and also excludes all damage resulting from the ownership, maintenance or use of any land motor vehicle, trailer or semi-trailer, farm machinery or equipment, aircraft, or watercraft. The exclusion relating to vehicles and watercraft is more extensive than the similar exclusion under the liability coverage. If any of the equipment listed is involved in the damage, there is no coverage.

Losses Covered Under Section I. Finally, the policy excludes under the damage to the property coverage any loss for which insurance is provided under Section I of the policy. As the student will no doubt recall, the definition of insured property under Section I includes not only owned property, but also any property which is used by an insured. If the insured borrows personal property, it may be considered insured property just as if it were owned by the insured. If such property is damaged by one of the perils insured against under Section I, the insured must collect for the damage under that section of the policy.

The Damage to Property of Others insuirng agreement provides an important extension to the basic liability policy. It provides a limited amount of coverage (up to $250) for damage to property of others in the care, custody or control of the insured. In addition, it provides the same limited amount of coverage for intentional damage which is caused by minor children, provided that they are under the age of 13. Finally, it provides some coverage in those cases where there is no legal liability, but in which the insured feels a moral obligation.

[12]The liability coverage would be applicable, however, if the college student were injured as a result of a condition in the premises.

AUTOMOBILE INSURANCE

The automobile is probably the most widely owned major asset in the United States. It is also one of the chief sources of economic loss. The ownership or operation of an automobile exposes the individual to many sources of loss: a person may be killed or injured while operating a car, or being struck by one; one may be held legally liable for injuries to others; the car itself may be damaged, destroyed or stolen.

Before turning to the legal environment and the legal principles governing the operation of automobiles, it may be worthwhile to review briefly the general nature of the automobile coverages that are available for protection against these losses.

A BRIEF OVERVIEW OF AUTOMOBILE COVERAGES

For the purpose of our discussion that follows, it will be helpful if you will keep in mind the distinctions among the following four automobile insurance coverages.

Automobile Liability Insurance

Automobile liability insurance protects the insured against loss arising from legal liability when his or her automobile injures another or damages another's property. This coverage may be written with a single limit similar to that of the Homeowners Policy, or it may be written subject to "split limits," usually expressed $10,000/$20,000/$5,000, or more simply as $10/$20/$5. The first two figures refer to the bodily injury liability limit, and the third refers to the property damage limit. Thus, $10/$20/$5 means that coverage is provided for up to $20,000 for all persons injured in a single accident, subject to a limit of $10,000 for one individual, and that property damage up to $5,000 is payable for a single accident.

Medical Payments Coverage

Automobile medical payments coverage is a promise by the insurer to reimburse the insured or members of the insured's family for medical expenses for an injury involving an automobile. The protection also applies to other occupants of the insured's automobile. Like the medical payments under the Homeowners Policy, coverage for automobile medical payments has no relationship to the liability coverage; it applies as a special form of accident insurance. Unlike the Homeowners, the coverage applies specifically to the insured and members of his or her family. It is written subject to a maximum limit per person per accident, which usually ranges from $500 to $5,000.

Physical Damage Coverage

Physical damage coverage insures against loss of the policyholder's own automobile, and in this sense resembles Section I of the Homeowners. The coverage is written under two insuring agreements, Comprehensive and Collision. Collision, as the name implies, indemnifies for collision losses; comprehensive is a form of all-risk coverage that provides protection against most other insurable perils. Physical damage coverage applies to the individual's own automobile regardless of fault. If another automobile damages the car, the insured has the option of collecting from the other driver (or from the other driver's insurance company, which would pay for the loss under the other's liability coverage) or collecting under his or her own policy and permitting the insurance company to subrogate.

Uninsured Motorists Coverage

Uninsured motorists coverage is a unique form of automobile insurance, under which the company agrees to pay the insured, up to the policy limits, the amount the insured could have collected from a negligent driver who caused injury when the other driver was uninsured or was guilty of hit and run. Uninsured motorists coverage usually has the same limits as the bodily injury coverage of the liability section of the policy.

Understanding the following discussion will be much easier with a firm grasp of the distinctions among these four coverages.

LEGAL LIABILITY AND THE AUTOMOBILE

Before we examine the automobile insurance contract, it might be well to discuss some of the basic principles of legal liability as they apply to the ownership, maintenance, and operation of an automobile. The liability of the owner or operator of an automobile is based on those principles of negligence which were discussed previously. However, special laws affecting automobile liability have been enacted which modify some of the basic principles of liability. Several of these laws relate to the responsibility of others when the driver is negligent. In addition some laws deal with the liability of the operator toward passengers.

Vicarious Liability and the Automobile

Vicarious liability involves a situation in which one party becomes liable for the negligence of another party. In the case of automobile liability, various states have enacted vicarious liability laws. When the average individual thinks of his possibility of being held legally liable for the operation of a motor vehicle, he normally has in mind a situation in which he is the driver. However, because of the vicarious liability laws, it is entirely possible that an individual may be held legally liable in a case where is not the operator.

First, if the driver of the automobile is acting as an agent for some other individual, the principal may be held liable for the acts of the agent. In addition, in the states of California, Connecticut, Florida, Idaho, Iowa, Massachusetts, Michigan, Minnesota, New York,

North Carolina, Rhode Island, Tennessee, and the District of Columbia, the owner of an automobile is liable for personal injury or property damage caused by another person operating the automobile with the permission of the owner. Certain other states make anyone furnishing an automobile to a minor legally liable for any damage caused by the minor in operating the automobile.

The courts have evolved a concept known as the "family purpose doctrine", which is now applied in about 20 states. Iowa is not included in these states. Under this doctrine, any automobile which is normally used for the family is considered to be used for the purpose of the family whenever it is used by a member of the family. The operator is deemed to be acting as an agent of the head of the family, making the head of the family vicariously liable for any damage caused under these circumstances. The basic intent of this doctrine is to make parents responsible for the acts of their children in the automobile. Of course, if it can be demonstrated that the parent himself was negligent in the supervision of his minor child, he may be held liable for damage caused by that child, but this is a case of the negligence of the parent making the parent liable, and not a case of the negligence of the child being imputed to the parent.

One additional point bears mention. The vicarious liability laws and doctrines do not relieve the driver of his liability; they merely make the other party (owner or parent) jointly liable.

Guest Laws

The second statutory modification of the principles of legal liability with respect to the automobile involves the liability of a driver or owner toward the passengers of his automobile. So-called "Guest Laws" have been enacted in many states, which restrict the right of the passengers of an auto to sue the owner or the driver. For example, Section 321.494 of the Code of Iowa specifies that the owner or operator of a motor vehicle shall not be liable for injuries to a guest unless the injury is "caused as a result of the driver of said motor vehicle being under the influence of intoxicating liquor or because of the reckless operation by him of such motor vehicle." The obvious reason for this modification is the opportunity which such suits would present for defrauding insurance companies. In the absence of such laws, the guest in an automobile who was injured might easily induce the driver to admit liability in return for a portion of the settlement which the driver's insurance company might make with the insured guest. Under a standard guest law, the injured guest can collect from the negligent driver only if the driver was operating the automobile in a "grossly negligent manner". Gross negligence is defined as a "complete and total disregard for the safety of one's self or others". Some laws further require that the guest must protest the grossly negligent manner in which the automobile was being operated.

Automobile Liability Insurance and the Law

Basic coverage for the automobile begins with adequate liability coverage. Unless the individual has adequate limits of liability, a judgment could very easily wipe out the entire assets of the family. The question of what constitutes "adequate" limits of liability has become more and more pertinent in recent years as the size of damages assessed has increased. In spite of the unreasonableness of such a course of action, many persons operate motor vehicles without adequate liability insurance.

Until quite recently, very few of the states had taken positive steps requiring the operator of a motor vehicle to carry liability insurance. As late as 1971, only three states (Massachusetts, North Carolina, and New York) had compulsory automobile liability laws. However, with the enactment of the No-fault laws discussed later in this section, many of the states also mandated automobile liability insurance. By early 1979, 21 states had laws requiring the owners of automobiles registered in the state to have liability insurance or, in some instances, an approved substitute form of security. The states with some form of compulsory automobile insurance are California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Kansas, Kentucky, Maryland, Massachusetts, Michigan, Minnesota, Nevada, New Jersey, New York, North Carolina, North Dakota, Pennsylvania, South Carolina, and Utah.

Most other states (including Iowa) have attempted to solve the problem of the financial responsibility of automobile drivers through what are known as "financial responsibility laws." Under the provisions of such laws, anyone involved in an automobile accident which results in bodily injury or property damage in excess of some stated amount, must show proof within a specified period of time that the loss has been settled, or that at the time of loss he was protected by a valid automobile liability policy with certain minimum limits. The limits are usually expressed in terms of three amounts, corresponding to the three limits of liability under most automobile insurance policies. As an example, the financial responsibility law of Iowa requires a driver to show proof of financial responsibility in the amount of $10,000/$20,000/$5,000. These limits, which are usually expressed as "10/20/5", indicate that the insurance company will pay no more than $10,000 for the injuries sustained by any one person, $20,000 for all bodily injuries in one accident, and $5,000 for property damage resulting from one accident. It is important to note that not only the party at fault must show evidence of financial responsibility, but all persons involved in the accident must do so. Proof of financial responsibility is normally demonstrated by filing with the Department of Public Safety a certificate (called SR-21), which is a certification by the driver's insurance company that a valid policy was in force at the time of the accident. Failure to do so will result in a suspension of the driver's license until any judgments against him

have been paid, and until he shows proof of financial responsibility for possible future accidents. Proof of future responsibility, which may also be required as a result of certain traffic violations, is made by filing a form known as an "SR-22" in which the insurance company certifies that a policy is in effect and that the company will pay future claims against the insured.

THE AUTOMOBILE INSURANCE PROBLEM AND CHANGES IN THE TORT SYSTEM

It is not at all unusual to hear complaints about automobile insurance today. Almost everyone connected with the automobile insurance business have what they consider to be a legitimate grievance. Insurance companies complain that they are losing money because of inadequate rates. The buyers complain that the rates are already too high. Young drivers (and to some extent older ones) complain that they frequently have difficulty in obtaining coverage. Finally, many who have suffered losses maintain that the settlements do not measure up to the economic loss. With all this dissatisfaction, it is not surprising that proposals for change have found widespread support.

While a part of the criticism has been aimed at insurance, most of the critics contend that the problem today is not so much with insurance as such, but rather with our method of compensating the injured. These critics maintain that our tort system is wasteful, expensive, unfair, and excessively time-consuming; and they recommend that we abolish it for automobile accidents.

One major criticism is that many persons who are injured remain uncompensated or are inadequately compensated. The accident victim may be unable to obtain reimbursement because he himself was negligent, the guilty party is insolvent, or the guilty party is unknown, as in the case of a hit-and-run driver. Additionally, the amount of compensation that is finally awarded may depend more on the skill of the victim's attorney than on the facts. Other criticisms attack the high cost of operating the insurance mechanism, the contingency fee system, and the congestion of the courts which results in long delays before the injured are finally compensated. Finally, the critics contend, the system is too expensive, paying more for the operation of insurance companies and the work of attorneys than it delivers to those who are injured.

For these reasons, the tort system has been under attack, and numerous proposals have been made to substitute a no-fault compensation system. As noted above, a number of states have actually adopted no-fault laws.

The No Fault Concept

Under the tort system, if you are involved in an accident and the accident is your fault, you may be held liable for the injury and be required to compensate the injured party through payment of damages. If you are found negligent in an accident, your insurance company will pay for the other party's injuries. If the other party is found to have been negligent, his or her company will pay for your damages. If you are injured through your own negligence, you must bear the loss yourself, either out of existing resources or under some form of first-party insurance where the insurance company makes direct payment to you.

Under a no-fault system, there is no attempt to fix blame or to place the burden of the loss on the party causing it; each party collects for any injuries sustained from his or her own insurance company. Under a pure no-fault system, the right to sue the driver who caused an accident would be entirely abolished; and both the innocent victim and the driver at fault would recover their losses directly from their own insurance. Compulsory first-party coverage would compensate all accident victims regardless of fault. Although some no-fault proposals have included abolition of tort actions for damage to automobiles, the principal focus has been on bodily injuries.

Differences Among Proposals

Although the basic no-fault concept is simple enough, several modifications of the idea have developed; and there are significant differences among the various proposals. Unfortunately, there is a tendency to refer to every proposal for reform of the automobile liability system as a "no-fault" plan. It is important to distinguish among the various approaches. Basically, the proposals for reform fall into one of three major classifications.

1. **Pure no-fault proposals.** Under a pure no-fault plan, the tort system would be abolished for bodily injuries arising from auto accidents. (Some proposals would also abolish tort actions for damage to automobiles.) Anyone suffering loss would seek recovery for medical expenses, loss of income, or other expenses from his or her own insurer. Recovery for general damages (pain and suffering) would be eliminated.
2. **Modified no-fault proposals.** Modified no-fault proposals would provide limited immunity from tort action to the extent that the injured party was indemnified under a first-party coverage. Tort action would be retained for losses above the amount recovered under first-party coverage. In some of the modified no-fault plans, payment for pain and suffering would be limited or eliminated.
3. **Expanded first-party coverage.** Here there is no exemption from tort liability. Instead, the injured party collects benefits under a first-party coverage, retaining the right to sue for losses in excess of the amount paid by the first-party coverage. Most important, the responsibility of the negligent driver is retained by permitting subrogation by the insurer paying the first-party benefits.

Unfortunately, the "no-fault" label is frequently applied to all three classifications. It is clearly a misnomer to refer to the expanded first-coverage approach as no-fault. Plans in this category, which do not change the tort system, cannot be called no-fault plans any more than fire insurance, health insurance, or even life insurance are no-fault plans. Before a plan qualifies as "no-fault," the requirement that motorists carry first-party coverage to protect themselves against medical expenses and loss of income must be accompanied by some restriction or outright elimination of the right to sue, together with the elimination of subrogation rights by the insurer making payment.

Existing State Laws

By 1979, a total of 16 states had passed no-fault legislation. In addition, eight others had enacted laws that are frequently referred to as "no-fault," but which in reality are expanded first-party coverage systems.

There are vast differences among the modified no-fault laws, not only in benefit levels, but also in the tort exemption. Benefits range from a modest $2,000 to unlimited medical expenses and wage-loss benefits. Most of the existing laws permit accident victims to sue for general damages when medical costs exceed a certain "threshold" level. In eleven of the states, the threshold is $1,000 or less, and in seven it is $500 or less. Florida and New York do not use a dollar threshold, but permit recovery for pain and suffering when disability exceeds 90 days.

AUTOMOBILE INSURANCE FORMS

There are many automobile forms in use in the United States today. Some of these policies were designed to cover specialized types of risks, while others were differentiated for the purpose of competition. Many companies have developed independent forms which differ in some details from the bureau forms. We will confine our discussion to the bureau forms, for virtually all policies are based on these forms.

There are three basic policy forms in use today:

1. **The Family Automobile Policy.** This policy form is passenger automobiles (including station wagons and jeeps) ¾ ton farm trucks, and ¾ ton utility trucks. The Family Auto Policy, (or the FAP as it is called) constitutes the broadest form of protection available to the individual.

2. **The Special Auto Policy.** The Special Auto Policy is designed for the same classes of business as the FAP. It is distinguished by a single limit of liability (e.g., $25,000 rather than the more familiar $10,000/$20,000/$5,000). Many of the provisions of the Special Auto Policy are more limited than the provisions of the FAP. The Special is often written on a continuous form, under which the policy remains in force as long as the premiums are paid. In many cases the premium is paid directly to the insurance company rather than to the agent, under a so-called "direct billing" approach. The Special is also often written with a "safe driver rating plan", under which the insured is rewarded with a discount at renewal if he has not had any accidents.

3. **The Personal Automobile Policy.** The Personal Automobile Policy is the newest form of coverage available, first introduced by the Insurance Services Office in 1977. It is written in simplified terminology and it is anticipated that it will eventually replace both the Family Auto Policy and the Special Auto Policy.

4. **The Standard or Basic Automobile Policy.** This contract, which is far more complicated than either the Family Auto Policy or the Special Auto Policy, is used to insure most commercial vehicles. It is also used to insure any other vehicles owned by an individual which do not qualify for either the Family Auto Policy or the Special. In most respects the coverage is more limited than that of either the FAP or the Special.

THE FAMILY AUTO POLICY

The automobile policy that will be examined in detail is the Family Auto Policy. It is by far the most widely sold of the automobile forms, broadest of the forms, and by far the most important from an educational point of view.

As noted previously, the automobile insurance policy is one of the most complicated of all insurance contracts. The complicated nature of the contract results from the need to provide a contract which will provide coverage against different types of losses, and under many differing circumstances. The ownership or operation of an automobile involves three possibilities of loss:

1. Legal Liability
2. Injury to the insured or members of his family
3. Damage to or loss of the automobile

The FAP is a package policy, providing protection against all three of these losses. The policy is a combination of three types of insurance: liability insurance, health insurance, and property insurance on the automobile itself.

In addition to the various types of losses protected against, the policy must provide protection in various situations. In a highly mobile society such as ours, most people operate motor vehicles; and in many cases the automobile being operated may not be owned by the operator. For example, Jones may loan his auto to Smith; and as we have seen, Jones may be held liable with Smith if Smith is negligent. Therefore it is necessary to devise a contract which will protect the insured when someone else is operating his automobile. In addition, it is deemed desirable to provide protection for the insured when he is operating someone else's automobile. Both of these requirements add to the complicated nature of the contract.

The FAP is composed of four basic types of coverage, and is divided into four sections. Each of the four sec-

tions constitutes a different form of insurance, and two of the sections are further subdivided into various coverages. The FAP is a five page contract, with 25 definitions, 26 exclusions, and a large number of extensions, conditions, provisions, and stipulations. A Speciman of the FAP should be referred to in following the discussion of the contract.

For our purposes, the important portions of the contract will be the coverages and sections listed below:

Section I
Coverage A — Bodily Injury Liability
Coverage B — Property Damage Liability
Section II
Coverage C — Medical Payments
Section III
Coverage D — Comprehensive
Coverage E — Collision
Section IV
Coverage J — Uninsured Motorists

Section I — Liability

Section I of the FAP is the liability coverage. It is composed of two insuring agreements, designated Coverages A and B. Coverage A, which covers bodily injury liability, has two limits of liability, one limit which is the maximum which the company will pay for injury to any person, and a second, which is the maximum which the company will pay for all persons injured in one accident. The "per occurrence" limit is two or three times as large as the per person limit. Thus the insured has an option of the various combinations of limits for bodily injury listed below, in addition to other higher limits:

$10,000 per person/$20,000 per occurrence
$25,000 per person/$50,000 per occurrence
$50,000 per person/100,000 per occurrence
100,000 per person/300,000 per occurrence

The property damage limit of liability is the maximum amount which the company will pay for damage to the property of others as the result of one occurrence. The options available under the property damage insuring agreement are $5,000, $10,000, $25,000, $50,000, and $100,000.

The insuring agreements for Coverages A and B are extremely broad, promising to pay all sums which the insured becomes legally obligated to pay as damages because of either bodily injury or property damage, arising out of the ownership, maintenance, or use of either an owned automobile or a non-owned automobile.[13]

Supplement Payments

In addition to paying the sums which the insured is legally obligated to pay, the liability section includes another set of promises which are extremely important. First, the company promises to defend the insured in any suit which is brought alleging negligence in the operation of an owned or non-owned automobile. This promise is in effect a legal retainer which is always available to the insured in the event that he is sued for negligence in connection with the operation of an automobile. The promise to defend is in addition to the promise to pay any judgment, and any expenses incurred in investigation or defense are payable in addition to the maximum limit of liability. To illustrate, let us say that Jones has an FAP with the basic 10/20/5 limits of liability, and that he is sued for $20,000 by an injured party. The policy will pay $10,000 of the judgment under insuring agreement A, and will pay any court costs and defense costs in addition to this.

In addition to the promise to defend, the policy also promises to pay the cost of any appeal bonds, bonds to release attachments, or bail bonds which are required from the insured because of an accident or traffic law violation connected with an automobile. This last provision, relating to bail bonds, is often overlooked simply because insureds do not know that it exists. If the insured is arrested for speeding, drunken driving, or any other traffic violation, the policy will pay the cost of his bail bond.[14]

Finally, the company agrees to pay any expenses which are incurred by the insured at the time of an accident in providing immediate surgical or medical care to a person injured in an accident involving an insured automobile, or any other expenses which are incurred by the insured, (except loss of earnings), which are at the company's request.

Persons Insured

The section of the FAP entitled "Persons Insured" is one of the most crucial portions of the contract. There are four types of individuals covered under the liability section of the policy, and this coverage is provided for both owned and non-owned automobiles. The FAP includes a "severability of insureds" provision similar to that of the CPL, which states that the insurance afforded under the policy applies separately to each insured against whom suit is brought. Thus one insured under the policy could sue another insured and the insurance company will be required to respond for any damages which are assessed by the court.

[13]The terms "owned automobile" and "non-owned automobile" have precise meanings and are defined in the policy. For the present we may consider an owned automobile to be the automobile described in the policy, and a non-owned automobile any other automobile not owned by the insured or a member of his family.

[14]However the company is not required to furnish the bond; it will merely pay the cost of the bond. Suppose Mr. Jones is arrested for speeding, taken to jail, and his bond is set at $500. If the bondsman charges 10% of the bond, the insurance company will pay the $50 fee which the bondsman charges for posting the $500.

Persons Insured — Owned Automobile. The following persons are insured with respect to the owned automobile:

1. The Named Insured (including a spouse if a resident of the same household).
2. Residents of the same household.
3. Any other person using the owned automobile with the permission of the Named Insured.
4. Any other person or organization who might be held vicariously liable because of negligence on the part of one of the three above listed insureds.

Note that the definition of "Named Insured" in the policy includes the spouse of the person listed in the declarations. This is an important point, since the coverage afforded under the policy for a "Named Insured" is considerably broader than the coverage for other insureds.

Residents of the insured's household other than a spouse are also covered as insureds under the policy, and do not need the permission of the Named Insured to be covered while operating the owned automobile. The term "resident" has a special legal connotation and may extend beyond the named insured's household. If a relative, such as a son or daughter, is temporarily away from home, he or she is still considered to be a resident if he considers the named insured's home to be his residence and intends to return to it.

In addition to the coverage provided for the named insured and residents of his household, the policy provides coverages for any other person using the owned automobile, provided that they have the permission of the Named Insured. Note that only the Named Insured, (including a spouse if a resident of the same household), can give permission and have coverage apply. Although children residing in the insured's household are "Insureds" under the policy, they are not "Named Insureds" and they cannot, therefore, permit friends to drive the owned automobile and have coverage apply.

The inclusion of any person who might be held vicariously liable because of the negligence of an insured is intended to provide liability protection for the employer of anyone who might be operating the automobile as an "insured", (i.e., the named insured, a resident of the same household, or someone else who is operating the automobile with the permission of the Named Insured). Employers often request that they be named as additional insureds under their employee's auto policy, but this provision makes such action unnecessary.

Persons Insured—Nonowned Automobile. As in the case of the definition of persons insured for the owned automobile, the definition of persons insured for a nonowned automobile is quite specific. Coverage is provided for the following parties with respect to a nonowned automobile while being used with the permission of the owner:

1. The named insured (including a spouse if a resident of the same household)
2. Resident relatives, but only with respect to a nonowned private passenger automobile
3. Any other person or organization, except the lender of the nonowned automobile, who might be held vicariously liable because of negligence on the part of one of the above listed insureds

Note first the coverage for nonowned automobiles is provided only for the named insured and resident *relatives.* Note also that resident relatives are covered only for the use on nonowned private passenger automobiles. The named insured, on the other hand, is covered while operating any automobile (a truck for instance). Note finally that no coverage is provided for the owner of the nonowned automobile.

The coverage granted for non-owned automobiles can be a source of great difficulty as far as the liability coverage of the Family Auto Policy is concerned. Let's take a simple example and explore the possibilities. For the sake of our example, let us assume that Mr. Jones has an FAP with himself as the Named Insured, with liability limits of $10,000/$20,000/$5,000. His neighbor, Mr. Smith, also has an FAP with the same limits. Mr. Jones has a son and Mr. Smith has a daughter. On the evening in question, Jones Jr. is driving his father's car. Of course he is insured, since he is a resident of his father's household. Smith's daughter asks Jones Jr. to teach her how to drive and Jones Jr. agrees. This proves to be a serious mistake for shortly after Miss Smith gets behind the wheel she smashes into a bus, caroms into three other vehicles, and finally hits a pedestrian. The law suits may very well be substantial, and Miss Smith is in real trouble. Is there any coverage under either of the two policies to protect her from the liability which she incurs? Unfortunately the answer is no. Jones' policy will not provide any protection because she did not have permission of the **Named Insured.** Children may be insured under their parent's policies, but they do not enjoy the right to grant permission to others. By the same token Miss Smith will not have coverage under her father's policy, for the drive-other-car coverage of his policy requires that the nonowned automobile be operated with permission of the **owner.** Since she does not have the permission of the Named Insured, Jones' policy will not provide coverage. Since she does not have permission of the owner of the non-owned automobile (who in this case is Jones Sr.) she does not have coverage under her father's policy. Is she had had the permission of Jones Sr., then both policies would have applied.[15] In such situations,

[15]Some may say "This may all be very true, but the only thing that Miss Smith has to do is to get Mr. Jones to say that she had his permission. If he will just do this, then both policies will cover her". As you will recall from the discussion of vicarious liability as it relates to the automobile, the owner of an automobile is held liable for the operation of his auto by someone else who is operating the auto with his permission. Since by admitting that Miss Smith had his permission Jones would leave himself open for a substantial amount of legal liability, he may be reluctant to say that Miss Smith had his permission.

that is, in those cases where there are two policies that may cover the loss, the insurance on the car being driven is primary. It will pay first; after the limits of liability under the policy covering the auto being driven have been exhausted, the excess policy will apply.

Important Definitions

Certain of the definitions of the FAP are particularly important. Perhaps the two most important are the definitions of an "owned automobile" and a "non-owned automobile". Under the FAP, an **owned automobile** is defined as:

(a) a private passenger, farm or utility automobile described in this policy for which a specific premium charge indicates that coverage is afforded.

(b) a trailer owned by the Named Insured.

(c) a private passenger, farm or utility automobile ownership of which is acquired during the policy period provided

(1) it replaces an owned automobile as defined in (a) above

(2) the company insures all private passenger, farm or utility automobiles owned by the Named Insured on the date of such acquisition and the Named Insured notifies the company during the policy period or within 30 days of the date of such acquisition of his election to make this and no other policy issued by the company applicable to said automobile, or

(3) a temporary substitute automobile.

The portion of this definition that deserves attention is the part dealing with the acquisition of a new automobile during the policy period. As the provisions of the definition indicate, there is automatic coverage on a new car purchased by the insured, if it replaces an auto which was insured under the policy. Even in the case of an additional automobile, the policy will provide automatic coverage, provided that all of the automobiles owned by the Named Insured are insured by the company. For instance, if Mr. Jones has a 1956 Ford and he trades it on a 1965 Ford, the 1965 Ford will be covered automatically. If, on the other hand, he **keeps** the 1956 Ford **and** buys a 1965 Ford, the additional auto will be covered only if Jones does not have any other cars which are insured in some other company. Of course the company is entitled to an additional premium for covering the additional auto; but even if Jones has an accident before he notifies the company about the additional auto, the policy will cover him. Note that notice to the company is required only during the policy period or within 30 days; notice within either period will provide coverage.

A **non-owned automobile** is defined in the policy as an automobile or trailer not owned by or furnished for the regular use of the named insured or relative who is a resident of his household. This means that the liability coverage of one member of the family will not apply to an automobile owned by another member of the family. If the father has an automobile insured in his name, and the son owns an automobile insured in his name, the father's insurance will not cover him while he is driving the son's car. As far as the father's policy is concerned, the son's car is not a "non-owned automobile", for it is owned by a relative who is a resident of the same household. At the same time, it is not an "owned auto", since it does not meet the definition of "owned auto" in the father's policy. In the event the father drives the son's car, only the insurance on the son's car will apply. This can be an important factor. Most insurance companies are unwilling to write high limits of liability on automobiles operated by youthful drivers. If the father has high limits of liability on his own car, he may feel adequately protected while driving the son's car, which might have minimum limits. In the event of an accident, the father will find to his dismay that his policy does not protect him while driving the son's car.[16]

On the other hand, if either the father or the son is operating a private passenger automobile which qualifies as a non-owned automobile, both policies will apply. For example, let us say that both Jones and Jones Jr. have their automobiles insured under the FAP, each with $10/20/5 limits of liability. If Jones Jr. is involved in an accident while driving a friend's private passenger automobile with permission, both policies will provide coverage on an excess basis (after the insurance on the car being driven). Jones Jr. has drive-other-car coverage under his own policy; and as a resident of his father's household, he also has drive-other-car coverage for a private passenger automobile under his father's policy.

Trailers

Under the liability section of the FAP, the definitions of both an "owned automobile" and a "non-owned automobile" include a "trailer". A trailer is defined as:

> a trailer designed for use with a private passenger automobile, if not being used for business or commercial purposes with other than a private passenger, farm, or utility automobile, or a farm wagon or farm implement while being used with a farm automobile.

This definition is sufficiently broad to include virtually any type of trailer. The only restrictions imposed are that the trailer must be designed for use with a private passenger auto, and if it is being used for business, it must be used with a private passenger, farm, or utility automobile. If it is not being used for

[16]There is one exception to this statement. The son's auto might qualify as a "temporary substitute automobile", if it is being used by the father while his own car is withdrawn from use because of mechanical breakdown, servicing, or repair. A temporary substitute automobile may be owned by a resident of the insured's household, although it may not be an auto owned by the Named Insured himself.

business, a trailer is covered when used with any automobile.

The coverage afforded under the FAP for trailers is an important feature of the policy. Under the basic auto policy, and at least one major non-bureau form, the liability coverage on the automobile is suspended if the auto is used with any trailer (except a utility trailer), which is not specifically insured in the same company. Not only are both owned and non-owned trailers covered under the liability section of the FAP, but there is no additional premium required for such coverage.

Exclusions

There are ten exclusions under the liability portion of the Family Auto Policy:

Exclusion (a) excludes liability while the insured automobile is used as a public or livery conveyance. There is no intent under this exclusion to exclude coverage when the insured uses his auto in a car pool or a similar arrangement. The basic characteristic of a public or livery conveyance is the fact that the insured has no control over who he carries. If the insured carries fellow workers to the job and charges them, this does not make his auto a public or livery conveyance.

Exclusion (b) deals with damage caused intentionally or at the direction of the insured. Since the policy is written on an occurrence basis rather than on an accident basis, this exclusion is necessary to eliminate coverage for intentional torts. As noted previously, such coverage would be contrary to public policy.

Exclusion (c), which deals with nuclear energy liability, and exclusion (d), which excludes liability arising out of the operation of farm machinery, are self explanatory.

Exclusions (e) and (f) both deal with liability in connection with persons who are entitled to workmen's compensation benefits. Exclusion (e) excludes bodily injury liability to employees of the insured if workmen's compensation benefits are payable or required to be paid under a workmen's compensation law. Exclusion (f) deals with liability to fellow employees of the insured, and excludes liability to fellow employees if they are injured as a result of the operation of an insured automobile in the business of the employer. However, the exclusion states that the exclusion does not apply to the Named Insured. In other words, if the Named Insured should be sued by a fellow employee who was entitled to workmen's compensation benefits, the policy would protect the Named Insured. The basic intent of this provision is to exclude the employer from coverage for bodily injury to a fellow employee of the Named Insured.

Exclusion (g) excludes liability completely when the auto is used in the automobile business by anyone except the Named Insured, a resident of the same household, a partner of the Named Insured, or an agent or employee of the Named Insured. The basic intent is to deny liability coverage for a garage or other automobile business which might have custody of the automobile. This liability must be covered under a separate business contract. If Mr. Jones takes his automobile into a garage to have it serviced, his FAP will not provide protection to the garage or to an employee of the garage who is driving or testing the automobile.

Exclusion (h) is similar to exclusion (g), in that it deals with business use of automobiles. This exclusion excludes any non-owned automobile from coverage while it is being used in the automobile business, or any other business of the insured. The exclusion states that it does not apply to the named insured with respect to a private passenger auto operated by the named insured in a business other than the automobile business. Thus the exclusion would not provide coverage for the Named Insured while operating a non-owned automobile in the automobile business, but it would cover him while operating a non-owned private passenger auto in any other business. The intent of this provision is to exclude coverage for automobiles that should be insured under a business liability policy. If the named insured works for a garage, his FAP will not provide protection while he is driving a non-owned auto in connection with his occupation.

Exclusion (i) is one of the most important of all of the exclusions. It states:

> This policy does not apply under Part I to injury to or destruction of (1) property owned or transported by the insured or (2) property rented to or in charge of the insured other than a residence or private garage.

This is the "care, custody, and control" exclusion of the FAP. It is important because it modifies the coverage which is provided with respect to "non-owned automobiles." When the insured borrows or rents an automobile, the liability exposure connected with the operation of that non-owned automobile is covered, **except** with respect to damage to the non-owned automobile itself. For example, let us say that Mr. Jones rents a car from "Hertz." His FAP will pay for any damage which he causes in connection with the use of the rented automobile, but it will not pay for damage to the Hertz car itself, for the car is property which is "rented to or in charge of the insured". It is important to remember that the liability coverage of the FAP will not provide indemnification for damage to an automobile that is borrowed or rented.

Section II — Medical Payments

Medical payments coverage has been available in one form or another in the automobile liability policy since 1939. Under the medical payments section of the policy, coverage is provided for necessary medical, surgical, dental, and funeral expenses which are incurred within one year from the date of an accident.

Medical payments coverage is divided into two sections, corresponding to earlier forms of coverage which were called "basic medical payments" and "extended medical payments". The medical payments coverage originally applied only if the insured or a member of his family were injured while occupying an auto. This was the basic medical payments. The coverage could be extended to provide coverage if the insured or a member of his family were merely struck by an automobile.

Division 1 of the medical payments section provides protection for the named insured and each relative who suffers bodily injury caused by accident, while occupying or through being struck by an automobile. By policy definition, the term "occupying" is stated to include in or upon or entering into or alighting from. This division, Division 1, covers the Named Insured and resident relatives of his household.

Division 2 provides coverage for persons other than the Named Insured and members of his household, but the coverage is not as broad as that provided under Division 1. Persons covered under Division 2 are covered only when they are occupying an automobile under certain conditions. First, they are covered while occupying an owned automobile, while it is being used by the named insured, a resident of the household, or any other person who has the permission of the named insured. In addition, they are covered while occupying a non-owned automobile, provided that the injury results from the operation or occupancy of the non-owned automobile by the named insured or a resident relative. As under the liability section, the relative has coverage only for a non-owned private passenger automobile, while there is no such restriction with respect to the Named Insured. Both the Named Insured and resident relatives must have the permission of the owner of the non-owned automobile, and the operation must be within the scope of the permission.

It is important to note that the insuring agreement which provides the medical payments coverage is a separate insuring agreement. Unlike the medical payments of the CPL, the medical payments of the FAP are designed to pay for members of the insured's family and others who are occupying an automobile operated by the Named Insured or a resident relative, or who are occupying the owned automobile with the permission of the Named Insured. Medical payments coverage **does not** apply to persons who are injured by the insured unless they are occupants of an insured automobile.

One of the important features of the medical payments coverage is that it applies to the named insured or resident relatives when they are struck by an automobile, even though they may not be in an automobile at the time. A child of the insured might be struck by an auto while crossing the street. In such a case, the medical payments of the family auto policy would pay for the medical expenses involved, up to the limit available.

The basic limit of liability under the medical payments portion of the policy is $500 per person, with no maximum limit per accident. For a small additional premium, (a few dollars per year), this limit can be increased to any amount up to $5,000 per person, with no aggregate limit per accident.

Exclusions under Medical Payments. There are relatively few exclusions under the medical payments section of the FAP.

Exclusion (a) excludes injury sustained while occupying an owned automobile which is being used as a public or livery conveyance, or a trailer that is being used as a residence, such as a house trailer.

Exclusion (b) excludes injury sustained by the Named Insured or a resident relative as a result of being struck by a farm type tractor or other equipment designed for use off of public roads unless it is on public roads, or as a result of being struck by a vehicle operated on rails or crawler treads.

Exclusion (c) deals with persons covered under Division 2, and excludes payment to such persons while occupying a non-owned automobile which is being used as a public or livery conveyance or which is being used in the automobile business. In addition, there is no coverage for injuries to such persons while occupying any non-owned automobile used in business unless the injury results from the operation or occupancy of a private passenger automobile by the Named Insured, his private chauffeur, or domestic servant.

Exclusion (d) deals with injuries sustained by a person who is entitled to workmen's compensation benefits. The coverage is extremely broad in this respect. Medical payments are payable in addition to any benefits payable under workmen's compensation unless the individual is employed in the automobile business.

Many people underestimate the importance of adequate limits under the medical payments portion of the auto policy. Those who have hospitalization policies often feel they can do without this coverage. Yet this coverage is probably one of the best insurance buys available. It is designed to cover not only the members of the insured's family, but also guests in the car. Every responsible motorist feels a sense of obligation to his passengers; yet if these passengers are injured due to the negligence of the driver, the guest hazard statute would probably prevent them from collecting. A driver who has high limits of liability can meet the obligation which he feels without forcing the guest to resort to legal action. This is probably one of the most important points concerning medical payments coverage: it is not a liability coverage. There need have been no negligence or liability in order to collect under the medical payments portion of the policy. The medical payments coverage provided under the FAP is simply a specialized type of health insurance which has been made

a part of the auto policy. The benefits under this coverage are payable in addition to benefits which may be received from other sources. For example, if Mr. Smith is struck by an automobile, his medical payments coverage will pay any medical expenses which result, up to the limit of the coverage. In addition, Mr. Smith may sue the driver of the vehicle which struck him and collect for his medical expenses, for there is no subrogation provision applicable to the medical expense coverage. In addition, medical payments under the FAP are made regardless of coverage under any other health and accident policy which the insured may have.

Section IV — Uninsured Motorist Coverage

Uninsured Motorist Coverage, designated Coverage J in the FAP, is designed to protect the insured and members of his family from the acts of financially irresponsible motorists. In spite of the financial responsibility laws and the dictates of common sense, some people still drive without automobile liability insurance. Uninsured motorist coverage is designed to meet the need for protection against bodily injury which an insured may suffer as result of being struck by an uninsured driver or a hit and run driver.

In its simplest terms, Section IV promises to pay the amount which a person insured could have collected from the insurance company of an uninsured driver or a hit and run driver, if such a driver had carried automobile liabilty insurance. The coverage is an attempt by the insurance companies to provide a solution to the problem of uninsured drivers and forestall compulsory automobile insurance.

Persons Insured. Under Section IV, an insured person includes:

1. The named insured and resident relatives
2. Any other person while occupying an insured automobile.
3. Any person, with respect to damages he is entitled to collect because of bodily injury to the named insured, a resident relative, or any other person occupying an insured automobile.

Note that the Named Insured and resident relatives are covered even when they are not occupying an automobile. If the insured or a resident relative is struck by an uninsured automobile, there is coverage. Others are covered only while actually in an automobile which is covered under the policy as an "owned automobile" or a "non-owned automobile."

There are five situations in which coverage does not apply:

1. If the insured is involved in an accident with an automobile that is insured for an amount at least equal to the minimum limits of liability required by the financial responsibility law of the state, there is no coverage under the Uninsured Motorist coverage.
2. If the insured is involved in an accident with an automobile which is owned or operated by a qualified self insurer, there is no coverage under the Uninsured Motorist section.
3. If the insured is involved in an accident with a government owned vehicle, there is no coverage under the Uninsured Motorist section, even though the government vehicle may be uninsured.
4. If the insured is involved in an accident with an automobile owned by the Named Insured or any resident of the Named Insured's household, there is no coverage under Uninsured Motorists coverage, regardless who is operating the uninsured auto.
5. There is no coverage under the Uninsured Motorist section if the insured or his representative makes any settlement with the guilty party without written consent of the insurance company.

Limit of Recovery Under Section IV

The basic limits of liability for the Uninsured Motorists Coverage are $10,000 per person and $20,000 per accident. When the insured has purchased higher limits for his own Bodily Injury liability coverage, he may select a higher Uninsured Motorist coverage limit. For example, an insured who has purchased $50,000/$100,000 Bodily injury limits or $100,000/$300,000 Bodily Injury limits is eligible for the same limits of coverage under the Uninsured Motorist Coverage. When the higher limits of Uninsured Motorist coverage is purchased, the policy covers losses caused by "underinsured motorists" as well as "uninsured" motorists. An "underinsured" vehicle is any vehicle with liability limits less than the applicable limits under Section IV of the policy. It should be noted that this coverage applies only to bodily injury caused by an uninsured or underinsured motorist, and that it does not afford coverage for property damage caused by such a motorist.

There is a possibility that the insured and the company may not be able to agree as to whether the operator of the uninsured automobile is legally liable, or on the amount to which the insured would have been entitled to collect. The policy specifically provides that a judgment against the negligent party is not taken to be conclusive proof of the amount to which the insured is entitled under Section IV. In the event that the insured and the company cannot agree, the policy provides that settlement is to be made through arbitration in accordance with the rules of the American Arbitration Association.

Uninsured Motorist coverage is an essential part of the Family Auto Policy. In some jurisdictions this coverage has been made mandatory on all policies sold. In view of the relatively low cost of the coverage, ($3.00 per year), it is an exceedingly worthwhile coverage and should be included in every policy. In the state of Iowa it is included in all policies unless specifically rejected by the insured.

Underinsured Motorist Coverage. A variation of the Uninsured Motorist Coverage concept, which has recently become available in many states as an optional endorsement to the Family Automobile Policy, is called "Underinsured Motorist" coverage. Underinsured Motorist coverage provides for payment, up to the limits specified for the coverage, of sums which the insured could have collected from the insurer of a negligent driver in those instances where the other driver had insurance, but where the limits of his or her policy are inadequate to pay the damages suffered and are also less than the limit of the Underinsured Motorist Coverage. Coverage is available up to the limits of the bodily injury liability coverage of the policy, usually with a maximum of $100,000 per person and $300,000 per occurrence. Although this coverage developed out of the Uninsured Motorist Coverage, it does not in any sense duplicate or overlap with Uninsured Motorist coverage. Uninsured Motorist coverage applies when the driver of the other automobile does not have insurance, is a hit-and-run driver, or in some states, if the insurer of the negligent driver becomes insolvent. Underinsured Motorist coverage applies only when the other driver had insurance, but the limits are less than the amount to which the injured person is entitled to collect and also less than the limits of the Underinsured Motorist Coverage.

Section III of the FAP — Physical Damage

As noted previously, the ownership or operation of an automobile involves three possibilities of loss:

1. Legal Liability
2. Injury to the insured and passengers in the automobile
3. Damage to or loss of the automobile

Thus far, it has been demonstrated that the Family Automobile Policy does a remarkable job of filling the first two of these needs. All that remains now is to provide protection for the insured or damage to or loss of his own automobile.

The physical damage section of the Family Auto Policy provides coverage against loss of the automobile or damage to the automobile. There are six coverages available:

Coverage D — Comprehensive
Coverage E — Collision
Coverage F — Fire, Lightning, and Transportation
Coverage G — Theft
Coverage H — Combined Additional Coverage
Coverage I — Towing and Labor Cost

We will confine our discussion, for the most part, to the first two of these six coverages, comprehensive and collision. These are the coverages that are most frequently purchased. As we shall see, Coverage D (comprehensive) includes protection against all of the perils insured against under Coverages F, G, and H. These coverages are seldom used, simply because the difference in cost between them and comprehensive, (which is an all risk coverage), is so small.[17]

Coverage D — Comprehensive

Comprehensive is essentially an "all risk" type of property insurance. Under the comprehensive insuring agreement, the insurance company promises to pay for "loss caused other than by collision to the owned automobile or to a non-owned automobile". The purpose of excluding collision under the comprehensive insuring agreement, and then providing this coverage under a separate insuring agreement, is to permit the application of a deductible to collision losses. If it were not desirable to use a deductible on collision losses from an underwriting and price standpoint, it would be possible to combine comprehensive and collision into one insuring agreement.

The comprehensive insuring agreement states that for purpose of this coverage, breakage of glass, and loss caused by missiles, falling objects, fire, theft and larceny, explosion, earthquake, windstorm, hail, water, flood, malicious mischief or vandalism, riot or civil commotion, or colliding with a bird or animal, shall not be deemed to be loss caused by collision.

In other words, since these losses are not deemed to be losses caused by collision, they are losses covered under the comprehensive insuring agreement. The insured would prefer to have any losses that occur covered under the comprehensive insuring agreement rather than the collision coverage, since the collision coverage is written with a deductible.[18] To illustrate the intent of the above provision, suppose that Mr. Jones has an FAP with comprehensive and collision, and that the collision coverage is written with a $50 deductible. If Mr. Jones' car is stolen and later found wrecked, the insurance company will be obligated to pay the entire loss, without any deductible, for the policy specifically states that a loss due to theft shall not be deemed to be a loss due to collision.

The comprehensive coverage also provides some limited coverage on personal effects of the insured while they are in or upon the owned automobile. The coverage for personal effects is widely misunderstood, particularly in the case of the Family Auto Policy. The Family Auto Policy will pay for loss of personal effects, up to $100, while they are in or upon the owned auto-

[17]About the only time that coverages F, G, and H are sold is in the case of an older car, such as an antique. In such a situation the owner may want physical damage coverage, but the insurance company is unwilling to provide comprehensive coverage because of the broadness of the insuring agreement. As an alternative the owner can purchase the separate named peril coverage.

[18]Comprehensive coverage may also be purchased with a deductible; and while it was not common in the past, comprehensive is sold more and more with a deductible applicable.

mobile, provided that they are damaged by fire or lightning. It should be noted that this coverage is extremely limited. Fire and lightning are the only insured perils with respect to the contents of the automobile. Many persons who have their automobile insured under an FAP mistakenly think that the policy provides coverage for theft of articles from the automobile. Comprehensive includes theft coverage, but this theft coverage applies to the automobile itself, and not to articles stolen from the automobile.

Coverage E — Collision

The collision coverage of the FAP is simple enough to understand. The company promises:

> To pay for loss caused by collision to the owned automobile or a non-owned automobile but only for the amount of each such loss in excess of the deductible amount stated in the declarations as applicable hereto.

The insuring agreement further provides, and this is an important provision which is often overlooked.

> The deductible amount shall not apply to loss caused by a collision with another automobile insured by the company.

The deductible amount is normally either $50 or $100, although other options are available.

Under the collision portion of the policy, the company promises to pay for damage to the owned automobile (and to non-owned automobiles, a provision which will be discussed later), which is caused by collision with another object or by upset, no matter whose fault the accident is. Collision coverage can therefore be a valuable coverage even if the accident is not the insured's fault. In those cases where the driver of the other automobile is at fault, we would expect his liability coverage to respond for damages to the owned automobile. However, the other party may not have insurance. If the innocent driver has collision coverage, he can collect the amount of loss (less any deductible) and then leave the task of collecting from the negligent driver to his insurance company. The physical damage section of the FAP includes a subrogation provision, under which the insured is required to assign to the company all right of claim against a negligent third party, to the extent that he collects from his insurance company. Also, in the case where the insured is at fault, his collision coverage will pay for the damage to his automobile, in addition to the payment made under liability for damage to the other party's automobile.

Non-owned Automobile Coverage Under Section III

Drive-other-car coverage similar to the liability coverage is also provided under the physical damage section of the policy. The insured is protected from the financial consequences which he might suffer if he damages an automobile which he has borrowed or rented. As you will recall from our discussion of the liability section of the policy, there is a liability exclusion relating to the property of others in the care, custody, or control of the insured. If Mr. Jones borrows Smith's car, his liability policy will provide protection for any damage which he causes, but it will not provide coverage for damage to Smith's car. However, if Jones also has comprehensive and collision coverage, these coverages will apply to Smith's auto as a "non-owned automobile." Coverage is provided with respect to a non-owned automobile regardless of whether or not the insured is legally liable.

The coverage with respect to a non-owned automobile is excess. In other words, if Smith has collision coverage, Jones' collision coverage will apply only after Smith's policy has paid. If Smith has no collision coverage, then Jones' policy will pay for the loss, less the deductible. If the deductible on the non-owned automobile is higher than the deductible on the policy which is excess, the excess policy will pay the difference between the deductibles. Perhaps another example will serve to illustrate the point.

Mr. Smith has a 1975 Chrysler, which he has insured under an FAP with a $100 deductible on the collision coverage. Jones, who wishes to impress a young lady which he has just met, borrows Smith's car. Jones has a 1937 Nash, also insured under an FAP, but with $50 deductible under the collision coverage. While showing the young lady what a superior driver he is, Jones piles the Chrysler into a brick wall and totally demolishes it (the car, not the wall). Since the coverage on the automobile being driven is primary, Smith's policy will pay for the damage to the Chrysler, less the $100 deductible. As excess coverage, Jones' policy will pay the amount of the remaining loss, ($100, less his deductible — $50). Jones' policy will theretofore pay an additional $50. Jones will probably have to pay the remaining $50 himself or lose Smith's friendship (or possibly both).

The drive-other-car coverage under Section III of the policy is somewhat more limited than the drive-other-car coverage of the liability section. Under the physical damage coverage, the Named Insured and resident relatives are covered for physical damage to an automobile which they are driving or which is in their possession; however, a non-owned automobile is defined more narrowly under the physical damage section than it is under the liability section. As you will recall, the named insured has drive-other-car liability coverage for any type of automobile, while the resident relatives are covered only for a private passenger automobile. Under the physical damage section, both the named insured and resident relatives are covered only for non-owned private passenger automobiles. Again, as under the liability section, a non-insured automobile is defined as an automobile which is not owned by or furnished for the regular use of the named insured or a resident relative.

Trailers Under Section III

Under the physical damage section of the FAP, an owned trailer is covered against loss under collision or comprehensive only if the trailer is listed and a premium paid therefore. In addition, the definition of a trailer is somewhat more limited under Section III than under the liability coverage. Under the physical damage coverage, a trailer is defined as:

> a trailer designed for use with a private passenger automobile, if not being used for business or commerical purposes with other than a private passenger, farm, or utility automobile, and if not a home, office, store, display or passenger trailer.

Under the definition of a non-owned automobile in the physical damage section, a non-owned utility automobile is covered against loss under comprehensive and collision, but with a maximum limit for any loss of $500.

Physical Damage Supplementary Payments

The supplement payments portion of the physical damage coverage provides certain additional benefits to the insured without additional premium. The supplementary payments are in a sense "fringe benefits" which have been added to the contract over a period of time as competitive devices. The most important of the supplementary benefits under the physical damage section is the promise to pay for loss of use following the theft of the owned automobile; the company agrees with the insured:

> to reimburse the insured for transportation expenses incurred during the period commencing 48 hours after a theft covered by this policy of the entire automobile has been reported to the company and the police, and terminating when the automobile is returned to use or the company pays for the loss; provided that the company shall not be obligated to pay aggregate expenses in excess of $10 per day or totaling more than $300.

The payment for loss of use as a result of the theft of the automobile is payable in addition to the applicable limit of liability for the automobile.

The physical damage coverage under both comprehensive and collision is on an "actual cash value" basis. The company is not required to replace the used automobile with a new one. As a matter of fact, the company may not replace the automobile at all. The policy provisions give the company three options in loss settlement:

1. The company may pay for the loss is cash.
2. The company may repair the damaged property.
3. The company may replace the damaged property.

The choice of which option it elects is up to the company. If the insured and company cannot agree on the amount of a loss, either party may, within a period of 60 days after the submission of the proof of loss, demand an appraisal of the loss. The procedure used in appraisal is the same as that under the fire policy. Each party selects a competent and disinterested appraiser; the appraisers then selects a competent and disinterested umpire. The appraisers independently determine the amount of the loss, and failing to agree they submit their differences to the umpire. An agreement on the part of any two of the three parties involved in the appraisal is binding.

Coverage I — Towing and Emergency Road Service

The towing or road service coverage is available for a nominal premium. This coverage is designed to pay for any on the road service or charge for towing the automobile to a garage which may be necessary due to a mechanical failure. Towing is not a crucial coverage; the insured can probably afford to pay such expenses himself rather than purchase insurance protection. However, as in the case of many insignificant losses, many individuals prefer to purchase this protection rather than budget such expenses. The normal limit for this coverage is $25 per disablement.

Exclusions Under Section III

Taken together, Coverages D and E constitute a broad form of all risk coverage on the automobile. There are eight exclusions applicable to the coverage under Section III of the Family Auto Policy.

Exclusion (a) excludes loss to any automobile when it is being used as a public or livery conveyance. As we have seen, participation in a car pool, or carrying friends, even though a charge might be made, does not constitute use as a public or livery conveyance.

Exclusion (b) excludes any loss due to war.

Exclusion (c) excludes loss to any non-owned automobile arising out of its use by the insured while he is employed in the automobile business. If the insured works for a garage, his FAP will not provide coverage on customer's automobiles which he may be driving.

Exclusion (d) excludes loss to any automobile owned by the insured, which is not described in the policy, if the insured has other valid and collectible insurance against such a loss. Essentially this exclusion eliminates coverage for additional acquired automobiles, if the insured purchases insurance to cover such automobiles.

Exclusion (e) excludes damage which is due to wear and freezing, mechanical or electrical breakdown or failure, unless such loss results from a theft covered by the policy. If the insured's automobile is stolen, and when recovered is found to have suffered substantial wear and tear, the loss would be covered as a loss due to theft.

Exclusion (f) excludes loss to tires, unless they are damaged by fire, malicious mischief or vandalism, or stolen or unless the loss by coincident with and from the same cause as other loss covered by the policy. For in-

stance, if the insured suffers a blow-out while driving down the road, the loss would not be covered. However, if the blow-out happened as a result of a collision, the loss to the tire would be covered.

Exclusion (g) excludes loss due to radioactive contamination.

Exclusion (h) states that breakage of glass is excluded under Coverage E (collision), if insurance with respect to such loss is otherwise provided. In other words, if the insured has purchased comprehensive, glass breakage. If he has not purchased comprehensive, but carries collision, the glass breakage which is a result of a collision will be covered under collision, subject to the deductible.

Conditions of the FAP

There are 18 conditions to the FAP. In addition to those which have already been noted, the following are a few of the more important.

Policy Period and Territory. One of the more important conditions of the policy limits the territory in which the policy applies to the United States, its territories and possessions, or Canada, or while the auto is being transported between ports thereof. Note that there is no coverage under the policy in Mexico, a rather important exception in this day of travel. If the insured drives into Mexico, he must obtain coverage from a company in writing auto insurance in Mexico.

Two or More Automobiles. The FAP is often used to insure two automobiles which are owned by the same individual. When two or more automobiles are insured under the same policy, the terms of the policy apply separately to each automobile. An automobile and a trailer which are being used together are considered to be one automobile for the liability coverage, and two automobiles with respect to the physical damage coverage. Thus, since they are considered to be one automobile for liability, only the limits of liability listed in the policy are available to the insured. Since they are considered to be two automobiles for physical damage, the deductible would apply to each.

Cancellation. The FAP has a limited cancellation provision. The insured may, of course, cancel the policy at any time he desires. In the event that the insured decides to cancel, the return premium is computed on a short rate basis. If the company cancels, the return premium is computed on a pro-rata basis. The company's right to effect cancellation is limited after the policy has been in force for 60 days. After the policy has been in effect for 60 days, or, if the policy is a renewal effective immediately, the company cannot cancel Section I (liability coverage) except in certain instances which are specified in the policy.

In Iowa the right of an insurance company to cancel an auto policy is subject to restriction by statute, and these statutory restrictions, which are discussed later in this section, overide the restrictions in the policy.

THE SPECIAL AUTO POLICY

The Special Auto Policy has already been described briefly. At this point we will discuss the major differences between the Special and the Family Auto Policy, which has just been examined in detail.

The Special was introduced in 1959, has since been revised twice (once in 1963 and again in 1967) and marks a departure from many of the principles of the Family Auto Policy. Although the eligibility requirements are technically the same as for the FAP, the Special is written with a Safe-Driver rating which imposes surcharges for accidents and traffic violations. The underwriting requirements are more exacting in most companies.

The policy is usually written for a period of 6 months, and is renewed by a certificate of renewal rather than by being replaced with a new policy. The renewal premiums are paid by the insured directly to the insurance company, giving rise to the descriptive term "Direct Bill Policy."

There are a number of changes in coverage. In some instances the coverage is broader than that of the FAP, while in other areas it is considerably narrower. In those instances where the coverage is narrower, it is primarily a result of an attempt to avoid duplication of coverage and elimination of those situations under which an injured party might collect more than once for the same injury. The policy is a package in the sense that there are certain mandatory coverages. Liability, medical payments, uninsured motorists coverage and an accidental death benefit come as a package and the insured must purchase all of them. These are referred to as Part I of the Special. Part II consists of the physical damage portion of the policy, which is optional.

The accidental death benefit is a relatively simple insuring agreement and requires little in the way of explanation. It applies to the Named Insured and spouse and agrees to pay $1,000 in the event of death caused by accident, directly and independently of all other causes, as a result of being struck by an automobile or while occupying an automobile.

Major Differences in Coverage between the FAP and the Special

1. A single limit of liability under the Special gives the insured a choice of $25,000, 50,000, 100,000, 200,000 or 300,000. The medical payment limit is related to the amount of coverage under liability. This single limit is preferable from the point of view of the insured. Under an FAP policy written with limits of $10/$20/$5, the insured would have only $10,000 in protection for injury to a single person, or only $5,000 in coverage for property damage. Under a single limit, he would have the $25,000 for either of these occurrences.

2. Residents of the Named Insured's household must

have permission of the Named Insured in order to be covered while driving the owned auto. They do not need such permission under the FAP.

3. A person related to the Named Insured and residing in his household is not a relative under the terms of the special if he owns a private passenger automobile. This means that such a person does not enjoy the coverage afforded a relative. For example, he would not have drive-other-car coverage under the Special policy while operating a non-owned automobile. Under the FAP, he would have coverage under both his own policy and that of the relative.

4. Notice must be given to the company within 30 days for coverage to apply to an additional automobile, or for physical damage coverage to apply to a replacement automobile. Under the FAP notice is required only during the policy period.

5. Medical payments are paid only if the injured party executes a written statement that the medical payments will be applied toward the settlement of any claim against the insured under the liability section of the policy.

6. Medical payments are made only to the extent that expenses are not paid or payable under:

(a) Other automobile or premises medical payments insurance
(b) Individual, blanket, or group accident and health
(c) Medical or surgical reimbursement plans
(d) Workmen's compensation.

Under the FAP, medical payments are made regardless of other coverage which the insured may have or workmen's compensation benefits (except workmen's compensation benefits for persons engaged in the auto business).

7. The insurance company may require a subrogation right against a third party equal to medical payments paid. Under the FAP there is no provision with regard to subrogation for medical payments.

8. Comprehensive and collision are applicable to a non-owned private passenger auto only if the insured is legally liable for the loss (and without regard to the insurance on the non-owned auto). Under the FAP coverage is afforded on non-owned private passenger automobiles regardless of the insured's liability, to the extent that coverage does not exist on those automobiles.

9. There is no automatic coverage on physical damage to non-owned trailers under the Special Auto Policy. Under the FAP there is automatic coverage on non-owned trailers up to $500 (when physical damage on the owned auto has been purchased).

10. The Special pays for loss by fire, lightning, flood, falling objects, explosion, earthquake, theft of the entire auto and collision (if collision coverage is purchased) for robes, wearing apparel and luggage including the contents, belongings to the insured or a relative while in or upon the owned auto for up to $200 per loss. The family auto policy covers only against the perils of fire and lightning and the limit is only $100.

11. The Special provides coverage for reimbursement for bail bonds up to $250. The FAP provides only $100.

12. The Special provides for reimbursement for loss of wages up to $25 per day, when incurred at the request of the company because of attendance at trials and hearings.

13. There is an exclusion providing that there is no liability coverage on any auto (even one that is specifically insured), when that automobile is being used to tow a trailer (other than a utility trailer) that is not specifically insured with the same company. This exclusion, called the "cross trailer exclusion", has existed in commercial auto policies for many years; but it is only with the advent of the Special Auto Policy that the individual homeowner is exposed to the dangers it involves. It is of special importance to persons who own or who may rent house trailers. Under the Family Auto Policy such trailers would be covered automatically (for the liability coverage) without additional premium. Under the Special Auto Policy not only would the trailer not be covered, but the automobile pulling the tralier would not be covered.

The Personal Automobile Policy

Although the Family Auto Policy and the Special Auto Policy remain the most common forms used to insure private automobiles, the trend toward intelligible policy wording may result in their replacement in the not too distant future. The Insurance Services Office has developed a new, simplified automobile policy which is designed eventually to replace both the Family Auto Policy and the Special.

In general, the wording simplification follows the trend discussed in connection with the Homeowners forms. "You" and "your" are used throughout to refer to the named insured and spouse, and "we," "us," and "our" are used to refer to the company. In addition to the plainer language, the Personal Auto Policy also introduces a number of changes in coverage. The following are the principal differences in coverage between the Personal Auto Policy and the Family Auto Policy:

1. The liability coverage is written with a single limit of liability for bodily injury and property damage (like the Special Auto Policy) rather than the split limits of the Family Auto Policy.
2. The liability section of the Personal Auto Policy covers damage to borrowed private passenger automobiles, trailers, motorhomes, and pickup or panel trucks. Neither the Family Auto Policy nor the Special provides payment under the liability

coverage for damages to borrowed vehicles, because of the "care, custody, and control" exclusion. While damage to borrowed vehicles is covered under the liability section of the Personal Auto Policy, there is no coverage under comprehensive or collision for nonowned vehicles. Under the Family Auto Policy, comprehensive and collision apply to both owned and nonowned vehicles.

3. Comprehensive and collision are combined into a single insuring agreement under the Personal Auto Policy, with collision coverage effected through an entry in the policy declarations.
4. The medical expense coverage applies to expenses incurred within three years of an accident, while the Family Auto Policy provides a one-year limit. For automobile accidents the medical payments coverage of the Personal Auto Policy is primary over available hospitalization, accident, or disability insurance.
5. Underinsured motorist coverage is available by endorsement to the Personal Auto Policy. It pays the damages the insured is legally entitled to recover from the owners or operator of a vehicle that is insured but whose coverage limits are inadequate to cover the full amount of the damages.
6. The Personal Auto Policy requires the insured to notify the company within 30 days of the acquisition of an additional automobile for coverage to apply, and also within 30 days for physical damage protection on a replacement automobile.
7. Under the liability and medical payments coverages, the named insured is covered on an excess basis while using a vehicle owned by or furnished for the regular use of a resident relative. Under the Family Automobile Policy and the Special Auto Policy, the definition of "nonowned automobile" eliminates coverage in such a situation.

THE BASIC AUTOMOBILE POLICY

Although the Family Auto Policy and the Special Auto policies have been specifically designed to cover the automobile exposure of the individual and the family, instances may arise in which yet another contract must be used to afford coverage for these classes. Due to the rigid underwriting and eligibility requirements of both the FAP and the Special, there are some automobiles and some drivers that do not qualify for these contracts. In such instances, coverage must be provided through the use of the Basic Auto Policy. As you will recall, only private passenger, farm or utility automobiles owned by an individual or by a husband and wife are eligible for the FAP or Special policy. The Basic Auto policy, although narrower in coverage than either the Family or Special contract, is much broader in terms of eligibility. It may be used to insure any type of automobile, including not only private passenger autos, but motorcycles, motorscooters, trucks, buses, and the like. In addition, some drivers are not eligible for the broad coverage of the FAP or the Special because of bad driving records. In such cases they can obtain coverage only under the Basic Auto Policy. For example, insurance obtained through the Assigned Risk Pool is usually written on the Basic form. In addition, coverage offered by the substandard carriers (or so called "distress" carriers) is usually written on this form. Obviously, there is a distinct possibility that the agent will be called on to provide coverage to some of his clients under circumstances that will necessitate the use of the Basic policy. For this reason we will look at the principal differences between the Basic Policy and the Family Auto Policy.

Many of the differences between the Basic Auto Policy and the FAP are the same as those between the FAP and the Special. The major differences are:

1. Residents of the Named Insured's household are not covered automatically when driving the owned automobile. They must have specific permission from the Named Insured. (This same provision exists in the Special).

2. "Drive other car" coverage is afforded only for the Named Insured and his spouse (and is afforded only if the insured is an individual or husband and wife). Members of the insured's family are not covered when driving a non-owned automobile. (Coverage for such use of non-owned autos can be provided for members of the Named Insured's family by adding the Drive Other Car Endorsement for an additional premium. This is one of the most significant differences between this policy and the others. **There is no automatic drive-other-car coverage for resident relatives.**

3. Notice must be given to the company within 30 days for coverage to apply to an additional auto or for physical damage to apply to a replacement auto. (This same provision exists in the Special).

4. Contractual liability is excluded. Therefore any liability assumed under a contract (as for example in the case of a rent-a-car agreement) would not be covered. There is no such exclusion in either the FAP or the Special.

5. There is no liability coverage on any auto (even one that is specifically insured) when that automobile is being used to tow a trailer (other than a utility trailer) that is not specifically insured with the same company. (This provision also exists in the Special).

6. Persons having custody of the owned automobile are not additional insureds under the physical damage (collision - comprehensive) section of the policy. This means that in the event of damage to the owned vehicle, the insurance company may require an assignment of right of recovery from the insured for the amount paid. To illustrate the effect of this provision, let us look at an example. Mr. Brown, who is insured under a Basic

Auto Policy for collision, loans his auto to Mr. Smith. Smith is involved in an accident and demolishes the car. Brown will collect from the insurance carrier, but the carrier will then subrogate against Smith, seeking damages equal to the amount which was paid to Brown. This possibility is eliminated in the FAP by making the person who has custody of the owned auto an insured (provided, of course, that the custody is with permission of the Named insured, and the use is within the scope of that permission).

There are other miscellaneous differences between the FAP and the Basic Auto policy. However, those discussed above are the most significant differences. The students is advised to study the other distinctions through reference to a detailed analysis of the policies.

NAMED NON-OWNER POLICY

Occasions sometimes arise in which an individual who does not own an automobile desires coverage for those instances in which he or she may borrow an automobile. As the reader may recall, under such circumstances, coverage for the borrower is provided under the automobile policy applicable to the borrowed car, provided the borrower had permission of the Named Insured under that policy. However, the possibility always exists that the borrowed automobile might not be insured, or that the limits of liability on the borrowed car might be inadequate. When the borrower has his own policy, coverage under that policy will apply on an excess basis, but for the individual who does not own an automobile there could be a serious deficiency.

A special form of coverage, called Non-Owner coverage may be written for a person who does not own an automobile, but who desires his or her own coverage in the event that a borrowed automobile is inadeqately insured. Coverage is normally provided under the Basic Auto Policy, with a special endorsement called the Non-Owner Endorsement. Under the provisions of this form of coverage, protection is provided for the Named Insured (and spouse, if a resident of the same household) for liability arising out of the use of any automobile not owned by the named insured or spouse or by any member of the Named Insured's household. The coverage is excess over any other coverage applicable to the borrowed automobile, and the coverage does not apply to the owner of the automobile. However, as in the case of the Family Auto Policy or the Special, other persons or organizations held vicariously liable for the operation of the borrowed automobile by the Named Insured or his spouse are covered.

Insurance for Motorcycles

The increasing popularity of motorcycles and motor scooters in recent years has brought about a corresponding increase in demand for insurance for such vehicles. As noted previously, motorcycles are not eligible for coverage under either the Family Auto Policy or the Special Auto Policy; coverage for motorcycles and motor scooters is usually written under a Basic Auto Policy, modified to recognize the special hazards involved in the operation of these vehicles.

Standard coverages include liability and physical damage coverage. The liability coverage usually excludes injury to passengers, but Passenger Liability coverage is available as an option for an additional premium. Some companies also offer Medical Payments coverage, usually subject to a deductible. The liability rates for motorcycles and motor scooters vary with the size of the engine, with premiums increasing with the increase in the cubic centimeters of the machine. Physical damage coverage is usually provided for Fire, Theft, and Combined Additional Coverage, and Collision. Some companies also offer Comprehensive Coverage.

THE IOWA AUTOMOBILE INSURANCE PLAN

The Iowa Automobile Insurance Plan, (formerly called the Iowa Automobile Assigned Risk Plan), is a voluntary agreement on the part of the automobile insurance companies for granting automobile bodily injury and property damage liability insurance to individuals who are unable to secure such insurance through normal channels. The purpose of the plan, as stated in the Iowa Automobile Insurance Plan section of the **Automobile Liability Manual,** is two fold:

1. To make automobile bodily injury and property damage liability insurance available subject to the conditions stated in the plan.
2. To establish a procedure for the equitable distribution of risks assigned to insurance companies.

Insurance companies are in business to make money, so it is not surprising that they are reluctant to insure some drivers. Persons who fall into high risk classifications or drivers who have had a record of violations and accidents may experience difficulty in obtaining insurance. Some people feel that many of the drivers on the highways today should not be permitted to drive, but this is not a decision which the insurance companies can make. The position of the industry is that if such persons are licensed and permitted to drive, they should have automobile liability insurance, if for no other reason than to protect those whom they might injure. The Iowa Automobile Insurance Plan and its counterparts in the other 49 states is a vital public service provided by automobile insurers to drivers who cannot obtain insurance through regular markets. When a motorist is found unacceptable to the insurance companies because of a poor record or some other reason, he may make application to this plan, under which risks are assigned to participating companies.

Eligibility

Any resident of the State of Iowa who cannot obtain automobile liability coverage in the usual fashion may apply to the Iowa Automobile Insurance Plan. The

applicant is required to complete an application in which he certifies that he has made efforts to obtain insurance during the immediately preceding 60 days and has been unable to do so. Non-residents may also be eligible for participation in the plan under two circumstances:

1. A non-resident may apply to the plan only with respect to an automobile registered in the state.
2. Military non-residents who are stationed in the state are eligible, even though the automobile may be registered in another state.

Not all persons who might make application are eligible for participation. The plan specifically excludes the following from eligibility under the plan:

1. A person who does not make application in good faith is not eligible for coverage under the plan. This means that the applicant must report all information of a material nature, and must refrain from willfully making any incorrect or misleading statements.
2. Certain physical impairments may make the applicant ineligible.
3. Persons engaged in illegal activities or who have been convicted of a felony or high misdemeanor within the past 36 months are not eligible.
4. Persons with a record of driving violations may be ineligible for participation. The rate manual contains a list of various traffic violations and the number of each that will disqualify the applicant.

Operation of the Plan

A motorist who is unable to obtain coverage through the normal market channels makes application to the plan. Upon receipt of the application, the Iowa Automobile Insurance Plan designates a company to handle the risk. Although membership in the plan is voluntary, once a company agrees to participate, it must accept whatever risks are assigned to it. The applicants to the plan are distributed to the participating companies according to a formula which is designed to allot to each company a percentage of the applicants which corresponds to the amount of directly written auto liability which the company has in the State.

When making application, the applicant pays a deposit (ranging upward from $25.00) as specified in the manual. This is forwarded to the designated company with the application. The company to which the application is sent then issues a policy. Although the company is required to issue a policy, the policy need not be a Family Auto Policy, and the company is required to provide only the minimum limits of liability specified by the Financial Responsibility Law, $10,000/$20,000/5,000. A risk which does not have a record of violations or accidents is written at the regular rates filed by the company, without surcharge. The plan permits additional charges, over and above the company's filed rates in those instances where the applicant has a record of traffic violations and accidents. The charges are made on a point basis, with each violation or accident providing the basis for a percentage surcharge. Despite the surcharges, the assigned risks have been a losing proposition for the insurance industry. Since the first plan became effective in 1938, participating companies have paid $160,000,000 more in claims than they have received in premiums, and this does not include the commissions which have been paid or the cost of handling the business.

If for any reason the applicant refuses to accept the policy, the insurance company cancels it and retains the short-rate earned premium for the period of coverage, or $10.00 per car, (whichever is greater), and returns the balance of the deposit to the insured.

If the applicant accepts the policy, the carrier is required to continue the protection for a period of three years. The rules of the plan specifically state that no risk shall be assigned to a designated carrier for a period in excess of three consecutive years. If the driver is unable to obtain insurance at the end of the three year period, reapplication for insurance may be made to the plan.

The insurance carrier may cancel the policy only under certain specified conditions:

1. If the insured is not or ceases to be eligible or in good faith entitled to the insurance.
2. If the insured fails to comply with reasonable safety requirements.
3. If the insured violates the terms or conditions on the basis of which the insurance was granted.
4. If the insurance was obtained through fraud or misrepresentation.
5. If the insured fails to pay premiums when due.

Statutory Limitation on Right to Cancel or Refuse Renewal

Insurance in connection with the automobile is a critical necessity in the modern society; and for this reason a serious conflict of interest may arise between the policyholder and his insurance company, particularly in the event that the company wishes to discontinue providing insurance. The decision on the part of a company to cancel a policy, or even to decline to renew a policy, may have serious implications for the policyholder. Not only is he deprived of his existing coverage, but the fact that he has been cancelled or declined the right to renew may seriously affect his ability to obtain insurance from another company. Because of this situation, legislation has been enacted in Iowa aimed at control of policy cancellation and non-renewal.

The Iowa Automobile Insurance Cancellation Control Act, which was enacted in 1970, applies to any auto policy issued to an individual or related individuals who

are residents of the same household, covering a private passenger automobile or any other 4 wheel vehicle with a load capacity of less than 1,500 pounds which is not used in the business or profession of the insured. The reader will recognize that this is essentially the same definition as that of automobiles eligible for coverage under the family auto policy and special auto policies. The provisions of the act do not apply to policies issued through the Iowa Insurance Plan.

Under the provisions of this act, the right of an insurance company to cancel an auto insurance policy or to refuse to renew a policy is rigidly controlled. After a policy has been in effect for at least 60 days, or effective immediately if the policy is a renewal, cancellation is permitted only for certain specified reasons:

1. Nonpayment of premium
2. Nonpayment of dues to an association or organization where payment of dues is a prerequisite to obtaining or continuing insurance in force
3. Fraud or misrepresentation affecting the policy or the presentation of a claim
4. Violation of the terms or conditions of the policy
5. Suspension or revocation of the driver's license of the named insured or any other operator of the same household or who customarily operates the auto, either during the policy period, or if the policy is a renewal, during the policy period or 180 days immediately preceding the effective date.

In order to effect cancellation for any of the reasons listed except nonpayment of premium, the notice of cancellation must be mailed or delivered to the insured at least 20 days prior to the effective date of cancellation. When cancellation is for non-payment of premium, 10 days notice is required.

In addition, when notifying the insured of cancellation, the company must either state the reason for the cancellation, or state that the reason will be provided if the insured requests it in writing prior to fifteen days before the date of cancellation. If the insured does request notification of the reason for cancellation, the insurance company must deliver or mail the statement of the reason to the insured within 5 days of the receipt of the request.

Not only are restrictions imposed on the insurance company's right to cancel, the stature also specifies conditions which must be met in the event the insurance company elects not to renew a policy. The law specifies first of all, that the insurer may not refuse to renew a policy solely because of the age, residence, race, color, creed, or occupation of the insured. A notice of the intention not to renew the policy must be mailed or delivered to the insured at least 30 days prior to the expiration date of the policy. As in the case of cancellation, the notice of intent not to renew must state the reason, or state that the reason will be given if the insured so requests in writing at least 20 days prior to the expiration of the policy. The insurer must then mail or deliver the statement of the reason for non-renewal to the insured within 10 days of the receipt of the request.

After the insured has received notification from the company of either cancellation or intent not to renew the policy and the reason for the cancellation or non-renewal, the policyholder may request a hearing before the commissioner of insurance, providing that the request is made within fifteen days of the receipt of the statement of the reason. The purpose of this hearing is to provide recourse to those insureds who feel that they are being unfairly treated, and to require the insurance company to establish the existence of the proof or the evidence used in reaching its decision to cancel or not renew the policy. If the hearing discloses that the reason for cancellation was something other than one of those for which cancellation is permitted, or that the reason for non-renewal was one of the prohibited reasons, the Commissioner will require the company to continue the coverage.

AUTOMOBILE MECHANICAL BREAKDOWN POLICY

Although the fundamental purpose of insurance is to protect the individual against the financial consequences of those losses that he could not afford to bear himself, it may also serve the additional but less important function of financing the payment of losses which, while not catastrophic, might still be inconvenient. There are many insurance coverages available that provide protection against losses that are moderate in their severity, but for which a given individual may desire protection. While such contracts should never be purchased at the expense of a coverage that provides protection against the really severe losses, they may be attractive to some people. A recent example of such contracts, and a policy that is now available in the State of Iowa, is the Automobile Mechanical Breakdown Policy.

The Mechanical Breakdown Policy, typically marketed through automobile dealers who hold agents' licenses specifically for the purpose of selling this and other forms of automobile coverage, is designed to pay the owner-purchaser of an automobile in the event that the automobile suffers a "mechanical breakdown" as defined in the policy. The coverage should not be confused with a manufacturer's or dealer's warranty, since the coverage applies to losses other than those covered under such a warranty. The policy specifically excludes any losses that are covered under a manufacturer's or dealer's warranty.

Coverage varies, depending on whether the insured automobile is new or used. In general, new cars are insured for 36 months or 36,000 miles, whichever comes first, and used cars are insured for 12 months or 12,000 miles, again whichever comes first. The cost of the coverage varies with the price of the automobile, on the premise that the more expensive automobiles are more

costly to repair. The coverage of the policy is simple and straightforward, with two simple insuring agreements and a minimum of exclusions. The insuring agreements are designated:

I. Mechanical Breakdown

II. Rental Reimbursement

Mechanical Breakdown Coverage

The first of the two coverages provided under the policy, Mechanical Breakdown coverage, promises to pay the cost of repairing or replacing specific parts of the insured automobile when such repair or replacement is due to a mechanical failure or breakdown during the policy period. This coverage is written with a deductible of $25 or $50, which is designated to eliminate coverage for small insignificant repair bills. The parts of the automobile which are covered for mechanical breakdown or failure are designated in the policy:

ASSEMBLY	PARTS COVERED
Engine	All internal lubricated parts, water pump, fuel pump, engine block, cylinder head, and engine housing.
Transmission	The transmission case and all internal parts including the torque converter.
Drive Axle	Front and rear drive axle housings including all internal parts, propeller shafts, and universal joints.
Steering	The steering gear housing and all internal parts, power steering pump, valve body, piston, and rack.
Brakes	Master cylinder, vacuum assist booster, wheel cylinders, hydraulic lines and fittings and disk brake calipers.
Electrical system	Generator or alternator, voltage regulator, windshield wiper motor, wiring harness, switches and starter motor.
Air conditioner	Compressor, condenser and evaporator if factory installed.

If any of the covered parts of the automobile suffer "mechanical breakdown or failure", defined as ". . . the inability of any covered part that has received customary lubrication services to perform the function or functions for which it was designated . . .", the insurer will pay the usual and reasonable charges for the parts and labor to repair or replace the assemblies covered.

Rental Reimbursement Coverage

The Rental Reimbursement coverage applies when the insured automobile has suffered a mechanical breakdown or failure and the insured incurs expenses for the rental of a substitute equivalent auto. The rental reimbursement applies only if the insured automobile is withdrawn from use overnight, and applies only for the period of time required for repair. Coverage under the rental reimbursement section of the policy is limited to $10 per day, with a maximum limit of $50 for any one period. The deductible of the policy does not apply to the rental reimbursement.

Exclusions

There are a limited number of exclusions under the policy, and few of the exclusions should cause difficulties for the average insured.

The first exclusion eliminates coverage for any mechanical breakdown that is covered under the manufacturer's warranty or a repairer's guarantee. Since such losses are covered elsewhere, the exclusion is of little concern.

The second exclusion, designated Exclusion (b) is composed of two parts. First, the policy excludes coverage if the odometer has been disconnected or altered to misrepresent the automobile's actual mileage. Since the coverage applies only for a specified number of miles, this exclusion performs the function of limiting coverage to the period contemplated by the premium. In addition, exclusion (b) eliminates coverage for any losses covered under the standard forms of physical damage as provided by the Family Auto Policy, the Special Auto Policy, or the Basic Auto Policy.

Exclusion (c) eliminates coverage for certain types of standard automobile maintenance, including adjustment or alignment of any parts not covered under the policy, brake linings, seals, gaskets, oils, or lubricants, unless such parts are required in connection with the repair or replacement of insured parts. In addition, it excludes the cost of recharging an air conditioner unless such recharging is required in connection with repair or replacement of insured parts.

Exclusion (d) eliminates coverage for any mechanical breakdown or failure resulting from competitive driving or racing. In addition, any loss caused by pulling a trailer or other vehicle with a gross weight of over 4,000 pounds is excluded unles the insured automobile is equipped as recommended by the manufacturer.

The last exclusion, Exclusion (e) excludes loss if the owned automobile is used for commercial, livery, rental or delivery purposes.

Conditions

The policy also includes a Conditions section, setting forth the insured's duties in the event of loss, the policy period and territory, a subrogation provision, and various other elements of the coverage. Among the more important of these provisions are the following:

Policy Period, Mileage, Territory. The policy becomes effective upon issuance of the policy at the time of purchase, and expires at the end of the months or the miles specified, whichever comes first. Coverage is limited to mechanical breakdown or failure occurring within the United States, its territories or possessions, or Canada.

Insured's Duties in the Event of Loss. In the event of mechanical breakdown covered under the policy, the insured has three basic obligations:

1. To protect the automobile from further damage resulting from the mechanical breakdown or failure.
2. To give notice as soon as possible to the company or any of its authorized agents.
3. To file a proof of loss within 30 days, including information pertaining to the loss and, at the company's request, exhibit the insured automobile.

Appraisal. The policy sets forth a standard procedure for settling losses in those instances in which the insurance company and the insured cannot agree on the amount of the loss. In the event that the insured and company cannot agree on the amount of a loss, either party may demand an appraisal. Under this procedure, each party selects a competent appraiser, and the two appraisers together select an umpire. The two appraisers state what they feel to be the amount of the claim, and if they do not agree, they submit their differences to the umpire. An agreement in writing by any two of the three determines the amount of the loss. It is important to note that this procedure is applicable only in those instances in which the insured and company cannot agree on the amount of the loss. It is not used when there is a disagreement over whether or not a loss is covered.

Subrogation. The policy also contains a standard subrogation clause, in which the insured is required to assign to the insurance company any rights of recovery against a third party to the extent that he is reimbursed by the insurer for the loss. In addition, the policy stipulates that the insured shall do nothing after a loss to prejudice the insurer's right of action against such a third party.

Although there are other conditions included in the policy, those that have been discussed above are the most important. The reader may refer to a standard copy of the policy used by the insurer he or she represents for a more detailed analysis of the coverage.

INSURANCE COVERAGE FOR THE FARM

The modern farm is a business operation far removed from the traditional family farm of a generation ago. Most modern commercial farms are characterized by a heavy investment in land, buildings, and in equipment. As a heavily capitalized enterprise, the modern farming operation faces potentially catastrophic risks similar to those of any other business enterprise.

Historically, insurance coverages for farms were written on a monoline basis, with separate fire policies, inland marine contracts, and general liability policies. With the multipleline transition, a package policy similar to the Homeowners program is known as the Farmowners-Ranchowners program. Like the Homeowners program, it combines property and liability insurance into a single contract.

Although package policies are used in the field of farm insurance, there are many instances in which monoline forms are also used, with separate fire insurance and liability contracts used to provide coverage. The Farmowners-Ranchowners program is based on the concept that a farm is basically a personal or residential risk, with an added business operation. Because many farms are complex operations, the coverage of the Farmowners-Ranchowners forms are sometimes too inflexible to meet the needs of a farmowner, and the separate forms of coverage must be used. In most instances, the choice between a Farmowners-Ranchowners package and the separate monoline forms will be dictated by the insurance needs of the farm and the coverage available under each approach. In addition, the underwriting philosophy of the company providing the insurance may also influence the manner in which protection is provided.

FARM FIRE COVERAGES

As noted above, under some circumstances it is not possible to provide insurance on farm property under the Farmowners-Ranchowners program. In such instances, coverage is provided under a Standard Fire Policy, with one of several Farm forms. The following discussion deals with two of these forms, the Farm Property Form and the Farm Personal Property Blanket Form.

Farm Property Form

The basic form used to complete the Standard Fire Policy when providing insurance protection on farm property is the Farm Property Form (FM 00 01). This form may be used to cover farm structures (including farm dwellings, garages, barns, cribs, hog houses, silos, and similar structures) and personal property (such as household goods and personal effects, farm machinery, vehicles, implements, livestock, grain, hay, and straw). Provision is made under the form for sixteen separate items:

A. Dwelling Coverage
B. Barns, Buildings and Structures Coverage
C. Portable Building Coverage
D. Private Power and Light Pole Coverage
E. Outdoor Radio and Television Equipment Coverage
F. Unscheduled Personal Property (Household) Coverage
G. Grain Coverage
H. Hay, Straw and Fodder in Buildings
I. Hay, Straw and Fodder in Stacks in the Open
J. Machinery, Vehicle, and Equipment Coverage
K. Specifically Insured Machinery Coverage
L. Poultry Coverage
M. Livestock Coverage
N. Fire Department Service Charges Coverage
O. Fence Coverage
P. Farm Operations Records Coverage.

Insurance applies only to those items for which a specific amount has been scheduled. In addition, there are specific limitations in the coverage with respect to various classes of property. The form itself should be consulted with respect to these specific limitations. The rates and rules for each of the classes of property which may be insured under this form are contained in the FARM Section of the Insurance Services Office **Commercial Lines Manual.**

Perils Covered. The Farm Property Form provides protection against the basic perils of fire, lightning, and removal and, when the appropriate additional premium is paid, the perils of Extended Coverage plus loss caused by Electrocution of Livestock, Theft of Livestock and Specifically described machinery, and collision of specifically described Machinery. The form also includes the Vandalism and Malicious Mischief insuring agreement, which is made applicable by the payment of an additional premium.

Extensions of Coverage. As in the case of most other fire insurance forms, the Farm Property Form includes certain extensions of coverage. There are six extensions of coverage under the form.

1. **Unscheduled Personal Property (Household) Coverage.** The insured may apply up to 10% of the amount of coverage on household personal property to cover such property while away from the described premises, but within the Continental United States, Canada, and the State of Hawaii.
2. **Grain coverage.** The insured may apply up to 10% of the amount of coverage on grain to cover grain while away from the premises but within

100 miles of the described premises, except while such grain is stored in or is being processed in public elevators, warehouses, or manufacturing plants.

3. **Machinery, Vehicle and Equipment Coverage.** The insured may apply up to 10% of the amount of coverage specified for such equipment to cover property off premises and within 100 miles of the premises.
4. **Specifically Insured Machinery.** Specifically insured machinery is covered while away from the premises and within 100 miles of the premises.
5. **Livestock Coverage.** Insured livestock is covered while away from the described premises, except while in transit by common carrier or in public stockyards, public sales barns or yards, packing plants or slaughter houses.
6. **Newly Acquired Farm Equipment, Machinery and Vehicles.** When farm equipment, machinery and vehicles are insured under the form, newly acquired property of this type is automatically covered for 30 days from the date of acquisition, subject to a maximum of $5,000.

Note that there are no extensions which cover appurtenant structures. All buildings on which coverage is desired must be specifically scheduled.

Farm Personal Property - Blanket Form

Those farm owners wishing to do so can insure their farm personal property on a blanket basis, using the Farm Personal Property - Blanket Form (FM 00 07). This form provides coverage on personal property usual and incidental to the occupancy of a farm, while on the described premises. Certain types of farm personal property are specifically excluded (for example, race horses, show horses, tobacco, automobiles, trucks, motorcycles, and snowmobiles). In addition, provision is made for excluding other classes of property on which the insured does not desire coverage.

Perils Insured. The perils against which protection is provided under the Farm Personal Property Blanket Form are the same as those of the Farm Property Form discussed above.

Extensions. The Farm Personal Property Blanket Form includes three extensions of coverage:

A. **Grain Coverage.** Grain is covered while away from the premises (without a percentage limit and without a mileage restriction), except while stored in or being processed in public elevators, warehouses, seed houses, drying plants or manufacturing plants.

B. **Machinery, Vehicle and Equipment Coverage.** When machinery, vehicles and equipment are covered under the policy, coverage is extended to cover such property while temporarily off premises up to 100 miles.

C. **Livestock Coverage.** Insured livestock is covered while away from the premises (no mileage restriction) except while in transit by common carrier or in public stockyards, public sales barns and yards, or while in packing plants or slaughter houses.

Coinsurance Provision. When coverage on farm personal property is written on a blanket basis, an 80% coinsurance clause applies, which means that the insured agrees to maintain insurance equal to 80% of the actual cash value of the property insured. As long as insurance is maintained in the required amount, loss or damage is payable in full up to the specified amount of insurance. However, if the amount of insurance is less than the specified percentage of the actual cash value of insured property at the time of the loss, the insured will recover only a part of the loss.

Payment under the coinsurance clause is made on the basis of the following formula:

$$\text{RECOVERY} = \text{LOSS X } \frac{\text{Insurance Carried}}{\text{Insurance Required}}$$

Thus, if the insured has farm personal property valued at $100,000, and carries the required $80,000 in coverage, any loss up to the $80,000 limit would be payable in full. However, if the insured carries only say, $60,000, with property valued at $100,000, and then suffers a $10,000 loss, only $7,500 would be payable:

$$\text{RECOVERY} = \$10{,}000 \text{ X } \frac{\$60{,}000}{\$80{,}000}$$

In essence, the coinsurance clause attempts to encourage insurance to value. Since the insurance purchased applies to all of the property covered, the insured must be required to insure a high percentage of the property values.

Farm Dwelling Buildings and Contents Broad Form

Those property owners who desire broader coverage on their farm dwelling and household goods may obtain such coverage under the Farm Dwelling Buildings and Contents Broad Form. This form generally parallels the Dwelling Buildings and Contents Broad Form (DF-1), and provides broad form named perils coverage on the insured dwelling and personal property. However, unlike Form DF-2, the Farm Dwelling Buildings and Contents Broad Form does not provide replacement cost coverage on buildings. In addition, there is no extension to cover appurtenant structures.

THE FARMOWNERS-RANCHOWNERS POLICY

The Farmowners-Ranchowners Program is an extension of the Homeowners concept into the farm field, and in many respects the Farmowners-Ranchowners policy is quite similar to the Homeowners policy. Like the Homeowners forms, the Farmowners-Ranchowners policy provides coverage on the insured's residential exposure by covering his dwelling and contents and his personal liability in a single package policy. The Farm-

owners-Ranchowners Policy does this, and in addition, provides coverage on the farming exposure, with Farmers Comprehensive Personal Liability coverage and provisional for optional coverage on farm personal property and farm barns and buildings.

Eligibility

In order to be eligible for the Farmowners-Ranchowners policy, the main farm dwelling must be a one or two family dwelling used exclusively for residential purposes. However, as in the case of the Homeowners forms, incidental office, professional, private school, or studio occupancies are permitted. There is no requirement that the farm be owner occupied in order to be eligible, and a Farmowners-Ranchowners policy may be written for the owner who lives elsewhere than on the insured farm, provided that the farm is not vacant. Vacant farms are ineligible. If the owner does not live on the farm, it is eligible for the Farmowners-Ranchowners only if it is operated under his management or that of a management contractor. In other words, if he simply rents the farm out to a tenant, it is not eligible. (However, the tenant would still be eligible for a Tenants form of the Farmowners-Ranchowners policy).

In addition to the occupancy and residency requirements, only farms with a specified minimum valuation on the dwelling are eligible. Under the Farmowners-Ranchowners rules, farm dwellings are divided into three classes, designated Type 1, Type 2, and Type 3, reflecting their desirability from an underwriting point of view. For example, Type 1 dwellings are of superior character and excellent repair, with an approved heating system and indoor plumbing. The minimum coverage on the dwelling (and on the contents in the case of the Tenant's form) varies with the class of dwelling. The minimum amount of coverage on the dwelling for a Type 1 class dwelling is $12,000; for Type 2 it is $10,000, and for Type 3 it is $8,000. The minimum contents coverage under the Tenant's form is $6,000 for Type 1 buildings, $5,000 for Type 2, and $4,000 for Type 3.

Coverages

As in the case of the Homeowners forms, the Farmowners-Ranchowners is divided into Section I and Section II. Section I, which provides the coverage on the insured's property, consists of six coverages. Section II, the Farmer's Comprehensive Personal Liability Coverage, consists of two coverages, corresponding to the two coverages of the liability section of the Homeowners. Section II is discussed later in this section.

The six coverages of Section I, which provide coverage on the insured's property, are designated A through F:

Coverage A Dwelling
Coverage B Unscheduled Personal Property
Coverage C Additional Living Expense and Rental Value
Coverage D Scheduled Farm Personal Property
Coverage E Unscheduled Farm Personal Property
Coverage F Farm Barns, Buildings and Structures

The essential difference between the Farmowners-Ranchowners and the Homeowners consists of the Farmowners-Ranchowners coverages, D, E, and F, under which the insured may elect coverage on farm personal property and farm barns and buildings. These coverages are optional for an insured who is an owner occupant. If the owner does not live on the farm, he must include coverage under one or more of these farm property coverages. The owner non-occupant must purchase at least $15,000 on unscheduled farm personal property or at least $10,000 in coverage on scheduled farm personal property, or at least $10,000 on farm structures.

The Residential Exposure

The first three coverages under the Farmowners-Ranchowners (that is, the Dwelling, Unscheduled Personal Property, and the Additional Living Expense and Rental Value Coverage) are almost identical with their counterparts under the Homeowners program. They cover the normal residential exposure in connection with the farm, but do not include coverage for any farm personal property or farm buildings. Note that unlike the Homeowners coverage, the Farmowners-Ranchowners policy does not provide automatic coverage on the garage or other appurtenant private structures. If such coverage is desired, it must be specifically scheduled. The coverage on the dwelling is on an actual cash value basis rather than a replacement cost basis as in the case of the Homeowners forms. If the insured desires replacement cost coverage on the dwelling, it may be added by endorsement (FR 00 04). In addition, the Farmowners-Ranchowners policy does not include the extension of coverage for trees, shrubs, plants and lawns. With these exceptions, the coverage generally follows that of the Homeowners.

Forms. There are four forms designed for insuring the residential exposure under the Farmowners-Ranchowners program.

Form FR 00 01, the Basic Form, is the approximate equivalent of the Homeowners Form HO-1. It provides coverage on the dwelling, contents, and additional living expense and rental value against the perils of fire, lightning, removal, extended coverage, vandalism and malicious mischief and theft. It does not include glass breakage as does the Homeowners form.

Form FR 00 02, the Broad Form, is the equivalent of the Homeowners Broad Form, HO-2, and provides coverage against the same broad form perils as does the Homeowners form.

Form FR 00 03, the Special Form, is the equivalent of the Homeowners Special Form HO-3, and provides all risk coverage on the dwelling and Broad Form named

perils coverage on the contents. Only Type 1 dwellings are eligible for Form FR 00 03.

Form FR 00 04, the Tenants Broad form, is the equivalent of the Homeowners Tenants Form, HO-4, and provides coverage on unscheduled personal property and the additional living expense and rental value exposure.

There is no equivalent of the Homeowners form HO-5 under the Farmowners-Ranchowners Program.

Farm Personal Property

Coverage on farm personal property may be provided under Coverage D, designated "Scheduled Farm Personal Property," or under Coverage E, "Unscheduled Farm Personal Property." Form FR 00 06 is used when the coverage is to be provided on a scheduled basis under Coverage D, while FR 00 07 is used to provide unscheduled coverage under Coverage E. The perils insured are the same under both forms, providing coverage against loss by fire, lightning, removal, the perils of Extended Coverage, vandalism and malicious mischief, electrocution of livestock, collision, and theft. The collision peril provides coverage for damage to farm personal property or covered vehicles caused by collision of a vehicle or upset or overturn of the vehicle. Coverage under either form may be extended by endorsement to cover accidental shooting or drowning of livestock.

Scheduled Coverage. When coverage is written on a scheduled basis, specific amounts of coverage may be written for individual animals or individual pieces of equipment, or coverage may be scheduled by class of property. Separate amounts of coverage may be provided on grain and hay, machinery, farm vehicles and equipment, livestock, and farm records.

Unscheduled Coverage. When coverage is written on a blanket (unscheduled) basis the minimum amount of coverage is $15,000. Blanket coverage on farm personal property is subject to an 80% coinsurance clause. The rate for unscheduled farm personal property is about one and one half times the rate for scheduled property.

Limits of Specific Classes of Property. Coverage on grain and hay applies only while such property is within an enclosure, except that coverage is provided for loss by fire to crops in stacks, shocks, windrows or bales. Under the scheduled form, grain hay is covered for up to 10% while away from the premises, subject to a 100 mile limitation. When the coverage is written on an unscheduled basis, grain and hay is covered off premises without a percentage or mileage limitation.

Coverage on livestock applies both on and off premises, under both forms, except while in transit by common carrier or while in sales barns, stockyards or packing plants.

The coverage on machinery and equipment applies on premises and within 100 miles of the premises. When coverage on machinery is scheduled by class, the off-premises coverage on such machinery and equipment is limited to 25% of the amount scheduled. Other classes of property are subject to additional limitations. A complete listing of these limitations is not possible here, and you should examine the forms themselves for a more complete analysis.

Farm Barns and Buildings

Farm barns and buildings are scheduled, and coverage is provided under From FR 00 08 against the perils of fire and lightning, removal, extended coverage, and vandalism and malicious mischief. The coverage is on an actual cash value basis. Replacement cost coverage may be added by endorsement (FR 04 04).

Deductible

The Farmowners-Ranchowners forms are subject to a flat $100 all-perils deductible, which applies to all losses under Section I except under Additional Living Expense and Rental Value and Fire Department Services Charges. Optional $250, $500 and $1,000 deductibles may be added by endorsement.

Extra Expense Coverage

Extra expense coverage may be added to the Farmowners-Ranchowners policy by endorsement. The endorsement provides payment, up to the limit of coverage selected, for extra expenses incurred by the insured to continue normal farming operations which would otherwise be interrupted as a result of damage to farm personal property insured under Coverage D or E, or farm barns and buildings insured under Coverage F. Payment is made for the necessary expense incurred to continue operations, for the period of time that would be required with the exercise of due diligence and dispatch to repair, rebuild, or replace the damaged property.

Coverage for Additional Interests

It is sometimes desirable to provide coverage under the Farmowners-Ranchowners policy (and under the separate Farmers Comprehensive Personal Liability policy discussed later in this section) for more than one individual. For example, two or more persons may actually own and operate a farm, or the farm may be operated as a corporation. Under such circumstances, it is possible to add additional insureds to the policy for both Section I and Section II coverages.

The interest of co-owners and partners who do not live on the farm may be added to the policy by endorsement (FR-40) without charge. Coverage is provided for liability arising out of farm operations, but not for personal liability. The individual named in this manner still needs his or her own Comprehensive Personal Liability coverage.

When co-owners both live on the farm in separate dwellings, a somewhat different endorsement is used, and an additional premium charge is made. FR-41 provides coverage for liability arising out of farming opera-

tions and also provides Comprehensive Personal Liability coverage for the individual named.

Corporate farms are eligible for the Farmowners-Ranchowners policy if the corporation is financially controlled by an individual or by an individual and his or her family residing on the same farm premises. When a corporation is involved, the policy is written in the name of the individual, and the corporation is added by endorsement as an additional insured.

FARM INLAND MARINE COVERAGES

In addition to the coverage under the farm fire forms and the Farmowners-Ranchowners policies, there are a number of inland marine floater policies which are designed to cover farm personal property, such as farm machinery and livestock. While these classes of property may be insured under the fire forms and the Farmowners-Ranchowners forms, broader coverage is available under the floater policies discussed below.

Mobile Agricultural Equipment Floaters

The Mobile Agricultural Equipment Floater is designed to provide "all risk" coverage on farm machinery and equipment. Coverage may be provided on a blanket basis or on a scheduled basis:

Mobile Agricultural Equipment Floater A (unscheduled)

Mobile Agricultural Equipment Floater B (scheduled)

It is also possible to combine scheduled and unscheduled coverage in a single contract, with specific insurance on some items, and blanket coverage on other property.

Mobile Agricultural Equipment Floater A. This form, which provides blanket coverage, is designed to cover all property falling within the description

"Unscheduled mobile agricultural machinery and equipment, including harness, saddlery, liveries, blankets and similar equipment."

Automobiles, trucks, motorcycles, aircraft, watercraft, snowmobiles, mobile homes, housetrailers and vehicles licensed for road use (other than wagons, trailers, and machinery designed for farming purposes and used principally on premises) are specifically excluded. In addition, cotton-pickers and harvester-thresher combines are excluded, but may be specifically insured under Form B discussed below.

Coverage applies on all risk basis. Infidelity of the insured, employees or agents is excluded, along with wear and tear and mechanical or electrical breakdown or failure.

The form is subject to an 80% coinsurance clause and a $50 deductible applies to each claim. Coverage may be provided on agricultural equipment owned by others and in the insured's custody.

Mobile Agricultural Equipment Floater B. Mobile Agricultural Equipment Floater B is intended for scheduled property. There are two items of coverage under this form. The first includes machinery and equipment as scheduled. The second item, which is optional, provides $5,000 or 10% of the scheduled amount (whichever is less) to cover unscheduled equipment up to $250 for any one item. Coverage is subject to an 80% coinsurance clause, which applies not only to the blanket coverage, but also to each scheduled item.

When coverage is provided on a scheduled basis, newly acquired mobile agricultural machinery and equipment (other than cotton-pickers and harvester-thresher combines) is automatically covered up to 25% of the amount of insurance or $25,000 (whichever is less). This automatic coverage applies for a period of 30 days.

Livestock Floaters

Livestock may be insured under the farm fire forms or under the Farmowners-Ranchowners policy. However, some farm owners desire broader coverage on their livestock than that provided by either of these two approaches. Inland marine livestock floaters may be used to provide such coverage. Specific classes of livestock for which coverage may be provided include cattle, sheep, swine, horses, mules, and goats. Coverage may be provided under three forms: an unscheduled or blanket form, a scheduled form, and a monthly reporting form. Coverage under each approach is provided for the same named perils.

The policy insures against:

1. Death or destruction, directly resulting from or made necessary by:
   a. Fire and lightning
   b. Windstorm, cyclone, tornado, hail, explosion, riot, riot attending a strike, civil commotion, aircraft, objects falling therefrom, smoke;
   c. Earthquake, flood, collapse of bridges or culverts;
   d. Collision or derailment or overturn of a vehicle on which the insured property is being transported; collision with other vehicles except those owned or operated by the insured or any tenant of the insured.
   e. Stranding, sinking burning or collision of vessels, including general average and salvage charges.
2. Theft, but excluding escape of mysterious disappearance.

The policy may be extended by endorsement to include coverage for death or destruction caused by or necessitated by:

1. Accidental shooting (except by the insured, members of the insured's family, employees of the insured, or tenants of the farm premises).
2. Drowning from external causes
3. Artificial electricity

4. Attack by dogs or wild animals
5. Collapse of building

Loss as a result of dishonesty or infidelity of the insured, family members, employees, or others to whom the property has been entrusted is excluded. Loss due to acceptance of counterfeit money or bad checks is also excluded. Losses caused directly or indirectly by snow or sleet is also excluded. Finally, nuclear damage and war are also excluded.

Livestock Floater A. Livestock Floater A provides coverage with a specific limit per animal, subject to an 80% coinsurance clause, and blanket with a single amount of insurance applying to each class of animals. Coverage might be provided on a specific class, for example, for $1,000 per head, with a total of $75,000. In the event of loss, payment is made on an actual cash value basis, up to the limit per animal specified, subject to the application of the coinsurance clause.

Livestock Floater B. This form provides coverage on a scheduled basis, either for individual animals or by type of animal, or both. The limit per animal not specifically scheduled is the lesser of $1,000 or 120% of the amount obtained by dividing the total insurance on the specific class by the number of animals of that type owned at the time of loss. This form is not subject to a coinsurance provision, but the limit per animal, as determined above, accomplished the same result. Of course, recovery on any animal is limited to its actual cash value, regardless of whether the animal is scheduled or insured by type.

Monthly Reporting Live Stock Form. This form is similar to Form A, but does not include the 80% coinsurance clause. Instead, the insured is required to submit a report of values as of the last day of the month, and the report must be submitted not later than the 15th of the following month. The premium is based on the average values exposed to loss. In the event of loss, payment is made on an actual cash value basis, up to the limit of liability specified for each animal. However, if the insured has underreported (reported less than the full value of the animals on hand) payment is made for that proportion of the loss that the last value reported bears to the actual cash value of the insured property on the date for which the report was made.

Animal Mortality Coverage

In some instances, the owner of a valuable animal will desire even broader coverage on that animal than that available under an inland marine livestock floater. The broadest form of coverage available is an animal mortality policy, which is essence is term life insurance on the animal. Coverage is included for loss by death from natural causes, including illness, disease, accident, and necessary destruction of an animal that has suffered a severe injury.

Under some circumstances, underwriters will consider extending the policy to cover loss of fertility, but ordinarily there is no coverage for incapacity of breeding.

Livestock mortality insurance is usually written to cover valuable breeding animals, and is carefully underwritten with respect to the amount of insurance. Generally, the insurable value is the cost of the animal to the insured, although higher values may sometimes be permitted.

FARM LIABILITY COVERAGES

As in the case of the property coverages discussed above, liability insurance for the farm may be provided as a part of a package policy or under a separate monoline contract. The standard approach to insuring the farm liability exposure has traditionally been the Farmers Comprehensive Personal Liability form, which is included as Section II of the Farmowners-Ranchowners package. However, in some instances, the special exposures of a farming operation will require the use of the commercial lines Comprehensive General Liability form.

Farmers Comprehensive Personal Liability Coverage

The Farmers Comprehensive Personal Liability policy (FCPL) is an extension of the Comprehensive Personal Liability policy to the farm. Like the CPL, the FCPL may be sold as a separate contract, but more frequently it is sold as a mandatory part (Section II) of the Farmowners-Ranchowners policy. The discussion that follows is based on the provisions of the Farmowners-Ranchowners form FR 00 09, which is used to incorporate the FCPL into the Farmowners-Ranchowners policy.

General Nature. The FCPL is very similar in nature to the CPL. It is, therefore, only necessary for us to discuss the major points of difference. The FCPL includes the same basic insuring agreements as the CPL. In the Farmowners-Ranchowners form, the coverages are designated

Coverage G	Liability
Coverage H	Medical Payments

The contract is designed to cover premises and operations and all personal activities of the insured and members of his or her family. The exclusions of the CPL are all contained in the FCPL. In addition, the FCPL contains certain additional exclusions or modifications of coverage dictated by the farm exposure.

Coverage for the Farming Operation. The principal difference between the Farmers Comprehensive Personal Liability coverage and the CPL is the coverage provided under the former for the business activity of farming. This coverage is provided by stipulating that farming is not a "business' within the meaning of the business pursuits endorsement. Furthermore, the policy definitions state that farm property is not business property. Coverage is therefore provided for

farming operations and liability arising out of such operations.

The coverage is even broad enough to include coverage for liability arising out of the sale of farm products. Although there is no express insuring agreement to this effect, the broad liability insuring agreement and the absence of an exclusion of liability arising out of products, makes such losses covered.

Custom Farming. The policy automatically includes coverage for custom farming (work performed for other farmers under contract, such as plowing, combining, and so on). However, in instances where the amount of custom farming is substantial, the insurer is entitled to an additional premium for this exposure. When a farmer engages in a substantial amount of custom farming, the insurer will charge an additional premium for providing the coverage, or attach an endorsement excluding coverage for these operations.

Fire Legal Liability. One important difference between the CPL and the FCPL is with respect to the "fire legal liability coverage." The CPL automatically provides coverage up to the policy limit for damage by fire, explosion, or smoke from a heating or cooking unit to premises rented to or in the care, custody, and control of the insured. While this insuring agreement is also included in the FCPL, the provision stipulates that the coverage applies only away from the insured premises. This means that a tenant farmer needs specific fire legal liability coverage on the occupied premises. This coverage may be added by endorsement to either the Farmowners-Ranchowners form or to the separate FCPL. The basic limit for this coverage is $25,000; this limit may be increased up to $50,000.

Injury to Farm Employees. Like the CPL and Section II of the Homeowners forms, the FCPL provides coverage for both liability and medical payments for injury to domestic employees who are not covered or are not required to be covered under the workers compensation law of the state. However, the FCPL and Farmowners-Ranchowners specifically exclude coverage under both the liability coverage and under medical payments for injuries to farm employees, regardless of whether or not such farm employees are covered under the workers compensation law.

The Iowa workers compensation law applies to farm employees who are regularly employed or whose employer makes cash payments for farm labor of $1,000 or more a year. Such farm employees must be covered under a workers compensation policy. However, this leaves some part-time and occasional farm employees not covered under the law; and in the event such an employee is injured in the course of his employment, he may have a right of action against the employer and may sue for damages.

The liability coverage of the FCPL and the Farmowner-Ranchowners policy can be made applicable to farm employees who are not covered under workers compensation by endorsement to the policy and the payment of an additional premium. When the additional premium has been paid and coverage added for farm employees, the FCPL will provide coverage for defense and payment of any judgments up to the limit of the policy for injuries to such employees arising out of and in the course of their employment or otherwise. In addition, the policy will respond for the medical expenses involved in such an injury up to the limit of liability under the medical payments coverage.

Some confusion exists with respect to the situation in which a person is assisting the insured in a "neighborly exchange of work" for which the insured is not obligated to pay money. It is not unusual for farmers to help each other; one farmer may help his neighbor harvesting in return for help with his own work. Such a "neighborly exchange of labor" could be considered employment and, if the policy has not been extended to cover liability to farm employees, would be excluded under the liability coverage. However, a special exception to the exclusion of injury to farm employees under the Medical Payments coverage provides coverage for the neighborly exchange of work situation. It is most important to note, however, that this exception applies only under Medical Payments; and neighborly exchange situations are still excluded under liability (unless the farm employee liability coverage has been added).

Named Insured and Family Medical Payments. Just as in the case of the Homeowners policy, the Farmowners-Ranchowners Section II coverage (FCPL) excludes medical payments for injuries to the insured and members of his household. However, a special optional endorsement to the FCPL permits the purchase of medical payments coverage for the named insured and listed members of his family with respect to injuries arising out of farming operations. In a sense, this endorsement classifies the named insured and members of his family with other covered employees with respect to the medical payments coverage. The injury must arise in connection with farm work, and the form specifically excludes domestic and personal activities which are not necessary to farming operations. An additional premium charge is made for each person who is listed for the medical payments coverage, and only those persons who are listed are covered.

Animal Collision. Another optional coverage, designated "Animal Collision" is available by endorsement to the Farmowners-Ranchowners policy or the separate FCPL. This is not a liability coverage but merely physical damage coverage on the animals. It provides coverage for up to $400 a head on animals killed in a collision between the animal and a non-owned vehicle while the animal is on a public highway and not being transported. It is used only when the animals are not scheduled or covered on a blanket basis under Section I of the Farmowners-Ranchowners policy.

COMMERCIAL LINES SECTION

COMMERCIAL FIRE INSURANCE

As you will recall, damage to property may be a source of two types of loss: direct, which consists of the loss of the asset itself, and indirect, resulting from the loss of use of the asset. In this section, we will focus on those commercial fire coverages designed to protect businesses and other organizations against direct loss. Indirect loss coverages will be treated later.

There are an almost unlimited number of forms and endorsements in the commercial fire field, which are designed to meet the specialized needs of busineses and commercial firms. Since businesses are not nearly as homogeneous a group as homeowners, the forms used to insure dwelling property are multiplied many times over to meet the needs of business. While a detailed analysis of all of these forms is impractical, you should at least be aware of some of their main features.

GENERAL PROPERTY FORM

The General Property Form is the commercial equivalent of the Dwelling Buildings and Contents Basic Form. Like the basic dwelling form, it contains the definition of the property insured, certain permissive clauses, and a number of extensions of coverage. It also contains the provisions of the Extended Coverage Endorsement and a Vandalism and Malicious Mischief insuring agreement, each of which is made applicable by the payment of the appropriate premium. The provisions of the form are adaptable to the majority of business risks and to certain institutions such as churches and schools as well.

Property Insured

The form may be used to insure buildings only, contents only, or building and contents. In addition, provision is made for inclusion of personal property of others, which may be insured on a blanket basis together with the insured's own personal property or under a separate item. Coverage is provided under three insuring agreements, designated Coverage A, B, and C.

Coverage A, Buildings. When buildings are insured under the form, coverage applies to additions and extensions, fixtures, machinery and equipment constituting a permanent part of the building, yard fixtures, and personal property of the named insured used for the maintenance or service of the premises. When the policy is subject to a coinsurance clause of 80% or more, the cost of excavations and foundations which are below the undersurface of the lowest basement (or, if there is no basement, which are below the surface of the ground) are excluded. Outdoor signs (whether or not attached to the building structure) are not covered unless specifically described in the policy.

Coverage B, Personal Property of the Insured. When personal property is insured under the form, coverage applies to business personal property which is owned by the insured, and which is usual to the occupancy of the named insured. In addition, the insured's interest in personal property of others is also covered, to the extent of the value of labor, materials, and other charges incurred by the named insured. The coverage on all personal property applies to property while in or on the described buildings and also applies to property in the open or in vehicles on the premises or within 100 feet of the premises.

Coverage C, Personal Property of Others. Insureds who wish to do so may purchase insurance on the personal property of others in their care, custody, and control. A limited amount of coverage on the property of others is automatically provided (as discussed below), but this coverage is limited to $2000. When the insured desires to purchase coverage on the property of others, the coverage may be written as a separate amount under Coverage C; or Coverages B and C may be written on a blanket basis.

Improvements and Betterments

The General Property Form automatically covers Tenant's Improvements & Betterments as a part of Coverage B. Tenant's improvements and betterments are defined as fixture's alterations, installations or additions comprising a part of the building which are made or acquired at the expense of the insured tenant, and which the tenant may not remove. This coverage applies only when the insured is not the building owner.

The purpose of this coverage is to cover the improvements and betterments such as alterations or additions made to real property rented from others, against loss by the perils insured against. A tenant may spend a sizable sum of money on alterations or additions to a building owned by someone else. Usually these improvements become part of the building, and will belong to the building owner depending on the terms of the lease. Such improvements and betterments represent substantial investment to the insured and their loss of use constitutes a real risk. Therefore it is important that they be insured. However, if the insured does not desire coverage on the Improvements and Betterments, the policy must be endorsed, deleting the coverage.

If the improvements and betterments are repaired or replaced at the expense of the tenant within a reasonable time after the loss, the actual cash value will be paid.

If not repaired or replaced within a reasonable time after the loss, the amount paid will be that proportion of the original cost of the damaged or destroyed improve-

ments and betterments which the unexpired term of the lease bears to the date when such improvements were made, to the expiration date of the lease.

If the improvements are repaired or replaced by others, there is no loss of tenants improvements and betterments to the tenant; and, therefore, nothing will be paid.

Extensions

Although many of the provisions of the General Property Form are similar to those previously discussed in connection with the dwelling forms, the extensions of that General Property Form deserve special comment. There are six extensions under the form:

Personal Property of Others. The form provides an extension of up to 2% of the amount of coverage on contents subject to a $2000 maximum to cover property of others in the custody of the insured. If personal property of others in the insured's custody exceeds this amount, it may be specifically insured under the form, either as a separate item or together with the insured's personal property.

Off-Premises Coverage. Coverage applies on property away from the premises up to 2% of the amount on both buildings and contents, subject to a maximum to $5000 to cover property — excluding stocks of merchandise — while away from the premises for the purpose of cleaning, repairing, reconstruction, or restoration. It should be recognized that this is an extremely limited extension coverage. The exclusion of stocks of merchandise, and the restriction to property away from the premises for the purpose of cleaning, etc., means that for all practical purposes one might say that there is no off-premises coverage.

Newly Acquired Property. The insured may apply up to 10% of the amount of coverage on buildings, not exceeding $25,000, to cover new structures on the premises, or elsewhere, and up to 10% of the amount of coverage on contents, not exceeding $10,000 to cover newly acquired personal property. In each case the coverage applies for a maximum of 30 days with an additional premium due to the company for the automatic coverage provided.

Personal Effects of Officers and Employees. The insured may apply up to $100 per individual, with a $500 aggregate, to cover loss to personal effects of the insured, officers, partners, or employees of the insured, which are damaged by an insured peril on the premises. The extension does not apply to property covered by other insurance.

Valuable Papers and Records. Coverage for damage to valuable papers and records under the basic provision of the policy is limited to the cost of blank paper and the cost of transcribing the information. Under the Valuable Papers and Records extension the policy provides up to 5% of the amount of contents coverage, subject to a $500 maximum, to cover the cost of research necessary to reconstruct the information lost. Coverage in excess of this amount may be purchased under a separate Valuable Papers policy.

Trees, Shrubs and Plants. The insured may apply up to 5% of the amount of coverage on buildings and personal property, with a maximum of $1,000, to cover outdoor trees, shrubs and plants. Coverage on any one item is limited to $250; and coverage is provided only for the perils of fire, lightning, explosion, riot or civil commotion, and aircraft.

Perils Insured

The General Property Form includes the provisions of both the Extended Coverage Endorsement and the Vandalism and Malicious Mischief Endorsement. Coverage for either is activated by the payment of the required premium and entry of this premium in the declarations section of the policy.

Extended Coverage Endorsement. In general, the provisions of the extended coverage endorsement parallel the discussion of extended coverage contained in the Personal Lines Section of this manual. Coverage is provided against loss by Windstorm and Hail, Smoke, Explosion, Riot, Riot Attending a Strike, Civil Commotion, and Aircraft or Vehicles. The Windstorm and Hail perils specifically exclude damage to metal smokestacks, awnings, and outdoor radio and TV antennas.

Vandalism and Malicious Mischief. Coverage for loss occasioned by vandalism and malicious mischief is made applicable by the payment of the appropriate vandalism and malicious mischief premium. Coverage is provided for direct loss occasioned by vandalism and malicious mischief, including damage to the building caused by burglars. In general, the exclusions of the form apply to glass (other than glass building blocks constituting a part of the building), pilferage, theft, burglary, and larceny. Furthermore, there is no coverage if the building is vacant or unoccupied beyond thirty days. It should be noted that when this coverage is added to a policy covering property, all policies should have the endorsement added; for the same apportionment clause discussed in connection with the extended coverage endorsement also applies to the vandalism and malicious mischief endorsement.

Other Provisions

Many of the clauses and provisions studied in connection with the dwelling forms are included in the commercial forms. Other clauses are also included in the commercial forms, and the agent should be aware of the nature and intent of these provisions:

The Debris Removal Clause. This clause states that debris removal is covered, but the amount for debris removal and payment for loss cannot exceed the amount of insurance.

Divisible Contract Clause. This clause is not included in the dwelling forms. It states that if the policy covers two or more buildings, a breach of warranty in connection with one building does not affect the insurance on the other building.

Permits and Use Clause. The Permits and Use clause grants permission for a number of activities or situations which might otherwise void the coverage. First, permission is granted for the insured to make alterations and repairs. In addition, permission is granted for such use of the premises as is usual and incidental to the occupancy described. Finally, permission is granted for limited unoccupancy, as described below.

Vacancy and Unoccupancy. As we noted in our discussion of the Standard Fire Policy in the personal lines section of this study guide, the Standard Fire Policy provides that the policy is suspended "while the described building, whether intended for occupancy by owner or tenant, is vacant or unoccupied beyond a period of 60 consecutive days." The various dwelling forms give permission for the dwellings to be vacant or unoccupied beyond this limit of time. Under the General Property From FGP-1, permission is granted only for such unoccupancy as is usual for the type of business insured. This would permit, for example, a school to be unoccupied during the summer or a drive-in movie to be unoccupied during the winter. However, there is no blanket permission for vacancy or unoccupancy as in the case of the dwelling forms, and any vacancy or unoccupancy other than that usual to the type of business insured will suspend coverage after 60 days.

The legal distinction between vacancy and unoccupancy if fairly well defined. A building is vacant when it has neither occupants nor contents. A building is unoccupied when it has contents, but not occupants. Vacancy or unoccupancy of buildings other than dwellings will suspend the coverage unless the policy is endorsed to provide for continuing coverage. When a mercantile, warehouse, or other non-manufacturing risk is vacant or unoccupied, Vacancy or Unoccupancy Permit must be attached to the policy. The endorsement provides coverage on the vacant or unoccupied building for a specified period of time, which may not exceed six months. If the building is a manufacturing risk, a somewhat different permit must be used, which permits unoccupancy only, also for a period not to exceed six months.

The Subrogation Clause. The provision of Form FGP-1 that is entitled "Subrogation Clause" is of special interest. As the student will recall, the subrogation clause contained in the Standard Fire Policy provides that the insurer may require an assignment of any right of recovery that the insured may have against a third party to the extent that payment is made under the policy. The subrogation clause of the Building and Contents Form permits the insured to waive such right of recovery, so long as the waiver is in writing and is done before the loss:

> This insurance shall not be invalidated should the Insured waive in writing prior to a loss any or all rights of recovery against any party for loss occurring to the property described herein.

If Mr. Smith, the landlord, desires to protect Mr. Jones, the tenant, from subrogation by Smith's insurer, he may insert a provision in the lease under which he waives right of recovery against Jones in the event of fire damage to the premises. In the event of a fire, Smith would collect from his insurer and the insurer would be precluded from bringing action against Jones even though Jones might have been responsible for the loss.

ENDORSEMENTS INCREASING RECOVERY

Replacement Cost Coverage

Some business property is eligible for replacement cost coverage similar to the replacement cost coverage which was examined in connection with the Broad Form Dwelling Forms and the Homeowners Contracts. In the case of commercial buildings, however, the underwriting requirements are considerably more stringent. Like the dwelling form extensions, the replacement cost endorsement applicable to other forms of fire insurance provides that no deduction will be made for depreciation in the event of a loss, provided that the insured has maintained insurance equal to a specified percentage of the replacement cost value of the building. Under the replacement cost endorsements used for commercial property, it is normally a requirement that the building must be rebuilt on the same premises for the same occupancy before the insured can collect on a replacement cost basis.

Special Endorsements Increasing Recovery

In many municipalities throughout the State, building codes and zoning ordinances specify that buildings must be of a specified type of construction. These ordinances generally apply to all buildings erected after a given date, and also provide that any existing building that does not meet these requirements and that is damaged beyond a given percentage (for example, 50%) must be demolished and replaced by a building of approved construction. These building codes, together with the disclaimer clause, create a special exposure to loss for property owners located in those areas to which the codes apply. If their buildings are destroyed, they will collect on the basis of the existing construction, but will not be permitted to replace the building with that type of construction. Furthermore, the possibility exists that in the event of a partial loss, they will not be permitted to use the remaining portion of the building in reconstruction. This special loss exposure must be covered by endorsement to the policy. There are three special coverages that apply.

Increased Cost of Construction Endorsement. The "increased cost of construction endorsement" permits the insured to purchase coverage on the basis of the construction requirements of the building code, rather than on the basis of his existing structure. The endorsement provides that payment will be made on the basis of the cost of replacing the building with the type of structure required by the provisions of the building code. If the required replacement is of a more expensive type, loss will be paid on the basis of the improved construction, provided that the insured has purchased the correct amount of coverage and added the "increased cost of construction endorsement." This endorsement is written only in conjunction with the replacement cost endorsement.

Contingent Liability from Operation of Building Laws Endorsement. A second endorsement, called the "contingent liability from operation of building laws endorsement," extends the policy to cover the undamaged portion of a building when the building code requires that the remaining part of the structure be demolished. In those jurisdictions in which the code specifies that buildings destroyed to a certain percentage may not be rebuilt, the endorsement is an important extension; because without it, the insurer would pay only for the damaged part of the building, even though the insured owner would not be permitted to use the remaining part of the building in reconstruction. In other words, when this endorsement is attached to the policy, the insurance company agrees to pay any loss in excess of the percentage damaged when the building code does not permit rebuilding. The rates for the perils insured against are increased when this endorsement is used. No additional insurance is invovled; the insurer's liability is merely increased beyond that of the basic policy and form when the building code specifies that the undamaged part of the building may not be used in rebuilding.

The Demolition Cost Endorsement. The "demolition cost endorsement," which may be used only with the "contingent liability from the operation of building laws endorsement," extends the policy to cover the actual cost of demolishing the undamaged portion of the building. When the building code specifies that the undamaged portion of the building may not be used in rebuilding after a loss, the contingent liability endorsement discussed above makes the loss payable as a total loss, covering the undamaged part of the building. The demolition cost endorsement covers the cost of demolishing that undamaged portion, so that the new structure may then be rebuilt.

Market Value and Selling Price Clauses

A manufacturer who has a large stock of finished goods on hand may face an exposure that is not covered under the standard forms of coverage on stocks of merchandise — the loss of expected profits on the goods if they are destroyed. The Standard Fire Policy provides for payment only on the basis of the actual cash value of the goods, not their selling price. If the goods should be destroyed, expected profits might never be earned because customers may turn elsewhere to purchase the goods. Furthermore, while business interruption insurance will pay for the loss of income suffered during a period of discontinued operations, the loss of profits on already-completed stock would not be covered. Although the exposure in this area is more severe for manufacturers than for mercantile establishments, even mercantile firms face an exposure. A merchant can replace stocks of merchandise more quickly than can a manufacturer, but a possibility of loss still exists in the case of goods that have been sold by the merchant but not delivered. There are two fire policy endorsements (one for manufacturers and one for mercantile establishments) designed to cope with this gap: The Market Value Clause and the Selling Price Clause.

Market Value Clause. Coverage for manufacturers is provided under the Market Value Clause, which provides that the value of finished stock shall be the price for which the stock would have sold, had no loss occurred. The form expressly provides for a deduction from the market value of all discounts and unincurred expenses to which the stock would have been subject. This Market Value Clause is applicable only to finished stocks of manufactured goods. The provisions of the Market Value Clause must be added to the policy by endorsement.

Selling Price Clause. A similar clause is used for mercantile stocks, called the Selling Price Clause. The Selling Price Clause applies only to stocks already sold but not yet delivered and provides that, with respect to such merchandise, the value for loss settlement is the amount for which the merchandise was sold, less all discounts and allowances. The Selling Price clause is automatically included in the General Property Form (FGP-1).

COINSURANCE

Coinsurance is one of the most misunderstood topics in the entire area of commerical fire insurance, yet this principle is not really difficult. To understand the basis for the coinsurance concept, it is necessary to understand something about fire insurance rates.

It is a well documented fact that most fire losses are partial. Loss frequency is a far more important factor in fire insurance rates than is severity of loss. Statistical data gathered by the fire insurance rating bureaus indicate that about 85% of all fire losses involve less than 20% of the value of the property, and only about 5% of the losses involve over 50% of the value of the property insured. Since most losses tend to be partial, many individuals do not purchase complete coverage. Since the fire rate is based on the ratio of the amount of losses to the amount of coverage purchased, the rate

will be higher if individuals insure a lower percentage of their property values than if they insure the property for some high percentage of its value. Since insurance to value has such a direct relationship to the adequacy and equity of rates, some concession must be made in the rating structure for those who insure their property for some high pecentage of its value. This is precisely the intent of the coinsurance mechanism.[1]

Under the provisions of the coinsurance clause, the insured agrees to maintain insurance equal to some specified percentage of the value of his property in return for a lower rate. In effect, the coinsurance rate is a quantity discount. If the insured agrees to purchase insurance equal to the agreed percentage, the rate which he must pay per $100 of coverage is reduced. If the insured fails to maintain the amount of insurance which he agreed to maintain, he may suffer a penalty at the time of a loss. The provisions of the coinsurance clause are as follows:

> In consideration of the reduced rate and the form under which this policy is written, it is expressly stipulated and made a condition of this contract that in the event of loss, this company will be liable for no greater proportion thereof than the amount hereby insured bears to the specified percentage of the actual cash value of the property described herein at the time such loss shall happen.

More simply, at the time of a loss the insurance company will make payment on the following basis:

$$\frac{\text{Insurance carried}}{\text{Insurance required}} \text{ X Loss} = \text{Amount paid}$$

The application of the provision is simple: as long as the insured carries insurance equal to the required percentage, all losses covered by the policy will be paid in full. If he does not maintain the insurance to value required, he will collect only a part of his loss.

To illustrate, let us assume that the insured in question has purchased insurance on a $100,000 building, with an 80% coinsurance clause. In keeping with the requirement of the coinsurance clause, he purchased $80,000 in coverage. In the event of a $5,000 loss, the company would pay:

$$\frac{\text{Insurance carried}}{\text{Insurance required}} \text{ X } \$5{,}000 = \$5{,}000$$

[1]The coinsurance clause is not used in the field of dwelling property. In the field of dwelling coverages, the loss constant is used to provide for equity between property owners. Under the loss constant rating structure, the insurance company makes a flat charge per policy of some amount (e.g., $6.00) and then charges some rate per $100 of coverage in addition. The effect is a schedule of rates that varies with the amount of insurance purchased, giving property owners who purchase higher amounts of insurance a lower rate per $100.

Now let us assume that as time goes by, construction costs increase and increases in price level act to increase the replacement cost of the building. In spite of the fact that the actual cash value of the building has increased, the insured continues to maintain $80,000 in coverage. At the time that his next $5,000 loss occurs, it is determined that the actual cash value of the building has increased to $200,000; and to comply with the 80% coinsurance clause, the insured should have been carrying $160,000 in coverage. In this case he becomes a coinsurer, and suffers a penalty equal to the coinsurance deficiency:

$$\frac{\text{Insurance carried (\$ 80,000)}}{\text{Insurance required (\$160,000)}} \text{ X } \$5{,}000 = \$2{,}500$$

Two important points are illustrated by the above examples. First, the coinsurance requirement is applied at the time of loss; and the amount of insurance required to comply is based on the actual cash value of the property at the time of loss, and not the value of the property when the policy is originally taken out. Second, the burden of maintaining the proper amount of insurance is on the insured. The insurance company does not check to see if the insured has kept his promise until a loss takes place.

The coinsurance clause penalty is applicable only in the case of partial losses. In the event of a total loss, (or any loss equal to or exceeding the amount of insurance required by the coinsurance clause) the face of the policy is payable.

BLANKET INSURANCE

Thus far, we have discussed only one form of fire insurance, that form known as "specific" insurance. Specific insurance applies a definite amount of insurance to a stated item. In addition to specific insurance, insurance may also be written on a "blanket" basis, under which one amount of insurance covers more than one type of property at more than one location. For example, a firm with a number of buildings may purchase specific insurance on each; but it can also insure them on a blanket basis, with a single amount of insurance applicable to all. When coverage is written on a blanket basis, 90% coinsurance is usually required. Blanket insurance may be used to fill three needs:

1. Blanket insurance may cover one subject or insurance at more than one location (e.g., $20,000 or cover machinery at locations "X" and "Y").
2. Blanket insurance may cover two or more subjects at one location (e.g., $20,000 to cover building, machinery, and equipment at location "X").
3. Blanket insurance may be used to cover two or more subjects at two or more locations (e.g., $50,000 on buildings and contents at locations "X" and "Y").

Blanket insurance is designed for firms with insur-

able property composed of different elements. It is used when the individual elements that make up the total fluctuate, but the total values remain stable. Under these circumstances (where the total remains stable, but the components fluctuate), specific insurance is inconvenient, for it would be necessary to constantly adjust the amount of insurance as the values changed. If the specific amounts of coverage were not adjusted, the insured might find that he had too much insurance on one item and not enough on some other.

In addition to providing a convenient means of insuring property with fluctuating components, there are other advantages to the blanket approach since the full amount of blanket insurance is available to cover loss to any single item. Suppose, for example, that the XYZ Company owns ten buildings, each worth $100,000. If the properties are insured on a blanket basis, subject to a 90% coinsurance clause, XYZ must purchase $900,000 in blanket coverage. In the event of a loss, coverage would apply to any building up to the full $100,000 of its value, provided XYZ meets the coinsurance requirement at the time of the loss. If the same ten buildings were insured for $90,000 each on a specified basis, recovery would, of course, be limited to the $90,000 applicable to each.

When coverage is written on a blanket basis with less than 90% coinsurance, it is normally mandatory to attach a form known as the "pro-rata distribution clause." The effect of the pro-rata distribution clause is to make blanket insurance specific at each location. This clause provides that the total amount of insurance is to be divided among the locations on the basis of the percentage of total values that the property at each location represents. Thus if the insured mentioned above had purchased $120,000 in coverage rather than the $150,000 which the insurable value represented, the coverage would be divided among the three locations as follows:

Warehouse #1 — $45,000 (30% of the total values)

Warehouse #2 — $45,000 (30% of the total values)

Warehouse #3 — $60,000 (40% of the total values)

The $120,000 in coverage would be divided among the locations on the basis of the above percentages. If the property at location #1 was totally destroyed, the insured would collect only $36,000 (30% of $120,000). The need for the pro-rata distribution clause is obvious; without it the insured could purchase a small amount of insurance equal to the maximum values at any one location and use it for insurance at the additional locations as well. The clause forces the insured to maintain insurance to value at all locations.

REPORTING FORMS

For a large number of mercantile risks, the value of stock on hand fluctuates substantially during the year. A specific amount policy is unsatisfactory in such instances because it either under-insures or over-insures the property at risk during the year. If insurance is purchased in an amount sufficient to cover the peak value, the stock is over-insured most of the time and the insured is paying for more insurance than he will be permitted to collect. If some amount of insurance less than the peak value is selected, there will be occasions when the insured will be under-insured and exposed to the possibility of an uninsured loss.

Monthly reporting type policies are especially designed to meet the needs of such mercantile risks. They work just like a rubber band. The amount of insurance in effect during the year stretches up and down with the values on hand. The policy is written with a maximum limit of liability that is sufficiently high to cover the maximum expected values, and the amount of insurance adjusts automatically to the values exposed to loss subject to this maximum. The insured makes monthly reports of his current values and is charged on the basis of these reports, paying only for the values exposed to loss, and not for the limit of coverage specified as the maximum. The premium cannot be known until the year is over, and so a provisional premium is paid at the inception of the policy and then adjusted at the end of the year to reflect the true cost of the protection provided.

The insured is required to report 100% of the values of the property insured. Any violation in late reporting or under-reporting, whether intentional or otherwise, is a violation of the policy conditions and may result in a penalty in the event of a loss. The "full value reporting clause" (also called the "honesty clause") provides that if the insured under-reports his values, the liability of the insurance company is limited to the percentage of the loss that the last reported values bear to the values that should have been reported. Thus, if the insured reports values of $100,000 when the value of the property on hand is $200,000 and then suffers a loss of, say, $2,000, he would collect only the percentage of that loss that the values reported represent to the actual values: 50% or $1,000. In the case of a late report, the amount of insurance is limited to the values reported in the immediately preceding report. In other words, when the insured is late in reporting, the maximum limit specified at the inception of the policy is suspended, and the last reported values become the maximum amount that is recoverable.

Peak Season Endorsement

When the fluctuation in value is limited to an identifiable period, an alternate approach, the peak season endorsement, may be used instead of a reporting form. Under the peak season endorsement, the amount of coverage is increased by some specified amount to cover the increased values during the period, and a pro-rata premium charge is made for the additional amount of insurance.

OTHER SPECIALIZED FORMS

Builder's Risk Coverages

When a building in the course of construction is to be insured, it is normally covered under a specialized form known as a Builder's Risk form. These builder's risk forms may be written to include practically any combination of perils, including all risk coverage. There are five builder's risk forms.

Builder's Risk Basic Form. The Builder's Risk Basic form covers the building listed in the policy while it is in the course of construction. Coinsurance under this form is optional, but when 80% or higher coinsurance is included, the form also covers property of others and coverage for materials and supplies located on the premises.

Builder's Risk Completed Value Form. The Builder's risk completed value form covers the building listed while in the course of construction. The amount of insurance shown on the policy is the final full value of the buildings, less any excludable items. The rate used to determine the premium is 55% of the applicable 100% coinsurance builder's risk rate, to reflect the progressive increase in coverage from zero to the final completed value.

The policy may be written to cover the interest of the building owner, the general contractor, and any subcontractors, all of whom have an insurable interest in the building under construction.

The insured must notify the company at the time the building is occupied. If the building is occupied before it is fully completed, the policy must be endorsed to permit coverage to continue until the building is finally completed.

Builder's Risk Reporting Form. Under the Builder's Risk Reporting form, the insured must make a report each month of the value completed to that point. Under the Builder's Risk Reporting form, as under most reporting forms, the final premium is based on the average values at risk, as reported by the insured to the insurance company.

Contractor's Automatic Builders Risk Form. The Contractor's Automatic Builder's Risk Form is designed to provide temporary protection for contractors with a large number of building projects, pending the issuance of a separate policy for each location. In a sense, the form provides binder coverage on new construction until individual builder's risk forms can be issued. A limit of liability for any one location is designated in the policy.

Contractor's Automatic Builders Risk Completed Value Reporting Form. The Contractor's Automatic Completed Value Reporting Form provides automatic coverage on all building projects begun during the year. Coverage is provided for the completed value of the projects, and the premium is determined on the basis of monthly reports. This form eliminates the need for individual policies for each job. The monthly reports indicate the date and completed value of construction begun during the month, and the date and completed value of construction completed during the month. A final premium adjustment is made at the end of the policy period.

Special Building Form

The Special Building Form is used to extend the standard fire policy to provide all risk coverage on eligible buildings. Virtually all classes of buildings are eligible for coverage under this form except:

(1) boarding and rooming houses
(2) builder's machinery and tools written under a builder's risk form
(3) builder's risks insured under the Contractor's Automatic Builder's Risk Completed Value Form
(4) farms or farming operations
(5) grain elevators, tanks, and grain warehouses
(6) nuclear reactor plants
(7) risks written under special rating schedules, such as Highly Protected Risks, Petroleum or Petrochemical plants, electric generating stations, or natural gas pumping stations.

All Risk Insuring Agreement. The insuring agreement of the Special Building form is simply and straightforward:

> "This policy insures against all risks of direct physical loss subject to the provisions and stipulations herein and in the policy of which this form is made a part."

The actual coverage of the form is determined by the exclusions and by the limitations imposed on certain types of property.

Exclusions and Limitations of Coverage. A complete discussion of all of the exclusions and limitations of the form is beyond the scope of this manual. However, a few of the more important limitations in coverages are the following:

1. Steam boilers and other steam vessels are not covered for loss by explosion or other loss caused by a condition within such objects.
2. Coverage on glass is limited to $50 per plate and $250 per occurrence unless caused by the perils of fire and extended coverage.
3. Loss caused by enforcement of ordinances regulating repair or demolition of structures is excluded.
4. Loss caused by artificial electricity is excluded, except loss by an ensuing fire.
5. Loss caused by earthquake, earthmovement, flood, surface or underground water is excluded.
6. Loss caused by war and nuclear damage is excluded.

7. Wear and tear, deterioration, rust, corrosion, mold, wet or dry rot, inherent defect, mechanical breakdown, and losses caused by animals, birds, vermin or termites is excluded.
8. Vandalism and malicious mischief is excluded when the premises are vacant or unoccupied beyond 30 days.
9. Certain types of water damage is excluded, such as leakage of pipes resulting from freezing when the building is vacant or unoccpied (unless the insured has exercised diligence in maintaining heat or the water has been shut off and the pipes drained) and damage which results from continuous or repeated seepage over a period of time.
10. Theft of any property which is not an integral part of the building.

Extensions of Coverage. The Special Building Form includes several important extensions of coverage. In addition to the extension of coverage for newly acquired buildings, the off premises extension, and the extension for trees, shrubs and plants (which were discussed in connection with the General Property Form), the Special Building Form also includes a special Replacement Cost Extension. Under the provisions of this extension, losses of less than $1,000 are paid on a replacement cost basis, provided the insured has met the coinsurance percentage specified in the policy.

The Special Personal Property Form

The Special Personal Property Form may be used to provide all risk coverage on business personal property, subject to specific exclusions. Coverage may be provided on personal property of the insured, on personal property of others in the custody of the insured, or on both classes. The all risk insuring agreement of the Special Personal Property Form is identical to that of the Special Building Form discussed above.

Exclusions Under the Form. The all risk insuring agreement of the Special Personal Property Form is identical to that of the Special Building Form discussed above. However, since personal property by its very nature is subject to a wider range of loss possibilities, the exclusions of the Special Personal Property Form differ from those of the Building form. In addition to those exclusions noted above in connection with the Special Building form, the Special Personal Property Form also excludes:

1. unexplained or mysterious disappearance of property, or shortage of property disclosed by an inventory.
2. fraudulent or dishonest acts by the insured, employees or agents of the insured, or any person to whom property has been entrusted.
3. voluntary parting of property as a result of a fraudulent scheme, trick, device or false pretense.
4. breakage of glass, statuary, or other fragile or brittle articles unless caused by the perils of fire and extended coverage, vandalism, or discharge of a fire protective system.

Other Limitations. Certain classes of property are subject to specific dollar limitations, which apply to losses from any cause except fire, extended coverage, vandalism and malicious mischief, or sprinkler leakage. Coverage for losses except by these "specified perils" is limited to:

1. $1,000 per occurrence on furs and fur garments.
2. $1,000 per occurrence for jewelry, watches, precious and semiprecious stones and precious metals.
3. $1,000 per occurrence on patterns, dies, molds, models and forms.
4. $250 on stamps, tickets and letters of credit.

All risk coverage for amounts in excess of these limits may be obtained under inland marine forms.

Extensions of Coverage. The Special Personal Property form includes seven extensions of coverage. Four of these are the same as those in the General Property Form.

A. **Property at newly acquainted locations.** This is essentially the same extension discussed previously in connection with the General Property Form, but applicable only to personal property.
B. **Personal Effects.** This extension of coverage up to $500 on personal effects of officers and employees is the same as the extension of the General Property Form.
C. **Valuable Papers.** This is the same $500 extension contained in the General Property Form.
D. **Extra Expense.** The insured may apply up to $1,000 to cover the necessary expense incurred to continue operations following damage by an insured peril to buildings or personal property at the described location. Coverage in excess of this amount may be purchased as specific Extra Expense Insurance.
E. **Damage to Buildings, from Theft, Burglary or Robbery.** Although the coverage of the form applies to personal property, this extension provides coverage for damage to the building occupied by the insured if damaged in the process of burglary, robbery, or theft.
F. **Transportation.** The insured may apply up to $1,000 to cover insured property while being transported in vehicles owned, leased or operated by the named insured away from the premises. This extension does not apply to property such as samples in the custody of salesmen. It is important to note that while the basic coverage of the policy is on an all-risk basis, the Transportation Extension provides coverage only for loss

caused by fire, extended coverage, vandalism and malicious mischief, collision or overturn of the vehicle, or theft resulting from forcible entry into the vehicle. Coverage would apply under this extension, for example, to property in a delivery truck owned by the insured firm.

G. **Non-owned Personal Property.** This is the same extension (2% of the amount of insurance up to $2,000) on property of others in the insured's custody discussed in connection with the General Property Form.

ALLIED LINES AND MISCELLANEOUS PROPERTY COVERAGES

"Allied Lines" is a term that is used to describe coverages that are closely associated with and usually sold in conjunction with fire insurance. Unfortunately, there is no generally accepted definition of what allied lines are and no list of the coverages that should be included in the term. The following are generally considered to be "allied lines."

1. Sprinkler Leakage Insurance
2. Water Damage Insurance
3. Earthquake Insurance
4. Radioactive Contamination Insurance

In addition to those coverages classed as "Allied Lines," there are certain other miscellaneous coverages that were traditionally sold by casualty insurers, such as Plate Glass Insurance and some coverages, like Accounts Receivable Insurance and Valuable Papers coverage that were sold by both fire and casualty companies. Finally, there are a number of newer coverages, such as Flood Insurance and Difference-in-Conditions coverage that do not fit conveniently into any special classification. We will discuss all of these coverages in this section.

Sprinkler Leakage

A sprinkler system is one of the most effective means available for keeping a fire under control once it has broken out. A sprinkler system consists of pipes which carry water to sprinkler heads, which are valves designed to open when temperatures reach 135-165° fahrenheit or higher.

Every owner or occupant of a building in which there is an automatic sprinkler system should consider the need for sprinkler leakage insurance. Sprinkler systems are installed to protect against the fire hazard and to help reduce fire insurance rates. While they do aid in fire loss prevention, they also increase another possible source of loss.

The basic fire policy will cover any damage caused by water from a sprinkler system when the discharge is caused by a fire; however, it does not cover the damage caused by accidental leakage. Accidental leakage must be covered under the sprinkler leakage coverage. The coverage defines sprinkler leakage as leakage or discharge of water or other substance from any "automatic sprinkler system", including heads, pipes, valves, fittings, tanks (including component parts and supports), pumps and private fire protection mains connected with the automatic sprinkler. The policy also covers direct loss caused by the collapse or fall of a tank forming a part of the automatic sprinkler system.

Like the Fire Policy, the coverage under the Sprinkler Leakage coverage is on the basis of the actual cash value of the property at the time of the loss. Sprinkler leakage is usually written subject to a coinsurance clause, but with a much wider range of coinsurance options. The insured has a choice of coinsurance percentages of 5%, 10%, 25%, 50%, 80% or even higher. The higher the coinsurance percentage selected, the lower the rate. Different coinsurance percentages may be applied to specific insurance written on different items. For example, the coinsurance on the building might be 10%, while the coinsurance on the contents might be 25%.

Coverage is provided under one or more of six items in the form.

Item No. 1—Covers the buiding

Item No. 2—Covers the contents

Item No. 3—Covers Improvements and Betterments

Item No. 4—Covers personal property of employees or members of the firm.

Item No. 5—Is used to cover contents, when only a part of the contents (e.g., machinery or fixtures) are to be covered.

Item No. 6—Covers damage to the sprinkler system itself. Coverage is for damage resulting from freezing or breakage of parts, subject to a $25 deductible.

The sprinkler leakage coverage is not reduced by loss.

Water Damage

Water damage coverage is designed to cover the accidental discharge or overflow of water or steam from within any of the following sources:

1. Plumbing systems (excluding sprinkler systems, which, as noted above, are covered under the sprinkler leakage policy).
2. Plumbing tanks for the storage of water for the supply of a plumbing system, heating system, elevator tanks and cylinders, standpipes for fire hose (except when supplied by a sprinkler system).
3. Industrial or domestic appliances.
4. Refrigerating or air-conditioning systems.

In addition, the policy also covers the accidental admission of rain or snow directly to the interior of the building through defective roofs, leaders or spouting, or through open or defective doors, windows, skylights, transoms or ventilators. Subject to certain exclusions, the policy also covers direct loss caused by collapse or fall of a tank or any component part or support thereof which forms a part of the plumbing system.

Finally, the policy covers accidental discharge or leakage of water from underground water supply mains and fire hydrants.

EARTHQUAKE INSURANCE

Commercial property forms, such as the General Property Form, specifically exclude loss caused by earthquake, except for any ensuing fire damage. Several methods are available for providing earthquake insurance. There are two ISO Earthquake forms:

1. **The Earthquake Extension Endorsement.** This endorsement is attached to the standard fire policy. It extends the fire policy to include the peril of earthquake, and is used in conjunction with a form providing protection against the perils of extended coverage, additional perils, or all risk. This form may be used to provide coverage against direct loss or consequential loss (such as business interruption). Eighty percent coinsurance is required, and the insured may elect 90% or 100% coinsurance. If the fire coverage is written subject to an Agreed Amount Endorsement, the earthquake coverage may be written on the same basis.
2. **The Earthquake Form.** This form is attached to a Standard fire policy, converting it into an Earthquake Peril Policy only (that is, no coverage is provided for the peril of fire). Only direct damage coverage may be provided under this form, subject to a minimum coinsurance percentage of 40%.
3. **Sprinkler Leakage Earthquake Extension Endorsement.** This separate form may be attached to a standard fire policy which is written to provide sprinkler leakage coverage. It extends the sprinkler leakage protection to include loss resulting from an earthquake. The Sprinkler Leakage Earthquake Extension Endorsement is not necessary if either of the above forms are used, since both include provisions extending the coverage to the sprinkler leakage peril.

Earthquake Insurance Provisions. In general, the provisions of the earthquake form are dictated by the nature of the peril.

A single earthquake occurrence is defined as including any shocks that take place within a period of seventy-two consecutive hours.

A loss deductible clause, specified as a percentage of the actual cash value of the property, supercedes any other deductible in the policy as respect earthquake coverage. This deductible applies separately to each building or structure, the contents of each building, and property in the open.

One additional important distinction between the coverage under the fire forms and that of the earthquake forms is that the earthquake forms do not, as do the fire forms, exclude foundations and excavations. These items are specifically covered under the earthquake forms.

The earthquake forms also contain an apportionment clause. When the earthquake extension endorsement is used, loss is apportioned on the basis of the total amount of **fire** insurance in force.

FLOOD INSURANCE

Until the enactment of the 1968 Housing and Urban Development Act (HUD) which initiated the National Flood Insurance Program, flood insurance on fixed location property was available only on an extremely limited basis. The HUD Act of 1968 established a federally subsidized flood insurance program, under which flood insurance is made available to both individuals and to business firms.

General Provisions of the Flood Insurance Program

The National Flood insurance program is open to any community that pledges to adopt and enforce land control measures designed to guide the future development of the community away from flood prone areas. Once a community has agreed to adopt the specific controls required, it becomes eligible for the "Emergency Program." Under this program, coverage is available at subsidized rates for up to $35,000 on single-family dwelling and up to $100,000 on other eligible structures. Residential contents are protected up to $10,000 and nonresidential contents may be insured up to $100,000. Although the program originally provided coverage only for residential property, the eligibility has gradually been expanded. At the present time, virtually all industrial, commercial, agricultural and public buildings are eligible for coverage.

When the community actually implements the controls and the actuarial studies have been completed, it becomes eligible for the Permanent Program. Under the Permanent Program, property owners may purchase additional insurance at nonsubsidized rates calculated to take into account the probability of flood losses in the community. Actuarial rates may range from $.05 to $30 per $100 of insurance.

The program makes a distinction between "Small Business" and other nonresidential risks, and provides larger amounts of coverage to those firms that qualify as a "Small Business." The amounts of subsidized and nonsubsidized coverage available and the rates at which the coverage is available are as follows:

	First Layer (Subsidized)	Subsidized Rate per $100	Second Layer
SMALL BUSINESS - Buildings	$100,000	.40	150,000
SMALL BUSINESS - Contents	100,000	.75	150,000

OTHER NONRESIDENTIAL - Buildings	100,000	.40	100,000
OTHER NONRESIDENTIAL - Contents	100,000	.75	100,000

A "Small Business" for the purpose of the National Flood Insurance Act includes any firm with assets of $5,000,000 or less, a net worth of $2,500,000 or less, and an average net income after Federal Income taxes for the preceding two years of not in excess of $250,000.

Because the original law did not make the program mandatory, participation was less than hoped for. In 1973, the Flood Disaster Protection Act amended the provisions of the original law to coerce property owners into purchasing flood coverage by denying them access to federally assisted financing if they did not. The 1973 amendments require the purchase of flood insurance in any "special flood hazard area" as a condition to receiving any form of financing from financial institutions under the supervision of or insured by a government instrumentality. A "special flood hazard area" is a specifically designated area which, on the average, is likely to be inundated at least once every 100 years. The 1973 amendments also eliminate the possibility of a property owner's receiving federal disaster funds following a flood in any locality identified as a special flood hazard area unless the individual has purchased flood insurance in the amounts available. These penalties apply regardless of whether or not the place in which the special flood hazard area is located has qualified for flood insurance.

Although increased amounts of coverage are available to small businesses, the maximum amount of coverage required of a small business in order to comply with those provisions of the law regarding federal financing and disaster relief funds is the same as for other nonresidential properties: $100,000 on buildings and $100,000 on contents where the emergency program only is in force, and $200,000 on buildings and $200,000 on contents where the Regular Program is in force.

The Flood Insurance Policy

There are two flood insurance policies. One is designed for one to four family dwellings and their contents, and the other is designed for multi-family residential property such as apartment houses and nonresidential structures and their contents. Here we are concerned with the latter form, referred to as the General Property Policy.

In general, this form is patterned after the Standard Fire Policy, and the General Property Form used with the fire policy. There are, however, a number of significant differences outlined below which are dictated by the nature of the flood peril.

Protection under the flood policy is provided under three items, designated Coverages A, B, and C, insuring the building, contents, and debris removal, respectively. Coverage may be purchased on the building, its contents, or both. The debris removal coverage is included in the limit of liability applicable to the property insured.

The Insuring Agreement. The insuring agreement of the flood policy follows the wording of the insuring agreement of the Standard Fire Policy, almost word for word, substituting the term "flood" for "fire, lightning, and removal . . ." Although the contract states that property that has been removed for protection from the peril insured against is covered pro rata at its new location for up to 30 days, removal is not an insured peril, and the coverage during removal and during the 30 days is not all-risk as is the case under the Standard Fire Policy. However, the policy does include specific coverage reimbursing the insured for reasonable expenses of moving insured contents to a safe area and temporary storage for not exceeding 45 days when such property is in imminent danger of flood.

Flood Defined. Flood is defined in the policy as a general and temporary condition of partial or complete inundation of normally dry land areas, resulting from overflow of inland or tidal waters or the unusual and rapid accumulation or runoff of surface waters from any source. Coverage is also provided against loss by mudslides which are caused or precipitated by accumulations of water on or under the ground.

The policy includes the standard exclusions of war, nuclear reaction, the operation of building codes, and neglect of the insured to protect and preserve the property at the time of a loss. In addition, there is a specific exclusion of loss caused by fire, windstorm, explosion, erosion, earthquake, landslide, or other earth movement except mudslide.

Building Coverage. The definition of the building generally follows that of the fire insurance General Property Form, and includes extensions and additions attached to the building. Coverage is also provided under the building item for building service equipment and personal property of the landlord pertaining to the service of the premises, such as fire extinguishers, carpeting, and similar items, while within the building. Materials and supplies intended for construction and repair of the building are covered, but only while within a fully enclosed structure.

Contents Coverage. Contents under the General Property Policy may include household goods (as in the case of furnished apartments) or property other than household goods. When property other than household goods is covered, coverage is provided for furniture, fixtures, machinery and equipment, merchandise and stock, and materials and supplies. Coverage on contents applies only to property while located within the described building.

DIFFERENCE-IN-CONDITIONS INSURANCE

Difference-in-conditions insurance, generally referred to as DIC coverage, is a special form of all-risk coverage written in conjunction with basic fire coverages and designed to provide protection against losses that are not covered under standard fire forms. It is always written as an adjunct to separate policies covering against fire, extended coverage, and vandalism and malicious mischief (plus sprinkler leakage when the exposure exists), and does not provide coverage against loss caused by these perils. It does, however, provide coverage for most other insurable perils, including (in some instances) earthquake and flood.

There is no coinsurance clause and no pro-rata clause in the DIC policy, and the contract may be written for a different amount of insurance than the basic policies it complements.

The coverage is subject to a deductible, which is usually substantial, ranging upward from $10,000. When coverage for earthquake and flood is included, the limits for these perils and the deductibles may differ from those applicable to other perils under the policy.

There is no standard form of DIC coverage, nor are there standard rates. Each DIC policy is individually rated, and the coverage may differ not only from company to cmpany, but also from policy to policy within the same insurer.

DIC coverage was originally available only to giant firms, but some insurers have recently developed "mini-DIC forms" for medium to small businesses. In some instances, consequential loss coverages (such as business interruption and extra expense coverage) and transit coverages are included.

ACCOUNTS RECEIVABLE AND VALUABLE PAPERS INSURANCE

Accounts Receivable and Valuable Papers Insurance were originally written by both fire insurers and casualty insurers. These coverages are currently classified and rated from the Crime Section of the **Commercial Lines Manual,** but it seems appropriate to discuss them with the other coverages treated in this section.

Accounts Receivable Insurance

Accounts receivable insurance protects against the inability to collect amounts owed to the insured because of destruction of records by fire or other insured perils. The coverage is usually written as all-risk, and both a reporting and nonreporting form are available. The coverage is on an indemnity basis and compensates the insured for any amounts that are uncollectible because of the destruction of the accounting records (with allowance for bad debts). In addition, payment is made for expenses incurred to reconstruct the records, for collection expenses above normal costs, and for the interest charges on loans taken out by the insured to offset the impaired collections.

Valuable Papers Insurance

Limited coverage for valuable papers is provided under the extensions of several of the forms used in connection with the Standard Fire Policy. Those firms that need additional coverage on valuable papers may obtain it under a Valuable Papers Form.

Valuable papers coverage may be written to insure various types of important records, including maps, film, tape, wire or recording media, drawings, abstracts, deeds, mortgages, and manuscripts. Coverage is on an all-risk basis and can be either blanket or scheduled. Items specifically insured are covered for an agreed amount, while papers covered on a blanket basis are insured for their actual cash value.

PLATE GLASS INSURANCE

Although fire insurance policies on buildings cover glass which constitutes a part of the building, the coverage is on a named peril basis and is subject to certain exclusions. For example, we have seen that the vandalism and malicious mischief coverage excludes loss to glass. Because of the limited coverage afforded on glass under the fire policy, individual business owners may wish to purchase broader coverage afforded under a Comprehensive Glass Policy, which covers glass on an extremely broad all-risk basis. Under the Plate Glass Policy, the insured is indemnified for damage to the glass, insured lettering, or ornamentation caused by accidental breakage (except by fire) and acids of chemicals accidentally or maliciously applied, provided the glass, lettering, or ornamentation is unfit for further use. This is probably the broadest insuring agreement in existence, covering all breakage and excluding only fire and war. However, only those plate glass panels specifically insured are covered, and lettering is not covered unless it, too, has been specifically insured.

The Plate Glass Policy does not cover marring or scratching of the glass, except as provided under the coverage with respect to acid or chemicals. The insuring agreement covers "breakage," and unless the break extends through the entire thickness of glass, it is not considered to be breakage. The policy provisions give the company the option of replacing the broken glass or paying for the glass in cash. Normally, the company elects to replace the glass.

The policy also covers the cost of repairing or replacing frames or sashes up to $75, the cost of boarding up or installing temporary plates in broken windows up to $75 and the cost, not exceeding $75, of removing and replacing fixtures and other obstructions.

CONSEQUENTIAL LOSS COVERAGES

In addition to the direct physical loss or damage, there are other losses that may result from the direct damage. These are "consequential losses." If a business is forced to suspend operations because of a fire or other insured peril which damages the building or its contents, there will be no income and the business will be forced to dip into its capital funds in order to pay continuing expenses. In addition, profit will be discontinued during the period of interruption.

Unlike the dwelling forms, commercial fire forms do not provide coverage for consequential loss resulting from damage to insured property. Such protection must be added by endorsement or purchased under a separate contract. The major consequential loss coverages are rent or rental value insurance, business interruption insurance, extra expense insurance, contingent business interruption and contingent extra expense insurance, and leasehold interest coverage.

RENTAL VALUE INSURANCE

The consequential loss coverage with which most readers are already familiar is Rental Value coverage, which is automatically included in both the dwelling forms and the Homeowners policies. Similar coverage is available to owners of apartment houses, office buildings, and other types of businesses which derive their income from rental property.

Rental value insurance is insurance against loss of rental income of property made untenantable by fire or some other insured peril. It may be written in a separate policy or it may be endorsed onto a policy covering direct damage to the building. The policy then agrees to cover the loss of rents when a building is rendered untenantable by a peril insured against. The insurer is liable for an amount not exceeding the actual loss sustained, based on the loss of rental income, less expenses which do not continue, up to the face amount of the coverage. The period of untenantability is computed from the date of the damage for that period that would be required with due diligence and dispatch to restore the premises. Expiration of the policy does not limit the period of payment. If a loss occurs during the term of the policy, liability may continue through the period of untenantability which extends beyond the expiration date of the policy.

There are two basic Rental Value forms available: a monthly limitation form and a contribution (coinsurance) form.

Monthly Limitation Form

The Monthly Limitation Form of Rental Value Insurance designed for commercial risks is similar to the Rental value coverage provided under the Dwelling Buildings and Contents Basic Form. Coverage applies to the actual loss sustained during the period of restoration, and the insured may collect up to a specified fraction of the face amount of insurance during any month of untenantability. The insured may select a monthly limitation of 1/6, 1/9, or 1/12 of the face amount as the monthly limitation.

If an insured purchases coverage equal to the total rents anticipated during a period of six months, the 1/6 monthly limitation would provide coverage for a total shutdown of up to six months. However, it should be recalled that expenses which do not necessarily continue are not payable. This means that the actual amount of coverage that should be carried will generally be something less than the full rental income during the anticipated period of restoration.

It is also important to note that the form does not specify a maximum period (other than the period of restoration) for which the loss is payable, and the selection of a 1/6 monthly limit does not necessarily limit the period of payment to six months. For example, if the insured purchases coverage equal to the total rental income for six months, and then suffers a loss in which only a portion of the rental units are rendered untenantable, the amount of insurance purchased would provide indemnification for a period in excess of six months.

Contribution (Coinsurance) Form

Under the Contribution Form, the insured agrees to carry insurance equal to a specified percentage of the rental value that would have been earned, had no loss occurred, during the twelve months following the date of the loss. Contribution percentages of 60%, 75%, 80%, 90% and 100% are available. Thus, a property owner who anticipates a period of restoration of say, twleve months, could purchase coverage equal to the annual rental value and select a 100% coininsurance provision. If such a property owner could predict that expenses equal to 10% of the rental income would not continue in the event of a shutdown, he or she could purchase coverage in an amount allowing for such reduction, and select a 90% coininsurance clause.

Note that as in the case of the monthly limitation form, the contribution percentage selected does not limit coverage to a special period of time. For example, an insured who anticipates a shutdown of say six months, and purchases coverge equal to six months, and purchases coverage equal to six months rental income, would have coverage for a loss of longer duration if only a portion of the units were damaged or destroyed.

BUSINESS INTERRUPTION

In addition to the direct physical loss or damage, there are other losses which may result from the direct damage. These are the consequential losses. If a

business is forced to suspend operations because of a fire or some other insured peril which damages the building or the contents of the building, there will be no income and the business will be forced to dip into its capital funds to pay continuing expenses. In addition, profit will be discontinued during the period of interruption. It is the purpose of business Interruption Insurance to pay both the continuing expenses and the profits that would have been earned during this period of interruption.

Business interruption insurance is designed to indemnify the insured for his loss of income during the period of time that it takes to restore the property to a useful condition. It undertakes to replace income, minus expenses which do not continue, which would have been earned if the property had not been damaged. The insurance company agrees to pay for this loss of income for the period of time that would be required "with due diligence and dispatch" to rebuild, repair, or replace that part of the building or other property that was damaged by an insured peril. Business interruption is generally written as a contract of indemnity, limiting the recovery to the actual expenses (including a normal profit) which continue.

General Conditions of Business Interruption Insurance

Under the provisions of the business interruption forms, the insured is reimbursed for the actual loss sustained from the date of the loss to the date of restoration, but in no event for more than the amount stated in the policy. The restoration period for which payment is made ends when the location again occupied by the insured and the machinery and equipment in the building are returned to operating condition.

In determining the amount of the loss, the insurance company considers the insureds experience before the loss and probable experience after the loss if no loss had occurred.

The peril causing the interruption must be an insured peril under the policy, and the damage must have occurred during the policy period. The period of time for which a recovery may be obtained is not limited by the expiration of the policy.

Expense to Reduce Loss

The policy requires the insured to use all reasonable means to get back into operation as soon as possible. If it is possible for the insured to get back into business at a temporary location, even on a reduced scale, he is required to do so. Any costs incurred by the insured in attempting to get back into business, or any higher than normal repair costs that are incurred in attempting to expedite repairs will be payable under the policy. A policy provision "Expense to Reduce Loss" provides for the payment of costs incurred to reduce the amount of the loss. These are payable so long as the total amount paid does not exceed the amount which would have been paid out under the interruption coverage if the costs had not been incurred.

Business Interruption may be written to provide coverage against the same perils as the direct damage coverages: Fire and lightning; Fire, lightning and extended coverage; Fire, lightning, extended coverage and vandalism and malicious mischief; and even "all risk" coverage. The coverage may be written on a coinsurance basis, under one of the Gross Earnings forms, or without coinsurance under the Earnings or "No-coinsurance" form.

The Gross Earnings Form

There are two gross earnings forms available, one for mercantile and non-manufacturing risks (Gross Earnings Form 3), and one for manufacturing risks (Gross Earnings Form 4).

Gross Earnings Form 3, the Mercantile Form. This form provides for indemnification for loss sustained from necessary interruption by damage to the described premises by an insured peril. The term "Gross Earnings" is defined in the form as:

> "Total net sales plus other earnings derived from operations, minus cost of merchandise sold, materials, and services purchased from outsiders."

A merchant is engaged in the business of selling; when his business is interrupted, he loses sales. Therefore in the mercantile form, gross earnings are defined as "total net sales" less the "cost of merchandise sold".

Gross Earnings Form 4, the Manufacturing Form. This form defines gross earnings as:

> "Sales value of production less the cost of raw stock from which production is derived."

The essential difference between the Manufacturing Form and the Mercantile Form is the provision relating to stock. The mercantile form provides that the merchant is back in business when the premises are restored and the stock is replenished. Under the manufacturing form coverage extends to the point where raw stock is replenished and stock in process is returned to the point it had been when the loss occurred.

Coinsurance options of 50%, 60%, 70%, and 80% are available under both of the Gross Earnings forms. The coinsurance clause of the business interruption forms (also called a "contribution clause") serves the same function as the coinsurance clause in the fire insurance direct damage coverage: to induce the insured to carry a high percentage of insurance to value. The clause operates in much the same manner as in the direct damage policies: If the amount of insurance carried is less than the required percentage at the time of the loss, the insured will be penalized.

The rate for business interruption coverage varies with the coinsurance percentage selected. The higher the percentage of annual Gross Earnings insured, the lower the rate per $100. The percentage of the total annual Gross Earnings that should be selected will depend on the period of time that will be required for restoration of the premises, and the maximum potential earnings that will be lost during the maximum period of time required for restoration. Thus a business which is seasonal in nature should insure a higher percentage of its annual gross earnings.

The Gross Earnings Forms include coverage on ordinary payroll. It is possible to eliminate this payroll from coverage, or to limit the coverage on payroll to 90, 120, 150, or 180 days. If the insured wishes to eliminate or limit the payroll from coverage, he is required to select the 80% coinsurance clause.

When all ordinary payroll is to be excluded, an endorsement entitled "Ordinary Payroll Exclusion Endorsement" is used. This form simply states that the form does not include any of the ordinary payroll expenses which is defined as "the entire payroll expense for all employees of the insured, except for office, executives, department managers, employees under contract, and other important employees."

Underinsurance in Business Interruption

The determination of the correct amount of insurance is a major problem in the business interruption area, because a business may have a growth of earnings over time. The insured is required to estimate his future earnings, and in some cases these earnings must be estimated far in advance of the actual earnings. If the insured over-estimates, he pays for more insurance than he can collect. If he underestimates, he may suffer not only an insufficiency of insurance to cover a long period of restoration, but he will be penalized during the short period of shutdown because of the coinsurance requirement.

To illustrate the importance of the contribution clause in business interruption insurance, let us assume that the insured in question purchases business interruption insurance under the Gross Earnings Form with a 50% contribution clause. An examination of the insured's records indicates that the gross earnings last year were $120,000, and the insured therefore purchases $60,000. Three years pass and the firm maintains the same amount of business interruption coverage. Then, at the time that the loss takes place, the books are examined and it is determined that the insurable value of the firm has doubled, making the insurable value $240,000. Obviously the insured has not complied with the contribution clause and will suffer a penalty. If the firm is shut down for three months, the loss to the firm is $60,000 (3/12, assuming that the business is spread equally through the year). Even though the firm has $60,000 in business interruption coverage, it will not collect its entire loss. Recovery will be limited to $30,000 because of the deficiency in the coinsurance requirement.

$$\frac{\text{Amount of insurance carried} \quad \$\ 60{,}000}{\text{Amount required} \quad (50\% \text{ of } \$240{,}000) = \$120{,}000} \times \text{Loss}$$

The very great difficulty in estimating future earnings means that unless great care is taken in estimating future earnings, and unless these estimates are revised regularly, the insured may be penalized. It is possible to protect against underinsurance and a coinsurance penalty through the use of one of the two endorsements described below, which have been designed to cope with this problem.

Agreed Amount Endorsement. Gross Earnings Form 3 (the mercantile and non-manufacturing form) may be written on an Agreed Amount basis. Under this approach the insured files a statement of values with the insurance company listing his predicted "Gross Earnings". The policy is then written for the agreed percentage of this agreed value. In the Agreed Amount Endorsement the insurance company agrees that the earnings insured will be accepted as meeting the coinsurance requirment. The provisions of the endorsement provide that the insured will not be penalized if his earnings increase and that for the next year the coverage will be considered as meeting the coinsurance requirement.

Premium Adjustment Endorsement. This endorsement may be used on either Form 3 or 4 when ordinary payroll is included and the Agreed Amount Endorsement is not used. Under the provisions of this endorsement the insured is entitled to a return of a part of his premium if the amount of insurance which he purchased is in excess of the amount that would have been required to meet the coinsurance percentage for the year.

Under the premium adjustment endorsement, the insured selects an amount of insurance that is in excess of the amount which he feels will be needed. This provides a margin for safety. If the business grows more rapidly than anticipated, the Business Interruption policy has a safety margin built in that prevents a coinsurance deficiency. If the business grows at the rate anticipated, the insurance company will return the premium for that part of the coverage that was not needed to comply with the coinsurance requirement.

The Endorsement to Extend the Period of Indemnity

In determining the amount of coverage, consideration should also be given to the possibility that earnings may not return to their previous level immediately upon physical restoration of the premises. The business interruption forms provide that the insurance company will pay for the loss of earnings during the period of time required to restore the property. In some instances, the loss of earnings may continue past this

point in time. Consider, for example, the case of a restaurant. In the event of fire forcing a suspension of operations, customers may turn to other restaurants in the area, and the business following the reopening may be far lower than the business immediately preceding the fire. Under such circumstances, the insured may be protected against loss through an endorsement entitled the "Endorsement to Extend the Period of Indemnity." Under the provisions of this endorsement, the insurer will continue to pay for loss of earnings past the date at which it would normally have ceased payments. The period of time following restoration of the premises for which payment is to continue is selected by the insured when the policy is written. The insured may select thirty, sixty, ninety days, or up to a full year, and be covered for the lag between the reopening of the business to normal business as it existed before the loss. The premium for the business interruption coverage is surcharged by a percentage specified in the manual for this endorsement. The percentage surcharge varies with the period of time for which the indemnity is to be extended.

Business Interruption Insurance — Earnings Form (No Coinsurance Form)

The Earnings Form of business interruption coverage is an easy-to-understand coverage, designed to insure loss of earnings of mercantile and non-manufacturing risks. It is designed for the relatively small firm, and is characterized by its simplicity. In many cases, a small business owner is reluctant to open his books to the insurance company, fearing that he might divulge what he considers to be his "business secrets". Yet in order to compute the Gross Earnings as required under the Gross Earnings forms, a detailed analysis of the records of the firm is necessary. In addition, many insureds do not understand the coinsurance mechanism and find it distasteful. Since there is no coinsurance requirement in the Earnings Form, many insureds are more willing to make use of it.

In order to determine the amount of insurance required under the Earnings form, it is only necessary for the insured to determine what the monthly loss of earnings would be if he were forced to close down during his busiest season. Once this figure has been determined, the amount of insurance purchased is some multiple of this amount. Instead of a coinsurance requirement, there is a limit of the face of the policy, expressed as a percentage, which the insured can collect during any one month of shut down. In the basic loss of earnings endorsement, this limitation is 25%. Thus if the insured purchases $10,000 in coverage under the loss of earnings endorsement, he can collect up to $2,500 per month. Since there is no coinsurance requirement to be met, the insured cannot suffer a coinsurance penalty. If the insured underestimates the amount of his future earnings, the only penalty is that the amount of insurance will be insufficient to cover his total loss.

It should be remembered that the Earnings form is designed for smaller risks. The rate for this coverage is always higher than the Gross Earnings form, but while the rate is higher, the premium may be lower, for the insured can purchase any amount he desires and is not required to insure 50% of his gross earnings.

EXTRA EXPENSE INSURANCE

It may be impossible for some types of businesses to shut down their operations in the event of a fire. Under certain circumstances it might be necessary for the business to continue its operations at some other location. Extra expense insurance is an alternative and sometimes a supplement to business interruption insurance for those businesses which can continue operations through the use of other facilities. The Extra Expense policy provides payment for expenses over and above the normal expenses, when such additional expenses are incurred to continue operations after damage to the insured premises by an insured peril.

Extra expense insurance is available under two forms, one of which provides extra expense only, and a second form which combines extra expense insurance with business interruption coverage.

Extra Expense Insurance

The insuring agreement provides for reimbursement of those expenses involved in continuing operations, including the expense of temporary premises and equipment, moving, extra labor, advertising, printing, travel for employees, etc.

The extra expense form does not include a coinsurance clause, but instead includes a schedule of cumulative monthly limits of the face amount of the policy. The period of indemnity may not be less than three months, and no more than 40% of the amount of insurance purchased may be used during any one month. The most commonly used percentages are:

- Up to 40% of the face of the policy payable during the first month
- Up to 70% of the policy payable during the first two months
- Up to 90% of the policy payable during the first three months
- Up to 100% of the policy payable during the first four months.

If insurance is not used during the scheduled period, the balance is available for the actual period of restoration. The rates for the coverage are based on the building rates, and the actual rates charged are determined by factors coinciding with the schedule of limits. The smaller the percentage used during a given month, the lower the rate. The rate diminishes, in other words, as the percentages are increased.

Extra Expense may be written to cover:

1. Fire and Lightning
2. Fire and Lightning and Extended Coverage

3. Fire and Lightning, Extended Coverage, Vandalism and Malicious Mischief
4. "All risk" under the Special Extended Coverage Endorsement.

Combined Business Interruption and Extra Expense Insurance

Business Interruption and Extra Expense insurance may be provided under a combination form (called the Combined Business Interruption and Extra Expense Insurance Form 19K). This form provides conventional business interruption coverage, similar to that of the gross earning forms, with a limited amount of extra expense coverage. The extra expense insurance is a specified percent of the amount of business interruption insurance, and is not additional coverage. The insured may elect that 10%, 20%, 30%, 40%, or 50% of the amount of business interruption coverage may be payable for extra expenses: the business interruption rate is surcharged 20%, 40%, 60%, 80%, or 100%, depending on the option selected. The extra expense coverage is subject to a monthly limitation exactly as in the case of separate Extra Expense coverage (i.e., the insured may collect a specified percentage of the amount of extra expense insurance during the first month, second month, and third month in which extra expenses are incurred.) For example, the following table indicates the amounts collectible on a month by month basis under the various extra expense options available:

	Percentage of Business Interruption Insurance Payable for Extra Expense				
First month	4%	8%	12%	16%	20%
Second month	8%	16%	24%	32%	40%
Three months or more	10%	20%	30%	40%	50%

The rating structure applicable to this form takes into consideration the relationship between extra expenses and business interruption exposure, and provides a discount for the inclusion of both coverages in a single form. When insurance is written under this form, payroll may not be limited or excluded under the business interruption coverage.

CONTINGENT CONSEQUENTIAL LOSS COVERAGES

Contingent Business Interruption

Contingent Business Interruption insurance is a means of protecting the firm against loss as a result of interruptions which are caused by a fire or other insured peril at premises which are not owned, controlled, or operated by the firm. There are three situations in which this coverage is used:

1. When the insured depends on one or a few manufacturers or suppliers for most of the materials or services to conduct his business. The firm upon which the insured depends in this situation is called the contributing property.
2. When the insured depends upon one or a few businesses to purchase the bulk of his products. The business to which the bulk of the insured's production flows is called the recipient property.
3. When the insured depends upon a neighboring business to help attract customers to his place of business. A common way of referring to the attracting business is the leader property.

Basically, the policy covers the interruption of the insured's business which is caused by fire or other insured peril at the other non-owned property. It is not necessary that the contributing or recipient property be shut down in order to cause a contingent business interruption loss to the insured. A supply of finished goods intended for the insured may be destroyed at the plant of the contributing firm, forcing the insured to shut down. The insured would collect, even though the contributing firm was not shut down for so much as an hour. Conversely, the fire might close the contributing plant; but the insured, having stocked up in advance might not be affected. In this situation there would be no business interruption loss. The essential point is that the insured's business is interrupted because of damage to someone else's property.

Contingent business interruption coverage may be provided under one of three forms. There is a Contingent Business Interruption Form (Contributing Properties) and a Contingent Business Interruption Form (Recipient) Properties. When coverage is provided in connection with a leader property, the "Contributing Property" form is used, with modifications describing the relationship between the leader property and the insured. The third form, the Contingent Business Interruption Extension Endorsement, is used with the Gross Earnings business interruption form, and extends that form to include contingent business interruption protection with the regular business interruption.

Contingent Extra Expense Insurance

Contingent extra expense insurance is designed to protect against the increase in expenses that might be occasioned through damage to or destruction of property that is not owned, controlled, or operated by the insured. It is similar to contingent business interruption in the sense that it is property of some other firm, rather than the insured's own property, whose destruction would cause the loss. Contingent Extra Expense insurance might be used, for example, in instances in which a manufacturer has a low-cost source of raw materials. Damage to or destruction of the plant of the supplier would force the insured to obtain these materials elsewhere at a higher cost. Contingent extra expense provides protection against such losses.

Business Interruption Coverages for Individuals

Although it is common to think of business interruption as a loss exposure for the firm, it is less often con-

sidered as a loss exposure for individuals whose income depends on the continued operation of the firm. There are two situations in which some form of personal business interruption coverage may be warranted:

1. A store manager or other businessman whose income is derived primarily from commissions or bonuses that are tied to sales or receipts. For example, several national chain stores pay their branch managers a nominal salary, with a bonus which is closely tied to the overall performance of the store under his management.
2. Selling agents whose line of merchandise consists primarily of the output of a single manufacturer or a small number of manufacturers.

The exposure here is clearly a contingent one; as in the case of the contingent forms of business interruption discussed above, the loss of income involved is triggered by damage to or destruction of property owned by someone else. However, coverage for the individual's loss of income may not be written under a Contingent Business interruption form. It must be written under one of two specifically designed forms of coverage that have been developed to meet this need.

Loss of Income Coverage. Loss of Income insurance provides protection against the loss exposure faced by the store manager or other businessman whose income is dependent on the continued operation of a specified business. Insurance for this exposure is written under a form called the "Loss of Income Form" (Form 110). This form provides coverage for loss of personal income suffered by a named insured which results from damage to or destruction of property and interruption of a named business. The form defines "Income" as the salary, commissions, and other earnings accruing to the insured from the operation of the named business, less any income guaranteed to the insured by the named business.

Commission of Selling Agents. The Commission of Selling Agents Form (Form 22) is similar to the Loss of Income coverage discussed above, but covers the insured for his actual loss of commissions when a manufacturing property is unable to fill contracts for the insured because of damage to the premises caused by an insured peril. The insured may name one or more factories or plants, but each location must be designated in the form with an amount of insurance applicable to each location. The coverage is written subject to a coinsurance clause, and the insured may select 50%, 60%, 70%, or 80% coinsurance agreement. The coinsurance clause applies to the commissions that would have been earned during the twelve months immediately following the date of the loss, had no loss occurred.

LEASEHOLD INTEREST

Leasehold interest insurance is designed to provide protection against loss due to the termination of a favorable lease as a result of fire or other insured peril. The lessee or the lessor may suffer financial loss as a result of the termination of a favorable lease, and many lease of premises agreements provide that the lease is to be cancelled in the event of destruction of the property or damage to the property which renders it untenantable.

Suppose, for the sake of example, that a firm has leased property for $1,000 a month under a contract that provides for cancellation of the lease in the event of fire or damage to the premises. Suppose also that prevailing conditions make it impossible to secure similar quarters at less than $2,000 a month, and that the current lease has six years (72 months) to run. This existing lease creates a leasehold interest of $1,000 a month for the 72 month period.

Although the insured would "lose" $1,000 a month for 72 months, the insurable value of this leasehold interest is the present value of $1,000 a month for 72 months, discounted at 6%. Reference to a Table of Leasehold Interest Factors (contained in the fire section of the ISO Commercial Lines Manual) indicates that the present value of $1,000 a month for 72 months at 6% is $60,643.

The amount of insurance under a leasehold interest form decreases month by month, with the amount of insurance always approximately equal to the insured's insurable interest in the lease. In the event of a loss that terminates the lease, the insured is paid a lump sum equal to the discounted value of the leasehold interest for the remaining months of the lease. The premium computation for leasehold interest insurance makes appropriate allowance for the decreasing level of protection.

BOILER AND MACHINERY INSURANCE

Boiler and Machinery insurance is a specialized line covering a wide range of power producing equipment. It originally developed out of the efforts of a group of engineers in Hartford, Connecticut, who offered to provide an inspection service for steam boilers and, for a small additional charge, to guarantee their inspection service by providing insurance against loss up to some limit selected by the client.

One of the most important aspects of Boiler and Machinery insurance is still the inspection service that the insurer provides. Those insurance companies that write boiler and machinery insurance maintain inspection services for underwriting and loss prevention purposes. The Boiler and Machinery Policy provides that the insured shall permit the insurer to make inspections at all reasonable times during the policy period, and two such inspections are usually made annually. One inspection is made during the heating season, and one is made when the boiler is not in use, if possible. In addition, before issuing a policy, the insurance company inspects the boiler to determine if it is safe enough to insure.

The insurance company's inspector examines the boiler and pressure vessels during the inspection, both internally and externally. If the boiler fails to pass the inspection, the inspector is authorized to suspend the coverage immediately, requiring repair or replacement of the boiler before the coverage becomes effective again. A boiler on which the insurance has been suspended may not be operated until it has been put in condition satisfactory to the insurer.

Although the inspection service is a critical part of the boiler and machinery insurance area, indemnification for losses that do occur is equally important from the point of view of the insured. As the reader may recall, the provisions of the Extended Coverage Endorsement specifically exclude damage caused by explosion of a steam boiler, which means that the property owner who owns or operates a boiler needs specific insurance to cover this exposure. The Boiler and Machinery policy provides coverage for loss arising out of the operation of pressure, mechanical, and electrical equipment, including both the loss suffered by the boiler and machinery itself and damage to other property of the insured. In addition, the policy may be written to include coverage for indirect or consequential losses such as business interruption.

DIRECT DAMAGE COVERAGE

Boiler and machinery insurance protects against losses resulting from an "accident" to a specified "object." The terms "accident" and "object" are defined in the schedule attached to the general boiler and machinery policy. An "object" may include such items as boilers, boiler piping, pressure vessels or machines. Since different objects insured under a boiler and machinery policy are subject to different types of occurrences that may cause loss, the word "accident" has a special definition with respect to whatever kind of object is insured, and the specific definition must be examined to determine the extent of the coverage.

With respect to insurance on boilers, the insured may choose between a so-called "broad" form of coverage and a "limited" form. The definition of "accident" in the broad form is:

> . . . a sudden and accidental breakdown of the object, or a part thereof, which manifests itself at the time of its occurrence by physical damage to the object that necessitates repair or replacement of the object or part thereof.

The limited form of coverage is restricted to explosion. Under the limited form, the definition of "accident" is:

> . . . a sudden and accidental tearing asunder of the object or a part thereof, caused by the pressure of the water or steam therein . . .

The definition of the limited form is obviously less liberal, and the premium for this form of the coverage is lower than for the broad form.

The boiler and machinery policy insures against four types of losses: damage to the insured's own property, expediting expenses, and bodily injury and property damage liability. The coverage is provided under six insuring agreements, designated A, B, C, D, E, and F, or, in some cases, I, II, III, IV, V and VI.

Section I covers loss to the property of the insured damaged directly by an accident to an insured object. As the reader will recall, the provisions of the extended coverage endorsement exclude explosion of a steam boiler that is owned or operated by the insured. If such a boiler exists, coverage for damage resulting from an explosion must be covered under the boiler and machinery policy. Section I of the policy, which applies to all property owned by the insured, fills this gap. The amount of coverage under the boiler and machinery policy should, therefore, be sufficiently large to cover the total values that could be destroyed. Replacement cost coverage, similar to that examined in connection with the fire insurance policy, is available to eliminate any deduction for depreciation. Otherwise, the coverage is on an actual cash value basis.

Section II covers expediting expenses. Subject to the limit of the policy, the coverage provides reasonable amounts to pay for the extra cost of making temporary repairs and for expediting the permanent repairs. Payment under Section II (or as it is sometimes designated, Coverage B) is limited to $1,000 or any part of

the face of the policy that has not been paid out under Section I.

Sections III and IV cover property damage liability and bodily injury liability. These sections protect against liability imposed on the insured for property damage or for bodily injury that results from an accident to an insured object. The coverage under Sections III and IV is excess over any other liability insurance that the insured may have.

The boiler and machinery policy is somewhat unique in that it provides one amount of insurance that can be used for all four of the losses listed. The entire amount of the policy is available to pay for loss under Section I, with any amount not paid under Section I available for payment under Section II. If payment for loss under Section II does not exhaust the policy limit, payment is made under Section III; and finally, if any coverage is still left, payment is made for loss under Section IV of the policy.

Section V, "Defense, Settlement, Supplementary Payments," provides for payment of defense services, payment of court and other costs of investigating claims under Sections III and IV, including payment of interest on judgment and premiums on appeal bonds, and release of attachment bonds. All such expenses are covered regardless of the limit per accident.

Section VI, designated "Automatic Coverage," provides automatic coverage on newly acquired objects. The policy provides automatic coverage for up to ninety days on any object similar to the object already insured under the policy. Such newly acquired objects may be newly installed at existing locations, or it may be in newly acquired premises.

There are two methods of insuring objects under boiler and machinery policies. Objects may be insured under the Blanket Group Plan or each object may be specifically insured. The Blanket Group Plan provides automatic coverage at each insured location for all objects by the Blanket Group Description. The Blanket Group Plan also provides for annual premium adjustment on a pro-rata basis.

Indirect Loss Coverages

Indirect loss coverages may be added by endorsement to the general Boiler and Machinery Policy in the same manner as they may be added under the fire policy. These indirect loss coverages provided under the Boiler and Machinery policy are an essential part of the total coverage against indirect loss. The loss of income sustained by the firm will be the same regardless of whether the shutdown is occasioned by a fire or a boiler explosion.

There are three consequential loss coverages available under the Boiler and Machinery Policy, two of which are time element coverages paralleling the business interruption coverage and extra expense previously discussed. The third, called "Consequential Damage" insurance, covers loss caused by spoilage of specified property resulting from an accident to an object.

Use and Occupancy. Use and Occupancy is the business interruption coverage of the Boiler and Machinery Policy. It provides coverage for loss due to a total or partial interruption of business or for expenses incurred to reduce loss resulting from such interruption. There are several forms of the coverage available, and it may be written on a valued basis or an actual loss sustained basis. Under the valued form, payment is made up to the daily limit selected for a total or partial suspension of operations caused by an accident to an insured object. Payment under the indemnity forms is the same as under the indemnity forms of fire business interruption.

Extra Expense. Boiler and Machinery Extra Expense coverage performs essentially the same function as the extra expense forms available for use with the fire policy. It provides payment of additional expenses incurred by the insured in order to continue operations, which are occasioned by an "accident" to an insured "object." It replaces an older form of coverage, known as "outage" insurance, which provided a specified indemnity for each working hour or day during which an insured object was not available for service because of an "accident."

Extra expense may be used instead of Use and Occupancy firms that would be required to continue operations in the event of an accident, or firm's whose income would not be affected by the loss of use of an object, but which would be required to incur additional expenses. A bank, for example, which derives its income primarily from loans and investments, would experience little, if any, reduction in income as a result of damage to an insured object. However, it would probably be necessary for the firm to rent temporary facilities in order to continue operations.

Consequential Damage. Consequential damage coverage provides indemnity for the actual loss of specified property of the insured and also for such amounts as the insured is obligated to pay by reason of his liability for property of others, when such loss is due to spoilage form lack of power, light, heat, steam or refrigeration at specifically described premises caused by an accident to an insured object. A freezing plant or a meat locker might, for example, purchase Consequential Damage coverage to cover the indirect loss resulting from breakdown of its freezing equipment.

INLAND MARINE INSURANCE

HISTORICAL BACKGROUND OF INLAND MARINE INSURANCE

With the spread of population across the continental landmass, transportation came to play a crucial role in the development of business. In conjunction with the spread of transportation facilities, a demand arose for insurance coverages to protect against the financial loss involved in damage to products in shipment.

Inland marine is something of a contradiction of terms. Essentially inland marine is an outgrowth of ocean marine insurance. Often coverage under the ocean marine contract was provided not only when the cargo was on the water, but on a warehouse to warehouse basis. The warehouse to warehouse coverage was simply an extension of the ocean marine contract to cover property transported over water while that property was on land. Gradually, the term inland marine came to include protection against any of the perils of transportation which was provided on property of a mobile nature.

As time went by, inland marine forms were used to insure a number of items that were non-movable. The trend resulted from a period of vigorous competition between marine underwriters and property insurers. Marine insurers were able to offer broader and more comprehensive coverage on property than the fire insurance companies, because the typical marine form could be written on an "all risk" basis. Eventually everyone agreed that definite guidelines were needed which would outline the types of property which were eligible for coverage under inland marine forms. In 1933 the National Association of Insurance Commissioners proposed their so called "Nationwide Marine Definition", which recognized the following classes of property as being eligible for ocean marine coverage.

A. Imports
B. Exports
C. Domestic Shipments
D. Instrumentalities of Transportation and Communication
E. Personal Property Floater Risks

The 1933 definition has been revised twice, once in 1953 and again in 1977.

The first three classes are fairly self-explanatory. The hazards connected with the shipment of goods can be covered under inland marine policies, and virtually all shipments of goods will fit under one of the three classifications. The fourth class, instrumentalities of transportation and communication, includes bridges, tunnels, piers, wharves, docks, pipelines, power transmission and telegraph lines, radio and TV communication equipment, and outdoor cranes which are used to load, unload, or transport property. All of these items may be covered under inland marine contracts.

The fifth class of eligible risk, Personal Property Floater Risks, include a wide range of eligible types of property which, because of their mobile nature, are subject to the perils of transportation and may therefore be insured under Inland Marine contracts. The following classes of coverage, selected at random from the text of the Nation Wide Definition, indicate the broadness and variety of this fifth classification: The personal property floater, personal fur and jewelry floaters, livestock floaters, equipment floaters, jeweler's block policies, bailee's customers policies, and cold storage locker-plant policies.

Based on the provisions of the Nationwide Definition, we may divide the Inland Marine Coverages into four distinct classes of coverage:

1. The transportation forms, which are designed to cover shipments of goods by rail, motor carrier, or air carrier. These include forms which cover the interest or legal liability of a common carrier, and forms designed to protect the owner of the goods against loss resulting from damage to his goods.
2. The forms designed to cover instrumentalities of transportation and communication. These forms provide coverage on fixed objects such as bridges and tunnels, pipelines, power transmission lines, radio and TV communication equipment, and so on.
3. The Bailee Forms, which are designed to cover goods while those goods are in the custody of someone other than the owner, to whom the goods have been entrusted. These forms may be written to cover the interest of the bailee only, or they may be written to cover the interest of the bailor as well.
4. Floater policies for personal property, including business personal property of various types. The personal lines section of this study guide has discussed floater policies for the individual which are designed to cover such personal items as jewelry, furs, cameras, coin collections, fine arts, and musical instruments. In this commercial lines section, we will discuss the various business floaters and dealers forms.

TRANSPORTATION COVERAGES

Damage to property in the course of transportation may cause financial loss to two interests: (1) the owner of the goods, and (2) the person or organization to whom the goods have been entrusted for transportation. Inland marine transportation policies are written to protect against both types of loss. There are transporta-

tion forms designed for the owner of the goods, and a trucker's liability form which is designed for use by the trucker. In general, the transportation forms are designed to protect the insured against loss or damage to goods in transit, usually by express, railroad freight, public trucking, owners trucks, coastwise steamers, inland steamers, air, or any combination of these.

The Liability of Common Carriers

One of the most important principles for the agent to understand in connection with transportation insurance is the legal liability of a carrier for goods which it transports. A common carrier is defined as a person or organization that carries goods for hire for the public. A distinction is made between a common carrier, which makes its services available to anyone who wishes to purchase them, and a contract carrier, which carries goods only for specific firms under contract.

The legal liability of a common carrier for goods entrusted into its care for transportation is quite strict. Only a few causes of loss are considered to be beyond the control of the common carrier, and with the exception of these exclusions, the common carrier is legally liable for any loss of or damage to goods which it transports. Losses resulting from the following cause are excepted:

1. Acts of God
2. Acts of the public enemy (a foreign power)
3. Exercise of public authority
4. Fault or neglect of the shipper
5. Inherent vice, which is defined as a quality in a good that causes the good to destroy itself (e.g., butter will spoil)

Even losses caused by one of the five causes listed may result in the carrier being held liable, if the negligence of the carrier contributed to the loss.

The common carrier can and does limit its liability through the use of a Released Bill of Lading, under the terms of which the carrier specifies the maximum amount for which it will be held liable. For example, a common carrier may use a bill of lading with the stipulation that its liability will be limited to .50 per pound. Under the terms of the Interstate Commerce Act as amended, a common carrier may limit its liability if it provides for a difference in rates, offering a lower rate to those who are willing to accept this limitation, and charging a higher rate for those who do not accept the release bill of lading.

Motor Truck Cargo Policy — Truckers Form

Truck cargo forms are designed to insure public truckmen against their legal liability for loss or damage to merchandise in their possession. Coverage is also available to insure the owner of merchandise while shipping on his own trucks or trucks which he leases. Truck cargo is the largest single premium class in the Commercial Inland Marine field.

There are two forms available both of which are intended to insure the legal liability of public truckmen; a named peril form and the "all risk" form. The named peril form covers the perils of fire, collision, overturn of vehicles, collapse of bridges or docks, rising of navigable rivers or floods, perils of the sea, lakes, rivers or inland waters while on ferries, cyclone, tornado, and windstorm.

The basic form covers cargo while loaded for shipment and in transit, and if coverage is desired while the cargo is off of vehicles in terminal or other locations, it must be endorsed onto the policy. Public truckmen operating for hire are usually insured on a gross receipts reporting cargo form.

The coverage under the Motor Truck Cargo policy indemnifies the trucker for his loss or damage resulting from legal liability as a carrier. The policy does not pay for loss to property in the care of the common carrier unless the carrier is legally liable for such loss. The perils normally included under the policy include:

1. Fire
2. Cyclone, windstorm, tornado. (In spite of the fact that these are acts of God, the carrier still might be held liable for loss resulting from one of them, if the loss was in part due to the negligence of the carrier or its employees.)
3. Perils of the sea, lakes, rivers and inland water while on a ferry.
4. Collision
5. Upset and overturn of the motor truck
6. Collapse of bridges
7. Flood
8. Theft insurance may and sometimes is added by endorsement. When theft is added, the insurer may require a sizeable deductible with the additional requirement that only theft of an entire shipping package be covered, thus excluding loss by pilferage.

The Interstate Commerce Commission Endorsement

During the early 1930's, it became increasingly evident that interstate motor truck carrier operations should be regulated. In 1935 the congress passed the Motor Carrier Act as an amendment to the Interstate Commerce Act, providing for the regulation of motor common carriers. One of the most important provisions of the Motor Carrier Act dealt with insurance and provided that the commissions may require insurance policies or other evidence of security to make certain that the trucker will meet his obligations to the public. Under the authority of this provision, the commission requires that the trucker provide insurance of $2,500 for loss or damage to the contents of each vehicle, and $5,000 in coverage for aggregate losses or damages at any one time and place. Insurance policies issued to interstate motor common carriers must contain an en-

dorsement prescribed by the commission. This endorsement makes the insurance company responsible for any claim for which the policyholder is liable, regardless of the cause of the damage to property, up to the limits of $2,500 per truck and $5,000 per accident. This responsibility is not limited to the coverage written into the policy, but covers the full common carrier liability. This makes the policy an extremely broad "all risks" contract. The policy includes a reimbursement clause which provides that the assured will reimburse the insurance company for any loss paid by the insurance company for which the insurance company is not liable under the terms of the basic policy. Thus, if a loss occurs as a result of a peril not covered under the basic policy (which is usually written to cover the perils of Fire, Windstorm, perils of the sea while on a ferry, collision upset, collapse of bridges and flood), the insurance company is required under the terms of the I.C.C. endorsement to make payment to the owner of the goods, but may then seek reimbursement from the insured for the amount paid. In actual practice, the trucker reports losses to the insurance company only when the loss is covered by the basic policy. The trucker pays his customers directly for other losses. It is uncommon that the insurance company pays losses under the I.C.C. endorsement and then seeks recovery from the insured. The risk that the insurance company assumes under the I.C.C. endorsement is that the trucker may reach a point at which he is unable to pay customers for those losses which are not covered under the basic policy, but which are covered under the I.C.C. endorsement; and at this point the insurer would be forced to pay the customers and could not be reimbursed by the insured.

Coverage for Owners and Shippers

Even though the legal liability of the common carrier is extremely broad, there are some instances in which the carrier might not be held liable. In addition, it has been noted that carriers frequently make use of the release bill of lading. Both of these factors constitute reasons why the owner of the goods being shipped may desire coverage on his goods in addition to that carried by the trucker. In addition to these reasons, the owner of the goods may not want to wait until he can collect from the trucker for the loss. It may be more convenient to collect from his own carrier and then permit his carrier to subrogate against the trucker. For these reasons many businesses purchase policies to cover their goods while in transit.

There are two standard approaches in insuring the owner's interest in goods in transit; the Annual Transit Policy, and a modified version of the Motor Truck Cargo Policy discussed above. In addition to these two contracts, there are more specialized forms designed to insure single shipments, goods shipped by railway express, and property shipped by parcel post or registered mail. Finally, there is an Air Cargo form available for those who utilize this means of shipment. Space does not permit a detailed examination of all of these contracts, but several of the more important forms are discussed below.

Motor Truck Cargo — Owner's or Shipper's Form

Goods shipped on the owner's own trucks may be insured under the Motor Truck Cargo Policy with an "Owner's Form" attached. This form may be used to provide all risk coverage or named perils protection for owner's goods on owner's trucks. The perils included in the named peril form are the same as those discussed in connection with the Trucker's form.

When goods are shipped by common carrier or contract carrier, a "Shipper's Form" is used.

Annual Transit Policy

The Annual Transit policy, purchased by the owner of goods, is designed for the business which ships merchandise, either by common carrier, by contract carrier, or on its own trucks. It is desirable even for those firms which ship by common carrier.

The transportation forms are not controlled, and as a result there are no standard forms. Policies are written to meet the requirements of the individual risk. There are three basic forms used, depending on the need of the insured.

Coverage is normally on a named peril basis, covering fire and lightning, and the perils of extended coverage (except strike, riot and civil commotion, which are optional), plus theft, plus the perils of transportation.

Coverage applies while the goods are in the custody of a common carrier, although the coverage may be written to cover goods in the custody of a contract carrier or on the insured's own trucks. Since the subrogation rights are somewhat less in the later cases, higher rates apply. The limit of liability applies at any one place, with a further limit on any one disaster. The limit for any one place should be determined by the largest amount shipped or received in one day and the number of goods which might accumulate in any one place.

Transportation Form A is designed to provide coverage for loss to property while that property is in the custody of any railroad or express company, any coastwise ship line, or any public trucker, or other land transportation company, provided that these carriers are used in connection with the railroad and steamer means.

Transportation Form B is similar to Form A, except that it does not cover any coastwise ship lines.

It should be noted that these forms do not cover the property while it is in the hands of motor carriers, unless the motor common carriers are used in connection with railroad or steamer shipments. Coverage may be endorsed onto the policy providing coverage on mer-

chandise shipped by common motor carrier not in connection with the railroads or steamers.

Some insureds may also use their own trucks to carry their merchandise. If coverage is desired on goods shipped by the insured's own trucks, this must be endorsed onto the policy.

Owner's Goods on Owner's Trucks are covered under a Special endorsement, Endorsement "C", which provides an amount of insurance coverage applicable to each truck owned by the insured.

Trip Transit Policy

This form fills the same function as the annual transit policy, except that it covers a specified lot of goods for a specified trip. The trip transit coverage may be written in a specific policy, or it may be written under a master policy with certificates of insurance for each trip. Rates vary with the type of carrier (common, contract, or the insured's own trucks), the length of the trip, and the type of goods.

Household Furniture Movers

This is a special form of trip transit coverage, usually written to include the interest of the owner of the goods. In most cases the carrier makes use of the release bill of lading and limits his liability to .50 per pound for items damaged. The owner of the furniture can be provided with additional coverage through individual certificates issued in connection with the policy.

Parcel Post Policy

This form is designed for the firm that makes many parcel post shipments, and wishes to avoid the inconvenience caused by waiting in line at a post office to obtain government insurance. There are certain other benefits. Claim settlements are usually made much sooner under the parcel post policy purchased from a private insurer than is the case with government insurance. The contract provides all risk coverage on merchandise shipped by parcel post, registered, or unregistered mail. The policy does not cover shipments made by express and does not cover money and securities. Money and securities must be covered under a Registered Mail policy described below.

The coverage applies only within the continental United States, Canada, and Alaska. The coverage is written on an "open" form with no expiration date. An initial premium is paid at inception, with additional premiums due and payable as shipments are made. The insured registers each shipment on the day that it is made in a register. Only those shipments which the insured desires to insure are recorded, and premiums are charged on the basis of those recorded. Coverage is on an actual cash value basis, with a limit of $100 on any package shipped by ordinary parcel post or unregistered mail and $500 on any package shipped by registered mail or insured parcel post.

Registered Mail Policy

The Registered Mail Policy is designed for banks and other types of businesses which ship securities, money, or other valuable property which is sent by registered mail or express. The need for the coverage arises because of a maximum of $1,000 to which the government limits recovery on any one package sent by registered mail. In addition, the various money and security forms provide no coverage on property while being transported by mail or express. The coverage may be written under an open policy, in which the coverage is continuously in force and shipments are reported to the company, or it may be written under a trip policy, which covers a specific shipment.

INSTRUMENTALITIES OF TRANSPORTATION AND COMMUNICATION

Bridges

Bridges are structures that are very similar to buildings, but which need all risk coverage because of the hazards to which they are exposed. The insuring of bridges under Inland Marine contracts was originally justified because of the experience which ocean marine underwriters had had with dry docks and the marine hazard of collision.

The coverage under an inland marine policy on bridges is all direct physical loss, which is broader than the normal all risk coverage. There are four exclusions which actually determine coverage:

1. War damage. This exclusion is similar to other inland marine war risk exclusions.
2. Riot, civil commotion and lockout
3. There is a special version of the inherent vice and wear and tear exclusion. The exclusion is worded to cover collapse of the bridge regardless of the causes, but excludes any loss which results from a lack of maintenance.
4. Also excludes loss caused by failure of the insured to save and preserve the property at the time of or after a loss.

Coverage is normally on an actual cash value basis, although replacement cost coverage (subject to an 80% insurance to value requirement) on steel and concrete bridges. The contract normally includes a 1% or $1,000 deductible. Debris removal is included in the coverage.

Tunnels

Tunnels also qualify as instrumentalities of transportation and may be insured under the same conditions as a bridge.

Builder's Risk Coverage on Bridges

Coverage on bridges in the course of construction is available under two inland marine forms. One, the named peril form, covers fire, lightning, flood, ice, explosion, windstorm, earthquake and collision. The second is an all risk form, which is subject to certain

exclusions. The coverage may be written on a completed value form or it may be written on a monthly reporting form.

Bridge Business Interruption Insurance

This coverage is the equivalent of the business interruption coverage which is available under the fire coverages for loss of income to a business. It covers the loss of income of a bridge or tunnel operating authority.

Revenue is defined as "The income from tolls and other operating sources less such maintenance and operating charges and expenses as do not necessarily continue during the period of total or partial suspension of use."

Coverage is written on a "per diem" basis, with 1/365th of the total amount of insurance collectible for each day of shutdown. There is a 7-day deductible applicable. The coverage may be changed from this per-diem basis to a no daily limit basis, subject to 100% co-insurance. There is also an "Adjusted Values Basis" which is similar to the Premium Adjustment Endorsement used in Business Interruption written to cover fire losses.

BUSINESS FLOATER POLICIES

The need for business floater policies arises because certain types of business personal property is subject to movement and may be located elsewhere than on the insured's premises. To meet this need there is a large number of inland marine floater policies which cover property which is movable in nature and which is subject to special hazards because of its movability. The classes into which we may divide these business floaters are as follows:

1. **Equipment Floaters,** which are designed to cover business personal property that is not held for sale or on consignment and that is in the hands of the owner to be used for the purpose for which it was intended. An example of this type of equipment might be equipment owned and used by a construction firm.

2. **Processing or Storage Floaters,** which are designed to cover property in temporary storage and property undergoing processing outside the owner's premises.

3. **Consignment or Sales Floaters,** which are designed to cover goods which are being held for sale under consignment, goods which are being installed, or goods that are being sold under an installment plan.

Once again, a complete and detailed analysis of each of the forms of coverage under each of these classifications is impossible. The following brief description of these coverages, however, provides a summary of the more important features and provisions of these coverages.

Form B is intended for scheduled property. There are two items of coverage under this form. The first includes mobile agricultural machinery and equipment as scheduled. The second item, which is optional, may include $5,000 or 10% of the scheduled amount (whichever is less) to cover unscheduled mobile agricultural machinery and equipment, including harness, saddlery, liveries, blankets and other similar equipment for not more than $250 on any one item. This form also includes an 80% coinsurance clause, which applies not only to the blanket coverage, but also to each scheduled item.

Contractor's Equipment Form

This form is designed to cover mobile equipment of practically any nature from hand tools to large machines. It can be written to cover equipment owned, borrowed, or rented to the insured, and equipment rented out to others. The coverage is usually written on a schedule basis, with a specific amount of insurance for each item. In some cases, blanket coverage may be written. Regardless of whether the coverage is written on a schedule or a blanket basis, a coinsurance clause of 80% or 90% is usually included. Coverage may be provided on either a named peril form or an all risk basis.

Named Peril Form. The named peril form is usually written to cover fire, lightning, explosion, windstorm, flood, collapse of bridges, and, subject to a deductible, theft, collision, landslide, upset and overturn.

All Risk Form. In addition to the usual all-risk exclusions of wear and tear and mechanical and electrical breakdown, most all-risk forms include the following exclusions:

(1) loss due to conversion of embezzlement by the insured's employees or other persons to whom the equipment has been entrusted.

(2) damage occasioned by the weight of a load exceeding the rated capacity of the machine.

(3) damage to booms by collision

(4) loss to the property while waterborne.

Some insurers will delete the last two exclusions.

Subrogation. One final important provision relates to subrogation. Most companies include a provision that prohibits the insured from waiving right of recovery against any third party for damage to the insured equipment, before or after the loss.

Installation Floater Form

This form is designed to cover property consisting principally of machinery and equipment which is to be installed, while that property is in transit to the place of installation and during the period of installation and testing. Originally, building materials could be covered only while in transit to the place of installation and upon arrival until installed. The 1977 version of the Nationwide Definition makes provision for continuation of coverage until the structure is completed and accepted when coverage is written for the owner. When coverage

is written for a seller or contractor, coverage ceases when the interest of the seller or contractor ceases. The perils which may be covered under this form vary from the perils of fire and transportation to "all risk" coverage. The form may be written not only for owners and contractors, but also for mechanics (such as plumbers or electricians) who take custody of property for the purpose of installation. When written for a contractor or installer, the form may be written to cover one contract, reporting or nonreporting, or to cover all contracts the insured enters into in the future on a reporting basis.

Floor Plan Merchandise Form

This coverage is designed to insure merchandise subject to a floor plan (or similar financing arrangement) while the goods are in the hands of the dealer. Under a floor plan arrangement, the dealer borrows from a financial institution, using the stock of merchandise as the security. The form covers the dealers interest and may also be written to cover the interest of the lender only, or it may be written to cover the interset of both.

Coverage is on an all risk basis, and attaches to merchandise that is specifically identifable as encumbered to a bank or lending institution.

Installment Floater

This coverage is designed for those businesses which sell merchandise (such as household furniture, appliances, etc.) on installment sales arrangements. There are two forms of the coverage available, one of which covers the insured's interest as measured by the unpaid balance. The other form covers the interest of both the buyer and the seller. Coverage applies from the time the merchandise leaves the seller's shipping room until it reachs the purchaser's premises, and then continues to cover at the purchaser's premises until all indebtedness has been satisfied or until the merchandise is returned to the seller's premises.

The coverage is available on both a named perils and all risk basis. The named perils form covers fire and lightning, derailment or overturn of vehicles or collapse of bridges, plus the marine perils while on ferries. Other perils may be added by endorsement.

It should be noted that there is no coverage under this form while the property is located in the stores or in warehouses. The insurance is excess over any other insurance covering against the insured perils.

DEALER'S INSURANCE

The 1953 National Marine Definition provided for covering the merchandise of the following types of dealers under inland marine forms:

Jewelers
Fur Dealers
Musical Instrument Dealers
Camera Dealers
Agricultural and Contractor Equipment Dealers
Fine Arts Dealers
Dealers in Stamp and Coin Collections

The coverage for jewelers and fur dealers is provided under the Jeweler's and Furriers' Block policies. Coverage for the remaining business is provided under the various dealers' forms which are discussed briefly below.

There are a large number of inland marine policies designed to meet the needs of business to cover property of a movable nature. Included in our discussion of these we will discuss the block policies, which are designed to provide all risk coverage at fixed locations.

The Block Policies

The term "Block" is used to describe all risk coverage which is provided to certain businesses on business personal property. The term Block comes from the French "en bloc" which means "all together". Thus block policies are intended to cover all of the property of the business in a single contract.

The Jeweler's Block Policy

The Jeweler's Block Policy is one of the few inland marine forms which covers property at a fixed location with little transportation hazard. The policy is designed to cover the stock of a jeweler, including the following:

1. Stock actually owned by the jeweler
2. Goods in a bailee status (such as customer's goods)
3. Goods of other jewelers which has been entrusted to the insured.

Coverage on customer's goods includes both the interest of the insured and the customer, so coverage is provided regardless of whether or not the jeweler is legally liable for the damage or loss. Coverage on goods belonging to other jewelers includes only the insured's interest, so the policy provides coverage on these goods only if the insured is liable, and then only for the extent of his liability.

The coverage is written on an "all risk" basis. Therefore the exclusions are of primary importance. There are 12 major exclusions:

1. Employee infidelity
2. Delay, loss of market, deterioration, moth, vermin, inherent vice, or damage to property while it is being worked on.
3. War damage
4. Damage at the insured's premises resulting from flood, surface water, tidal wave or earthquake.
5. Certain shipments
   (a) Mail shipments are covered only if sent registered first class

(b) Railway express and air express covered only up to $1,000

(c) Rail, air, water or motor carrier covered only in connection with parcel transportation service or armored car service.

6. Breakage of brittle articles unless caused by burglary, fire, or damage to the conveyance.
7. Property worn by the insured, officers, or members of their family
8. Property being worn by models unless coverage is endorsed onto the policy.
9. Property at public exhibition
10. Property left in unattended vehicles
11. Mysterious disappearance, unexplained shortages
12. Loss or damage to property in show windows unless coverage is endorsed onto the policy.

The insured is required to maintain a proper inventory of goods, and must produce these records and submit to examination of these records by the insurer.

The form provides that the coverage is excess over any other valid and collectible insurance.

Because of the broad nature of the coverage, underwriting must be carefully done. The proposal for the Jeweler's Block is far more important than the application for other inland marine coverages. It must be filled out in detail and signed by the insured; it is then made a part of the contract and all statements by the insured are considered to be warranties. A statement of values is required, and although no coinsurance is required, the degree of insurance to value is taken into consideration in determining the premium. A specific rate must be computed for each risk, based on a rating schedule.

Furriers' Block Policy

The policy designed for dealers in furs is quite similar to the Jeweler's Block policy discussed above. It covers the stock of furs which the insured carriers for sale. It does not, however, cover the furs of customers which are in storage or are being worked on. Coverage for this property is afforded under the Furrier's Customer policy, which is discussed under the bailee coverages.

The coverage of the Furrier's block is written on an all risk basis with exclusions similar to those of the jeweler's block policy. Rating is approximately the same as under the Jeweler's Block; rates are computed for each property on the basis of a schedule.

Equipment Dealers' Policy

The Equipment Dealers Form is designed to cover farm implement dealers or heavy machinery dealers for loss or damage to stocks of equipment (including customers' property) while on their premises, in transit, or elsewhere. The policy provides for all risk coverage, subject to the normal all risk exclusions. Certain classes of property are specifically excluded from coverage:

1. Automobiles, motortrucks, motorcycles, aircraft or watercraft
2. Property sold by or under encumbrance to the insured or property leased or rented to the insured to others after it leaves the custody of the insured or an employee of the insured.
3. Property while in the course of manufacture.

Musical Instrument and Camera Dealers Forms

Cameras and musical instruments are frequently insured under all risk forms for the individual owners of such property. The Inland Marine Insurance Bureau and the Transportation Insurance Rating Bureau both prescribe forms to be used in covering cameras and musical instruments which are the property and stock of dealers. Basically the coverage is all risk on the insured's stock of musical instruments or cameras, materials and supplies or other incidental stock, and customer's goods in their custody. The form may be extended to cover furniture, fixtures, tenants' improvements and betterments, and machinery and tools.

The coverage is divided into four separate limits of liability:

1. Property at the insured's premises
2. Property in transit
3. Property away from the premises but in the custody or control of the insured or his employees
4. Property elsewhere.

The forms are subject to an 80% coinsurance clause, which applies to the aggregate value of all insured property (except property in transit) at all places at which coverage applies. The forms spell out in considerable detail the obligations of the insured in keeping records, requiring that the insured take a physical inventory at least every 12 months, maintain a complete record of all purchases and sales, and a record of the property of others in the insured's custody.

The normal all risk exclusions apply, plus employee infidelity, theft from an unlocked, unattended vehicle. In addition, the form excludes property sold by the insured or under encumbrance to the insured after it has been delivered to a customer.

BAILEE COVERAGES

Bailee Liability

A bailee is someone other than the owner of property, to whom the property in question has been entrusted. The bailee is responsible to a somewhat more limited extent for the safety of the property than is a common carrier. The bailee is obliged to use ordinary care, and he is legally liable for any damage resulting from ordinary negligence. The degree of care required of a bailee varies with the type of bailment. A bailee who is paid for the bailment is required to exercise a greater degree of care than one who is not paid. While it is true that the bailor must prove negligence on the part of the

bailee in order to collect for any damage to the property, the bailor can make a **prima facie** case of negligence by showing that the goods were not returned or that they were returned in poor shape.

Obviously, the bailor may insure his property under all conditions, including the period that it is in the custody of a bailee, but the general principle is that the coverage purchased by a bailor on his property shall not benefit the bailee. Therefore the bailee must purchase insurance coverage to protect his legal liability exposure. In addition, the bailee will probably desire coverage that will pay for damage to his customer's goods even when he is not legally liable for the damage, in order to preserve good will. It is therefore desirable to have a contract which covers the interest of the bailee (that is, one that will pay when the bailee is legally liable) and which will also cover the interest of the bailee's customer (i.e., which will pay even though the bailee may not have a legal responsibility).

Bailee's Customer's Policy

The Bailee's Customer's policy, which is a basic policy for bailees' customer's insurance, is completed by the attachment of a special form designed for the particular class of risk. The coverage may be afforded under these forms for such businesses as launderies, dyers and dry cleaners, processors and service risks. In general, the Bailee's customer's policy covers all kinds of lawful goods and articles which are the property of customers while being transported in the custody of the insured to and from the customers and the stores or agents of the insured, and while in the premises occupied by the insured at the specified address. Many of the bailee policies are referred to as "floaters" because they cover property which moves from one location to another.

The normal perils covered under the Bailee customer's policy include fire, lightning, windstorm, explosion, riot, earthquake, sprinkler leakage, burglary and hold-up, and confusion of goods caused by any of these perils while in transit and at the insured's premises. In addition it also covers the usual perils of transportation.

There are four important exclusions in the form: Loss caused by infidelity of the insured's employees; property left in delivery vehicles overnight; damage which may be due to or result from processing; and losses in excess of the policy limits are, of course, excluded.

There is a Dyers' and Cleaners' Form of Bailees' Customer policy, a Laundry Form, a Tailor's Form, (which is designed for tailor shops and firms engaged in repairing and pressing), a Rug and Carpet Cleaner's Form, and other forms which are designed for appliance repair stores, radio and TV repair stores, and other service industries of a similar nature. In addition, there are several more specialized forms with somewhat unique characteristics that are described below.

Furrier's Customer's Form

This form is designed to cover furs belonging to customers of the insured while those goods are in his custody or control for alteration, repair, cleaning, remodeling or preparation for storage and while in storage. The coverage is on an all risk of loss or damage to the insured property, including the insured's legal liability thereof, except for certain exclusions.

It is customary to include coverage by a special endorsement to protect the furrier's liability for loss on the amount representing the difference between the value specified in the storage receipt and the actual value of a garment in those cases where a coat may have been placed in storage at a declared value of less than the actual value.

Cold Storage Locker Bailee Floater

Cold storage lockers represent a special type of bailee. The cold storage bailee floater is designed to cover the customer's property while in the custody of the cold storage locker. The form may be written on an "all risk" basis or a named perils basis. When written on a named peril basis, the perils normally insured against are fire, lightning, windstorm and hail, explosion (except explosion of a steam boiler), riot, civil commotion, aircraft and vehicles, earthquake, collision of the conveyance on which the property is being carried, and theft. In addition the policy covers spoilage of the goods stored which is caused by the destruction of the refrigerating equipment. Like the bailee's customer's policy, the cold storage locker bailee floater covers confusion of goods caused by a peril insured against.

Processors' Floaters

Many firms engaged in the manufacturing of a product send the product or components of the product outside their plant for some service or operation. When the processor receives the goods to be processed he becomes a bailee and assumes the same legal liability for damage to the product as any other bailee. However, for the same reasons that other businesses desire to do so, processors desire coverage that will cover the goods of their customers regardless of the liability.

The processors' floater covers both the bailor's and the bailee's interest, and is usually written on a specified perils basis. The perils normally insured against are fire, lightning, sprinkler leakage, windstorm, cyclone, tornado, riots, strikes, burglary and hold-up.

CRIME COVERAGES

(INCLUDING FIDELITY)

The broad field of dishonesty insurance includes all cases in which the cause of the loss is the wrongful taking of property belonging to the insured. Historical development led to the development of two distinct classes of dishonesty coverages:

1. Fidelity Bonds, which are designed to cover theft or dishonesty on the part of employees of the insured.

2. Crime Coverages, which are designed to cover dishonest acts of persons who are not employees of the insured.

Each of these classes provides incomplete protection against the peril of dishonesty. In order to provide more complete protection, they must be combined, so it is well to discuss them together. The artificial distinction between "Employee dishonesty insurance" and "Non-employee dishonesty insurance" is gradually disappearing, and with the advent of package crime policies, both type of criminal losses are frequently insured in the same contract.

FIDELITY BONDS

Each year, thefts by employees amount to several times the amount lost by burglary, robbery, and other forms of larceny. Less than 10% of these losses are insured. Fidelity bonds are designed to protect the insured against loss resulting from dishonesty on the part of his employees. As such they constitute only a part of the protection needed against criminal loss. Fidelity bonds cover loss or damage to money, securities, or other property, resulting from the acts (fraud, forgery, embezzlement, theft) of the person bonded, up to the face amount of the bond, which is called the "Penalty". There are several forms under which the bond may be written:

Name Schedule Bonds

Originally, fidelity coverage was issued on an individual basis, with the person to be bonded specifically named. This type of bond is seldom written today, having been replaced by other forms. Under a Name Schedule Bond, employees to be bonded are all listed by name. Only those persons listed in the bond are covered, and only for the amount of the penalty on each person named. The obvious disadvantages of this form of bond are the lack of coverage on employees not scheduled, and the need for constant revision.

Position Schedule Bond

Under the position Schedule Bond, the positions to be covered are listed rather than the individual. Thus, if a person leaves the firm or moves to another position, his replacement is covered for the same position. Only those positions listed are covered. A provision in this form of bond provides that if there are more individuals occupying a listed position than the number originally specified, all are covered, but on a decreased basis. For example, if the bond provides for two cashiers, with a $10,000 penalty applicable to each, and there are actually four cashiers, loss caused by one of these cashiers would be covered, but only up to $5,000.

Blanket Bonds

Blanket bonds are designed to cover all employees, regardless of position, automatically. Changes in the composition of the force of workers employed does not affect the coverage. Under a blanket fidelity bond, employees are divided into three classifications:

Class 1 employees, which includes employees who, as a part of their regular duties, handle or have custody of money, securities, or merchandise.

Class 2 employees, which includes canvassers of all insureds, plus chauffeurs, collectors, demonstrators, drivers, and driver's helpers, outside salesmen, and other persons occupying similar positions in certain types of businesses. (See manual).

Class 3 all others, which includes the remaining employees, who do not handle money or securities as a part of their duties.

The rating of the bond is based on the total number of class 1 employees, as described above, plus a certain percentage of all other employees not listed in class 1 or class 2. There is a special charge for class 2 employees. All of the employees are covered, and new workers are covered automatically.

The penalty under a bond is never cumulative from year to year, and always applies to the loss when it is discovered. The dishonesty must result while the bond is in effect,[2] although the Discovery Period provision provides that losses that are discovered within a specified period after the bond is cancelled will be covered, provided that the actual loss took place during the policy period. Fidelity bonds are continuous in form, running until cancelled by the insured or the company.

The two major forms of blanket bonds are the Primary Commercial Blanket Bond and the Blanket Position Bond. Although they are very similar in their coverage and provisions, there are two major points of difference.

Primary Commercial Blanket Bond

The Primary Commercial Blanket Bond is designed

[2]The Discovery Bond, a special type of blanket bond, covers losses regardless of when the dishonesty occurred, provided the loss is discovered while the bond is in force. In other words, a Discovery bond (which should not be confused with the Discovery Period) will cover a loss which occurred prior to the inception of the bond, if the loss is discovered during the period of the bond.

to cover all employees on a blanket basis. Its chief characteristic is the manner in which the penalty or face amount of the bond is applied. The bond provides coverage up to the face amount for any loss caused by one or more employees. The penalty is the aggregate penalty for one loss, regardless of the number of employees involved in the loss. The discovery period under the Primary Commercial Blanket Bond is one year, which means that losses that occur during the period of the bond must be discovered within one year after the bond is terminated or there is no coverage.

Blanket Position Bond

Under the Blanket Position Bond the face amount of the bond applies separately to each employee. For this reason the Blanket Position Bond is also called a "multiple penalty" bond, for it permits the insured to collect up to the face of the bond for each employee involved in a collusive loss. The discovery period under the Blanket Position Bond is two years.

The difference between the two bonds can be illustrated by a simple example. Suppose that the insured has a blanket bond with a penalty of $10,000, and suffers a loss in which each of three employees steals $5,000. A Primary Commercial Blanket Bond would pay a maximum of $10,000, but a Blanket Position Bond would pay the entire $15,000, since each of the employees is covered up to $10,000.

Superseded Suretyship Provision

Both the Primary Commercial Blanket Bond and the Blanket Position Bond include a provision called "Superseded Suretyship" or "Loss Under Prior Bond." Subject to certain restrictions, this clause provides that if a bond is replaced in another surety company, the succeeding surety becomes liable for losses which occurred during the term of the previous bond. This provision applies only when there is absolutely no lapse of coverage from the old bond to the new bond, and the loss is discovered after the end of the discovery period of the old bond. If the amounts of the bonds differ, the lower penalty will apply. The Superseded Suretyship provision may be included in Name Schedule Bonds and Position Schedule Bonds.

Other Important Provisions in Fidelity Bonds

One of the important provisions found in all fidelity bonds in an exclusion of any employee from the time that the insured (obligee) has knowledge of dishonesty on the part of that employee. The coverage ceases for such a dishonest employee whether or not the discovered loss is reported to the surety.

The fidelity bonds also provide that losses which are based on or can be proven only by an inventory shortage are not covered.

The Salvage Clause of the fidelity bonds provides that if the insured sustains a loss which exceeds the amount of coverage under the bond, he is entitled to any recoveries or salvage up to the point where he has been fully reimbursed for his loss. Any salvage recovered after the insured has been fully reimbursed goes to the surety company.

NON-EMPLOYEE CRIME COVERAGES

Policies designed to cover against loss of property or money through dishonest acts of persons other than employees may be classified on the basis of the perils they insure against. There are policies designed to protect against loss by robbery, burglary, theft, forgery, or larceny. In addition, there are broad form "all risk" policies designed to insure money and securities. Each of the above classes insures against a specific peril or set of perils. Since the terms "burglary" and "robbery" have technical definitions in these contracts, it is important to determine at the outset what each of these terms means.

> Burglary is defined as "felonious abstraction of property from within a building, safe or vault by someone who has made unlawful entry therein by force and violence of which there must be visible marks at the place of such entry, or by someone making forcible exit from the premises, of which there must be visible marks of such exit on the interior of the premises."

> Robbery is defined as "felonious or forcible taking of property by violence inflicted upon the person having care or custody or rightful access to the property; or by putting such person in fear of violence; or by any other overt felonious act committed in the presence of such person and of which such person was actually cognizant."

> Theft is much broader in meaning than either burglary or robbery. It is intended to be broad in scope and include any illegal taking of the property of another without his consent. Theft includes both burglary and robbery.

There are various types of burglary and robbery forms available, each of which is designed to afford protection against designated perils for designated types of property. The important point to keep in mind is that only the specified type of criminal activity insured against is covered, and the coverage exists only when the loss occurs under conditions which meet the definition of the peril insured against.

Mercantile Open Stock Burglary Policy

The Mercantile Open Stock Burglary Policy is designed to cover loss of merchandise, furniture, fixtures, or equipment as a result of burglary. It does not cover loss of money or securities. Damage caused by burglars to the premises is also covered. In addition, the policy is extended to cover loss caused by robbery or attempted robbery of a watchman employed exclusively by the insured, while on duty within the premises, while the premises are not open for business. Coverage under the

Mercantile Open Stock Burglary Policy applies only when the premises are not open for business.

The coverage is subject to certain exclusions. First of all, the loss must be the result of burglary (or robbery of a watchman). Unless there are marks of forcible entry into or exit from the premises, coverage for loss does not apply. Losses resulting from employee infidelity are not covered. In addition, losses resulting from war are excluded. Any burglary which occurs during a fire in the premises is also excluded.

A special provision in the policy deals with the failure of the insured to maintain protective devices which he warranted would be maintained. For protection devices other than alarm systems (such as guards), failure to maintain the protection device reduces the coverage to the amount which the premium paid would have purchased without the discount granted for the protection device. If an alarm system was warranted, and the alarm system is out of order for some reason beyond the control of the insured, a watchman must be provided during the period of time that the alarm is out of order. If this is done, the company will pay any loss that occurs, but again on a reduced basis. The amount of coverage is reduced to the amount that the premium paid would have purchased without credit for the alarm system.

Coinsurance applies to the Mercantile Open Stock Burglary Policy in a special manner. There are two coinsurance requirements: a territorial coinsurance requirement, expressed as a percentage, which reflects the severity of the crime exposure in the territory, and a trade group coinsurance requirement, which is expressed in dollars, and varies with the stealability of the goods. The territorial coinsurance requirement in Iowa is 50%. The trade group requirement varies from class of goods to class of goods. In the case of jewelry, the dollar coinsurance requirement is $15,000. For hardware stores, the coinsurance requirement is $7,500. The insured may satisfy the coinsurance requirement of the policy by meeting either of the two. If the coinsurance requirement is not met, the insured is penalized in the event of loss just as in the case of fire insurance. The penalty is applied on the basis of the smaller of the two requirements.

Mercantile Open Stock Theft

A Mercantile Open Stock Burglary Policy may be extended by the use of the Mercantile Open Stock Theft Endorsement to include the additional perils of robbery, theft, and larceny. When this endorsement is added to the policy, the policy covers whether or not the store is open for business. The form includes a $50 deductible; however, this deductible is not applicable to those losses which are covered under the basic Mercantile Open Stock Burglary Policy. While the endorsement extends the policy to cover theft, mere dissapearance is not covered. There must be some evidence of theft. For the same reason, inventory shortages are not covered unless there is some evidence of theft.

Mercantile Safe Burglary Insurance

The Mercantile Safe Burglary Policy is designed to cover direct loss of any property, including money and securities, when such property is lost as a result of forcible entry into a safe or vault. Again, the loss must be the result of **forcible** entry; if the burglar opens the safe by manipulation of the dial, there is no coverage. Coverage for burglary, robbery, or theft from cash registers, cash drawers, and key-locked safes may be added to the policy by endorsement. Removal of the entire safe from the premises is construed as **safe** burglary and such losses are covered.

The policy also covers damage to the safe or vault, furniture or fixtures, equipment or other property owned by the insured which are damaged by safe burglary or attempted safe burglary. So long as an attempt at safe burglary is made, any other property damaged is also covered. In this connection it is important to note that forcible entry into the premises does not constitute safe burglary unless there is also forcible entry (or attempt) into the safe. There is no requirement that the premises be entered forcibly.

The provisions with respect to warranties of protection devices are the same as under the Mercantile Open Stock Burglary Policy.

Mercantile Robbery Policy

The coverage of the Mercantile Robbery Policy is restricted to the peril of robbery, as defined at the beginning of this section. Robbery consits of taking property in one of three ways:

1. By violence inflicted upon a custodian or putting in fear of violence.
2. From one who has been killed or rendered unconscious by injuries inflicted maliciously or sustained accidentally.
3. By any other act committed in the presence of the custodian of the property of which he is actually cognizant.

This would include taking of property even where no violence is inflicted or threatened. For example, if an employee sees a thief grab an item and run out of the store, the loss would be considered robbery, since the overt felonious act was committed in the presence of the custodian and the custodian was aware of the act. For this reason also, loss resulting from smashing of a show window while the premises are open for business would also be considered robbery.

The coverage is written in two separate sections, each of which is independent of the other. The two sections are robbery within the premises and robbery outside the premises. The insured may select either or both of these, and separate amounts of insurance are purchased for each.

The Mercantile Safe Burglary Policy and the Mercantile Robbery Policy are often combined into a Mercantile Robbery and Safe Burglary Policy.

Paymaster Robbery

Paymaster Robbery coverage is designed to cover checks and money which are intended for the insured's payroll. Since such sums are not regularly on the premises, the cost of this coverage is lower than the cost of a regular Mercantile Robbery Policy. Coverage applies both on and off premises, as long as the money is intended for payroll.

Money and Securities Broad Form

The Money and Securities Broad Form provides all risk coverage on money and securities and somewhat more limited coverage on other property. Money and securities are covered under two separate coverages, Coverage A, which applies to loss within the premises, and Coverage B, which applies to loss outside the premises. As in the case of the Mercantile Robbery Policy, each section is independent of the other, and the insured may elect to insure for either or both.

The on premises coverage covers any loss or destruction of money or securities. In addition, other property on premises is covered, but only for the perils of Robbery and Burglary. Theft of merchandise is covered only if taken by Robbery or from a closed and locked safe. Robbery is defined in the same manner as under the Mercantile Robbery Policy, and includes kidnapping losses and stealing from a show window by a person who has broken the glass when the premises are open for business.

The off premises coverage applies within the United States, the District of Columbia, Virgin Islands, Puerto Rico, Canal Zone, and Canada. There is no coverage for losses occurring outside these limits. Coverage applies to money and securities in the custody of a messenger, while being conveyed by an armored car company, or while within the living quarters of a messenger.

The policy excludes losses resulting from employee infidelity. In addition, there are the usual exclusions of war and nuclear perils. Money, securities and a safe or vault is covered for loss by fire, but damage caused by fire to any other property is excluded, even if the fire is set by a person committing a crime of burglary or robbery.

PACKAGE CRIME POLICIES

There are a number of dishonesty policies which combine several crime coverages into a single contract. Several of these packages includes not only non-employee dishonesty coverage, but fidelity coverage on employees as well.

The Banker's Blanket Bond

The Banker's Blanket Bond is an excellent example of the package policy approach to crime coverages. This policy, which was originally marketed in this country by Lloyd's of London, contains five separate insuring agreements, covering both employee dishonesty and other non-employee dishonesty losses. Coverage is provided under five insuring agreements:

A. Fidelity

B. Premises Insuring Clause, under which coverage is provided for loss or destruction of money, coins, stamps, precious metals, jewelry, valuable papers and some 50 other classes of enumerated property, against loss or destruction caused by robbery, burglary, theft, false pretenses, misplacement, or mysterious unexplainable disappearance.

C. In Transit Insuring Clause, which provides coverage for loss of property through robbery, larceny, theft, hold-up, misplacement, or mysterious disappearance, or damage or destruction of property while in transit anywhere in the custody of a bank employee, messenger, or while in the custody of an armored motor vehicle.

D. Forgery Insuring Clause, which covers any loss through the accepting, cashing or paying of forged or altered checks, drafts, or similar instruments.

E. Securities Insuring Clause, which covers loss sustained by the bank in purchasing, extending credit on, or otherwise acting upon any security which proves to have been forged or counterfeited.

The Comprehensive Dishonesty, Disappearance and Destruction Policy

The Comprehensive Dishonesty, Disappearance and Destruction Policy, or as it is called, the 3-D policy, is the mercantile equivalent of the Banker's Blanket Bond. This policy, like the Banker's Blanket Bond, is a combination of fidelity and crime coverages. There are five insuirng agreements under the contract, and the insured may select any or all of the coverages; none is mandatory. The 3-D policy is a unique package policy, in that the premium is simply a summation of the individual premiums for the separate coverages. Unlike many package policies, there is no discount for the package. The chief benefit derived from the packaging is the elimination of conflict regarding which policy should apply in the event of a loss where more than one policy might be applicable. The five insuirng agreements of the 3-D policy are:

1. **Employee Dishonesty.** There are two options available to the insured. Option A is the Commercial Blanket Bond, in which the penalty applies on a per loss basis, regardless of the number of employoees involved. Option B is the Blanket Position Bond, in which the penalty applies per employee.
2. **Broad Form Money and Securities On Premises.** As discussed previously, this coverage provides all risk coverage on money and securities on the insured's premises or in a bank's premises.

3. **Broad Form Money and Securities Off Premises.** This coverage provides all risk coverage on money and securities outside the insured's premises while in the custody of an authorized employee, while in the custody of an armored car service, or while within the living quarters in the home of a messenger.
4. **Money Order and Counterfeit Paper Currency.** This coverage provides coverage against loss resulting from acceptance of post office or express money orders, or counterfeit United States or Canadian paper currency.
5. **Depositor's Forgery.** This coverage provides protection for losses caused by forgery or alteration of outgoing instruments such as checks, drafts, bills of exchange or similar promises to pay. Coverage under this section is extended to include the insured's bank, thus eliminating the question of the bank's liability.

The coverages of the package are essentially the same as their individual counterparts. The insured may add Open Stock Burglary, Theft, or Paymaster Robbery to the 3-D policy by endorsement. As a matter of fact, a total of thirteen additional coverages are available as options. The optional insuring agreements under the Comprehensive 3-D policy are:

Incoming Check Forgery
Mercantile Open Stock Burglary
Paymaster Robbery Coverage (inside and outside)
Paymaster Broad Form Coverage (inside and outside)
Paymaster Broad Form Coverage (inside only)
Burglary and Theft Coverage on Merchandise
Warehouse Receipts Forgery
Securities of Lessees of Safe Deposit Box
Burglary Coverage on Office Equipment
Theft Coverage on Office Equipment
Paymaster Robbery Coverage Inside Premises
Credit Card Forgery
Extortion coverage

Blanket Crime Policy

The Blanket Crime Policy provides coverage against the same five basic perils as does the Comprehensive Dishonesty, Disappearance and Destruction Policy. However, under the Blanket Crime Policy, there is a single limit for all coverages and not a separate limit for each. The fidelity coverage of the Blanket Crime Policy is written on the Commercial Blanket basis, with a single penalty applicable regardless of the number of employees involved in the loss. The coverage of the Blanket Crime Policy may be extended to cover mercantile open stock burglary, mercantile robbery, or theft of office equipment; but the wide range of coverages available under the 3-D policy may not be added.

Storekeeper's Burglary and Robbery Policy

This form is a package crime policy designed for small mercantile establishments. The insured may select $250, $500, $750, or $1,000 in coverage. The maximum amount of coverage that can be purchased is $1,000. There are seven distinct insuring agreements, each with a separate limit of liability, although the limits must be the same for all coverages. The seven coverages included are:

1. Premises Robbery. This agreement provides coverage on money, securities, merchandise and furniture and fixtures against loss by robbery on premises. The definition of robbery is essentially the same as in the Mercantile Robbery Policy.
2. Messenger Robbery (or Outside Robbery). This insuring agreement covers money and securities and merchandise against robbery from a messenger outside the premises, but within the U.S., District of Columbia, Virgin Islands, Puerto Rico, the Canal Zone, Hawaii, and Canada.
3. Kidnapping. This insuring agreement covers against loss of money, securities, merchandise, furniture, fixtures and equipment stolen resulting from the seizing or holding-up of a messenger outside the premises and forcing him to open the premises.
4. Safe Burglary. This coverage protects against loss of money, securities and merchandise from within a locked safe or vault, by forcible entry, as defined in the policy, or the stealing of the entire safe from the premises. In addition, there is also coverage for money and securities (but not merchandise) stolen from within the premises but not in a safe. The limit on property not in a safe is $50.
5. Theft from a Night Depository or Residence of a Custodian. Under this coverage the policy protects against theft from a night depository or the residence of a custodian. Only money and securities are covered under this section.
6. Burglary; Robbery of Watchman. This coverage is the approximate equivalent of Merchantile Open Stock Burglary Coverage. The coverage applies only to merchandise, furniture, fixtures, and equipment. Money and securities are not covered under this section. Coverage on any article of jewelry is limited to $50.
7. Damage to Property and Premises. Coverage applies under this section to damage to the premises or other property caused by burglary or attempted burglary or robbery.

The coverages afforded under the Storekeeper's Burglary and Robbery Policy are almost identical to the coverages that would be obtained by the purchase of the various individual policies. The coverage is subject to the usual exclusions of Employee Infidelity, war, and the nuclear perils.

Broad Form Storekeeper's Burglary and Robbery

This form is based on the Storekeeper's Burglary and Robbery Policy discussed above, but adds Employee Dishonesty Coverage, Depositors Forgery, and Damage caused by vandalism and malicious mischief following burglarious entry into the premises. It is sometimes referred to as a "Baby 3-D", because the extent and scope of the coverage is similar. Like the Storekeeper's Burglary and Robbery Policy, it is purchased in increments of $250, up to a maximum of $1,000. It provides coverage under the following nine insuring agreements:

1. Employee Dishonesty. All property, including money, securities, furniture, fixtures, merchandise, and equipment, is covered against loss by employee dishonesty.
2. Loss inside the premises. This coverage is the equivalent of the Broad Form Money and Securities on premises coverage.
3. Loss outside the premises. This coverage is the equivalent of the Broad Form Money and Securities off premises coverage.
4. Merchandise Burglary; Robbery of a Watchman. This is the equivalent of the Mercantile Open Stock Burglary Coverage, and is subject to the same limitations as the similar insuring agreement under the basic Storekeeper's Burglary and Robbery Policy.
5. Money Orders and Counterfeit Paper Currency. This coverage is the equivalent of the similar coverage under the 3-D policy.
6. Theft — Residence. Covers theft of money or securities from within the residence of a messenger.
7. Depositor's Forgery. This coverage is the equivalent of the similar coverage under the 3-D policy.
8. Damage by Vandalism and Malicious Mischief. Covers damage caused by vandalism and malicious mischief following burglarious entry. Applies only if the insured owns the building or is liable for the damage.
9. Other Damage. Provides coverage for damage to property resulting from an insured crime or attempt at an insured crime.

Office Burglary and Robbery

This form is a package policy similar to the Storekeepers Burglary and Robbery Policy, except that it is designed for individuals or firms occupying offices. It is intended primarily for professional offices and service businesses. Unlike the Storekeeper's forms, there is no coverage for merchandise. The coverge is sold in increments of $250. Unlike the Storekeeper's form, which has a maximum of $1,000, there is no maximum amount of insurance that may be purchased under the Office Burglary and Robbery Policy. Coverage is afforded under the following six insuring agreements:

1. Robbery Inside the Premises. Covers money and securities against robbery inside the premises, with robbery defined the same as in the Mercantile Robbery Policy.
2. Theft Inside the Premises. Covers loss of office equipment by theft.
3. Safe Burglary. Covers loss of money and securities by safe burglary (as defined in the Safe Burglary Policy). In addition coverage is afforded up to $100 for loss of money and securities not in a safe, but within the premises, if the premises are burglarized.
4. Robbery Outside the Premises. Covers money, securities, and office equipment against robbery away from the premises in the custody of a messenger.
5. Theft from a Night Depository or Residence. Covers loss of money and securities by **theft** from within any night depository of a bank or the living quarters of a messenger.
6. Damage. Covers damage to premises and to money and securities and office equipment, both on and off premises, which are damaged as a result of an insured crime or an attempt at such a crime.

The policy is subject to the normal exclusions of war and nuclear perils. Employee infidelity is also excluded.

GENERAL LIABILITY INSURANCE

Liability insurance for businesses and other organizations may be divided into three classifications:

Automobile liability

Employer's Liability and Workers Compensation

General Liability

Here we are concerned with the last of these three, liability which arises out of exposures other than automobiles, and which involves liability to persons other than employees.

Before examining the various contracts that are designed to protect against the hazard of legal liability, it may be helpful to examine the major areas which these contracts are designed to cover. Every business firm has certain legal liability exposures that must be covered under general liability contracts.

1. Ownership and maintenance of premises. This exposure includes both the building and the land. The owner of a building or a tenant of a building may be held legally liable in the event a member of the public is injured or damage to the property of others results from a condition in or arising out of the premises.

2. The conduct of business operations. In addition to the liability exposure which exists in connection with the premises occupied, the individual or firm may be held liable if a member of the public (or property of others) is injured by some activity of the insured or an employee away from the premises. For example, a contractor may injure someone at some place other than the firm's premises. The liability exposure in connection with the ownership and maintenance of the premises and the conduct of business operations is covered under the Premises and Operations coverage of general liability policies.

3. Products. This is perhaps the fastest growing area of potential legal liability. Any firm which has anything to do with a product that eventually reaches the public has a products liability exposure, regardless of whether it is the manufacturer, wholesaler, or retailer. In general, legal liability in connection with products may arise in two ways: on the basis of negligence and on the basis of warranty. In the first instance, the injured party must prove that he suffered injury or damage as a result of negligence on the part of the seller or manufacturer in the preparation or handling of the product. As an alternative, the injured party may bring action based on the doctrine of warranty. Common law holds that the seller of a product makes an implied warranty to the buyer that the product sold is safe for the purpose for which it was intended. In most instances, the Premises and Operations Coverage protects against liability caused by products while on the insured's premises, but after the product has been turned over to the customer and he has left the premises, the Premises and Operations coverage no longer applies. Coverage for liability arising out of products after they have been turned over to the customer must be obtained under a special coverage to protect against liability arising out of products.

4. Completed Operations. Completed operations may represent a liability exposure for all firms who do construction or installation work, servicing or repair work. While the work is being performed, the exposure is an operations exposure, and is covered under the Premises and Operations coverage. Once the work has been completed, the Premises and Operations coverage no longer applies. The legal liabilty exposures in connection with products and completed operations are both covered under the Products and Completed Operations coverage.

5. Contingent Liability. It is possible for an individual or a business to become legally liable because of work performed by independent contractors. In some instances, the negligence of the independent contractor may be imputed to the owner of the property who has engaged the contractor. Every risk which may have occasion to engage contractors, or contractors who engage subcontractors, to engage in construction, or demolition, or alterations which change the shape or size of structures, or make repairs, has a contingent exposure. This exposure is protected against the Owners and Contractors Protective Liability coverage, which is also called "Independent Contractors" coverage.

6. Contractual Liability. In certain instances, a business (or an individual) may assume liability under a contract. For example, it is not unusual in construction contracts to include a provision in which one party agrees to hold the other harmless for all claims for injuries arising out of the performance of the work. Certain types of contracts are covered automatically under the Premises and Operations coverage, but other contracts must be covered under Contractual Liability coverage.

GENERAL LIABILITY COVERAGES

General liability for businesses and other organizations is provided under a standard set of forms called "coverage parts," which are used in conjunction with a uniform policy jacket. The coverage parts are combined with the policy jacket in various combinations to furnish the desired coverage. The policy jacket contains general provisions, such as the definitions of certain terms, conditions relating to premium determination, the insured's duties in the event of loss, and similar items.

Each coverage part includes a basic insuring agreement for bodily injury and property damage, and the

exclusions applicable to the particular coverage. The coverage parts also include a separate schedule for exposures, rates, and premiums applicable to the hazards. Individual coverage parts are provided for over a dozen specialized insurance needs.

Policy Jacket

As noted above, the General Liability policy jacket contains general provisions, such as definitions, conditions relating to the insured's duties, and similar items. Although a complete analysis of these provisions is not possible in this manual, a few of the more important ones are noted below.

Supplementary Payments. Under the supplementary payments section, the insurer promises to pay, in addition to the limit of liability:

(a) all expenses incurred by the company in defending a suit against the insured and interest on the amount of the judgment from the time it is awarded until it is paid.

(b) premiums on appeal bonds required in such suits, and the cost of bail bonds required of an insured in connection with accidents and traffic law violations involving vehicles which are covered under the policy. The company is not obligated to furnish such a bond.

(c) expenses which are incurred for first aid to others at the time of an accident involving bodily injury to which the policy applies.

(d) other expenses incurred by the insured at the request of the company, including loss of wages up to $25 per day while attending trials or hearings at the company's request.

Insured's Duties in the Event of Loss. In addition to the provisions relating to the right of the company to inspect the premises, perform premium audits, and so on, the policy jacket sets forth certain obligations of the insured, the most important of which involve the duties of the insured in the event of loss:

(a) In the event of an occurrence that may give rise to a claim under the policy, the insured must give written notice to the company or its authorized agents as soon as possible.

(b) If claim is made or suit is brought, the insured must immediately forward to the company every demand, notice, summons, or other process which he receives.

(c) The insured must cooperate with the company and at the company's request, assist in making settlement. The insured must not, except at his own cost, voluntarily make any payment or assume any obligation, other than first aid at the time of the accident.

Other Insurance. The "other insurance" clause of the general liability policy jacket is somewhat different than that of other contracts that have been studied. It provides for "contribution by equal shares" whenever both policies covering a loss have the same apportionment provision. Under the contribution by equal shares arrangement, policies with differing limits of liability will share equally until the limit of the lower policy is exhausted. If the other contract does not have a "Contribution by equal shares" provision, loss is apportioned on the basis of the limits of each policy. To illustrate, let us assume that there are two contracts covering a given injury, one with a $10,000 per person limit for bodily injury, and the other with a $100,000 per person limit for bodily injury. If both policies have a contribution by equal shares clause, each policy will pay one-half of any loss up to a total of $20,000 (i.e., $10,000 each). At this point, the limits of the $10,000 policy will be exhausted and the $100,000 policy will pay the remainder up to its face amount. If either of the policies does not have the contribution by equal shares provision, the policy with the $10,000 limit will pay 10,000/110,000 of any loss up to $10,000, and the $100,000 policy will pay 100,000/110,000 of any loss, up to $100,000.

THE COVERAGE PARTS

A coverage part identifies the type of insurance for which coverge is provided. Each of the coverage parts contains:

(a) The basic insuring agreement for bodily injury and property damage and the agreement pertaining to defense.

(b) Exclusions applicable to the respective coverage.

(c) Definition of persons insured under the applicable coverage.

(d) A section explaining the manner in which the limits of liability apply to the respective coverage, and a reference to the policy period and territory.

Each coverage part also includes a separate schedule for exposures, rates, and premiums applicable to the hazards of its respective coverage. Separate coverage parts are provided for:

Comprehensive General Liability

Contractual Liability

Premises Medical Payments

Owners, Landlords and Tenants, including Structural Alterations

Owners, Landlords and Tenants, excluding Structural Alterations

Manufacturers and Contractors, including Independent Contractors

Manufacturers and Contractors, excluding Independent Contractors

Completed Operations and Products Liability

Comprehensive Personal Liability

Farmers Comprehensive Personal Liability

Personal Injury Liability

Owners and Contractors Protective Liability

Physicians', Surgeons', and Dentists' Professional Liability

Druggists Liability

Hospital Professional Liability

Elevator Collision

Storekeepers' Liability

Dramshop Liability

COMPREHENSIVE GENERAL LIABILITY COVERAGE

Although it is possible to purchase liability insurance against each of the individual areas of exposure discussed above separately, the preferred approach is to provide coverage against liability losses under the Comprehensive General Liability coverage part. This form automatically includes coverage for premises and operations, products and completed operations, and liability arising out of independent contractors. However, only limited coverage is provided under the C.G.L. for contractual liability, and a separate Contractual liability coverage part may be included in the policy jacket with the C.G.L. for more complete protection.

Coverage parts are available to permit the purchase of these coverages individually. For example, the premises and operations exposure may be insured under the Owners, Landlords, and Tenants Coverage Part (the O.L. & T.) or under the Manufacturers and Contractors Coverage part (M & C). However, neither of these forms include products and completed operations coverage. Products and completed Operations coverage is available separately under the Products and Completed Operations coverage part, and Independent Contractors coverage is available under the Owners and Contractors Protective Coverage part. (Independent Contractors coverage may also be included in the Manufacturers and Contractors Coverage part).

One of the unique features of the Comprehensive General Liability Policy (CGL) is that newly developed exposures are covered automatically without notice to the insurer. The premium for the CGL begins with an advance premium determined at inception. At the end of the policy period, an audit is performed to determine what, if any, additional exposures have developed; and an additional charge is made for these new exposures. However, this automatic coverage applies only to those exposures that are actually insurable under the form, excluding those specialized exposures for which some other form of coverage is available.

The CGL Insuring Agreement

Coverage of the Comprehensive General Liability coverage part (and the other coverage parts as well) is provided under two insuring agreements: one for bodily injury and one for property damage. Separate limits are provided for each, but there is no per person limit under the bodily injury coverage. Coverage is on an "occurrence" basis, with an occurrence defined as:

> . . ."an accident, including injurious exposure to conditions, which results during the policy period, in bodily injury or property damage neither expected nor intended."

The reference to "injurious exposure to conditions" provides coverage for losses that are not sudden or specifically identifiable as to time. For example, coverage would be provided for damage to buildings caused by a pile-driving operation, even though the exact time of the damage could not be fixed.

Exclusions

To a considerable extent, the scope of the coverage under the CGL form is determined by the exclusions. Some of these exclusions relate to exposures that are covered under other forms of protection. Some of the exclusions may be deleted or modified by endorsement. Still others cannot be removed or modified, and cannot be covered under any of the standard forms of coverage available. Because these exclusions are of special importance, they should be examined in detail.

Exclusion (a) excludes liability assumed under contract, except those contracts which are defined as "Incidental Written Agreements" in the policy. "Incidental Written Agreements" are covered automatically under the Premises and Operations Coverage, with no additional premium. Incidental Written agreements include:

(1) Lease of premises agreements

(2) Easement agreements except in connection with construction or demolition on or adjacent to a railroad

(3) Municipal ordinance agreements except as respects work done for the municipality

(4) Sidewalk agreements

(5) Elevator maintenance agreements

All other contracts are excluded and must be covered under Contractual Liability Insurance.

Exclusion (b) excludes liability arising out of any automobile or aircraft. Mobile equipment is covered, and it is important to note precisely what is included in the definition of mobile equipment. Mobile equipment falls into four basic classes:

(1) It includes a land vehicle not subject to motor vehicle registration, such as a truck operated for a long period at a construction site.

(2) It includes a land vehicle maintained for use exclusively on the insured's premises, including the ways immediately adjoining. This is illustrated by a farm vehicle or a truck used only in or about the insured's premises. However, coverage would be provided if on occasion the vehicle would be driven over public roads to a repair shop or service station.

(3) It includes a land vehicle designed for use principally off public roads, such as a piece of earth moving equipment.

(4) It includes certain specified contractor's equipment, such as power cranes and shovels.

Any piece of mobile equipment that fits into any of these classifications is considered to be "mobile equipment" within the meaning of the definition of "mobile equipment", and is therefore covered under the policy.

Exclusion (c) excludes "mobile equipment" while being used in any prearranged or organized racing or demolition contest, or in any stunting activity or practice for such activity, and also excludes the operation or use of any snowmobile or trailer designed for use with a snowmobile. Many garages, for example, own and operate racing stock cars, which, if not licensed, technically fall within the definition of "mobile equipment" discussed above. Such vehicles are specifically excluded by this provision, as are snowmobiles, which must be covered under separate contracts.

Exclusion (d) excludes liability arising out of the transportation of mobile equipment (as defined above) by an auto owned or operated by the insured. Thus, even though mobile equipment is covered under the policy, it is excluded from coverage while being towed by an automobile. It must be covered under the automobile coverage when being transported.

Exclusion (e) excludes liability arising out of watercraft away from the premises.

Exclusion (f) excludes pollution or contamination from the discharge, dispersal, release or escape of smoke, vapors, toxic chemicals or waste, unless such discharge, dispersal or release is sudden and accidental. The intent of this pollution exclusion is to eliminate coverage for pollution or contamination that results from controllable activities, such as dumping waste in a river, or air pollution by an industrial plant.

Exclusion (g) excludes war in all its forms.

Exclusion (h) excludes liability arising out of the business of manufacturing, selling, or servicing alcoholic beverages, or as the owner or lessor of premises used for such purposes. This exposure must be protected under a Dram Shop Liability Coverage.

Exclusion (i) excludes liability arising out of any workmen's compensation, unemployment compensation, disability benefits law, or any similar law.

Exclusion (j) excludes bodily injury to any employee of the insured arising out of and in the course of his employment by the insured.

Exclusion (k) excludes property damage to property owned by, rented to, or in the care, custody, or control of the insured. A special exception to this exclusion provides that it does not apply to property damage arising out of the use of elevators at the insured's premises, except for damage to elevators.

Coverage for damage to the elevator itself may be added to the policy by endorsement, through the Elevator Collision Part, provided that property damage liability has been included in the basic policy. The Elevator Collision coverage covers damage to the elevator itself and also to other property owned, occupied, rented to, or used by the insured. Although the exclusion relating to property in the care, custody or control of the insured does not apply to damage by elevators, it does apply to damage to property owned by or rented to the insured; therefore the need for Elevator Collision.

Exclusion (l) excludes liability arising out of damage to premises alienated by the Named Insured (that is, premises conveyed or transferred) if the damage arises out of the premises.

Exclusion (m) excludes liability for loss of use (where there has been no physical injury) which results from the insured's failure to complete a buiding on time or failure of the insured's product or work to measure up to the insured's warranty or representation. The exclusion does not apply if the loss of use is due to a breakdown of the insured's product or work after it has been put to use by the claimant.

Exclusion (n) excludes property damage to the insured products which arises out of the product.

Exclusion (o) excludes property damage to work performed by the insured or on behalf of the insured which arises out of the work performed.

Exclusion (p) is known as the "X C U" exclusion. It excludes liability resulting from explosion, collapse, or underground property damage. The exclusion does not apply to all insureds, but only to those firms within certain rating classifications that have a special exposure with respect to such damage. These include, for example, electric light and power companies, excavators, wreckers, sewer constructors, and similar firms. Those classifications which are subject to the exclusions are designated in a special endorsement attached to the policy. In some instances, it is possible to delete this exclusion for an additional premium and provide protection for losses arising out of these perils.

Need for Other Coverages

Although the CGL is the most attractive approach available for insuring the general liability exposures of a buisness or organization, it should be emphasized that it does not in itself provide complete protection. For example, as we noted, only certain "Incidental Written Agreements" are included in the contractual liability coverage, and more complete protection must be added under another form. Other coverage modifications are discussed later in this section.

THE OWNERS, LANDLORDS & TENANTS FORM

Although the preferred approach to providing general liability coverage is the Comprehensive General Liability form, there are other forms available which are sometimes used. The Owners, Landlords, and Tenants Form (OL & T) is designed to insure owners and lessess of buildings, vacant land, mercantile establishments of all kinds, and various service businesses of a non-manufacturing nature. It does not provide coverage for liability arising out of products or completed operations; and if the insured has an exposure in these areas, the CGL should be used.

The OL & T provides coverage for premises and operations, but on a somewhat more limited basis than does the CGL. There are two forms of the OL & T available: one which includes coverage for structural alterations and one which does not. If the insured is having structural alterations (new building, demolition, or construction which changes the size or shape of the building coverage should be written on the form providing coverage for such activities.

OL & T Exclusions

The principal difference between the OL & T form and the CGL is in the exclusions of the OL & T.

Exclusions (a) through (o) of the OL & T form are identical with the similarly designated exclusions of the CGL. Under the OL & T form, exclusion (p) excludes liability arising out of the products and completed operations exposure.

As noted previously, if a firm has an exposure in connection with either of these, coverage should be provided under the CGL rather than the OL & T Form.

Exclusion (q) excludes bodily injury or property damage arising out of operations on or from premises owned, rented, or controlled by the insured which are not "insured premises." Insured Premises are defined as those premises indicated in the declarations, premises alienated by the insured, and newly acquired premises, provided the insured notifies the company within 30 days of the acquisition.

Thus, under the OL & T form, unlike the CGL, automatic coverage on newly acquired premises applies only for a period of 30 days. Finally, the version of the OL & T which does not include structural alterations includes an exclusion of such activities.

Exclusion (r) excludes liability arising out of structural alterations. (This exclusion does not appear in the OL & T coverage part which is designed to provide coverage for structural alterations.)

THE MANUFACTURERS AND CONTRACTORS FORM

The Manufacturers and Contractors Form (M & C), as its title indicates, is designed for manufacturing firms and contracting firms. Like the OL & T form, it provides coverage only for premises and operations. However, the insuring agreement of the OL & T form is specific in nature, applying only to the described location and operations away from the premises which are necessary or incidental thereto. The M & C, on the other hand, covers all premises and operations not excluded.

Actually, the OL & T and the M & C are quite similar in nature, and the determination of which of them is to be used for a given firm depends on the manual classification and the rating basis of the business. In general, the OL & T is used for those firms where the exposure results primarily from property ownership or mercantile operations. The M & C form is used where the principal operations exposure is away from the insured's premises (as, for example, in the case of a contractor).

Like the OL & T, the Manufacturers and Contractors form covers only premises and operations, and does not provide coverage for products and completed operations. There are two versions of the M & C form: one which includes coverage for the acts of independent contractors, and one excluding such coverage.

M & C Exclusions

The scope of the coverage of the M & C form, like that of the OL & T coverage part, is defined by the policy exclusions. The exclusions of the M & C, like those of the OL & T, are quite similar to those of the CGL. Exclusions (a) through (o) of the M & C are identical with the similarly designated CGL exclusions.

Exclusion (p) of the M & C excludes liability arising out of the products and completed operations exposure. As in the case of the OL & T form, there is no provision for adding products and completed operations to the M & C form, and if the insured has an exposure in this area, the CGL form should be used to provide coverage.

Exclusion (q) is the "X C U" exclusion discussed in connection with the CGL form. It operates in the same manner as does the CGL exclusion.

Exclusion (r) excludes liability arising out of operations performed for the insured by independent contractors, except maintenance and repairs at the insured's own premises, or alterations which do not involve changing the size of or moving buildings or other structures. (This exclusion does not appear in the M & C form which provides coverage for independent contractors.)

Completed Operations and Products Liability Coverage Part

The Completed Operations and Products Liability Coverage part is used rather infrequently, since most insureds who have a need for this coverage also need premises and operations coverage, and the combination of these coverages must be provided under the Comprehensive General Liability policy. However, under cer-

tain circumstances, it may be necessary for a firm to purchase products and completed operations coverage separately from its premises and operations coverage.

The Completed Operations and Products Coverage part protects the insured against bodily injury or property damage claims arising out of work completed by the insured or products sold. Operations are considered completed at the earliest of three times:

(a) When all operations under the contract have been completed.

(b) When all operations at one site are complete in those instances where more than one site is involved.

(c) When the portion of the work out of which the accident arises has been put to its intended use by the person for whom the work is being done.

In most instances, the products portion of the coverage applies only after the product has been turned over to the customer and has left the premises. Exceptions to this are certain classes of business (such as restaurants) where the product is consumed on the premises. In these cases the products coverage applies from the time the product is sold and relinquished to the customer.

One of the most important aspects of the completed operations and products coverage is the definition of "Occurrence". As noted previously, the bodily injury is considered to be the accident that triggers coverage. The completed operations coverage and products coverage apply only to bodily injury or property damage that occur during the policy period. The time at which the product was sold or the work completed does not influence the coverage. For example, if an insured sells a product in 1968, and then purchases products liability coverage in 1969, and during the course of the policy period bodily injury or property damage arises out of a product sold in 1968, the policy in effect in 1969 will cover the loss. The policy that was in effect when the product was manufactured or sold is not applicable.

There are nine exclusions under the completed operations and products coverage, designated (a) through (i).

Exclusion (a) excludes liability assumed under contract, but this exclusion does not apply to a warranty of fitness or quality of the insured's product or work.

Exclusion (b) excludes liquor liability. This exclusion is the same as the one discussed in connection with the CGL.

Exclusion (c) excludes liability under workmen's compensation, unemployment compensation, or disability income laws. This exclusion is the same, as the one discussed in connection with the CGL.

Exclusion (d) excludes bodily injury to employees arising out of and in the course of their employment.

Exclusion (e) is the "Loss of Use" exclusion discussed above as exclusion (m) of the CGL coverage.

Exclusion (f) excludes damage to the named insured's product arising out of the product or any part of the product.

Exclusion (g) excludes property damage to work performed by or on behalf of the insured arising out of the work or any portion of the work. Both exclusion (f) and (g) have the same intent: to eliminate coverage for faulty workmanship. Only damage **to** the product is excluded here. Damage caused by the product or work completed is, of course, covered.

Exclusion (h) is called the "sistership liability exclusion." It excludes liability for damages or claims for damages arising from the withdrawal or repair of identical products which are defective or which are believed to be defective, in which the withdrawal or repair is for the purpose of avoiding injury. For example, in the withdrawal of products from dealers, distributors, or purchaser of such products as drugs, automobiles, or aircraft, because of a known or suspected defect, claims for damages because of loss of use of the product or costs of withdrawal are not covered.

Exclusion (i) is the pollution exclusion discussed above as exclusion (f) of the O L & T coverage.

The Contractual Liability Part

The Contractual Liability part of the general liability program may be used as a separate contract, or it may be included as a supplement to the O L & T or the M & C or to the Comprehensive General Liability contract. It should be noted that it is designed to cover designated contracts only. It is possible to purchase blanket contractual liability coverage, in which all contractual liability is covered, but it is provided only by certain carriers.

Normally the contracts to be covered under the contractual liability coverage must be submitted to the company for rating. Each agreement is specifically rated, with the final rate determined by the degree of liability assumed under the contract. The degree of liability assumed is classified as "Limited", "Intermediate", or "Broad." Although there is no such thing as a simple rule of thumb to distinguish between the three, the following examples may serve to illustrate the distinction:

Limited Contractual Liability Clause: The indemnitor agrees to indemnify and hold harmless the indemnitee for injury to persons or property

caused by the negligence of the indemnitor and arising out of the indemnitor's operations.

Intermediate Contractual Liability Clause: The indemnitor agrees to hold harmless the indemnitee for injury to persons or property in any manner arising out of the operations of the indemnitor except such injury as may be caused by the sole negligence of the indemnitee.

Broad Contractual Liability: The indemnitor agrees to indemnify and hold harmless the indemnitee for injury to person or property in any manner arising out of the operations of the indemnitor and irrespective of the negligence of the indemnitee.

There are fourteen exclusions applicable to the Contractual Liability Coverage part:

Exclusion (a) excludes liability arising out of professional services performed by the insured or the indemnitee in connection with the approval of maps, plans, inspection or engineering services.

Exclusion (b) excludes liability arising out of war in all its forms.

Exclusion (c) excludes liquor liability.

Exclusion (d) excludes liability imposed under workmen's compensation, unemployment compensation, or disability benefits law.

Exclusion (e) excludes liability to a third party beneficiary for bodily injury or property damage arising out of a project for public authority. Some public construction contracts require that the contractor become liable for damage to all property, regardless of who owns it.

Exclusion (f) excludes damage to property owned by, rented to or in the care, custody, or control of the insured.

Exclusion (g) excludes property damage to premises alienated by the insured arising out of such premises or any part thereof.

Exclusion (h) is the "Loss of Use" exclusion discussed above as exclusion (m) of the CGL coverage.

Exclusion (i) excludes damage to the insured's product. The wording and intent is the same as the identical exclusion in the completed operations-products coverage part.

Exclusion (j) excludes damage to work performed by the insured. It is the same as the identical exclusion in the completed operations-products coverage part.

Exclusion (k) is the sistership exclusion discussed above under the completed operations-products coverage part.

Exclusion (l) excludes mobile equipment while being raced; or used in any organized stunting activity or while being prepared for such activity. See exclusion (c) under the CGL.

Exclusion (m) is the pollution exclusion discussed above under the CGL coverage.

Exclusion (n) is the "X C U" exclusion discussed above under the CGL coverage.

Owners' and Contractors' Protective Liability Coverage Part

This coverage part is relatively simple. The insuring agreement agrees to pay all sums the insured becomes legally obligated to pay for bodily injury or property damage arising out of:

> "Operations performed for the named insured by the contractor designated in the declarations at the location designated or acts of omissions of the named insured in connection with his general supervision of such operations . . ."

There are eight exclusions:

Exclusion (a) excludes contractual liability, except liability assumed under an Incidental Written Agreement. The definition of Incidental Written Agreement is the same as under the CGL

Exclusion (b) excludes the completed operations hazard.

Exclusion (c) excludes any liability arising out of any act or omission of the named insured or his employees, other than general supervision of work performed by the independent contractor. This exclusion merely places such liability on the insured's Premises and Operations coverage.

Exclusion (d) is the standard workmen's compensation, unemployment compensation, disability benefits law exclusion.

Exclusion (e) excludes bodily injury to employees of the insured arising out of and in the course of their employment, but this exclusion does not apply to liability assumed by the insured under an incidental contract.

Exclusion (f) is the standard care, custody, and control exclusion.

Exclusion (g) is the standard war exclusion.

Exclusion (h) is the mobile equipment exclusion discussed as Exclusion (c) under the CGL above.

Exclusion (i) is the pollution exclusion discussed as exclusion (f) under the CGL above.

Exclusion (j) is the "loss of use" exclusion discussed as exclusion (m) under the CGL above.

OTHER LIABILITY FORMS AND ENDORSEMENTS

Although the Comprehensive General Liability form

and the Contractual Liability coverage part combine to provide protection against a wide range of exposures, there are certain areas of loss potential that are not covered by these or the other stndard forms discussed above. Coverage against additional types of loss may be added by endorsement or sometimes written under a separate policy. Although the following list is far from exhaustive, it outlines some of the additional forms of general liability insurance that may be needed by a given business or organization.

The Medical Payments Coverage Part

Like the premises medical payments of the Homeowners policy which was examined in the personal lines portion of this study guide, the Premises Medical Payment coverage is not a liability coverage. It is designed to pay for injuries of members of the public regardless of the insured's liability or lack of it. The Medical Payments coverage provides for payment of all reasonable medical expenses incurred within one year from the date of the accident for necessary medical, surgical, dental, ambulance, hospital, professional nursing, and funeral services, to each person who sustains bodily injury, sickness or disease caused by an occurence as defined.

The medical payments coverage is subject to the basic exclusions of the liability policy to which it is attached. In addition, certain classes of persons are excluded from the coverage of the medical payments. Medical payments are not payable to:

(a) the insured, any partner, or any tenant or other person regularly residing on the premises.

(b) any employee of the insured or tenant while engaged in the employment of the insured or the tenant.

(c) any person if benefits are payable under any workmen's compensation law.

(d) any person engaged in maintenance, alteration, demolition or new construction operations for the named insured or for any lessee of the insured, or any lessor of the premises.

(e) any person injured while practicing, instructing, or participating in any physical training, sport, athletic activity or contest.

The coverage may be included as an optional coverage under most of the general liability policies for businesses.

The Storekeepers' Liability Policy

This contract is a package policy for retail stores, which combines Premises and Operations coverage, Completed Operations and Products, Contractual Liability, and Owners Protective Liability into a single policy. In addition, medical payments are included as a part of the basic package. Unlike the CGL, the Storekeepers Liability policy does not provide automatic coverage for new operations and hazards that develop during the year. Elevators which are under the control of the insured must be specifically insured, for they are not covered automatically. In addition, the products coverage excludes liability arising out of the sale of gas for heat or power, and damage or bodily injury arising out of appliances sold which are operated by gas or liquid fuel, or out of the installation, servicing or repair of such appliances. There are certain classes of stores that are not eligible for this coverage. The agent can determine which classes of mercantile establishments are not eligible for this coverage from the manual.

Personal Injury Liability

The bodily injury insuring agreement of the CGL does not include coverage for liability arising out of such torts as libel, slander, or defamation of character. The Personal Injury Liability coverage part (which may be purchased separately or endorsed onto the CGL) provides coverage for three groups of hazards:

1. False arrest, detention, imprisonment, or malicious prosecution.
2. Libel, slander, defamation, or violation of right of privacy.
3. Wrongful entry or eviction or other invasion of the right of private occupancy.

The insured may choose one, two or all three of these groups of perils.

There are relatively few exclusions under this coverage. Liability assumed under contract is excluded. In addition, personal injury arising out of willful violation of a penal statute is excluded. Libel, slander, or defamation committed by the insured prior to the inception of the policy with knowledge that the statements were false is excluded. Finally, there is no coverage for personal injuries sustained by an employee of the insured. This exclusion represents a severe restriction in coverage. It can be and should be removed for an additional premium.

Fire Legal Liability

The tenant of any building is exposed to loss which may result from damage to the premises which he rents. If a fire occurs as a result of negligence on the part of the tenant or one of his employees, a right of action for recovery may be brought by the owner of the building (or by his insurance company under the provisions of the subrogation clause of the Standard Fire Policy.) Since the general liability policies all include a provision excluding damage to property "owned by, rented to, or in the care, custody, or control of the insured", there would be no coverage under the Premises and Operations coverage. This situation gives rise to the need for Fire Legal Liability coverage.

An interesting case in connection with this coverage is the case of Hardt vs. Brink (192 Fed Sup. 879), in which an insurance agent was held liable for $41,954

because he failed to recommend this coverage to a client who later suffered an uninsured loss.

Fire Legal Liability coverage may be written as an endorsement to the General Liability forms, or it may be written as a separate contract, using the Standard Fire Policy and a special fire form designed for the purpose.

The general liability forms providing fire legal liability coverage typically provide coverage for loss arising out of fire only, or out of fire, explosion, and smoke from a heating or cooking unit. When coverage is written under the fire policy coverage may be provided for loss by the perils of extended coverage, vandalism and malicious mischief, and sprinkler leakage. Liability assumed under a contract is specifically excluded under both approaches.

Coverage may be provided for damage to buildings and to contents. Usually, the property for which the insured may be held liable is specifically designated in the contract, although in some cases the coverage applies to any property rented to or leased to the insured.

Dram Shop Liability

The Iowa Liquor Control Act, subsequent to July 4, 1963, as amended, has required that any person licensed to dispense liquor by the drink (including beer) in Iowa, must post proof of financial responsibility against claims resulting from the Iowa Dram Act. The Dram Act states that a husband, wife, child, parent, guardian, employer, or other person has a right of action against any licensee or permittee who sells or gives beer or intoxicating liquor to any person while intoxicated, or serves such a person to a point where such person becomes intoxicated, when such husband, wife, child, parent, guardian, employer or other person suffers injury or property damage as a result. Dram Shop Liability insurance protects against the legal liability which may be imposed on a seller of liquor by the drink as a result of the law.

The Broad Form Property Damage Endorsement

One of the most troublesome of all areas in the field of liability insurance is the exclusion found in most liability forms which excludes coverage for damage to property in the "care, custody, and control" of the insured. (Exclusion K in the CGL) The exclusion is intended to eliminate coverage under liability policies for property in a bailment status. Such property may be insured along with property owned by the insured under a fire policy or one of the inland marine forms. However, while bailed property can be covered under direct damage forms, there are other aspects of the exclusion which remain.

The "care, custody, and control" exclusion also excludes property "as to which the insured is for any purpose exercising physical control." Suppose, for example, that a plumber stands in a tub while installing a shower head, thereby scratching the porcelain finish. Is the tub in the plumber's "care, custody, and control?" Perhaps not, but the point is moot. Clearly he was "exercising some form of physical control over it by standing it."

Another exclusion that frequently creates problems, and that is sometimes confused with the "care, custody and control" exclusion is the exclusion of damage "to work performed by or on behalf of the named insured . . ." (Exclusion 0 in the CGL)

A contractor completes a building. Six months later the roof collapses as a result of a structural deficiency. When the contractor submits a claim under the Comprehensive General Liability Policy he carries, he finds to his dismay that this form of property damage (which may be the exact type of loss he had in mind in purchasing the coverage) is not covered.

Both of these exclusions can be modified to provide broader coverage through the use of a form known as the Broad Form Property Endorsement. There are two versions of this form, one designated as Including Completed Operations and one Excluding Completed Operations. The distinction affects only the exclusion of damage to work performed by or on behalf of the named insured; the two forms are identical in their modification of the "care, custody, and control exclusion."

The BFPD Endorsement and Care, Custody and Control. Basically, the Broad Form Property Damage Endorsement deletes exclusion (k) of the CGL Policy (i.e., the "care, custody, and control" exclusion) and substitutes a somewhat less restrictive endorsement. However, it is important to recognize that even with this endorsement attached, most property in the care, custody, and control of the insured is still excluded. When the BFPD Endorsement is attached to the CGL, the policy still excludes:

1. property owned by the insured
2. property rented to or occupied by the insured
3. property on premises owned or rented by the insured
4. tools and equipment being used by the insured
5. property in the custody of the insured which is to be installed, erected, or used in construction by the insured.

The main effect of the endorsement is to modify the "care, custody, and control" exclusion with respect to "property as to which the insured for any purpose is exercising physical control." When the BFPD endorsement is attached to the CGL policy, the exclusion is limited to "that particular part of any property, not on premises owned or rented to the insured, upon which operations are being performed by or on behalf of the insured." In a sense, the endorsement clarifies the scope of the care, custody and control exclusion rather than eliminating it.

The BFPD Endorsement and Damage to Work Performed. The exclusion of damage to work performed (exclusion 0 in the CGL) can also be modified. That part of the exclusion refering to work completed "on behalf of the named insured," which excludes damage to work or arising out of the work of subcontractors, can be deleted for an additional premium and attachment of the Broad Form Property Damage Endorsement (Including Completed Operations). This endorsement is similar in most respects to the Broad Form Property Damage Endorsement (Excluding Completed Operations), except with respect to the work of subcontractors. Basically, the endorsement simply deletes any reference to the work completed "on behalf of the named insured." The net effect of this deletion may be summarized as follows:

1. The insured still has no coverage for damage to his work arising out of his work.
2. The insured has coverage for damage to his work arising out of the work of a subcontractor
3. The insured has coverage for damage to a subcontractor's work arising out of the subcontractor's work.
4. The insured has coverage for damage to a subcontractor's work arising out of the insured's work.

Broad Form C.G.L. Endorsement (G-222)

Broad Form liability endorsements were first introduced by individual companies, to broaden the coverage of the Comprehensive General Liability Policy. After several years of experimentation by individual companies, the Insurance Services Office developed a standard form of this endorsement, which is designed to provide twelve additional coverages under the CGL policy. Most of these coverages under the CGL policy. Most of these coverages were previously available as individual endorsements or separate coverage parts. The combination of the coverages into a single endorsement reduces the cost of providing the coverage, partly through savings in administrative expenses, but mainly through reduction of adverse selection.

The twelve coverages that are added to the CGL policy under the Broad Form CGL Endorsement are:

(1) Blanket contractual liability
(2) Personal Injury Liability and Advertising Liability
(3) Premises medical payments
(4) Host Liquor Liability
(5) Fire Legal Liability — Real Property
(6) Broad From Property Damage
(7) Incidental Malpractice
(8) Nonowned watercraft
(9) Limited worldwide coverage
(10) Additional persons insured
(11) Extended Bodily Injury coverage
(12) Coverage for newly acquired organizations

The nature and intent of each of these coverages can best be determined by a detailed analysis of the form itself. Briefly, however, the coverages added by this endorsement are as follows:

Blanket Contractual Liability. The Broad Form CGL Endorsement provides blanket contractual liability coverage by extending the definition of "Incidental Agreements" in the basic contract to include both written and oral agreements relating to the named insured's business. In addition, the form specifically eliminates the exclusions of automobiles, aircraft, and watercraft with respect to the contractual liability coverage.

Personal Injury and Advertising Liability. The personal injury coverage of the Broad Form CGL endorsement is similar to the separate coverage part already discussed. However, the Broad Form CGL Endorsement does not include the standard exclusion of employment related offenses, thereby providing coverage for such losses. However, liability for personal injury which is assumed under contract is excluded.

The Advertising Injury Liability coverage is a broad form of protection, covering injuries arising out of libel, slander, defamation, violation of the right of privacy, unfair competition, or infringement of copyright, title or slogan, which occurs in the course of the insured's advertising activities. This coverage is written separately, but is normally subject to a deductible. The coverage in the Broad From CGL Endorsement does not have a deductible.

Medical Payments. Coverage here is essentially the same as the premises medical payments coverage available under the standard coverage part.

Host Liquor Liability. The coverage provided under this insuring agreement does two things: First, it clarifies the exclusion of the CGL policy with respect to alcoholic beverages, making it clear that coverage is provided for liability arising out of serving alcoholic beverages as long as the named insured is not in the **business** of serving, selling, manufacturing, or distributing alcoholic beverages. However, coverage exists only if the loss involves **bodily injury** or property damage. Suits for loss of means of support where there is no bodily injury are not covered.

More important, the wording of the form provides coverage for liability assumed under contract, where the indemnitee is an organization to which the liquor exclusion might apply. For example, if the named insured should rent a country club, for example, to hold a party, and assumed the liability imposed on the lessor-country club, such liability would be covered under the Host Liquor insuring agreement of the Broad Form CGL endorsement.

Fire Legal Liability. The form provides fire legal liability coverge for damage to real property rented or leased to the insured, up to a specified limit of $50,000.

This limit can be increased for an additional premium. Coverage for loss caused by explosion is not covered.

There is no coverage for liability assumed under a contract, and the coverage applies only to real property. Coverage for damage to personal property may be obtained under a separate coverage part, or such coverage may be obtained under a direct property damage form such as the fire policy.

Broad Form Property Damage Liability. Coverage is provided for Broad Form Property Damage on the same basis as under the separate form Including Completed Operations discussed earlier.

Incidental Medical Malpractice. Coverage is provided for losses arising out of the rendering or failure to render medical services, regardless of whether or not the individual rendering or failing to render the services is an employee of the named insured or an independent contractor. (Coverage under the separate Incidental Malpractice Endorsement used by most companies limits coverage to services rendered by employees).

Nonowned Watercraft. The watercraft exclusion of the basic CGL is modified so as to provide coverage on nonowned watercraft less than 26 feet in length. Coverage applies to watercraft owned by employees; and in such a case, even the employee would be protected by the policy.

Limited Worldwide Coverage. Although there is some extension of coverage here, it would be easy for an insured to misunderstand the scope of this coverage. The emphasis is on the term **Limited.**

Coverage applies anywhere in the world, provided the original suit for damages is brought within the U.S., its territories, possessions, or in Canada. In this sense, the coverage is similar to that of the products coverage under the basic form; coverage applies to injuries outside the U.S. in connection with products originally sold in the U.S., as long as the suit takes place in the U.S.

Additional Persons Insured. The definition of persons insured is extended to include any spouse of a partner concerning business matters of the partnership and any employee of the named insured, while acting within the scope of his or her duties. There is still no coverage for bodily injury to a fellow employee, such losses being specifically excluded.

Excluded Bodily Injury Coverage. The Extended Bodily Injury coverage modifies the definition of "occurrence" to include intentional acts by or at the direction of the insured, which result in bodily injury, when such injury arises solely from the use of reasonable force for protecting persons or property.

Automatic Coverage — Newly Acquired Organizations. Newly acquired organizations are automatically covered under the endorsement for up to 90 days. Unless the newly acquired organization has been declared to the insurer within the 90 days, coverage ceases.

Officers and Directors Errors and Omissions Insurance

A special form of coverage known as Officers and Directors Errors and Omissions insurance is available to protect corporate officers and directors from suits alleging mismanagement. Such suits may be brought by stockholders or by persons outside the firm. The coverage is usually written subject to a deductible, and the insured is normally required to bear 5% of any loss in excess of the deductible. The policy excludes losses based on alleged personal gain of the insured, and losses resulting from failure to purchase proper insurance coverage. There is no standard form for this coverage.

Variations of this coverage are available to protect elected and appointed public officials. There is a Board of Education Liability Policy to protect elected or appointed members of school boards, administrators, teachers, and other employees of a school district from suits for wrongful acts. There is a Public Official Liability policy designed to protect public officials who are elected or appointed to office in a public body. Like the Officers and Directors coverage above, there is no standard form for these coverages, and they are usually sold by specialty insurers.

Pension Fiduciary Liability

The Pension Reform Act of 1974 (ERISA) imposed new responsibilities on employers and fiduciaries supervising pension plans and group life and health insurance plans, holding them liable to beneficiaries for violation of the prudent man rule in the supervision of such a plan. Pension fiduciary liability insurance protects against losses arising from this source. The coverage is sometimes written to include employee benefit errors and omissions coverage, which protects against liability arising out of errors in advising employees and from other types of mistakes related to fringe benefit programs.

PROFESSIONAL LIABILITY INSURANCE

The term "professional liability" refers to liability arising out of the failure to use due care and the degree of skill expected of a person in a particular profession. In cases where there is an exposure to bodily injury (as with physicians, surgeons, and dentists) the coverage is usually called "Malpractice insurance." In instances where the risk involves property damage (including intangible property) the coverage is called errors and omissions insurance; this is applicable to professions such as insurance agents, architects, attorneys, and accountants.

Malpractice Insurance

Malpractice insurance, which is written for physicians, surgeons, dentists and hospitals, is perhaps the best example of professional liability insurance. The

need for this coverage is obvious, and there are special forms of coverage available for anesthetists, barbers, beauticians, chiropractors, dental hygientists, masseurs, morticians, nurses, opticians, pharmacists, psychiatrists, radiologists, surgeons, and veterinarians. Although space does not permit a discussion of each of the various forms, a brief treatment of the physicians', surgeons' and dentists' professional liability coverage should suffice to illustrate the nature of the coverage.

Although there is a standard bureau form of Physicians', Surgeons', and Dentists' Professional liability coverage, most of the coverage is written by a limited number of companies using their own special forms. Many of the provisions of these forms have been changed in the recent past, primarily as a result of difficulties encountered by insurers in this field.

Several features of these forms deserve comment. First, the policy is not limited to bodily injury or property damage; it includes coverage for personal injury losses such as mental anguish even when there is no bodily injury. There is not even an exclusion of intentional acts—a logical feature—since the act which gives rise to the liability may be precisely the act that the physician or dentist intended.

At one time, most policies were written to cover errors or mistakes made during the policy period, with no time limit on the discovery of the injury. This resulted in a phenomenon known as the "long tail" on losses. If a surgeon left a sponge in a patient and the error was not discovered for twenty years, the insurer providing the coverage at the time of the original operation would be responsible for the loss. This made the pricing of the coverage extremely difficult, particularly in view of the rapidly increasing levels of malpractice awards. Many companies found themselves paying 1970 losses with 1950 premiums. To counter the situation created by these so-called "occurrence policies," many insurers changed to a "claims made form," under which the policy in effect at the time a claim is reported responds for the loss, regardless of when the error was made.

A second feature that has been modified by many insurers is the provision regarding defense and settlement. Under the older policy forms, the insurer was required to obtain the consent of the insured before settling any claim out of court. The reason, of course, was to protect the reputation of the doctor, since a voluntary payment by the insurer could be interpreted as an admission of fault, and could be injurious to the reputation of the physician. Most of the newer policies have deleted the requirement that the insurer obtain the consent of the insured before making an out-of-court settlement.

It is important to note that for coverage to exist under a professional liability policy, the injury must arise out of rendering or failure to render professional services. Liability arising from other causes is not covered, which means that professional liability insurance is not a substitute for other forms of liability coverage. It is a coverage that is purchased in addition to other general liability coverages.

Errors and Omissions Insurance

There are many professions having a possibility of property damage as a result of rendering or failure to render professional services. Included in this group are such diverse occupations as abstractors, accountants, insurance adjusters, architects, county clerks and recorders, engineers, insurance agents and brokers, lawyers, real estate agents, stockbrokers, and travel agents. In the case of each of these professions, errors and omissions coverage is tailored to suit the needs of the specific profession. The modern trend is to provide such coverage on a claims made basis, and to delete previous provisions which required consent of the insured for out-of-court settlement.

THE UMBRELLA LIABILITY POLICY

The Umbrella Liability Policy is a form of excess liability insurance, and differs from primary liability insurance in that the company promises to indemnify the insured for his ultimate net loss in excess of some retained limit. The policy limits are usually quite high, ranging upward from $1,000,000. When purchased in conjunction with the liability policies normally purchased by the business firm, the Umbrella serves three functions:

1. It applies as excess coverage over the other liability coverage purchased by the insured. It takes over when the limits of the basic policies are inadequate to pay any judgment against the insured.

2. It provides more comprehensive coverage than is afforded under the underlying policies. Certain losses which are not covered by the underlying insurance may be included within the broad scope of the Umbrella policy. In these instances the Umbrella provides protection against loss, subject to a deductible ranging from $10,000 upwards.

3. If the underlying coverage is exhausted, the Umbrella becomes the underlying coverage, subject to the terms and conditions of the underlying contracts.

In general, the Umbrella Liability Policy is written only for risks that have a broad and substantial program of underlying coverage. Normally the insurer requires Comprehensive General Liability coverage with Bodily Injury limits of $250,000/$500,000 and Property Damage limits of $100,000, and automobile liability coverage with the same limits. Employer's Liability coverage for $100,000 per accident is required, and when the exposures exist, bailee liability and aviation liability coverage may also be required. The policy conditions call for the maintenance of the underlying coverage, and the liability of the Umbrella carrier is deter-

mined as if the underlying coverage were in force, whether or not it is.

Likewise, the insurance carriers require that the amount of the net retention or deductible be substantial. Until recently, most Umbrella liability policies were written with a net retention limit on exposures not covered by underlying insurance of $25,000. Recently it has become possible to obtain policies with a $10,000 retention. It should be pointed out that the deductible or retention applies only in those instances where the loss is not covered by the underlying coverage. In other words, there is no "corridor" deductible on those losses which are covered by the underlying coverage.

Coverage Under the Umbrella Liability Policy

There is no "standard" form of Umbrella Liability. Each insurer draws up its own contract; and while most of the contracts are quite similar in nature, there may be substantial differences. These differences can be identified only by a detailed analysis of the specific contract being considered.

The insuring agreements are broad and comprehensive in nature. It is common to provide coverage under three sections:

1. Personal Injury
2. Property Damage
3. Advertising Liability

The Personal Injury coverage includes coverage for bodily injury, mental injury or mental anguish, sickness, disease, disability, false arrest or imprisonment, wrongful eviction, detention, malicious prosecution, discrimination, and humiliation, plus libel, slander, defamation of character and invasion of rights of privacy that are not the result of advertising activity.

The Property Damage coverage applies to damage to or destruction of all tangible property not owned by the insured. There is no exclusion of damage to property in the care, custody, or control of the insured.

Advertising Liability covers liability arising out of the insured's advertising activities, including libel, slander, defamation, infringement of copyright, title or slogan, piracy or unfair competition, or invasion of right of privacy.

The broadness of the Umbrella is evident from the brief discussion of the coverage above. A further indication may be made by the following list of perils and hazards covered under most Umbrella contracts, which are not normally covered under the underlying contracts:

1. The coverage is on a world wide basis.
2. The contract includes personal injury liability.
3. The contract includes blanket contractual liability.
4. Coverage is provided on property in the care, custody or control.
5. Malpractice coverage is afforded under some contracts.
6. Employer's liability is provided.
7. Employees are included as additional insureds.
8. Coverage is afforded for non-owned aircraft.
9. Coverage is afforded for non-owned watercraft.
10. Liquor liability is covered.
11. Innkeepers liability is covered.
12. Bailee liability is covered.
13. Advertising liability is covered.
14. Damage to property rented or occupied by the insured is covered.
15. Water damage legal liability is covered.
16. Explosion, collapse and underground damage (XCU) is covered.

Exclusions

While the coverge under the Umbrella Liability policy is far broader than that of the individual contracts, it is not all risk. There are exclusions, and many of the exclusions are quite important. Some of the more common exclusions contained in the current Umbrella liability contracts are the following:

1. The policies exclude any liability arising out of any workmen's compensation, unemployment compensation, or disability benefits law. As in the case of the underlying contracts, this exclusion does not apply to liability of others assumed by the insured under contract.

2. The policies exclude liability arising out of claims against the insured for repairing or replacing any defective products manufactured, sold, or distributed by the insured.

3. The policies exclude liability arising out of the ownership, maintenance, use, loading or unloading of any aircraft owned by or chartered without a pilot by the insured.

4. There is an exclusion of liability of any employee with respect to liability for injury to or death of a fellow employee. This exclusion is important because employees are included as insureds under the policy.

5. Many of the policies also exclude any error or omission, malpractice or mistake of a professional nature committed by or alleged to have been committed by or on behalf of the insured.

6. Many of the policies contain exclusions relating to watercraft over a certain size (e.g., 75 feet in length).

Defense Coverage Under the Umbrella

Practically all Umbrella liability contracts have a provision which in effect provides that the insured may take over or participate in the defense of a claim in

which it may be involved. Originally, few contracts provided any defense coverage on those claims which appeared likely to stay within the limit of the net retention. In the recent past, there has been a tendency to include defense coverage with respect to losses not insured under underlying contracts, even when the loss does not appear likely to involve the Umbrella contract.

COMMERCIAL AUTOMOBILE INSURANCE

Organizations, like individuals, are exposed to a wide range of losses in conjunction with the use of automobiles. The major exposure is, of course, liability arising out of the use of automobiles. In addition, there is the possibility of damage or loss to vehicles owned by the firm or for which the firm may be liable.

In those instances in which a business is organized as a proprietorship, a "business" automobile may be insured under one of the personal auto forms, such as the Family Auto Policy or the Personal Auto Policy, provided the automobile itself is otherwise eligible. However, if the firm is a partnership or a corporation, or if the automobile itself is not eligible for one of the personal automobile forms, coverage must be provided under a different form.

Prior to 1978, two approaches were used to insure commercial vehicles; a "Basic" form and a "Comprehensive" form which were used with the Comprehensive General-Auto Liability policy jacket. In 1978, the Insurance Services Office introduced a new policy, the Business Auto Policy, designed to replace the then-existing forms. This new policy, which follows the modern trend and uses simplified terminology, includes both liability and physical damage coverages.

Although it is anticipated that this new policy will eventually become the standard approach to insuring business automobiles, an interim period will exist in which some companies will continue to use the older forms. Although the following discussion focuses on the new Business Auto Policy, you should be aware of the fact that some of the companies that your agency represents may use slightly different forms.

LIABILITY COVERAGE UNDER THE BUSINESS AUTO POLICY

Liability may arise out of the use of automobiles that are owned, leased, or borrowed. Historically, automobile liability insurance for commercial insureds has recognized three classes of automobiles:

1. Owned automobiles
2. Hired automobiles
3. Nonowned automobiles

The classes "hired automobiles" and "nonowned automobiles" are mutually exclusive. "Hired automobiles" include those that are leased, hired, rented or borrowed, excluding autos that are owned by employees. Automobiles leased, hired, rented or borrowed from employees are considered "nonowned automobiles." Thus, the distinction between a "hired" and a "nonowned automobile" does not depend on whether or not payment is made for the use of the automobile, but rather on whether or not it is owned by an employee. This somewhat artificial distinction exists primarily for the purpose of rating and premium determination.

Businesses that own or lease automobiles usually recognize the exposure associated with these autos and obtain insurance coverage to protect against losses that may arise out of their use. However, many business owners overlook the exposure related to employee's autos. If an employee causes injury or damage while operating his or her own auto in the course of employment, the injured party may sue both the negligent employee and the employer. If the employee has coverage, the employer is automatically protected under the employee's policy. The danger exists, however, that the employee's policy limits may be inadequate. For this reason, employers need to purchase a form of excess coverage to protect themselves in the event of such a contingency.

Basic versus Comprehensive Liability Coverage

As noted above, prior to the introduction of the Business Auto Policy, two different forms were used to provide liability coverage for business firms. The Basic Automobile Liability coverage part provided coverage only for specifically described automobiles. Coverage for hired automobiles and nonowned automobiles was available by endorsement. The Comprehensive Automobile Liability coverage part provided completely automatic coverage for all of the insured's owned automobiles, for hired automobiles, and for nonowned automobiles.

The new Business Auto Policy continues the options of comprehensive liability or basic auto liability coverage. In describing those automobiles that are covered for each of the coverages the insured selects, the Business Auto Policy uses the term "Covered Auto." A series of numerical designations, each representing a class of automobiles, are entered in the declarations opposite the various coverages, indicating the types of automobiles covered under the policy. There are nine numerical symbols, which designate the automobiles for which the policy provides coverage:

1 = Any Auto
2 = Owned Autos Only
3 = Owned Private Passenger Autos Only
4 = Owned Autos Other Than Private Passenger Autos Only
5 = Owned Autos Subject to No-Fault
6 = Owned Autos Subject to Compulsory Uninsured Motorists Law
7 = Specifically Described Autos
8 = Hired Autos Only
9 = Nonowned Autos Only

It should be obvious that extreme care must be used in designating the class of autos to be covered by a specific policy. A typographical error, or the inadvertant substitution of one numeral for another may leave a significant class of automobiles for which coverage was intended completely uninsured.

Comprehensive Automobile Liability Coverage. The most effective means of providing automobile liability coverage for a business firm or other organization is the comprehensive liability approach. When this mode of coverage is desired, the numeral "1" (Any Auto) is entered opposite the liability section of the declarations. The Comprehensive automobile liability coverge provides protection against liability arising out of the ownership, maintenance or use of all owned, nonowned, and hired automobiles, including any replacements and additionally acquired automobiles. All owned and hired automobiles are scheduled at the inception of the policy, and additional exposures are covered automatically. At the end of the policy period an audit of the exposures that developed is made, and any additional premium due to the company is charged.

Basic Automobile Liability Coverage. Basic automobile liability coverage provides liability coverage on specifically scheduled automobiles and follows the format of the older Basic Automobile Policy, originally introduced in 1955. Under this mode of coverage, only the listed automobile or automobiles are covered. Under the older policies, Employer's Nonownership Auto Liability coverage (covering automobiles owned by employees but used in the business of the insured) and Hired Car coverage could be added by endorsement. Under the new Business Auto Policy, these two coverages are added by entering the numerals 8 and 9 in the declarations of the policy.

Although it is possible to do so, Basic Auto Coverage (numeral 7) should never be written without Hired Autos (Numeral 8) and Nonowned Autos (Numeral 9). While both Hired Automobile coverage and Nonowned Auto coverage are important forms of protection in their own right, the provisions of the Basic Auto Coverage contained in the new Business Auto Policy make it essential that both Hired Auto coverage and Nonowned Auto coverage always be written in conjunction with the Basic Auto coverage. Unlike the Family Automobile Policy, the Personal Auto Policy, and the older Basic Auto Policy, the new Business Auto Policy does not provide coverage for Temporary Substitute automobiles. This means that when Basic Auto coverage (Numeral 7) is designated alone, there is no coverage for an automobile used as a replacement for the scheduled automobile when that scheduled auto is withdrawn from use for servicing and repair. Writing Hired Autos and Nonowned Autos in conjunction with Basic Auto coverage eliminates this potential gap.

Persons Insured

The definition of persons insured under the Business Auto Policy provides liability protection to certain persons other than the named insured, but the coverage in any given situation depends on both the "Who is Insured" provision and the designation of "Covered Autos." In other words, the policy definition of "Who is Insured" must be interpreted in light of the particular automobile in question. If the auto involved in the loss meets the definition of a "Covered Auto," then the "Who is Insured" provision brings those persons designated under the protection of the policy. Because the provision is crucial in determining coverage for various individuals who might be joined in a suit, it is quoted in its entirety:

D. **WHO IS INSURED.**

1. **You** are an **insured** for any covered **auto.**
2. **Anyone else is an insured** while using with **your** permission a covered **auto you** own, hire or borrow except:
   a. Someone using a covered **auto you** hire or borrow from one of **your** employees or a member of his or her household.
   b. Someone using a covered **auto** while he or she is working in a business of selling, servicing, repairing or parking **autos.**
3. Anyone liable for the conduct of an **insured** described above is an **insured** but only to the extent of that liability. However, the owner or anyone else from whom **you** hire or borrow a covered **auto** is an **insured** only if that **auto** is a **trailer** connected to a covered **auto you** own.

A brief explanation should serve to clarify the intent of this provision.

First of all, the named insured (You) is insured for any covered auto. As noted above, whether or not an auto is a "covered auto" is determined by the numerical designations in the policy declarations. In the case of Comprehensive Auto Liability Coverage, the named insured is an insured for all owned, nonowned, and hired automobiles. In the case of Basic Auto Liability coverage (Numeral 7) the named insured is an insured only for the described auto.

Anyone else (for example, an employee of the named insured) is covered while using any covered auto with the permission of the named insured. However, these additional insureds are not covered while using a Nonowned auto. In other words, officers and employees of the firm are covered for owned and hired autos, but not for Nonowned autos. (This is essentially the same as the situation under the older forms of coverage).

The provision that denies coverage to anyone other than the named insured while that person is working in a business selling, servicing, repairing, or parking automobiles is designed to eliminate coverage for auto-

motive establishments that may be servicing or otherwise have custody of an insured automobile. This exposure is covered under the Garage Policy (discussed later in these pages).

The final section of the definition of persons insured provides coverage for persons or organizations held vicariously liable for the operation of a covered automobile. However, the extension of coverage to those held vicariously liable does not apply to the owner of a Hired or Nonowned auto (other than a trailer). For example, if Jones, an employee of the named insured, uses an automobile furnished to her by her employer (the named insured) in volunteer work for a church, the church would be covered for its vicarious liability. On the other hand, if Jones borrows an automobile from her neighbor for use in her work and is involved in an accident, the policy will not provide protection for the vicarious liability of the neighbor (or for Jones herself). The named insured would be protected for any liability that might arise, however.

Partnerships. Although the Business Auto Policy does not refer specifically to partnerships, when the named insured is a partnership, a special endorsement must be added to the policy. This endorsement specifically excludes any auto owned by a partner or a member of his or her household. Provision is made in this same endorsement for addition of coverage on automobiles owned by partners, subject to an additional premium. When coverage is added for autos owned by the partners, the endorsement specifically excludes from coverage any partner with respect to an automobile which he or she or a member of his or her household owns. This means that the coverage applies on essentially the same basis as does the coverage on Nonowned automobiles. The partnership is protected in the event of a suit, but the owner of the automobile must look to his or her own coverage for protection.

Newly Acquired Automobiles

Coverage on newly acquired automobiles varies considerably under the various modes of coverage. Under each of the options which provide coverage on owned automobiles (Numerals 1, 2, 3, and 4) all automobiles of the type to be insured which are owned by the insured must be declared and scheduled. All newly acquired automobiles of the type insured are then covered automatically. For example, under the Comprehensive coverage (Numeral 1), all newly acquired automobiles are automatically covered, and automobiles of the specified type are automatically covered under Owned Autos Only, Owned Private Passenger Autos, and owned Autos Other than Private Passenger Autos.

When Specifically Described Automobiles (Basic Auto Coverage, Numeral 7) is selected, the coverage on newly acquired autos applies on a more limited basis. Under the Basic Auto coverage, newly acquired autos are covered only if the company insures all autos owned by the insured or if the newly acquired auto replaces a previously described automobile. Furthermore, notice to the company is required within 30 days.

Trailers and Mobile Equipment

The term "automobile" is a broad generic term and includes any land motor vehicle, trailer or semi-trailer designed for travel on public roads. However, it does not include "mobile equipment," such as, construction equipment, vehicles that are not required to be licensed, and vehicles that are designed for use principally off public roads.

Coverage is automatically provided without charge for mobile equipment while being carried or towed by a covered automobile. Coverage is also automatically provided without charge for trailers with a load capacity of 2,000 pounds or less.

The situation with respect to mobile equipment seems clear enough, but the coverage for trailers requires some additional comment. Any trailer with a load capacity of 2,000 pounds or less is automatically covered, regardless of whether it is owned, hired, or nonowned. Trailers in excess of this capacity that are owned by the insured must be declared and listed at the inception of the policy. Nonowned trailers in excess of this capacity are covered only if the policy designates Comprehensive coverage (Numeral 1) or Hired and Nonowned autos (Numerals 8 and 9). When coverage does apply to a nonowned or hired trailer, the coverage is extended to protect the owner of that trailer as well as the named insured.

Exclusions

The Business Auto Policy contains eight exclusions.

Contractual Liability. The policy specifically excludes liability assumed under any contract or agreement. Such situations may arise in the case of leased or rented automobiles, where the lessee assumes liability imposed on the lessor. This exposure is covered under a Contractual Liability coverage part written in conjunction with the Comprehensive General Liability policy.

Workers' Compensation. Obligations of the insured under any workers' compensation law or disability benefit law are excluded. This exposure is covered under a separate workers' compensation policy.

Indemnification for Injury to Employees. The policy excludes coverage for any obligation of the insured to indemnify any third party for damages resulting from injuries to an employee. This contemplates situations in which an injured employee sues a negligent third party, who then seeks recovery from the injured employee's employer, either under a contract or on some other basis. This exposure is covered under the workers' compensation policy when the obligation to indemnify is based on a common law action, and it is covered under a contractual liability coverage part when the obligation is imposed under a contract.

Injury to Fellow Employees. Injured workers are precluded from bringing suits against their employers under most workers' compensation laws, but this protection does not apply in most cases to fellow employees of the injured worker. Since employees are insureds under the Business Auto Policy while using a covered auto with permission of the named insured, injuries to fellow employees are specifically excluded to eliminate coverage in those instances in which an injured employee might bring suit against a negligent co-employee who caused the injury. In the absence of such an exclusion, the number of such suits would undoubtedly be much greater than is the case given the exclusion.

Injury to Employees of the Insured. The third exclusion relating to employees excludes coverage for bodily injury to any employee of the insured, arising out of and in the course of employment. This exposure is insured under the standard workers compensation policy. An exception to the exclusion provides coverage for injury to domestic employees who are not covered under workers' compensation.

Care, Custody, and Control. Property owned or transported by the insured, or in the care, custody, and control of the insured is excluded. There are no exceptions.

Loading and Unloading. Previous forms of automobile liability coverage specifically covered liability arising out of "loading and unloading" of an insured automobile. While this originally seemed logical, the modest coverage intended by the policy drafters was expanded far beyond its initial intent by the courts. There were many instances in which the courts ruled that an auto policy applied to losses that took place during the entire process of unloading, including injuries far removed from the actual site of unloading. For example, some courts took the position that "unloading" continued until the item being unloaded came to its final resting place. In an attempt to counter these adverse court decisions, the policy drafters added a new exclusion to the Business Auto Policy:

> This insurance does not apply to . . .
>
> 7. Bodily injury or property damage resulting from the loading of property before it has been put in or on the covered auto or the unloading of property after it has been taken off or out of the covered auto.

The exclusion seems clear and unequivocal, and there should be little confusion in its application. Losses sustained in the process of loading and unloading, before the property has been put in the vehicle or after it has been taken off of the vehicle, are intended to be covered under the premises and operations coverage of the general liablity policy.

An exception to this exclusion states that it does not apply to (and coverage therefore exists for) loading and unloading by means of a mechanical device that is permanently attached to the covered auto.

Pollution. The final exclusion of the Business Auto Policy eliminates coverage for liability caused by the dumping, discharge, or escape of irritants, pollutants, or contaminants. Protection against such losses is considered contrary to public policy. An exception to the exclusion provides coverage in those instances in which the discharge is sudden and accidental. Thus, the policy will not provide coverage for damage caused by exhaust fumes, but would provide coverage in the event say, a garbage truck burst, dumping its cargo into a river.

BROADENING ENDORSEMENTS

Individual Named Insured Endorsement

When the named insured under a Business Auto Policy is an individual (or a husband and wife) broader coverage similar to that of the Personal Auto Policy may be added to the Business Auto Policy by endorsement. The endorsement used to provide this broader coverage is designated "Individual Named Insured." Under the provisions of this endorsement, coverage is extended for the use of nonowned automobiles by resident relatives of the named insured, as well as for nonbusiness use of nonowned automobiles by the named insured.

Like the Personal Auto Policy, whose provisions the endorsement follows, there is no coverage for business use of nonowned automobiles other than private passenger autos. Also, as in the case of the Personal Auto Policy, there is no coverage for use of a nonowned automobile owned by, furnished, or available for the regular use of the named insured or any resident relative.

Broadened Drive Other Car Coverage

Instances occasionally arise in which an individual does not own a personal automobile, and in which the only coverage available to a person is that of the Business Auto Policy. For example, the owner of a closely held corporation may have his or her auto titled in the name of the corporatin. Similarly, an employee who is furnished an auto by his or her employer may not own any other auto.

Under these circumstances, a potential gap in protection exists in the case of nonowned automobiles which may be used by such individuals outside of their business pursuits. For example, assume that Jones, the president of the XYZ Corporation, is on a vacation and has occasion to rent or borrow an auto for personal use. Jones needs liability coverage, but the Business Auto Policy does not provide coverage in this situation.

Drive-other-car coverage may be added to the Business Auto Policy for specifically named individ-

uals. This coverage may be written to include liability, medical payments, physical damage, and uninusred motorists coverage. A premium is charged for each person named, and that person and his or her spouse residing in the same household is then covered for the use of nonowned automobiles. The only restriction are that the nonowned automobile may not be owned by the named individual or by a member of his or her household, and the auto may not be used in the auto business.

BUSINESS AUTO POLICY PHYSICAL DAMAGE COVERAGE

Physical damage coverage for both owned and nonowned automobiles is available under the Business Auto Policy, and provides essentially the same forms of protection that are available on personal autos.

Automobiles Covered for Physical Damage

As in the case of the liability coverages previously discussed, coverage applies to the class of automobiles designated in the policy declarations as protected. With respect to the physical damage coverages, the insured may select from among five options:

2 = Owned autos only
3 = Owned private passenger autos only
4 = Owned autos other than private passenger autos only
7 = Specifically described autos
8 = Hired autos only

Symbols 2, 3 and 4 provide automatic coverage on newly acquired automobiles (known as "Fleet Automatic" coverage), while symbols 7 and 8 provide nonfleet coverage.

Fleet automatic coverage is available to those firms and other organizations that own five or more automobiles. All automobiles of the type to be insured that are owned by the named insured are scheduled at the inception of the policy. Newly acquired automobiles are covered automatically until the end of the policy period, at which time an audit determines the premium due for the autos that were automatically covered.

Nonfleet coverage is designed for organizations that have less than five autos of any type to be insured. Under the nonfleet approach, newly acquired autos are covered only under limited circumstances. Additional autos are covered only if the insurer already covers all owned autos for that coverage. Replacements are covered if the auto it replaced was previously insured for the particular coverage. However, notice to the insurer within 30 days of acquisition is required in either case.

Coverage on hired automobiles may be provided on either a primary or an excess basis. A "Hired Auto" includes any auto leased, hired, rented or borrowed except autos leased hired, rented or borrowed from employees or members of their household. The basic contract provides excess coverage, but coverage on hired autos may be provided on a primary basis by endorsement.

Coverage Options

The insured may select from among three options with respect to the perils insured against, and different classes of vehicles may be insured for different perils. The coverages available include:

Comprehensive Coverage
Specified Perils Coverage
Collision Coverage

Numerals corresponding to the class of autos for which each coverage is desired are entered in the appropriate sections of the policy declarations.

Comprehensive. The Comprehensive coverage parallels the comprehensive coverage available for personal autos (discussed in the Personal Lines section of this manual). It provides a broad form of all risk coverage on insured vehicles, excluding only collision and certain other types of losses noted below.

Specified Perils Coverage. Specified Perils coverage is an alternative to Comprehensive and provides a package of the following perils:

Fire or explosion
Theft
Windstorm, hail, or earthquake
Flood
Mischief or vandalism
Sinking, burning, collision, or derailment of any conveyance transporting the covered auto.

Collision Coverage. Collision coverage pays for loss to a covered auto and its equipment by collision with another object or overturn of the auto. Collision coverage is written with a deductible of $100 or more.

Towing: Towing coverage is also available, paying up to $25 for towing and for labor costs incurred at the place of a disablement. However, towing coverage applies only to private passenger autos.

Physical Damage Exclusions.

Exclusions under the physical damage coverage of the Business Auto Policy are simple and straightforward. The policy excludes wear and tear, freezing, and mechanical or electrical breakdown, unless caused by other loss covered by the policy. For example, normal wear and tear is not covered, but excessive wear and tear to a stolen auto which is later recovered would be covered. Similarly, blowouts, punctures, and other road damage to tires is excluded unless caused by other loss covered by the policy (a collision, for example).

Losses due to war, insurrection, or by the discharge of any nuclear weapon are also excluded.

There are three exclusions dealing with stereo equipment and citizen band radios. The first of these ex-

cludes tape decks and other sound reproducing equipment that is not permanently installed in the auto. The second excludes tapes, records, and other sound reproducing media designed for use with such equipment. The final exclusion eliminates coverage for CB and other mobile radios, telephone or scanning monitor receivers, and their antennae and accessories.

Limits of Liability Under Physical Damage

Coverage under the physical damage section of the policy gives the insurer the option of paying for the damaged property, repairing it, or replacing it. In the case of theft, the company has the option of returning the stolen property (at its own expense) and must also pay for any damage resulting from the theft. Coverage is limited to the actual cash value of the proprty at the time of loss, or the cost to repair or replace it.

THE GARAGE POLICY

As the reader will recall from the discussion of other automobile forms, the policies designed for both individuals and for business firms specifically exclude from coverage anyone other than the named insured who is operating the owned automobile while engaged in the automobile business. Likewise, the drive-other-car coverage provided under both personal and business auto policies specifically exclude nonowned autos while being used in the automobile business. These exclusions are designed to transfer the coverage for automobiles being used in the auto business to a special policy designed for automobile dealers and service garages, known as the Garage Policy.

The current version of the Garage Policy was introduced by the Insurance Services Office at the same time as the Business Auto Policy. Like the Business Auto Policy, the new Garage Policy is a self-contained document, which provides both liability coverage and physical damage coverage. It may also be written to include a special form of bailee liablity coverage known as Garagekeepers Insurance (formerly Garagekeepers Legal Liability coverage), which provides physical damage coverage on automobiles that belong to customers and which are in the custody of the insured garage.

The Garage Policy is designed to provide comprehensive liability protection (including both automobile liablity coverage and general liability protection) for those businesses commonly known as garages, or which are engaged in businesses pertaining to the sale, servicing, or storage of automobiles. The classes of business that are eligible for this contract include automobile sales agencies, repair shops, service stations, storage garages, and public parking places.

The contract may also be used to provide physical damage coverage on owned and hired automobiles, including the stocks of autos held for sale by automobile dealers. Because the exposures and coverage needed differ substantially between automobile dealers and nondealers, separate supplemental schedules are provided for Automobile Dealers and for Nondealers.

Garage Liablity Coverage

The garage liability coverage of the Garage Policy is a package of liability coverages, providing premises and operations, products and completed operations, and auto liability coverage.

Premises and Operations Coverage. The premises and operations liability coverage of the Garage Policy is basically the same as that of the O L & T policy, providing coverage for the ownership, maintenance, and use of the premises for garage operations, and all operations necessary or incidental thereto. The exclusions applicable to the premises and operations coverage are similar to those discussed in connection with the general liability coverages, with the following exceptions: The Garage Policy does not exclude, as do the other general liability forms, Alienation of Premises or Dramshop Liability. The drafters of the current edition of the Garage Policy felt that the exposure in connection with these two exclusions were minimal as respects most garage operations, so the exclusions were eliminated. However, if an exposure exists (in connection with liquor liability, for example) the insurer may exclude coverage by endorsement.

All of the other exclusions contained in the standard general liability forms which provide premises and operations coverage and which are included in the Garage Liability coverage of the Garage Policy have been discussed previously, so it is not necessary to repeat them at this point. Special mention should be made of the "care, custody, and control exclusion" however, since this provision creates an inordinate number of problems for garages and other eligible automobile businesses. It should be stressed that the care, custody, and control exclusion completely eliminates coverage under the liability section of the Garage Policy for damage to automobiles belonging to customers which are in the care of the insured. The exposure in connection with damage to autos belonging to customers may be insured under Garagekeepers Insurance, discussed below.

Completed Operations and Products. The Garage Policy completed operations and products coverage provides protection for losses arising out of bodily injury or property damage caused by products sold by the insured or work performed by the insured, after the product has been turned over to the customer or after the completed work has been turned over to the customer. The exclusions related to the products and completed operations coverage are essentially the same as those under the C G L policy. Most of the problems related to this coverage involve the exclusion of damage to the product sold or damage to the work completed. However, rules applicable to the Garage Policy permit elimination of the exclusion of damage to the insured's

products (for losses over $250) through the payment of an additional premium and attachment of the Broad Form Products Coverage Endorsement.

Automobile Liability Coverage. As in the case of the Business Auto Policy, the declarations of the Garage Policy indicates those automobiles that are insured for each of the coverages of the policy. The designation of "covered auto" is accomplished through the use of numerical classes, just as in the case of the Business Auto Policy. With respect to the liability coverage, the following options exist:

1 = Any auto
2 = Owned autos only
3 = Owned private passenger autos only
4 = Owned autos other than private passenger autos only
5 = Owned autos subject to no-fault
6 = Owned autos subject to compulsory uninsured motorists coverage
7 = Specifically insured autos
8 = Hired autos only
9 = Nonowned autos used in your garage business
10 = Autos left with you for service, repair, or storage

The mechanics of designating automobiles and the various classes operate in much the same manner as the Business Auto Policy already discussed. The major distinction is the addition of a tenth class, designed to cover automobiles left with the garage for service, repair, or storage.

Automobile Liability Exclusions. In addition to those exclusions noted above, which apply to both the automobile liability coverage and the nonauto coverage, there are two additional exclusions that relate specifically to automobiles. First, the policy excludes coverage on automobiles while leased or rented to others. However, an exception to the exclusion provides coverage on autos that are leased or rented to customers while their autos are being serviced or repaired. In addition, the policy excludes any automobile while used in an organized racing, stunting, or demolition contest, or while such an auto is being prepared for such activities.

Persons Insured. The policy contains two provisions with respect to persons insured. With respect to garage operations other than the operation of automobiles, in addition to the named insured, employees, directors, and shareholders are insured while acting within the scope of their duties.

The definition of persons insured with respect to the operation of automobiles is similar to that of the Business Auto Policy, but with several important qualifications. First, there is no coverage for persons employed in the automobile business other than the insured's business. This eliminates coverage, for example, when an automobile in the custody of one garage must be turned over to another garage for work. The Garage Policy of the second garage would provide coverage for its employees.

Another special provision limits coverage for the customers of automobile dealers, who are using a covered automobile with permission. In this case, coverage applies only if the customer has no other liability coverage available (or if the available coverage has limits lower than the requirements of the financial responsibility law). Furthermore, the coverage available to the customer using the covered auto applies only up to the limits required by the financial responsibility law.

Garagekeepers Insurance

As noted above, the Garage Liability coverage specifically excludes damage to property in the care, custody, and control of the garage. Since most garages work on customer's automobiles or may for other reasons take custody of a customer's car, this creates a need for a special form of bailee liability coverage. This coverage, known as Garagekeepers Insurance, may be included in the Garage Policy by payment of the appropriate premium and designating coverage effective in the declarations.

Perils Insured. Coverage may be written to provide payment for damage to customer's autos on several bases. First, the insured has a choice with respect to the perils against which protection is provided. The insured may select either Comprehensive Coverage or Specified Perils Coverage. In addition, Collision coverage is also available.

The Comprehensive insuring agreement provides the same broad "all-risk" coverage as under the Business Auto Policy, excluding only collision and certain other specified types of loss.

The Specified Perils coverage is somewhat more limited than that of the Business Auto Policy, and includes only fire and explosion, theft, and vandalism and malicious mischief.

As in the case of the Business Auto Policy, the Collision insuring agreement includes collision of the automobile with another object and overturn.

Basis of Coverage. In addition to selecting the perils to be covered, the insured may also select the basis on which the coverage will apply. Three options are offered:

Legal Liability basis
Direct Coverage — primary basis
Direct Coverage — excess basis

Under the first of these three options, coverage applies only in those instances in which the garage is legally liable for the damage. It will not provide payment, for example, when the insured is not liable, even though the damage or loss may have been caused by an insured peril.

The Direct Coverage — Primary basis insuring agreement provides payment for damage to a customer's automobile regardless of the liability of the garage, and regardless of whether or not the owner of the automobile carries physical damage coverage. A garage owner might elect this option rather than the legal liability option to preserve customer good will when an automobile is damaged while in the care of the garage, but where the garage is not legally liable for the loss.

The third option, Direct Coverage — Excess basis is similar, in that it pays regardless of liability, but the excess coverage in this case applies only if there is no primary coverage on the customer's automobile, or if the customer's policy is written with a higher deductible.

Garage Policy Physical Damage Coverage

The coverage for physical damage losses under the Garage Policy is designed to provide protection against loss to autos owned by the garage. As in the case of the Business Auto Policy, coverage may be on a fleet automatic basis, with automatic coverage on newly acquired automobiles, or, in the case of those firms with fewer than five automobiles, on a nonfleet basis. Nonfleet coverage is provided through the use of Numerals 7 and 8. Fleet automatic coverage is provided for physical damage coverage through the use of Numerals 2, 3, and 4.

Coverage may be provided for auto dealers and for nondealers. In the case of a dealer, the coverage applies to autos held for sale and those used in the business itself, such as demonstrators, salesmen's cars, service vehicles, and so on. For nondealers, the physical damage coverage provides essentially the same type of protection as does the physical damage coverage of the Business Auto Policy.

Physical Damage Exclusions. In addition to those exclusions contained in the physical damage coverage of the Business Auto Policy, the Garage Policy contains several additional exclusions dictated by the nature of the business.

As in the case of the liability coverage, the physical damage coverage excludes automobiles leased or rented to others, except to customers while their own automobiles are being repaired. In addition, the policy excludes loss of an insured auto by voluntarily parting with it as a result of a trick or scheme or under false pretenses. An example might include sale of an automobile and accepting as a trade-in an automobile that was not owned by the "buyer."

In addition to the exclusion of rented automobiles and loss as a result of a trick or a scheme, which apply to all insureds, the policy contains certain additional exclusions applicable to auto dealers only. The two most important of these exclude loss of automobiles at newly acquired locations (after 45 days) and collision losses to automobiles being transported from their point of purchase if the distance is over 50 miles. Many dealers purchase automobiles and drive or transport them from the place of purchase to the dealership. Coverage for this exposure is available by endorsement for an additional premium.

EMPLOYERS LIABILITY AND WORKERS COMPENSATION

In worker's compensation the basic principle of legal liability which maintains that there can be no liability without negligence is modified. Under the workmen's compensation laws that have been passed by the various states, liability is imposed on the employer of an injured worker regardless of the negligence involved.

EMPLOYER'S LIABILITY

Under English common law, (which had developed in a society dominated by handicraft industries) certain legal principles had been developed which made it difficult, if not impossible, for an injured worker to collect indemnity in the event of an industrial injury. Under the English common law, the employer had five obligations:

1. The employer was obligated to provide a reasonably safe place to work.
2. The employer was obligated to provide reasonably safe tools.
3. The employer was obligated to provide reasonably sane and sober fellow employees.
4. The employer was obligated to set up safety rules and enforce them.
5. The employer was obligated to inform the worker of any dangers inherent in the work which the employee could not be expected to know about.

Once he had done these five things, the employer was deemed to have complied with the "prudent man" obligation. This made it quite difficult for the employee to prove negligence on the part of the employer. Furthermore, there were certain defenses which the employer could use to bar the injured employee from recovery. They are known as the "Employer's Common Law Defenses".

1. **Contributory Negligence.** The doctrine of contributory negligence was used by employers to defeat the claims of workers. Under the doctrine of contributory negligence, any negligence on the part of the worker who had been injured, no matter how slight, was normally sufficient to defeat the claim.

2. **Fellow Servant Rule.** The fellow servant doctrine simply stated that a fellow servant of the injured worker, whose negligence caused the accident or injury, was not considered to be an agent of the employer. Under such circumstances, i.e., where the injury was caused by a fellow worker, the injured worker was expected to seek damages from that fellow worker, and not from the employer.

3. **The Assumption of Risk Doctrine.** The fact that more dangerous work normally carries a higher wage rate was implied to be payment for the risk which the worker assumed in the job. Since he was paid a higher rate for doing hazardous work, the worker should not expect to turn to this employer in the event of an injury; he had already been paid for taking the risk. Furthermore, if a worker continued his employment while knowing, or when he might have been expected to discover that the premises, tools, or fellow employees were unsafe, he was deemed to have assumed the risks connected with the unsafe conditions.

To establish negligence, litigation was necessary. In most cases the workers did not have the resources to bring suit. Even if the worker was successful in his suit for damages, a substantial portion of the judgment went to the attorney who had accepted the case on a "contingency basis". It was not unusual for the size of the attorney's fee to represent 50% to 75% of the amount of the judgment.

WORKMEN'S COMPENSATION LAWS

The unsatisfactory status of the worker and the social and economic consequences of the entire situation under common law finally led to the adoption of a new way of distributing the financial costs of industrial accidents, based on the notion that industrial accidents are an inevitable result of the industrialized society. Since the entire society gains as a result of the industrialization, the entire society should bear the burden of these costs. Workmen's compensation laws now exist in all 50 states. The provisions of the laws all differ somewhat, but the basic intent is the same in all of them. The workmen's compensation laws impose absolute liability on the employer for injury suffered by a covered employee, which arises out of or in the course of his employment. The basic purpose of the laws is to avoid litigation, lessen the expense of the claimant, and provide for a speedy and efficient means of compensating injured employees.

While the provisions of the workmen's compensation laws in the various states differ somewhat, there is a good deal of uniformity concerning the operation of these laws. The major differences between the laws of the various states involve the definition of persons covered under the act, the magnitude and duration of benefits, and the role of insurance. In general, all of the laws are based on the following broad general principles.

1. **Negligence is no longer a factor in determining liability.** The workmen's compensation laws impose absolute liability on the employer for injury suffered by the employee which "arises out of and in the course of his employment."

2. **Indemnity is Partial but Final.** The worker gives up his right to sue the employer in return for a schedule of benefits set forth in the law. The size of these benefits is based on the severity of the injury, the wage of the worker, and in some states, the size of his family.

In many cases the total benefits payable may be less than the empoyee could receive if he were permitted to sue; but he is entitled to the benefits as a matter of right, without the necessity of going through the courts.

3. **Periodic Payments.** In most cases the indemnity under the workmen's compensation law is payable on a periodic basis (weekly or monthly) rather than in a lump sum.

4. **The Cost of the Program is made a cost of Production.** Unlike many other social insurance coverages, the employees cannot be required to contribute to the financing of the workmen's compensation program. The employer must pay the premium for the insurance coverage, or pay the benefits required by law, without any contribution on the part of the workers. The employer can predict the cost of accidents under a workmen's compensation program and build this cost into the cost of his product, thereby passing the cost of industrial accidents on to the consumer.

5. **Insurance is required.** Most of the states require the employer to purchase and maintain workmen's compensation insurance to protect against the losses that are covered under the law. Since most employers do not have sufficient resources to guarantee indemnities, insurance provides the security which must be built into the program. While the workmen's compensation laws impose the obligation to provide the benefits payable under the law, he may transfer this obligation to the insurance company.

Insurance plays an essential part in the operation of the workmen's compensation laws. Under the workmen's compensation insurance policy, the insurance company promises to pay all sums that the insured (i.e., the employer) is obligated to pay under the law. In the event of an injury to an employee, the insurance company will pay the schedule of benefits which the employer would otherwise have been forced to pay.

THE IOWA WORKMEN'S COMPENSATION LAW

One way to obtain a better understanding of the way in which the workmen's compensation principle operates is to examine one of the laws. The explanation of the Iowa Workmen's Compensation Law is based on the Iowa Code, Chapter 85, including amendments thereto enacted by the state legislature.[3]

Like other workmen's compensation laws, the Iowa Workmen's Compensation Law imposes absolute liability on those employers who come under the act, for injury to employees which arises out of and in the course of employment. The law sets up a system of compensation under a statutory schedule which specifies the amount of the benefits which the employer is required to pay an injured worker.

In addition, the law specifically exempts the employer from tort liability, making the schedule of workmen's compensation benefits the exclusive remedy of the employee as respect the employer. The Iowa law makes workmen's compensation the exclusive remedy of the employee not only against his employer, but also against a co-employee for any injury which arises out of and in the course of employment. This means that an injured worker cannot sue his employer, nor can he sue a fellow-employee who caused the injury. An exception to this rules exists when the injury was caused by the fellow-employee's "gross negligence" (which is defined as "such lack of care as to amount to wanton neglect for the safety of another"), in which case the injured employee can bring an action against the negligent fellow employee.

Persons Covered

The Iowa Workmen's Compensation Act requires that unless specifically excluded, all persons employed must come under the provisions of the act.

First and foremost, the individual must be an employee; there must be an employer-employee relationship. Persons who are independent contractors do not come under the provisions of the act, since they are not "employees" of the person or persons for whom they are performing the services. An independent contractor is distinguished from an employee in his right to determine the manner in which he will achieve the ultimate result of the work. The Iowa Supreme Court considered the primary test of an employee-employer relationship to be the right to control and direct the manner in which the person renders his services. In addition, there are certain other circumstances which indicate that there is an independent contractor relationship rather than an "employee" one. Among these are the existence of a contract for a piece of work, the right of the contractor to employ and supervise assistants, the requirement that the contractor furnish his own tools, etc.

The Iowa law does not limit coverage to employers with some minimum number of employees. All employers of one or more employees are subject to the act, unless they are specifically excluded or excepted. At one time, all agricultural employees, domestic employees, and casual employees were excluded from coverage. However, in 1973 the law was amended, leaving the following classes of employees still excluded:

1. Persons engaged in any type of service in or about a private dwelling (i.e., domestic employees), who earn less than $200 from the employer during the thirteen consecutive weeks prior to an injury. The law specifically exempts domestic employees who

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[3]The student should obtain a copy of the booklet on the Iowa Workmen's Compensation Law for the schedule of current benefits, since these bneefits are subject to change. The booklet may be obtained from the Iowa Workmen's Comp Advisory Committee, PO Box 6068, East Des Moines Station, Des Moines, Iowa 50309, at a cost of $3.00 per book.

are members of the employer's household (such as a spouse or other relative) regardless of the amount of earnings.

2. Persons whose employment is purely casual and not for the purpose of the employer's trade or business (i.e., casual employees), who earn less than $200 from the employer during the thirteen consecutive weeks prior to an injury.
3. Persons employed in agriculture by an employer whose total cash payments to all such employees is less than $1,000 a year or who does not employ one such person regularly.

The first two classes do not require much in the way of explanation. Domestic employees are covered under act if they earn $200 or more from a single employer during a thirteen consecutive week period. Likewise, casual employees are excluded only if they earn less than $200 from the employer during a thirteen consecutive week period. Note that in order to be classified as "casual", the work must be both "casual" and "not for the purpose of the employer's trade or business". Thus, the mere fact that the employment is occasional, incidential, or irregular does not exclude it from coverage. Unless both elements are present in the employment (i.e., casual, meaning occasional, incidental or irregular, and not for the purpose of the employer's trade or business) the employment is not excluded, and the workers come under the provisions of the act regardless of the amount of earnings.

With respect to agricultural employment, agricultural employers who make total cash payments to employees of $1,000 or more in a given year are required to come under the act. In addition, an employer who employs a farm employee "regularly" is also subject to the provisions of the act and must provide coverage on all of his employees. A worker who is employed for a minimum of 40 hours a week for thirteen consecutive weeks is considered "regularly employed".

The law makes special provision for the case of farm employees who are resident relatives and for "exchange labor" (instances where one farmer helps a neighbor in return for the neighbor's help.) The law specifically exempts " . . . the spouse of the employer, and parents, brothers, sisters, children and step-children of either the employer or the spouse . . ." from the mandatory provisions of the law. This exemption also applies to the "president, vice-president, secretary, or treasurer of a family farm corporation and the spouses, parents, brothers, sisters, children, and step-children . . ." of such persons. Finally, the law specifically exempts "any person engaged in agriculture as a farm operator or spouse of such farm operator or parents, brothers, sisters, children or step-children . . ." while exchanging labor with another farm operator.

Coverage may be provided on a voluntary basis to all persons exempted from the mandatory provisions of the law. There are some farmers who want to provide workers compensation coverage to certain persons, including members of their own families, even though such coverage is not required by law. The purchase of workers compensation insurance with such workers specifically designated as covered brings such persons under the provisions of the law.

Officers and Directors

The status of officers and directors has been a source of considerable vacillation by the legislature. At the present time, executive corporate officers are included within the definition of employee, but partners or directors who are not employees are excluded. Directors, trustees, officers, and other managing officials of nonprofit organizations are excluded if they are not full time employees.

Iowa Law Compulsory

At one time, the Iowa Workmen's Compensation Act was "elective" in that either the employer or the employee could choose not to come under the provisions of the law. Even though the provisions of the law made it disadvantageous for either party to elect out, the option nevertheless existed. The Sixty-Third General Assembly removed the elective provisions of the act in 1970, thereby making it mandatory for all employers except those specifically exempted (as described above).

In making the law compulsory for all employers except those which are specifically exempted, the legislature also provided for the imposition of a rather severe penalty on an employer who fails to insure his workmen's compensation exposure (unless he is qualified as a self-insurer under the provisions of the act). If the employer fails to purchase workmen's compensation insurance as required by the law, he is nevertheless liable to the employee for any injuries arising out of and in the course of employment, and the employee may enforce his claim against the employer by electing to take the benefits prescribed under the law or he may bring suit for damages. If the employee elects to bring suit, it is presumed that the injury to the employee was the direct result of the negligence of the employer, and the employer has the burden of proving that he was not negligent. Furthermore, in attempting to prove that he was free from negligence, the employer is not permitted to interpose the common law defenses of contributory negligence, assumption of risk, or the fellow servant doctrine.

Injuries Covered

The workmen's compensation law provides that employee injuries are compensable only when connected with the employment, requiring that the injury arise "out of and in the course of employment." In the vast majority of cases there is little problem in determining whether or not the injury is compensable, but problems do arise. The question may arise first as to whether the injured employee was "in the course of employment" at

the time of the injury in instances in which the injury was sustained while coming to or going home from work or while engaged in social events connected with the employment. On the other hand, it may be clear that the injury was sustained "in the course of employment," but there may be a question as to whether it occurred "out of the employment." In many cases, the only way in which these questions can be settled is through litigation, and such litigation has been almost endless. In general, the courts have taken a liberal attitude and have done their best to compensate the injured worker or his dependents.

In addition to the traumatic type of injury, all laws also provide coverage for occupational disease.

Occupational Disease

Most state workmen's compensation laws provide occupational disease coverage for employees. In Iowa, there is a separate law, called the "Iowa Occupational Disease Law," which covers occupational diseases. In many states, only those diseases which are specifically listed are covered, and at one time this was the practice in Iowa. However, the 1973 Iowa Legislature amended the occupational disease law to provide full coverage for work related diseases. The statute defines an "occupational disease" as one which arises out of and in the course of the employee's employment, and which has a direct causal connection with the employment. A disease to which the employee is equally exposed outside of his occupation is not compensable as an occupational disease.

As in the case of the Workmen's Compensation Law, coverage is compulsory for all employments except those specifically excluded. The benefits payable for disability or death resulting from occupational disease are the same as those for any other injury or death under the Workmen's Compensation law.

Benefits

There are several categories of benefits payable to an injured worker or his dependents under the Iowa Workmen's Compensation Law. The specific categories of benefits with which you should be familiar are:

1. The Medical Expense Benefit
2. Temporary Total Disability Benefit
3. Temporary Partial Disability Benefit
4. Permanent Total Disability Benefit
5. Permanent Partial Disability Benefit
6. The Healing Period Benefit
7. The Death Benefit and Funeral Expense Benefit
8. Rehabilitation Benefits

Medical and Hospital Benefits

Under the Iowa law, the employer is required to furnish all reasonable surgical, medical, osteopathic, chiropractic, podiatrial, nursing, ambulance, hospital, and physical rehabilitation expenses sustained by a worker who is injured in an industrial accident. The amount payable for these expenses is unlimited.

Total Temporary Disability

There are several classes of disability benefits under the Iowa law. The most frequent type of disability is Total Temporary Disability, which exists when a worker is unable to work because of an occupational injury, but it is evident that he will eventually recover and will return to work.

The compensation benefit for Total Temporary Disability is a weekly benefit equal to the employee's average weekly spendable earnings, (that is, earnings after payroll tax deductions) subject to a statutory maximum and minimum. The maximum benefit is an amount rounded to the nearest dollar, equal to 100 per cent of the state average weekly wage as computed by the Iowa Employment Security Commission.[4] The minimum benefit is $36.00 unless the actual earnings of the injured worker were less than $36.00, in which case the actual earnings are payable. The benefit is payable for as long as the injured worker is disabled.

In order to reduce administrative costs and eliminate short periods of disability, the Iowa law provides that no compensation is payable for the first three days of disability unless the disability lasts for more than fourteen days. If the disability lasts for more than fourteen days, the compensation during the third week is increased by an amount equal to three days of compensation.

Temporary Partial Disability

Many of the state workmen's compensation laws include a specific provision for temporary partial disability, providing for payment of the difference between the wages received at the time of an injury and the earning power of the worker after the injury. The Iowa statute does not contain a provision relating to Temporary Partial Disability, but the absence of this provision does not mean that temporary partial disability is disregarded. In the past the Iowa court has provided for a partial reduction in the amount of the weekly temporary total disability benefits when the temporary disability is only partial.

Permanent Total Disability

A worker is defined as totally and permanently disabled when he is unable to obtain any gainful employ-

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[4]At one time, a fixed dollar maximum was prescribed. This was changed in 1970, making the dollar maximum variable on an annual basis, and equal to 46 per cent of the "state average weekly wage" paid to employees in the state as determined by the Iowa Employment Security Commission. Determination of the "state average weekly wage" is made annually on July 1, based on wages paid during the previous calendar year. The maximum was changed to 66 and ⅔ per cent of the state average weekly wage in 1973, and to 100 per cent of the state average weekly wage on January 1, 1975. Increases to 133 and ⅓ per cent, 166 and ⅔ per cent, and 200 per cent of the state average weekly wage are scheduled for July 1, 1977, 1979, and 1981 respectively.

ment as a result of an industrial accident. The emphasis is on industrial incapacitation.

Benefits payable to a totally and permanently disabled worker, like those payable to a temporaily disabled worker, are based on the worker's earnings at the time of the injury. The total permanent disability benefit is equal to 80 percent of the worker's average weekly spendable earnings, subject to the same statutory maximum and minimum as Temporary Total Disability. The benefit is payable for the entire period of disability.

Permanent Partial Disability

Permanent Partial Disability exists when a worker is permanently disabled in an industrial accident, but the disability does not prevent him from gainful employment. An injury resulting from an industrial accident may be deemed a partial permanent disability on one of two bases. In one instance, the loss of a member such as an arm or leg is considered to constitute partial disability. In addition, the disability may consist of disability of the body in general without the loss of a member, such as in the case of an injured spine.

The compensation for the loss of a member, such as an arm or leg, is based on the worker's average weekly spendable earnings, and is payable for a varying length of time, depending on the member lost. The amount of the weekly benefit is 80 per cent of the employee's weekly spendable earnings, subject to a statutory maximum and minimum. The statutory maximum is 92 per cent of the state average weekly wage as determined by the Iowa Employment Security Commission.[5] The minimum benefit is $18.00, unless the employee's actual earnings are payable. The length of time for which the benefits are payable, as noted above, varies with the member:

Loss of thumb	60 weeks
Loss of first finger	33 weeks
Loss of second finger	30 weeks
Loss of third finger	25 weeks
Loss of fourth finger	20 weeks
Loss of hand	175 weeks
Loss of arm	230 weeks
Loss of great toe	40 weeks
Loss of any other toe	15 weeks
Loss of foot	150 weeks
Loss of leg	200 weeks
Loss of eye	125 weeks
Loss of hearing (1 ear)	50 weeks
Loss of hearing (both ears)	175 weeks
Loss of both arms, hands, feet, legs, eyes, or any two thereof	500 weeks

Note that the loss of two arms, legs, hands, feet, or eyes, or any combination of two thereof is compensated at the rate of 500 weeks. In addition, if the worker is permanently and totally disabled as a result of the loss of any two extremities or eyes, he may also be entitled to compensation for total permanent disability.

In the event of permanent partial disability of the entire body (as distinguished from permanent partial disability involving the loss of a member) the law provides for payment of the benefit for a period of time determined on the basis of the extent of the disability. The period of time for which the benefit is payable is determined by applying the percentage of disability times 500 weeks. For example, if the worker is determined to be 50 per cent disabled, the Permanent Partial Disability benefit would be payable for 250 weeks; if 25 per cent disabled, the benefit would be payable for 125 weeks.

The Healing Period

At one time it was held that benefits paid for permanent partial disabilities (such as the loss of a hand, leg, etc.) were intended to exclude all other weekly compensations. Thus, a worker who lost a leg through an industrial accident and received benefits for 200 weeks was not entitled to any additional benefits for the period of time that he was disabled. In 1949 the state legislature enacted a change that provided for what is known as the "healing period benefit." Under the provisions of the laws as amended in those cases in which the employee sustains a permanent partial disability, the employer is required to pay a weekly indemnity computed on the same basis as the total temporary disability benefit for the period of time that the worker is incapacitated, in addition to the payment for the loss of the member. There is no waiting period under the healing period benefit as there is under the temporary disability benefit. The benefit is computed in the same manner as is the Total Temporary Disability benefit, and is payable for the period of time that the worker is incapacitated.

Death Benefit

In the event that the worker is killed in an industrial accident, the law provides for payment of burial expenses, subject to a maximum of $1,000. In addition, the Iowa law provides for payment of compensation to the widow or other persons who were wholly dependent on the worker at the time of his death. The amount of the weekly benefit payable to the dependents of the deceased worker is an amount equal to 80 per cent of the deceased worker's average weekly spendable earnings, subject to the statutory maximum and minimum. The maximum benefit is an amount, rounded to the nearest dollar, equal to 66 and ⅔ per cent of the average weekly wage in the state, as determined by the Iowa State Employment Security Commission. The minimum weekly benefit is $18.00, unless the actual earnings of the deceased worker were less than $18.00, in which case the

[5]This maximum is scheduled to increase to 122 and ⅔ per cent of the state average weekly wage on July 1, 1977, to 153 and ⅓ per cent on July 1, 1979, and to 184 per cent on July 1, 1981.

amount of the weekly earnings actually earned is payable.

A dependent may be a spouse, a child of the deceased worker, or a dependent parent. Under the provisions of the law, a child is defined as one under the age of 18, or over 18 if physically or mentally incapacitated, or under age 25 if attending an accredited educational institution. The child may be a natural born child, an adopted child of the deceased worker who was receiving support from the worker, or an unborn child if conceived at the time of the worker's injury.

The compensation is payable to a widow or widower for life or until remarriage. Children are entitled to the compensation benefit until they reach age 18 (or age 25 if attending an accredited educational institution) or, in the case of incapacitated children, for the period of their disability. If the widow or widower remarries while the children are still entitled to compensation benefits, payments continue to a compensation trustee for the benefit of the children. If there are no dependent children entitled to benefits at the time that the widow or widower remarries, two years' benefits are payable to the widow or widower in a lump sum.

Rehabilitation Benefits

The mutual interest of the disabled employee and the employer favor rehabilitation of the disabled worker. Although rehabilitation is an integral part of complete medical treatment, it may extend beyond medical treatment, particularly when it includes vocational training. In addition to providing compensation to injured workers for the loss of income and for the disabilities which they may incur in the course of their employment, the Iowa workmen's compensation law also provides additional payment during the period of time that a worker is undergoing rehabilitation. An injured worker who has suffered an injury resulting in either partial or total permanent disability for which compensation benefits are payable, and who cannot return to his employment because of the injury, is entitled to a weekly benefit specified by the law for each week in which he is participating in a vocational rehabilitation program. The vocational rehabilitation program must be one recognized by the state board of vocational rehabilitation. This benefit is payable for 13 weeks and may be extended to 26 weeks by the industrial commissioner.

Second Injury Funds

Under most state workmen's compensation laws the loss of both arms, feet, legs, or eyes, or any two thereof, is defined as total and permanent disability. As a result, situations may arise in which an injury which is partial in nature leaves a worker totally disabled. For example, a worker who has lost an arm or a leg as a result of an industrial accident and who has returned to work would be considered totally disabled if he should lose another arm or leg. Injuries to workers with pre-existing disabilities pose something of a dilemma in the application of the compensation principle. Obviously, it would be unfair to hold the new employer responsible for the earlier injury; yet if the worker is compensated for only partial disability when he loses a second limb, the indemnity is tragically inadequate.

Second Injury Funds have been established to meet the problem of injury to workers with pre-existing disabilities. The second injury provision of the Iowa Workmen's Compensation Law states that the employer "shall be liable only for the degree of disability which would have resulted from the latter injury if there had been no pre-existing disability." The injured worker is paid the difference between what the employer must pay for the second injury and the total disability benefit out of the second injury fund. The existence of the second injury funds helps to overcome any reluctance an employer may have in hiring the physically handicapped because of the possibility of paying such increased compensation.

The support for the second injury funds comes from assessments against insurance companies and self insurers. The insurance carrier or the self insurer is required to pay a specified amount to the second injury fund when a worker is killed and there are no dependents to whom the death benefits are payable.

WORKMEN'S COMPENSATION INSURANCE

The role of insurance in the operation of the workmen's compensation principle has been noted previously. Under the provisions of most workmen's compensation laws, the employer is required to insure his liability under the law. Under the provisions of the workmen's compensation policy, the insurance company assumes the liability which the law imposes on the employer. If a covered worker is injured, the insurance company will pay all sums which the employer would otherwise have been required to pay.

The workmen's compensation policy also includes a special type of liability insurance, "Employer's Liability Coverage". Under some circumstances, the employer might be sued by an injured employee. Such occasions would be rare; but if such a suit were brought, the policy would pay the costs of defense and also pay any judgment against the employer which resulted.

The workmen's compensation and employer's liability insurance policy is a relatively simple contract. There are two basic insuring agreements:

Coverage A:

> **Workmen's Compensation.** Under this insuring agreement the insurance company agrees to assume any liability imposed on the insured by a workmen's compensation law. The name of the state (or states) law which is applicable is entered in the declarations portion of the policy. The insuring agreement simply states that the company

will "pay promptly when due all compensation and other benefits required of the insured by the Workmen's Compensation Law".

Coverage B:

Employer's Liability. Under this insuring agreement the company promises to pay damages which the insured becomes legally obligated to pay because of bodily injury by accident or disease . . . by any employee of the insured arising out of and in the course of his employment.

It is important to realize that the Workmen's Compensation and the Employer's Liability coverages are entirely distinct. The workmen's compensation coverage will not apply unless the indemnity is payable under the workmen's compensation law. The Employer's Liability section applies only to those suits which are brought against the employer by an employee injured out of and in the course of his employment, distinct from any workmen's compensation benefits. It should be fairly obvious that the employer really needs both coverages to be completely covered. Coverage A is required by law. Even if the employer does not employ workers who are excluded from workmen's compensation, he may face a suit from a worker who has elected not to come under the Workmen's Compensation law. Although the worker's chance of collecting under such a suit is greatly diminished by the ability of the employer to use the common law defenses, there is still the problem of defending such suits. In addition, there is the possibility that someone other than the injured worker might sue the employer on account of the injury to the worker. For example, the wife of an injured worker might bring suit against the employer. Regardless of whether or not such a suit could be sustained, the cost of defense would have to be borne by the employer in the absence of the Employer's Liability coverage. Under the provisions of the Employer's Liability coverage, as contained in the Workmen's Compensation policy, the company promises to pay the cost of defending the insured in the event that such a suit is brought against him.

The standard limit of liability under Coverage B is $100,000 for each accident, regardless of the number of employees involved. This limit may be increased to $500,000 or $1,000,000 for an additional premium.

One of the most important points for the agent to understand in connection with Workmen's Compensation policy is that Coverage A, the Workmen's Compensation coverage, applies only to those obligations imposed on the insured by the law of the state or states which are listed in the contract. A worker who is employed by an Iowa employer, but who is injured outside of the State of Iowa, may still bring action for workmen's compensation benefits under the Iowa law. However, such a worker might bring action for benefit under the law of the state in which he was injured, if the benefits under that law were higher than those of his home state. In this instance, the loss would not be covered under the Workmen's Compensation policy, unless that state were listed in the policy. This means that unless the other state is listed in the policy, and the employee elects to make claim for benefits under the law of the other state, no coverage would exist. For this reason it is crucial that the agent determine which states the insured is likely to have operations in, so that these states may be listed in the declarations.

A special endorsement, the Broad Form All States Endorsement is used to protect the exposure to liability under the workmen's compensation laws of states in which the insured does not expect to have employees. This endorsement provides automatic coverage against liability under the Workmen's Compensation laws of states not listed in the declarations. This endorsement is not intended for use when it is known that the insured will operate in other states; when this is known, the states in which operations will be conducted should be listed.

Exclusions

There are six exclusions in the Workmen's Compensation Policy: two which apply to the Workmen's Compensation coverage and four which apply to the Employer's Liability Coverage.

With respect to Workmen's Compensation, the policy excludes any operations conducted at or from any location not described in the policy, if the insured has other Workmen's Compensation insurance on those operations or if he has qualified as a self insurer with respect to those operations. In addition, the policy excludes benefits to domestic employees or farm or agricultural employees, unless required by law or described in the declarations. Since the Iowa law excludes agricultural and domestic employees, this means that benefits are payable to these workers only if the insured has elected to voluntarily bring the employees under the law.

With respect to Coverage B, the policy contains the following exclusions:

1. Liability assumed under the contract is excluded.
2. Punitive or exemplary damages, or other liability in connection with employees employed in violation of the law is excluded, if the violation was with the knowledge of the insured or any executive officer.
3. Liability arising out of disease is excluded unless claim is made or suit is brought within 36 months of the expiration of the policy.
4. Liability arising out of the workmen's compensation law, disability benefits law, unemployment compensation law, occupational disease law, or any similar law is excluded. This makes it clear that the Employer's Liability coverage and the Workmen's Compensation coverages are separate and distinct.

Possible Gaps in Coverage

Situations may arise in which an employer is held liable under a workers' compensation law and the workers compensation policy will not respond. The workers compensation insuring agreement provides for payment of benefits required under the workers compensation law of a state listed in the declarations, and if the employer becomes liable under the law of a state that is not listed, the policy will not respond.

Most workers compensation laws are "extraterritorial," which means that the provisions of the law apply to injuries to employees while in the state and also while traveling outside its boundaries. In addition, some laws have further extraterritorial effect in that they impose liability on an employer who is located in another state if an employee is injured in a state where he or she is working. For example, the employee of an Iowa firm who is injured while working in Nebraska may still bring action for workers' compensation benefits under the Iowa law. In addition, however, the injured worker may decide to bring action under the law of the state where he or she was injured, particularly if the benefits of that state are higher. The worker in our example may elect benefits under the Iowa law or the Nebraska law, and the employer is obligated to make payment in either case. However, if Iowa is the only state listed in the declarations, the policy will not pay the employer's obligation under the Nebraska law.

Initially, the employer should list all states in which the firm has employees. The Broad Form All States Endorsement may be used to broaden the policy further. This endorsement extends the policy to cover the liability of the employer under the law of any state that is not listed in the declarations, where such coverage may be provided. The endorsement specifically excludes the states that operate monopolistic workers' compensation funds (Nevada, North Dakota, Ohio, Washington, West Virginia, and Wyoming). Employers who are exposed under these laws must purchase their compensation coverage from the state fund.

In addition to the Broad Form All States Endorsement, the policy may be extended to cover liability under the Federal Longshoremen and Harbor Workers Act (a federal statute which applies to injuries on navigable waterways of the U.S. and certain other classes of employment), through the use of a standard endorsement.

Premiums and Rates

The Workmen's Compensation Policy is written on a payroll basis and is subject to annual audit. Domestic servants are rated on a per-capita basis. Deposit premiums are charged at the inception of the policy, based on the estimated total payroll for the coming year. At the end of the year the final premium determination is made, based on the actual payroll of the insured for the year. A complete discussion of all the variations of premium determination is beyond the scope of this study guide. The student should refer to his Workmen's Compensation Manual for a discussion of this topic.

COMMERCIAL PACKAGE POLICIES

Although the package policy concept began with the Homeowners contract, the idea was soon applied to the field of commercial insurance. There are currently two standard bureau package programs designed for businesses and institutions: The Special Multiperil Program and the Businessowners Policy. In addition to these two programs, many insurers have developed their own commercial packages. In general, the independently filed commercial packages parallel the bureau forms discussed below.

THE SPECIAL MULTI-PERIL PROGRAM

The introduction of the Special Multi-Peril Program was one of the most significant developments in the multiple line trend. The SMP, as the program is called, is a package policy approach to insurance for commercial and institutional risks, which is similar in many respects to the Homeowners program for residential risks. Like the Homeowners program, the SMP permits the insured to purchase one policy with several insuring agreements, combining the coverage of individual policies into a single contract. The coverage can be tailored to meet the needs of eligible risks, covering most of the exposures which the businesses previously insured under separate contracts. The only major coverages that cannot be included in the SMP package are workers compensation, automobile coverages, umbrella liability, and surety bonds.

As a result of the packaging, there are fewer gaps in coverage, less overlapping, and premium savings for the insured. The aspect of the SMP program that has received by far the greatest attention from consumers is the package discount that the program entails. Depending on the type of business, discounts ranging from 5% to 20% of the cost of individual coverages can be realized.

Eligibility

The program has been in exercise since late in 1960, when it was originally developed for service type industries. When the SMP Program was first introduced in 1960, it included forms and rates for only one class of business: motels. Since that time, it has been extended to include hotels, apartment houses, offices, mercantile firms, processing firms, industrial and manufacturing firms, and most recently, contractors. The most recent revision of the program, in 1977, expanded eligibility under the program to virtually all commercial and institutional organizations, with only a limited number of businesses ineligible. The 1977 revision expanded eligibility to contractors and restaurants, which had previously been ineligible. The only classes that are not eligible for coverage under the program at the present time are:

- Boarding and rooming houses, and residences with less than 3 units
- Farms and farming operations
- Automotive risks, such as service stations and automobile dealers
- Grain elevators, grain tanks, and grain warehouses
- Property rated under special rating plans for Highly Protected risks and under schedules for petroleum and properties, petrochemical plants, electric generating stations, and natural gas.

Those risks that are eligible are classified into eight categories:

- Motel-hotel
- Apartment houses
- Offices
- Mercantile firms
- Institutional
- Service
- Industrial and processing
- Contracting firms

These eight risk categories determine the proper package premium modification (package discount) which varies by the type of business. Underwriting criteria and rules are not prescribed by the Insurance Services Office, but are left to the discretion of the individual companies.

The SMP Policy

It would have been needlessly expensive and complicated to provide a separate multiple contract for each of the specific groups within the overall commercial class. Instead of separate package policies for each of the various classes of business, the SMP program utilizes a single policy, which can provide coverage for each of the eight eligible classes.

The policy itself consists of a jacket and declarations page, and a "booklet form" Special Multi-Peril General Conditions and Definitions Form (MP-4). This booklet for General Conditions and Definitions, which is the foundation of the policy, includes three sections:

- General conditions
- Conditions applicable to Section I
- Conditions applicable to Section II

Provisions applicable to all SMP policies are included in MP-4. These include many of the provisions that appear in the Standard Fire Policy (the 165 lines of the Standard Fire Policy are not reproduced in the form), and the standard provisions of the separate monoline general liability contracts.

Coverage under the SMP Policy is divided into four sections:

Section I	Property Coverage
Section II	Liability Coverage
Section III	Crime Coverage
Section IV	Boiler and Machinery Coverage

Section I and Section II are mandatory. The minimum coverages required are fire and extended coverage on the insured's buildings and contents (if they are under common ownership), with premises and operations liability coverage. Business firms that do not own buildings must purchase fire and extended coverage on their personal property, along with the minimum required liability coverage.

With this coverage as a minimum, there is a wide range of optional coverages that may be added, including all risk coverage on both buildings and contents, earthquake coverage, replacement cost coverage, consequential loss coverages, employee and nonemployee crime coverages, comprehensive general liability coverage, personal injury liability, and a vast array of others.

The forms designed for use with the SMP program are lettered "MP" and are numbered to relate to the section of the policy to which they are effective. Thus, all property coverage forms and endorsements are numbered in the 100 series, liability coverage endorsements are in the 200 series, the crime endorsements are in the 300 series, and the boiler and machinery coverages are numbered in the 400 series. Although a detailed analysis of all of the forms designed for use with the SMP is beyond the scope of this manual, a brief discussion of a few of the more important ones should serve to indicate the range and scope of these forms.

Section I Forms

There are four basic forms that are used to provide coverage under Section I of the policy; a named peril and an all risk form for buidings, and a named peril and an an all risk form for personal property. These forms may be used in any combination. The four basic Section I forms are:

Form MP100	General Building Form
Form MP100A	General Personal Property Form
Form MP101	Special Building Form
Form MP101A	Special Personal Property Form

Forms 100 and 100A are, respectively, the named perils building form and the named perils personal property form. Both provide protection against the perils of fire, extended coverage, and vandalism and malicious mischief. The vandalism and malicious mischief coverage is not mandatory and may be removed by endorsement if it is not desired by the insured (or if the insurer desires to exclude it for underwriting reasons). Forms 101 and 101A are the all risk building form and the all risk personal property form.

General Building Form MP100

The General Building Form MP100, as noted above, provides Section I coverage on buildings only, against loss by the perils of fire, extended coverage, and vandalism and malicious mischief. The vandalism and malicious mischief coverage may be deleted by endorsement. The definition of building under this form generally follows that of the monoline General Property Form (FGP-1), and many of the standard provisions of that form are included in Form MP100.

Extensions of Coverage. Like the monoline fire General Property Form, the SMP General Building form includes certain extensions of coverage. However, since this form covers only the building, these extensions are confined to building items.

1. **Automatic coverage on newly acquired property.** The form provides automatic coverage for up to 30 days on newly acquired buildings, either at or away from the described premises. Coverage is limited to 10% of the amount of coverage on existing buildings, with a maximum of $25,000.
2. **Off Premises Coverage.** The insured may apply up to 2% of the amount of coverage on buildings (subject to a $5,000 maximum) to cover loss to building property by an insured peril while such property is removed from the premises for the purpose of cleaning, repairing, reconstruction, or renovation. However, the extension does not apply to property while in transit.
3. **Trees, Shrubs, and Plants.** Trees, shrubs, and plants are covered by extension against loss by fire, lightning, explosion, riot, civil commotion, or aircraft. The aggregate limit under this extension is $1,000, with a limit of $250 on any one tree, shrub, or plant.
4. **Replacement Cost Extension.** The SMP building forms include a somewhat unusual replacement cost extension. The SMP Program requires 80% coinsurance, based on the actual cash value of the property. The form provides for payment of losses to the building of less than $1,000 on a replacement cost basis, provided the insured has complied with the 80% coinsurance requirement (based on the actual cash value of the property). If the insured has selected a higher coinsurance amount, then the loss will be paid only if he has complied with the coinsurance requirement selected. Note that the requirement is not 80% of replacement cost; merely 80% of the actual cash value, and that the provision applies only to losses under $1,000. If the insured desires full replacement cost coverage, it must be added through the use of endorsement MP-126.

General Personal Property Form MP100A

Named peril coverage on personal property, similar to that provided on buildings under

MP100, may be provided under the General Personal Property From MP100A. Coverage may be written to cover personal property of the insured alone, or it may be written to include coverage on personal property of others in the care, custody, and control of the insured. The definition of personal property automatically includes tenants improvements and betterments; this coverage may be excluded if the insured does not desire the coverage. Like the provisions of MP100, the provisions of MP100A generally parallel those of the monoline fire General Property Form FGP-1.

Extensions of Coverage. The General Personal Property Form includes seven extensions of coverage:

1. **Property at newly acquired locations.** Property at newly acquired locations is covered automatically for up to 30 days. Coverage is limited to 10% of the coverage on personal property, with a maximum of $10,000. Note, however, that additional property at the insured location is not included within this extension; the additional property must be at a newly acquired location.
2. **Off Premises coverage.** As in the case of the building form, the insured may apply up to 2% of the coverage on personal property, with a $5,000 maximum, to cover property while away from the premises for cleaning, repairing, restoration, or renovation. The extension does not apply to merchandise, nor does it apply to property while in transit.
3. **Personal effects coverage.** This extension covers the personal effects of the insured, officers, partners, or employees, which is damaged by an insured peril on the premises. There is a $100 maximum per person, with a $500 aggregate. The extension of coverage does not apply if the loss is covered by other insurance.
4. **Valuable Papers and Records.** This extension covers the cost of research and other expenses incurred to reproduce valuable papers and records damaged or destroyed by an insured peril. The limit under this extension is $500.
5. **Trees, shrubs, and plants.** This extension is identical with the trees, shrubs, and plants extension of the General Building form, limiting coverage to specified perils, with a maximum of $250 per tree, shrub, or plant, with a $1,000 aggregate. When both MP100 and MP100A are included in the same policy, the limit under the extensions are not cumulative, so the maximum payable is the amount provided under the extension of one form.
6. **Extra Expense.** The insured may apply up to $1,000 to cover the necessary expenses incurred to continue as nearly as practicable the normal operations of the business following damage to buildings or personal property by an insured peril. If the insured desires more than this $1,000 in coverage, it may be provided for an additional premium through the use of endorsement MP-144.
7. **Nonowned Property Coverage.** The insured may apply up to 2% of the amount of coverage on personal property, with a maximum of $2,000, to cover property of others in the care, custody, and control of the insured. If higher limits of coverage on the property of others is needed, any amount desired may be scheduled in the declarations.

Special Building From MP101

Special Building From MP101 may be used to provide all risk coverage on building items. This form includes all of the basic provisions of the General Building Form MP100, and may therefore be used without the general form. It includes the same extensions of coverage as the General form, but substitutes an "all-risk" insuring agreement (subject to the normal all-risk exclusions) for the named perils coverage of the general form.

Special Personal Property Form MP101A

The Special Personal Property Form MP101A provides all risk coverage on personal property. The coverage under this form is extremely broad, including losses from any cause except those specifically excluded. It includes, for example, losses caused by burglary, robbery, and even theft, eliminating the need for specific coverage against loss by these perils.

Exclusions. Because the coverage of the Special Personal Property Form is determined by the exclusions of that form, it may be worthwhile to list them in our discussion. Although a detailed analysis of these exclusions requires examination of the form itself, the following should indicate the general nature of these exclusions. The policy specifically excludes losses arising out of:

1. earthquake and flood
2. enforcement of ordinances regulating construction or repair
3. unexplained shortages or mysterious disappearance
4. work on, installation, or testing of insured property
5. damage by artificially generated electricity
6. leakage of pipes caused by freezing
7. delay, loss of markets, interruption of business
8. wear and tear, deterioration, inherent vice
9. steam boiler explosion
10. voluntary parting with property through trick or scheme
11. dishonesty of the insured, officers, partners or employees
12. seepage or leakage of water over an extended time

13. rain, snow, or sleet to property in the open

Most of these exclusions have been encountered in other forms studied in this manual.

Extensions Under the Special Personal Property Form. For the most part, the extensions under the Special Personal Property Form are identical with those of the named peril General Personal Property Form. However, there are two exceptions. The Special form does not include the Trees, Shrubs and Plants extension, nor does it include the standard Off-Premises extension of the other forms. Instead, it substitutes the following extensions.

1. **Transportation coverage.** This extension provides up to $1,000 on personal property (except in the custody of salesmen) while being transported by any motor vehicle owned, leased or operated by the insured. However, unlike the on premises coverage, this transit coverage is named peril protection, and is limited to the perils of fire, lightning, windstorm and hail, explosion, smoke, riot, vandalism and malicious mischief, collision, upset or overturn of the vehicle, and theft of an entire shopping package from a locked vehicle with evidence of forcible entry.

2. **Theft, burglary, or robbery damage to the building.** If the insured is the owner of the building, or is liable for damage, the policy is extended to cover damage to the building or building service equipment caused by theft, burglary, or robbery. (Coverage against such losses is also provided by the all-risk building form, so this extension is meaningful only when the insured purchases named peril coverage on the building and all risk coverage on the contents, or when the insured is a tenant and is liable for the damage.)

Deductible Provisions

The standard Section I deductible under the SMP policy is a flat $100 deductible, subject to a $1,000 aggregate in any one occurrence. The deductible applies to all losses under Section I of the policy. It applies (1) separately to each building, including its contents, (2) separately to contents in each building if there is no coverage on the building, and (3) separately to personal property in the open. Higher optional deductibles are also available, for which additional premium reductions are granted.

Section II Forms

One of the major innovations of the 1977 revision of the SMP program was the replacement of many of the former Section II liability forms with standard monoline coverage parts. The General Conditions and Definitions of the basic policy are designed to permit the use of standard general liability coverage parts, and include all of the required provisions of the general liability policy jacket. Any of the standard liability coverages that may be written under a separate general liability contract may be included in the SMP policy, provided the company is willing to provide the coverage.

There are only three remaining liability forms with the "MP" designation designed for use with the SMP:

MP 200 Multi-Peril Policy Liability Form
MP 201 Amendment of Limits of Liability Form
MP 222 Employers Nonownership Automobile Liability Endorsement

Multi-Peril Policy Liability Form MP 200. The Multi-Peril Liability Form MP 200 is the basic liability form designed for use with the SMP policy. It may be used to insure premises and operations, products and completed operations and medical payments without alteration. However, only premises and operations coverage is mandatory; and if the products and completed operations coverage is not desired, it may be deleted by endorsement. The form provides coverage with a single limit of liability. If the traditional "split limits" are desired, they may be provided through the use of Form MP 201, the Amendment of Limits of Liability Form.

It should be noted that the liability coverage of form MP 200 is not comprehensive general liability coverage. If comprehensive general liability coverage is desired, it may be provided by substituting the separate monoline CGL coverage part for MP 200.

Employers Nonownership Automobile Liability MP 222. Form MP 222 is used to provide employers nonownership liability coverage under the SMP policy. However, there is a serious defect in providing the coverage in this manner, since there is no provision for adding hired car coverage. In order to provide complete protection, employers nonownership liability should always be written with hired car coverage. For this reason, the use of a separate automobile form combining employers nonownership and hired car coverage is generally considered to be the preferred approach.

Section III Forms

The basic form used under Section III of the policy is MP300, the Comprehensive Crime Coverage Endorsement, which is the equivalent of the Comprehensive Dishonesty, Disappearance, and Destruction (3D) Policy. As in the case of the separate 3D policy, the insured may choose from among the following five basic insuring agreements:

Blanket Fidelity Coverage
Loss Inside the Premises
Loss Outside the Premises
Counterfeit Money Orders and Paper Currency
Depositors Forgery

As in the case of the separate 3D policy, the insured may elect fidelity coverage on either a Commercial Blanket Bond basis or Blanket Position Bond.

Coverage is also available on the same basis as under

the separate Blanket Crime Policy, under Blanket Crime Coverage endorsement MP 301. In addition, institutions may select the coverage of a Public Employees Blanket Bond under endorsement MP-302.

Interestingly, mercantile open stock burglary coverage, mercantile theft, mercantile robbery and safe burglary coverage are available as endorsements to Section I of the policy, rather than under Section III. These forms provide coverage primarily on merchandise and other personal property, with only limited protection on money and securities. Coverage for employee dishonesty and broad form coverage on money and securities is provided under Section III, utilizing the endorsements outlined above.

Section IV Forms

Because the inspection service associated with boiler and machinery coverage requires a high degree of expertise, not all insurers offering the SMP policy include boiler and machinery coverage. However, in those cases in which the company has an engineering staff, or can contract with another insurer for the inspection service, boiler and machinery coverage may be included as an integral part of the package.

Boiler and Machinery Endorsement MP400. The basic form used under Section IV of the SMP policy is the Boiler and Machinery Coverage Endorsement MP 400. This endorsement incorporates the provisions of a special boiler and machinery policy into the SMP package. In general, the coverage of this endorsement is similar to that of the separate monoline boiler and machinery policy, except that the bodily injury insuring agreement of the separate policy is eliminated. Coverage may be provided on boilers, refrigeration equipment, electrical apparatus, and all types of machinery eligible for coverage under separate monoline boiler and machinery policies.

Consequential Loss Coverages. The same consequential loss coverages available under separate boiler and machinery policies are also available under the SMP. Use and Occupancy (referred to as Business Interruption under the SMP forms) is available on a daily indemnity basis (MP 407) or a weekly indemnity basis (MP 408). Extra expense coverage is available under Extra Expense Endorsement MP 409. Finally, consequential damage coverage (for example, spoilage of food or other property caused by lack of power, light, steam or refrigeration resulting from an accident to an insured object) is available under Consequential Damage Endorsement MP 411.

Optional Section I Endorsements

In addition to the four basic forms discussed above, there are over 50 optional endorsements available for use under Section I of the policy. Although a discussion of each of these endorsements is beyond the scope of this manual, a listing of some of the more important forms will indicate the flexibility of the program. A few of the more important optional endorsements which may be used under Section I include:

- MP- 24 Agreed Amount Endorsement
- MP-102 Builders Risk Completed Value Form
- MP-119 Reporting Form — Specific Rate
- MP-120 Reporting Form — Average Rate
- MP-122 Sprinkler Leakage Endorsement
- MP-123 Optional Perils Endorsement
- MP-124 Vandalism and malicious mischief exclusion endorsement
- MP-125 Peak Season Endorsement
- MP-126 Replacement Cost Endorsement
- MP-132 Earthquake Assumption Endorsement
- MP-140 Gross Earnings Endorsement
- MP-143 Loss of Earnings Endorsement
- MP-144 Extra Expense Endorsement
- MP-146 Loss of Rents Endorsement
- MP-147 Combined Business Interruption and Extra Expense Endorsement
- MP-156 Mercantile Open Stock Burglary Endorsement
- MP-162 Mercantile Robbery and Safe Burglary Endorsement
- MP-175 Accounts Receivable Endorsement
- MP-176 Valuable Papers Endorsement

The titles of most of these endorsements are self-explanatory, and describe the coverage provided under the endorsement. For the most part, the coverage provided under the various forms is identical, or nearly so, with the separate monoline policies with the same designation. The only endorsement listed above that requires additional comment is MP-123, the Optional Perils Endorsement. This form is used with MP-100 and MP-100A, and extends the policy to cover the additional perils of glass breakage, falling objects, weight of ice, snow, and sleet, water damage, and collapse.

Other Forms and Options

Although only the more important of the many forms and endorsements available for use with the SMP have been discussed, those that have been noted indicate the breadth of the coverages available. The student should familiarize himself or herself with the remainder of the forms and with their application to the SMP policy.

THE BUSINESSOWNERS POLICY

The Businessowners Policy (BOP) which is a package policy approach somewhat like the SMP, but designed only for smaller firms, was introduced in 1976. The program is available only for small and medium sized apartments, offices, and retail stores; but for those firms that are eligible, the program provides an extremely broad package of coverages on a simplified basis.

Coverage Provided under the Businessowners Policy. Like the SMP, the Businessowners Policy provides coverage on the insured's property under Section I and liability coverage under Section II. However, the approach differs considerably from that of the SMP, in that a wide range of coverages, available on an optional basis under the SMP, are automatically included under the Businessowners Policy. Some of the features of the BOP include the following:

1. Coverage on both buildings and contents is on a replacement cost basis, and there is no coinsurance provision. Furthermore, the form automatically includes a 2% quarterly increase in building coverage to compensate for increases in construction costs.
2. Business interruption coverage and extra expense are automatically included. There is no coinsurance clause or specific limit of liability, and the insured may collect the reduction in gross earnings for up to 12 months.
3. Property off premises and in transit is automatically covered up to $1,000.
4. Liability coverage is provided in the amount of either $300,000 or $1 million, with automatic coverage for personal injury, fire legal liability, and certain other specialized liability coverages.

Perils Insured. The perils covered under the policy depend on the form selected. Only two forms are available, a standard form and a special form. The standard form covers fire, extended coverage, vandalism and malicious mischief, and sprinkler leakage. The special form is all risk including theft, but incorporating the normal all-risk exclusions such as wear and tear, deterioration, mysterious disappearance, flood, and earthquake. Optional coverages available under either form include employee dishonesty and boiler and machinery coverage. Burglary and robbery are available as an option under the standard form only. The special form automatically includes burglary and robbery as a part of the theft peril.

AVIATION INSURANCE

The rapid growth and importance of the aviation industry makes it essential that the agent have a working knowledge of Aviation Insurance. Although it is not necessary to be a specialist in the field of Aviation Insurance, some knowledge of the subject is necessary.

Aviation Insurance is a general term embracing the risks encountered in or associated with the ownership, maintenance or use of aircraft. The most common aviation coverages are:

Aircraft Liability Insurance
Hull Insurance
Airport Liability Insurance
Hangarkeepers Legal Liability Insurance

Aviation Liability Insurance

Aircraft liability coverages are quite similar to automobile liability coverages with one major difference — Bodily Injury Liability is divided into two coverages:

1. Passenger Liability
2. Bodily Injury Excluding Passengers

While the basic limits of aircraft liabiilty insurance are patterned after those of auto liability, it should be borne in mind that most insureds desire much higher limits of liability to adequately cover the catastrophe exposure involved. It is possible to cover Bodily Injury Excluding Passengers, Passenger Bodily Injury and Property Damage Liability with a single limit to cover all three exposures.

The aviation liability coverage may be written to include medical payments coverage. The medical payments coverage is similar to that of the auto policy except that the injury must be sustained while in, entering, or alighting from the insured aircraft. Medical Payments coverage is included only when the policy contains Passenger Bodily Injury Liability.

Admitted Liability. Admitted Liability Coverage, also known as "Voluntary Settlement Coverage", is available only in conjunction with Passenger Legal Liability. It is written on a per seat limit basis, and promises to pay a certain sum for loss of life, limb, or sight by a passenger. When voluntary settlement is offered, a release of liability against the insured is obtained from the passenger to whom the settlement is paid. Although payment is made regardless of liability, if the injured party refuses to sign a release, the offer of payment is withdrawn. The injured party must then bring suit against the insured, who is then protected by the Passenger Bodily Injury coverage.

Hull Insurance

There are two basic forms of Hull coverage:

1. All Risk on the Ground, Limited Coverage in Flight
2. All Risk on the Ground and In Flight

All Risk on the Ground — Limited in Flight. Under this form of hull coverage, all risk coverage is provided on the aircraft while on the ground. The coverage while the aircraft is in flight is limited to the perils of fire, lightning, and explosion, but not fire or explosion following a crash or collision. The major perils not covered in flight are, therefore, crash or collision. The coverage is usually written with a deductible which applies to all losses except fire, lightning, explosion, vandalism and malicious mischief, transportation, or theft. The deductible may be written so that it applies while the aircraft is not in motion, or when the aircraft is taxiing.

All Risk — Ground and Flight. This is the broadest form of hull coverage and provides all risk coverage on the aircraft both while it is on the ground and while it is in flight. Deductibles may be purchased applying to the aircraft while on the ground or while in flight or taxiing.

Most of the policy provisions are quite similar to those of the auto policy. There are, however, certain unique exclusions which are applicable only in the field of aircraft coverages:

1. The policy excludes loss involving any aircraft not registered under a "Standard" Category Airworthiness Certificates issued by the Federal Aviation Agency.
2. The policy excludes loss when the aircraft is operated, while in flight, by other than the pilot or pilots stated in the declarations.
3. The policy excludes loss when the aircraft is operated in violation of the Civil Air Regulations.

Airport Liability Insurance

The Comprehensive Airport Liability policy is available for private, municipal and commercial airports. This contract follows the lines of the General Liability policy written for any business venture, and may include the following coverages:

1. Premises and Operations Liability Coverage
2. Contractual Liability
3. Independent Contractors
4. Products and Completed Operations

The Airport Liability Policy contains the standard care, custody, and control exclusion common to most liability contracts. Coverage for liability arising out of damage to non-owned aircraft in the care, custody, or control of the insured can be provided under a Hangarkeeper's Legal Liability endorsement which is similar to the Garagekeepers' Legal Liability coverage.

OCEAN MARINE INSURANCE

Ocean marine insurance is considered to be the oldest form of the modern insurance coverages; as a matter of fact, it was probably the first form of insurance written. Early traders recognized that there were perils involved in the use of the waters of the world as a means of transportation, and the logical result was the institution of some type of share-loss and risk transfer arrangements. In spite of the technological advances in marine transportation, ocean disasters remain an everpresent hazard for those engaged in foreign trade.

Types of Losses and Coverages

Ocean marine insurance consists of four distinct types of coverage, which are written to cover the four corresponding types of losses that may be involved in ocean forms of transportation. The four classes into which the ocean marine coverages are divided are:

1. **Hull Insurance.** Hull insurance is designed to protect the owner of a vessel against loss to the ship itself. The hull insurance coverage is generally written on a modified all-risk basis.
2. **Cargo Insurance.** Cargo insurance, which is written separately from the insurance on the ship, protects the owner of the cargo from financial loss that would result if the cargo were lost or destroyed.
3. **Freight Insurance.** Freight insurance is written to protect the owner of the vessel from the loss of the charges made for carrying the goods. If the ship is lost, the income that would have been earned upon the completion of the voyage is also lost. Under the freight insurance coverage, the owner of the ship is reimbursed for the loss of these charges.
4. **Protection and Indemnity.** Protection and indemnity coverage under ocean marine contracts is essentially liability insurance that protects the owner of the ship from the consequences of his negligent acts or the negligent acts of his agents. If the owner should be held legally liable for damage to a third party, the protection and indemnity coverage would provide protection against financial losses by paying those sums that the insured became legally liable to pay.

Ocean Marine Cargo Insurance

The most frequently used policy in ocean marine is the cargo policy. Therefore most of our discussion of ocean marine contract will involve this policy. Since the basic parts of the policies used for the insurance of hulls, cargo, and freight are essentially the same, the discussion of the cargo policy will provide some understanding of the hull and freight coverages as well.

Insurable Interest in Cargo Insurance. One of the most complicated aspects of ocean marine cargo insurance is that of determining when an insurable interest commences when goods are shipped from the seller to the buyer. The important question in this connection is at what point title to the property passes from seller to buyer; and in the case of goods moving in international trade, the answer is not always clear. Normally the need for insurance is dictated by the terms of the sale. The seller may agree to place the goods at the disposal of the buyer at various points and is responsible for the goods until they have been delivered to specified place. Title may pass at any designated place mutually agreed upon in the sales contract: the point of shipment, the point of delivery, or somewhere in between. Under some circumstances the price quoted for the goods includes transportation charges, or the seller may agree to pay for both the transportation and insurance. In other instances the obligation to provide insurance may be imposed on the buyer. In some instances the seller must provide the insurance coverage, and in others the buyer must arrange for insurance on the goods.[6]

The Open Policy and the Special Marine Policy. At one time it was the practice to arrange specific marine insurance policies only when they were needed, and this method is still used by those who make shipments only infrequently. It is now more common to insure cargo under contracts that are known as "open policies," which insure every shipment reported to the insurance company and which remain in force until cancelled. There are two methods used to report shipments to the insurance company. In those cases in which the individual insured under the open policy is insuring the goods for his own interest, a short form of notice suffices. This notice indicates the name of the vessel, sailing date, point of shipment and destination, the nature of the commodity and the amount of insurance desired, and the number of the open policy under which the insurance is being provided. In those cases in which the insured is required to furnish evidence of insurance to the other party in the import-export transaction, a "special marine policy" or "certificate" is issued. This certificate indicates that the shipment has been insured. It makes no reference to the open policy and is independent of the open policy. It may be used to insure the interest of either party in the transaction and is nego-

[6]There are six basic terms of sale: **Ex Point of Origin**, in which the buyer takes title to the goods at the warehouse or factory and is responsible for all charges from that point; **Free Along Side**, **Free On Board**, and **Ex Ship's Tackle**, which require the seller to be responsible for the goods until they are placed along side the ship, on board the ship at some designated point, or delivered on the dock at the port of destination; **Cost and Freight**, in which the seller is responsible for transportation charges to the final destination, but the buyer is responsible for loss or damage; and **Cost Insurance and Freight**, in which the seller is responsible for transportation charges and also insurance coverage up until the final point of destination.

tiable. When a special marine policy or certificate is issued under an open policy, it is as if a separate policy insuring the single shipment involved had been issued by the insurer.

Perils Insured Against. Because ocean marine insurance is internationally competitive, there is no standard policy. One of the most interesting aspects of ocean marine policies is that their wording is in language and terms of an age long past. A typical perils clause in a modern American policy reads as follows:

> While the goods are waterborne, the perils hereby insured against are of the seas, fires, jettisons, assailing thieves, barratry of the Master and Mariners, and all other like perils losses and misfortunes that have or shall come to hurt, detriment or damage of said goods and merchandise, or any part thereof except as may be otherwise provided for herein or endorsed hereon.[7]

In analyzing the perils clause, the student may conclude that it is an all-risk insuring agreement, but with certain limitations. Damage arising from perils "of the seas" is covered, and here the clause is definitely all-risk. Damage could be caused by waves, the ship stranding on reefs or rocks, lightning, collisions or the ship could sink from any number of causes due to perils of the sea. The list of such perils is almost endless. The clause also provides for coverage for "perils on the seas" specifically listed, including fires, jettisons,[8] assailing thieves, barratry,[9] and all other like perils. The coverage for perils on the seas then does not provide coverage for anything that could happen on the seas but only loss or damage arising from perils of the same nature as those specifically listed.

In addition to the specified perils, marine policies are frequently expanded to include other specified perils. A good example is the "Inchmaree clause," which covers bursting of boiler sand latent defect in machinery or erros in navigation or management of the vessel by the master or crew.[10]

Certain perils that would otherwise be included in the broad insuring agreement are specifically excluded. The two most important exclusions are the Free of Capture and Seizure Clause (F.C.&S.) and the strike, Riot, and Civil Commotion clause (S.R.&C.C.).

The F.C.&S. Clause. The basic insuring agreement covers war perils; however it is customary to incorporate into all marine policies a war exclusion known as the Free of Capture and Seizure clause. This provision excludes virtually everything that could be considered war in any of its aspects, including collision with a mine or torpedo where there was no hostile act. The policy could be made to include the war peril simply by deleting the F.C.&S. clause, but the common practice is to issue a separate war risk policy to provide coverage for the perils of war.

The S.R.&C.C. Clause. The basic policy also excludes, by means of the Strikes, Riot and Civil Commotion clause, loss or damage caused by the acts of strikers, rioters, or persons engaged in civil commotion. This exclusion may be delted if the underwriter is willing to assume the risk.

Average Conditions

The term "average" is considered by many persons to be the most important single word in the terminology of ocean marine insurance. It is synonymous with "partial loss." "Average" or loss under an ocean marine policy may be a "Particular Average" or "General Average." A "Particular Average" is defined as a partial loss to the property of a particular interest only. It is borne entirely by the owner of the property involved in the loss. A Particular Average is contrasted with a General Average loss, which is a loss that is borne by all parties to the venture.

General Average Losses. The General Average loss is a difficult concept for many to understand. It is a doctrine based on the principle of equity and imposed liability on all persons who have goods or property at risk in a maritime venture, when part of the goods are sacrificed for the benefit of the entire venture. It is based on ancient maritime law and requires that all persons involved in a venture share in the loss of the goods of one individual that are sacrificed to save the entire venture. The simplest example of a General Average loss involves the jettison of a part of the cargo to

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[7]Archaic as they may be, the terms of the American policy are modern compared with the Lloyd's policy, adopted in 1779 and still in use: "TOUCHING The Adventures and Perils which we the assurers are contenteded to bear and do take upon us in this Voyage, they are, of the Seas, Men-of-War, Fire, Enemies, Pirates, Rovers, Thieves, Jettisons, Letters of Mart and Countermart, Surprisals, Taking at Sea, Arrests, Restraints and Detainments of all Kings, Princes and People, of what Nation, Condition, or Quality soever, Barratry of the Master and Mariners, and of all other like Perils, Losses and Misfortunes that have or shall come to the Hurt, Detriment, or Damage of the said Goods and Merchandise and Ship, etc., or any Part thereof." There are, of course, good reasons for the continued utilization of wording so antiquated. Almost every word in the Lloyd's policy has been the subject of a court decision, so while the wording is quaint, there is no doubt about its meaning and any material change might weaken the legal force of the document.

[8]Jettison is the voluntary act of destruction in which cargo is cast overboard in order to save the ship.

[9]Barratry involves a situation in which the master and/or mariners steal the ship and its cargo, willfully sink or desert the ship, or put the ship in peril by disobeying instructions.

[10]This clause is named after the ship **Inchmaree**, which suffered loss as a result of breakage of a pump resulting from negligence in maintenance by the crew. The British House of Lords decided that the loss was not covered since it was not of the same nature as a "peril of the sea." To counteract this decision the Inchmaree clause was added to hull policies.

lighten the ship in time of stress. If goods are intentionally jettisoned in an attempt to save the ship, and the attempt is successful, the ship owner and the other cargo owners will share in the loss of the jettisoned cargo with its owner, based on the proportion of the total value of the venture that each owned. To illustrate, assume that a ship, valued at $5 million, is carrying cargo belonging to five different parties, each valued at $1 million. In the middle of the voyage the ship runs into bad weather and is in danger of sinking. In order to lighten the ship, the goods belonging to "X" are thrown overboard. The jettison is successful and the ship reaches port safely. The entire burden of the loss will not fall on "X" or upon his insurer. He will be forced to bear 10% of the loss since this was the proportion of the total value of the venture that he owned. If his cargo was insured, his insurer will indemnify him for this 10%. The owner of the ship will bear 50% of the value of the cargo jettisoned, and each of the remaining cargo owners will bear 10%. The other parties become liable to "X" for their share of the General Average loss. Under the terms of the ocean marine policy, the insurance company insuring each of the participants other than "X" will pay their insured's share of this General Average loss, since the company agrees to pay General Average and Salvage charges[11] in addition to amounts payable for loss of the insured property.

Free of Particular Average Clause. The Free of Particular Average or F.P.A. clause of the ocean marine policy is essentially an exclusion of all partial losses except those caused by a few specified perils. The Free of Particular Average clause provides that in addition to total losses, partial losses resulting from perils of the sea are recoverable, but only if the vessel has been stranded, sunk, on fire, or in a collision. Partial losses resulting from other causes are excluded.[12]

With Average Clause. As an alternative to the Free of Particular Average arrangement, coverage may be provided "With Average." Under the "With Average" provision, partial losses (other than those caused by stranding, sinking, burning or collision) are excluded only if they are less than a specified percentage of the value (e.g., 3%). Partial losses involving stranding, sinking, burning, or collision are covered regardless of the amount. Thus, under the With Average clause, the provision states that the policy is "Warranted Free of Particular Average if Less than 3 percent." If the loss is less than this amount, there is no recovery. If the loss exceeds the percentage specified, the entire loss is paid in full.

Other Important Features

Many of the practices and policy provisions in the field of ocean marine are unique and should be noted for a fuller understanding of the field.

Valuation Clause. One of the most important clauses in the policy is the Valuation clause. Before proceeding with a specific analysis of the valuation principles, it is important to point out that almost all ocean marine policies are valued contracts.[13] In addition, most ocean marine policies are interpreted as if they contained a 100% coinsurance clause.[14]

A typical Valuation clause reads as follows:

> The value of the shipments insured under this policy shall be the amount of the invoice, including all charges therein plus any prepaid and/or advanced and/or guaranteed freight not included in the invoice, plus . . . . . %.

A percentage (e.g., 10%) is designated to provide for the additional value of the cargo to the insured at the point of destination. This amount is the insured value and will be paid in the event of a total loss even though the market value of the goods at the port of destination may be substantially greater or less than this amount.

Implied Warranties. In the field of ocean marine there are, in addition to the express warranties which may be included in the contract, four warranties that are not stated but, rather, are implied. Here, in making the contract, the parties agree by implication that certain conditions exist and that certain rules will be followed in the conduct of the voyage. The first involves legal conduct, and it is warranted that the venture is not illegal. The second implied warranty is that the vessel is seaworthy.[15] The third involves prompt attachment of the risk. Since weather conditions may affect the risk involved, the underwriter has a right to assume that insurance purchased on a shipment of goods in May will not be providing protection against loss on a voyage in the middle of January. The final

[11]Salvage charges are expenses payable to third parties known as salvors for assistance rendered in saving property exposed to loss. Such charges may be incurred under contract, or they may be incurred to parties acting independently of any contractual obligation. For example, the ship owner and cargo owners might be assessed salvage damages if the ship was in danger of sinking and was forced to accept help from another vessel in order to reach port.

[12]There are actually two forms of the F.P.A. clause: Free of Particular Average English Conditions, and Free of Particular Average American Conditions. The English conditions merely require that one of the enumerated perils has taken place, without requiring that the damage result from the peril. The American conditions require that the damage must be caused by stranding, sinking, burning, or collision.

[13]You will recall that in a valued policy, the face amount of insurance is payable in the event of a total loss.

[14]The policy does not specifically contain a 100% Coinsurance Clause, but the legal custom of 100% insurance to value has been in existence for so long that legally it is considered to be a condition of the contract.

[15]The owner of cargo shipped on someone else's vessel probably as little opportunity to verify the seaworthiness of the vessel. Therefore the cargo policy typically contains a provision in which the seaworthiness of the vessel is admitted.

warranty is that of no deviation. Here it is warranted that the vessel will proceed without deviation by the most direct or customary route. There are excusable deviations, such as deviation arising from stress of weather or an errand of mercy to save life, but inexcusable deviations will void the policy.

The Warehouse-to-Warehouse Clause. Unless the policy designates to the contrary, coverage is provided only from the time the goods are actually loaded on the transporting vessel. However, since a shipment may originate at a point far from the place of ocean shipment, policies may be endorsed to cover the goods during transportation to the vessel. In these cases it is customary for the ocean marine insurer to endorse the policy to provide coverage for the entire exposure from the time the goods leave the premises of the shipper until they arrive at the premises of the consignee under the "Warehouse-to-Warehouse" clause.

Other Insurance. Once in a great while a cargo owner may inadvertently have double insurance on his property, i.e., insurance in two different companies on the same property. In this case, the American rule represents a rather unique loss adjustment condition in that the policy dated first must pay as the primary insurance and that dated later will be relieved of all liability except insofar as the prior policy is deficient in amount. The company having the later dated policy then returns the premium on that amount that constitutes over-insurance. If the two policies are identical in date, each company will pay its pro-rata share of the loss and will retain only its pro-rata share of the premium. In England the rule applicable to double insurance is quite different. Here, regardless of the inception dates of the policy, each company is liable for the full amount of its policy. However, since the insured cannot collect for more than the amount of his loss, he collects from any one of the insurers, and this insurer then has a valid claim upon the other insurers for a ratable contribution to the loss.

The Sue and Labor Clause. The Sue and Labor clause requires the insured to use all reasonable means to protect the property from further damage after a loss has occurred and to prevent or reduce the amount of the loss. In addition the provision requires the insured to enforce his legal rights against any third party who may be responsible for the loss by seeking recovery from the negligent party. The policy authorizes the insured to incur expenses for these purposes and will reimburse him for any expense so incurred. There is a distinct possibility that the insurer may be required to reimburse the insured for more than the amount of the insurance. For example, if after incurring expenses to save the cargo or a vessel a total loss still occurs, the insured must be indemnified for the total loss, plus the expenses incurred under the Sue and Labor clause.

SURETY BONDS

SURETY AND BONDS IN GENERAL

There is a difference of opinion as to whether or not bonds should be classified as insurance. Strictly speaking, there are fundamental differences between a bond and an insurance policy, and only a remote relationship between the two. However, bonds are marketed through the insurance distribution system and are regulated by the state insurance departments, so it is appropriate that they be discussed.

General Nature of Bonding

One of the most often cited differences between insurance and suretyship—that insurance is a two-party contract and a surety bond is a three-party contract—misses the real essence of the difference between the two. While it is true that surety bonds are three-party contracts, it is the relationship among the parties, rather than the number, that distinguishes suretyship from insurance.

The three parties involved in a surety bond are:

1. The Principal, who owes an obligation to perform or to refrain from doing certain acts.
2. The Surety, who guarantees that the Principal will perform the obligation or refrain from doing the acts.
3. The Obligee, to whom the Principal and the Surety owe the obligation.

Under the provisions of a surety bond, the surety (who is the equivalent of the insurer under an insurance contract) holds itself responsible to the obligee (who is the equivalent of the insured) to answer for the acts of the third party (principal) who is bonded. The surety guarantees a certain type of conduct on the part of the principal, and if the principal fails to behave in the manner guaranteed, the surety will be responsible to the obligee. If the principal defaults on the obligation, the surety may arrange to fulfill the obligation, may compensate the obligee for the financial loss incurred, or may forfeit the full amount of the bond as a penalty. It is appropriate to note that the face amount of a bond is actually called the "penalty."

Historically, the field of bonding has been divided into two classes: fidelity bonds and surety bonds. While all bonds are technically "surety" bonds, the term "surety" is generally used to refer to performance bonds as distinguished from fidelity bonds. Fidelity bonds are designed to protect the obligee against dishonesty on the part of his or her employees, and in many respects are closer to insurance contracts than they are to surety bonds. For this reason, fidelity bonds are treated in our discussion of Crime Insurance, along with nonemployee crime coverages.

Suretyship Distinguished From Insurance

The real distinction between surety bonds and insurance lies in the relationship among the parties and in the attitude of the surety toward losses. In a sense, the surety occupies a position similar to that of the co-signer of a note. Because the surety becomes co-responsible with the principal to the obligee for performance of the obligation, a surety will enter into the bond only when it is convinced that the principal has the ability to perform. While the insurance underwriter expects losses to occur, the surety underwriter does not.

Surety bonds differ from insurance contracts in other respects as well. Most surety bonds remain in effect for the term of the principal's obligation, and are not cancellable by the surety. Moreover, the protection provided to the obligee cannot be jeopardized by the principal's acts. Even if the bond were obtained through fraud, the surety is obligated to the principal.

Still another difference between suretyship and insurance is the position of the person purchasing the bond. The purchaser of an insurance contract is protected against loss. The purchaser of a surety bond is usually the principal who, as such, does not enjoy any protection, but is subject to subrogation by the surety for any loss that the surety sustains.

Classes of Surety Bonds

Most surety bonds are issued to firms doing contract construction, to persons involved in court actions, and to individuals or businesses seeking licenses or permits. The principal categories into which surety bonds may be divided are the following:

1. Contract bonds
2. Court bonds
3. License and permit bonds
4. Public official bonds
5. Miscellaneous bonds

CONTRACT BONDS

The general purpose of a contract bond is to guarantee that the principal, who is normally a contractor or supplier, will fulfill his commitment according to the specifications of the contract. For this reason, many of these bonds are designated "Performance Bonds." They provide for indemnification if the principal fails to perform on the contract.

Construction Contract Bond

This type of bond is designed for use in connection with contracts to build real property. Under a construction bond, the surety agrees to indemnify the obligee in the event that the principal fails to complete the construction according to specifications in the contract. If the contractor cannot, for some reason or another, finish

the agreed construction, it is up to the surety to see that it is done.

The majority of the surety bonds that are written for contractors involve public construction projects. Public bodies are generally required by law to award public work contracts to the lowest responsible bidder. In the absence of surety bonding, the public body would be required to investigate each bidder to determine if the contractor was capable of handling the job, by requiring a bond, the public body in a sense "hires" the underwriter's expertise in evaluating the capability of the bidding contractors.

Basically, the surety guarantees that the principal is honest and that he has the ability and financial capacity to carry out the obligation. Thus, the surety backs the credit of the principal and vouches for his ability to perform. For obvious reasons, sureties require extensive information about the principal before issuing a bond. In some instances, the surety may even require the principal to put up collateral before it will issue a bond. In the event of loss, the surety has the right to collect from the principal any amounts it has been required to pay the obligee.

The Construction Contract Bond may be written to include the terms of a Labor and Material Bond, which is discussed below.

Labor and Materials Bond

This form of bond guarantees that the principal will pay all bills for labor and material in connection with the contract, thus assuring the obligee that the work completed will be free of all mechanics' or other type liens. It may be written separately or it may be included in the provisions of a Construction Contract Bond.

Supply Contract Bond

A Supply Contract Bond is designed to guarantee faithful performance under a contract to supply goods or materials. The bond guarantees that the principal will furnish the obligee with the goods contracted for in accordance with the specifications in the contract to supply goods.

Completion Bond

Under a completion bond, the obligee is normally a lender who has furnished funds to a contractor in connection with construction work. It guarantees the obligee that the principal (who is the borrower) will use the money in accordance with the terms of the contract and will complete the work undertaken.

Bid Bonds

In many cases where a contract is being let for public bids, the person or persons letting the contract require all bidders to furnish a Bid Bond or some other guarantee of the bidder's proposal. (A certified check equal to from 5% to 10% of the bid is generally permitted as a substitute). The bid bond is required to establish that the bid is a **bona fide** bid by the one required to post the bond. It protects against loss resulting from failure of the bidder to accept the bid. If the bidder who is awarded the contract fails to sign the contract, or is unable to provide the required Performance Bond, the contract may then be awarded to the next lower bidder. Subject to the bond limit (usually not more than 10% of the amount of the contractor's bid), the surety guarantees that it will pay the difference between the bid of its principal and the next higher bidder if the contractor does not accept the contract. A point of frequent misunderstanding has to do with the obligation of the surety under a bid bond. The surety on a Bid bond is not required to furnish its principal with a Performance Bond if he is awarded the contract; however, if the principal cannot obtain a performance bond, the surety on the bid bond becomes liable.

COURT BONDS

In many proceedings conducted in a court of law, some form of bond may be required by the court. There are two basic forms of Court Bonds:

1. Fiduciary Bonds, which are required when an individual is appointed by the Court to hold, control, or manage the property of others. Examples of persons who are required to post fiduciary bonds are executors and administrators of estates, guardians, and receivers.
2. Litigation Bonds, which is required of a person who wishes to bring action in a court of law or equity. Normally these bonds are required when the person bringing suit wishes to tie up the assets of the other party in the suit or restrain the other party from doing something.

Fiduciary Bonds

A fiduciary is a person who is appointed by the Court to hold, control, or manage the property of others. The fiduciary bond guarantees that the fiduciary (who is the principal under the bond) will faithfully perform the duties of his trust. In most cases the form of the bond is prescribed by the court, and in addition the face amount of the bond (called the Penalty) is also set by the court.

In order to protect itself, the surety frequently asks for joint control of the assets of the estate. Under this arrangement, all of the funds of the estate are kept in a joint account; and disbursements from this account are made only with the signature of both the principal and the surety. The major sub-classifications of Fiduciary Bonds are the following:

1. Executor's Bond, which is the bond required of the person named in the will of the deceased to administer the estate.

2. Administrator's Bond. When a person dies without a will, the court appoints an administrator, whose duties are similar to those of an executor. The

obligee under both the Executor's Bond and the Administrator's Bond is the State or the Court for the benefit of the beneficiaries.

3. Guardian's Bond, which is required when it becomes necessary to appoint someone to adminster property belonging to a minor. The guardian is normally appointed by the Court; the Court then requires a bond which guarantees the faithful performance of the Guardian. The obligee is the State for the benefit of the minor.

4. Bonds in Trust Estates are required when the owner of property directs that the property which he owns be held in trust for his heirs, either for a given period of years, or until the death of the heirs. Such a trust may be established by will (Testamentary Trust) or it may be established during the lifetime of the owner of the property (Inter-vivos-trust). In either case, when a trust is established, the property must be turned over to a trustee who is responsible for its administration. The Trustee's Bond guarantees the faithful performance of the trustee.

5. Committee Bonds, which are required when a person is not competent to handle his own affairs and the Court appoints someone (known as the Committee) to protect his property. A Committee Bond guarantees the faithful performance of the Committee.

6. Miscellaneous Fiduciary Bonds. In addition to those already discussed, there are a number of other bonds of similar nature which are required of persons who have custody or control over the property of others. Examples of such bonds are Receiver's Bonds, which are required of a Court appointed receiver in bankruptcy proceedings; Trustee's Bonds, which are also appointed in bankruptcy proceedings, and bonds which are required of conservators or liquidators of business firms or partnerships.

Litigation Bonds

Bonds in this class are required for the purpose of obtaining some restriction on property of others or releasing property from such restrictions. If a person bringing action seeks to attach property, and the case is finally decided against him, the person whose property was attached might maintain that the action injured him and caused him damages. The bonds that are required in litigation will pay any such damages. In addition, under certain circumstances the person bringing suit must furnish security to guarantee the payment of court costs. The more common types of litigation bonds are:

1. Attachment Bonds, which are required when property is attached in advance of the court decision in order to prevent its disposal by the person having custody of it. The bond guarantees reimbursement for damages if the attachment is unjustified.

2. Garnishment Bonds, which are required when the plaintiff wishes to attach wages or financial assets in the hands of a third party. It is much the same as an Attachment Bond, except that the assets distrained are in the hands of a third party.

3. Replevin Bonds, which are similar to Attachment Bonds, except that the plaintiff is suing to recover specific property. The Replevin Bond guarantees that the property will be returned to the defendant in proper condition if the plaintiff loses the suit.

4. Bonds for Distraint of Rent, which is required of a landlord who seeks to have the personal property of his tenant seized in an action to recover rent.

5. Release of Attachment Bond, which enables the defendant, whose goods have been attached, to recover possession of the goods. It guarantees that the goods will be available and will be turned over to the plaintiff in the event that the defendant loses the suit.

6. Appeal Bonds are required of individuals who have lost in a suit and wish to appeal and suspend execution of the judgment pending the decision of a higher court. The bond guarantees payment of the costs of appeal.

7. Removal Bonds are required in certain cases when the defendant who is being sued in a state court wishes the suit removed to a federal court, or from the court of one state to another state. The bond guarantees the payment of court costs by the principal if it is found that the case was improperly removed to the new court.

8. Non-resident Cost Bonds are sometimes required when a non-resident of state, city or county wishes to institute action against a resident. The bond guarantees payment of costs in the event of failure of the suit.

9. Injunction Bonds are required when the plaintiff alleges that he is being injured by the actions of the defendant and requests the court to restrain the defendant from further action. If an injunction is granted, a bond is required of the plaintiff, which guarantees payment of damages if the injunction proves to be unwarranted.

10. Discharge of Mechanics Lien Bond. The owner of property can obtain removal of a lien before trial by furnishing a bond which promises to indemnify the claimant if the claimant wins the suit.

LICENSE AND PERMIT BONDS

Many state and federal licenses are required for manufacturing, tax, and occupational purposes. In many cases the applicant for a license is required to post a bond, guaranteeing faithful performance of duties or payment of taxes collected. The purpose and intent of these bonds is to protect the state and the public from damages arising out of the manner in which the business is conducted, or to guarantee the payment of taxes collected by the license holder. The major classes

of License and Permit bonds and some of the classes of individuals which require the bonds are:

1. Federal License Bonds for Manufacturers.

2. State Tax Bonds, which are required in connection with the sale of gasoline, cigarettes, liquor taxes, sales taxes, etc. These bonds guarantee that the principal will deliver to the state all taxes collected.

3. Occupational Bonds, which are required for security salesmen, liquor stores, undertakers, collection agencies, warehousemen, and a vast array of other occupational classifications. These bonds guarantee honest and faithful performance by the principal.

4. License bonds required in connection with placing or construction of materials which might cause injury or inconvenience to the public. In many cities permit bonds are required in connection with signs and billboards, or street obstructions. These bonds guarantee indemnity to anyone who is injured as a result of the construction or materials.

PUBLIC OFFICIAL BONDS

The law requires that certain persons elected to fill positions of trust must furnish bonds which guarantee their faithful performance of duties. The public officials are generally held to be liable for the faithful accounting for all money which they receive. If for any reason the public official cannot turn over to the state all of the money which he has received, or if he dissipates assets belonging to the governmental unit which he serves, he is personally liable. Public Offical Bonds are designed to guarantee payment of funds which the public offical has not turned over to which he has dissipated. These bonds are designed to protect against dishonesty, negligence and even lack of ability.

Most Public Official Bonds are referred to as "statutory", because they are required by law, and most of the forms are also prescribed by law. The surety cannot reduce its liability by inserting provisions in the bond; the provisions spelled out by statute take precedence. These bonds are normally written for the term of the elected or appointed official and are non-cancellable during its term. In most instances the cost of the bond is paid out of public funds.

Public Employees Bonds

A Public Employees Blanket Bond is also available to cover employees who are not required by law to post a bond, which includes most workers in public service other than tax collectors and treasurers. The minimum amount for which this bond may be written is $2,500. The coverage may be written to cover honesty of the public employees, or it may be written to cover "faithful performance". The faithful performance form will pay losses resulting from dishonesty of the bonded person, and in addition will pay for losses resulting from negligence or lack of ability.

MISCELLANEOUS BONDS

In addition to the bonds discussed above, there are others which do not fall into any of the described categories.

1. Lost Instrument Bonds. These bonds, which are also called Lost Securities Bonds, are required of an individual who has lost or accidentally destroyed securities or other valuable papers and wishes to obtain duplicates. The bond guarantees that the principal will reimburse the issuer of a duplicate instrument if the original security or instrument later turns up and its holder is able to collect on it.

2. Workmen's Compensation Bonds. The Iowa Workmen's Compensation Law permits certain employers to self-insure their workmen's compensation exposure. In order to guarantee that the benefits to which an injured worker is entitled will be paid, the self-insurer is required to post a Self-Insurer Bond. The bond guarantees payment of benefits to workers who are injured and entitled to workmen's compensation benefits under the Iowa Workmen's Compensation Law.

HEALTH INSURANCE

I. Concept - Human Life Value

Health insurance has the same economic basis as life insurance. Both life and health insurance provide indemnity for the loss of personal earning capacity. In addition, both provide indemnity for the cost of illness preceding death. Life insurance and health insurance, then, are teammates.

Although the human life value concept originally was proposed in a life insurance environment, it obviously embraces all risks of the life value, including those of disability. The hazards of temporary and total disability faced by all persons have tremendous economic consequences. Accordingly, health insurance to protect against the loss of earning power and the costs of medical care are a natural teammate of life insurance.

II. History and Growth of Health Insurance

In recent years, the growth of health insurance protection in the United States has been no less than phenomenal. However, there continues to exist in the insurance programs of many persons a definite "gap" in this area of essential protection. Relatively few persons have protection against loss of income as a result of a disabling accident or sickness; and of those who have some protection, only a small percentage have adequate protection. In addition to the possibility that disability may result in serious loss of income for an extended period of time, there is always the threat of catastrophic medical costs associated with disability. Here again, health insurance coverages are available to provide substantial reimbursement of these cost periods.

The health insurance business has an interesting past. Born into an environment where increasing numbers of people required its services, it often tried to walk before it crawled — to run before it walked. It sometimes tripped and blundered, but when it erred, it was on the side of generosity — trying to do too much for people. If we retrace its history through the years, we can better understand the business as it now exists.

Many centuries ago, ancient China had a form of sickness insuracne. The clever Chinese paid the doctor as long as they were well and able to work. But they ceased paying him whenever they were ill. The doctor had to care for his ill patients without pay.

In ancient Greece, the Benevolent Societies had an early form of sickness and accident insurance for their members. Later, in the Thirteenth Century, the sea laws of a port city in the Baltic Sea required "if the merchant obliges the shipmaster to insure the ship, the merchant shall be obliged to insure the master's life against the hazards of the sea." In 1863 the Netherlands Republic insured soldiers against loss of "eye or eyes, hand, arms, feet or legs."

In the Seventeenth Century in England, the Friendly Societies made accident and health protection available along with marine, fire and life insurance, etc. In 1757 the British Parliament passed a law making compulsory sickness insurance available for stevedores. The introduction of health insurance into the United States was **either** accident insurance or sickness insurance. The first accident policy was written by the Franklin Health Assurance Company of Massachusetts, 1850. This policy provided limited indemnities for injuries incurred as a result of railroad or steamboat accidents. The first company to write sickness insurance in the United States was the Massachusetts Health Insurance Company of Boston in 1847.

In 1859 Mr. James C. Batterson of Hartford, Connecticut, was intrigued with England's railroad accident insurance policy. As a result, the Travelers Insurance Company wrote its first accident policy in 1864.

From 1915 to 1925, non-cancellable accident and health insurance was most popular. However, the companies writing this business experienced very heavy losses with the result that they eventually withdrew from this field or modified their coverage. Today, more companies have returned to this field of coverage than prior to 1925 and a sizable volume of business is written on a non-cancellable basis today.

As a result of progress, many forms of new coverage have been developed in the health insurance field; namely, hospitalization, overhead, major medical, various type of business insurance as well as many forms of disability or loss of time insurance. All of these coverages have been written on an individual, family or group basis.

III. Economic Value

Although the hazard of disability is universal, it varies in its incidence and the burden of its impact. Many surveys have been made to determine the extent of disability. Their results vary according to their methodology, the definition of disability and the time when the survey is made. Variously, they have shown that something between 1½ per cent and 5½ per cent of the population are disabled at any one time. This means that in the United States, from 2/5 million to 8.5 million people are injured or ill at all times. On the average, each person suffers one substantial and recognized disability per year. About one-half of these disabilities are extensive enough to prevent the individual from engaging in his daily routine of work, school or other activity. Expressed on an annual basis, the days of restricted activity (days when customary activities are restricted because of illness or injury) amount to 15.9 days per person.

Poor health costs this country about 50 billion dollars per year, which is about equally divided into loss of income and expenditures for medical care. The income

loss is about half short term and half long term. In 1975, 40% of health care expenditures were publicly financed (state and federal government), and private spending accounted for 60%.

IV. Transfer of Risk

The American system of voluntary health insurance is unique. It not only performs a necessary service of providing funds from which income may be continued during disability, defraying the heavy expenses of illness, and maintaining the disabled insured's credit, but it accomplishes these purposes without imposing severe restrictions on the individual or society. The keen competition that exists in the health insurance business today has been productive of an enormous variety of different contracts, all with different benefits. In no field of insurance is there a greater variety of insurers in terms of organization or type of benefit. The principal division of the business, between insurers providing cash benefits and plans offering service benefits, has encouraged wholesome competition and stimulated improvement of all plans in the public interest. This has given the prospective insured the opportunity to pick and choose the type and amount of benefits best suited to his personal needs.

Routine and recurrent expense is better budgeted than insured. The hazard of severe and prolonged disability imposes costs that, for most people, can be met only out of an adequate health insurance program. Budgeting, saving or self-insuring for the costs of such disability is beyond the competence of the majority of people. Voluntary health insurance preserves for the individual free choice of physician and hospital. Insurance companies, whose function is to finance the cost of health care rather than actually provide such care, do not interfere with the relationship between the patient and his physician or hospital. By supplying the financial means for securing care, insurance companies help preserve the traditional freedom of choice which is a cornerstone of the private practice of medicine. Compulsory systems of insurance necessarily comply controls by government, not only as to those who receive the benefits but also to those who provide the health care services. Such controls are resisted vigorously by the medical profession as resulting in an inferior quality of medical care. A major contribution of voluntary health insurance is the support that it provides to the system of private enterprise in the United States.

The tremendous expansion of health insurance and of similar plans for spreading loss from disability indicates that a growing proportion of the population sees the wisdom of transferring this risk.

V. Nature of Health Insurance.

There is a basic ever-threatening problem more common to every man than dying too soon or living too long. It is "a prolonged sickness or serious accident."

A prolonged sickness or serious accident is a major problem which can destroy forever the happiness of a man's home, peace of mind, his own and his family's economic security and the decent living he worked so hard to provide. It can ruin forever his chances of attaining the five things — **happiness, peace of mind, economic security, decent living, and affectionate family** — he wants most out of life.

Unemployment need not destroy a man's life insurance plans. When he is unemployed, man can vigorously tackle the cost of living, hack off unessential expenses, cut out pleasant but unnecessary luxuries and he can pare the cost of living all along the line. When a man is unemployed, he can cut expenses while he is out working at the job of finding a job. Only one thing can wreck man's financial life completely and permanently while he helplessly watches his home fall bankrupt around him, and that is a prolonged sickness or serious injury. This cause can sweep through the life of a man so relentlessly that it wipes out his savings, consumes stocks and bonds which took many years of sacrifice to accumulate, can snatch children out of school or college and send them to work. It can also tear down the roof over the family's head, pushing youngsters out on the street, stealing their mother's time, upsetting the most carefully balanced insurance programs and leave in its wake broken hopes and plans and ruined dreams.

Most people overlook the fact that all they own—their home, their car, the very food they eat and clothes they wear—stems from one source—their income. They do not understand that assuming the continuance of their income while they are unable to work is the most pressing, most basic of all their problems. Instead, too frequently they insure the by-products of their labors —they insure their home, car, household possessions, wearing apparel—**but their most valuable asset,** the one which forms the very foundation on which their entire living is built, **their ability to earn income,** is often left uninsured.

VI. Types of Insurance

A. Perils

Health insurance policies are concerned with either or both of two perils: accidental injury and sickness. Accident has been defined as an undesigned (from the point of view of the person affected), sudden and unexpected event that may produce traumatic bodily injury.

Accidental injury is the term applied to bodily injury produced by accident. The term sickness is defined as a disorder of the body or mind, other than the immediate result of traumatic bodily injury. Sickness, illness, and disease are synonymous terms.

Health insurance policies may protect against losses resulting from both of these perils or from either one alone. However, sickness insurance rarely is written unless accident insurance also is carried with the same insurer.

Sickness insurance is defined as a form of health

insurance against loss by illness or disease. It provides benefits for loss occasioned by sickness. Illness or disease do not include accidental bodily injury. Sickness insurance may provide benefits in the event of loss occasioned by pregnancy or maternity and sometimes may include benefits for other medical expense such as preventative or diagnostic services.

Accident insurance is a form of health insurance against loss by accidental bodily injury. It provides benefits in the event of loss occasioned by accidental bodily injury or injury by accidental means. Usually this form of insurance does not cover disease except pyogenic infections resulting from accidental injury.

B. Type of Loss and Benefit

Health losses are of two major types: **loss of income** and **medical expense.** Most insurance policies define the covered event in disability income contracts in terms of loss of bodily function. This loss of function is referred to as disability.

The term medical expense refers to loss occasioned by the cost of medical care. The term medical care may include preventative, diagnostic or curative services, supplies and use of equipment and facilities related to the individual's physical or mental health or body condition.

Disability income (Loss of Income) insurance is a form of health insurance that provides periodic payments when the insured is unable to work as a result of illness, disease or injury. It may provide benefits only in the event of accidental bodily injury, only in the event of sickness (although sickness coverage rarely is written except in combination with accident coverage), or may cover both contingencies in one contract. Benefit eligibility is based on a presumed loss of income, but in practice this usually is defined in terms of inability to pursue an occupation.

Medical expense insurance is a form of health insurance which provides benefits for medical care. It provides benefits for expenses of physicians, hospital, nursing and related health services, and medications and supplies. It may include benefits for preventative, diagnostic and rehabilitative services as well as for services associated wtih curative treatment. Benefits may be in the form of reimbursement of actual expense up to a limit, valued or specified sums, or the direct provision of services. Medical expenses may be paid directly to the purveyor of services or to the insured.

Medical expense insurance may be classified further according to the type of expense covered and the extent of coverage. The main subdivisions are hospital, surgical, regular medical, major medical, and comprehensive benefits. In addition, there are less significant medical expense benefits such as "blanket accident," laboratory expense, nursing, and the like usually written as a supplement to other coverage. Insurers are experimenting with coverage of drug expense, nursing home services, dental services and preventative and diagnostic services. It is possible that some day one or several of these may become major branches of medical expense insurance.

Hospital insurance provides benefits for room and board and related hospital expenses of an ancillary nature. It is written by insurance companies, usually on a reimbursement basis, providing benefits up to a stated number of dollars per day for room and board and up to a stated dollar limit for hospital "extras" or ancillary services. It also is written by Blue Cross Associations and a few Blue Shield Associations and a number of independents, usually providing semi-private accommodations on a service basis. Coverage of hospital extras may be on a service or reimbursement basis, often with internal limits.

Surgical insurance provides payment for surgeons' fees according to a schedule in the policy, either direct to the surgeon such as Blue Cross-Blue Shield plans, or to the insured in insurance company plans. Unless the insured is in a low income bracket, he may find his coverage somewhat inadequate in either type of plan, although insurance companies now make fairly high schedules available.

Regular medical insurance provides payments on account of physicians' charges other than surgeons' fees. Most policies pay only for visits in the hospital, not for home and office visits. However, some plans pay whenever the insured is totally disabled and a few pay in all instances, sometimes subject to a small deductible—usually the first two or three visits for disability. Plans covering without requiring hospitalization or disability may be extended to cover perodic health examinations and immunizations. Blanket medical expense coverage for individuals sometimes is written, usually as a rider to a disability income policy for accidental injury only. Such a provision covers all medical expenses up to a low overall limit.

Major Medical insurance provides a large amount of protection against all medical and related expenses, subject to a deductible usually large enough to make the insured bear a portion of the cost above his basic hospital and surgical policies, if any. The greater the underlying coverage, the greater the deductible should be. In addition, such policies usually require the insured to bear a portion, such as 15% to 25%, of the loss himself. This percentage participation is, rather unfortunately, often termed "co-insurance." This tends to encourage the insured to be reasonable in his utilization of medical services, but may require him to bear a rather large loss in extreme cases. This coverage is still rather new and variation between companies in coverage, deductibles, co-insurance requirements and premiums is extreme.

However, this area represents a logical application of the principles of insurance programming to the risk of disability expense and is growing rapidly.

Comprehensive insurance represents an extension of the aforementioned principle down to basic medical and hospital costs. This is like Major Medical with a very low deductible. The growth of Comprehensive is extremely rapid at present. Policies of this type are issued mainly by insurance companies and only to a limited degree by the hospital or medical associations. Some comprehensive contracts are in effect a combination of basic hospital, surgical and medical coverage with major medical in a single policy.

There are other types of loss and benefits which should be mentioned at this point, namely **Overhead Insurance,** which provides benefits for loss occasioned by mostly professional people to pay the expense of operating their establishment. There is also another form of loss and benefit that should be mentioned—**Special Risks.** This form can apply to multiple and sundry activities related to medical expense, loss of time and is applicable to individuals such as hunters, sportsmen, etc., and as well to group risks covering travel away from home, etc. Space does not allow for including all types of loss and benefits inasmuch as the health insurance industry is of such progressive nature that new types of loss and benefits are being developed as needs arise.

C. Basis of Payment

Disability income, accidental death and dismemberment benefits usually are paid on a stated value basis but a reimbursement basis is more common for medical expense benefits. Stated value benefits involve an agreement by the insurer to pay to or on behalf of the insured, a specified or agreed amount of money upon the occurrence of a defined loss. Reimbursement benefits require an agreement by the insurer to pay to or on behalf of the insured, on the occurrence of a defined loss, an amount of money related to the amount of loss but not in excess of a specified maximum amount. Usually the actual loss is reimbursed, subject to the application of provisions such as deductibles and coinsurance, up to the agreed limit.

D. Continuance Provisions

Health insurance policies have a variety of provisions stating the respective rights of the company and the insured to continue or discontinue the policy, or they may be silent on this point. There are six main types of policies, classified according to continuance provisions.

1. **No provision** — Single term policy — contains no provision for renewal.
2. **Renewable at company's option** — Continuous term policy and permits renewal only if the company consents.
3. **Conditionally renewable** — Continuous term policy — the insured has the right to keep it in force under many conditions. However, the company may terminate it under certain stated conditions.
4. **Guaranteed renewable** — Continuous term policy guarantees right of insured to continue the policy to age 60 or 65. However, the insurer reserves the right to change its premium schedule for the entire class into which the insured's policy falls.
5. **Non-cancellable** — Continuous term policy — guarantees the premium as well as the right to keep the policy in force to age 60 or 65.
6. **Cancellable** — A contract that may be terminated by the insured or the company at any time (subject to notice, etc.).

The above classification is mutually exclusive and exhaustive and constitutes a true partition. In theory, each of the various types of continuous provisions might be used in either group, franchise or individual policies.
True group policies do not permit individual termination by the insurer except as a result of change in employee status.

E. Contractual, Underwriting and Merchandising Arrangement

It is difficult to find an appropriate name for this basis of classification; it relates in part to contracting parties, in part to underwriting, and in part to merchandising method. The basic distinction is one of contractual arrangement: individual and family policies on the one hand, group and blanket contracts on the other with franchise policies somewhere in between.

Group Insurance is policies made with an employer or other entity to cover a defined name or recorded group of individuals identifiable by reference to the relationship to the entity. The coverage may include dependent members of the families of the covered persons. Premiums may be paid entirely by the employer or other entity, partly by the covered persons or by the covered persons alone. Eligible groups are limited by state law in some states and by the underwriting criteria of insurers. Group insurance provides protection generally at a lower rate than individual coverages because of the limitation of adverse selection leading frequently to better loss experience and because of savings in expense. Expense savings result from the economy of a "wholesale-type" operation, from lower commissions, and from the fact that the employer or association performs certain administrative services which would otherwise be performed by the insurer.

In addition, a net savings in taxes occurs because the premiums for a qualified group plan are deductible by the employer and the value thereof is not considered taxable income to the employee. Thus, it is more economical for the employer to provide such insurance than to increase wages by an equi-

valent amount so that the employees could purchase individual policies.

Franchise contracts fall somewhere between group and individual contracts. Association group contracts also belong in this middle area. Franchise contracts are issued to individuals under a broad agreement with an employer or other entity who agrees to make the coverage available to his employees, withholds and/or contributes to premiums and otherwise facilitates the arrangement. If a sufficient proportion enrolls, group underwriting standards may be employed and the contracts issued to all who apply on a guaranteed issue basis. Association group contracts are similar except that they are issued to members of a professional or trade association and the covered persons usually remit premiums directly to the insurer. For both of these, rates and underwriting standards usually fall somewhere between the extremes of group and individual. Franchise arrangements involve the issuance of individual contracts while association group arrangements may or may not.

Individual contracts are policies made with an individual to cover him, and in certain instances, specified members of his family, usually dependents. The underwriting standards are applied to the individuals concerned, but some of these are issued with little or no underwriting.

F. Types of Insurers

Insurance companies active in health insurance include life insurance companies, casualty insurance companies and monoline or specialty health insurance companies. They usually are organized as corporations, either on a stock basis similar to corporations in other fields of activity, or on a mutual basis where the policyholders exercise the usual rights of stockholders, voting for directors and sharing "savings created by experiencing expense less than anticipated" through policyholders' dividends. A few risk health policies are written by the Underwriters at Lloyd's.

Unique to the health insurance field are the hospital and medical association—Blue Cross and Blue Shield and "independent" plans. Blue Cross Associations are a unique type or insurer, active only in this field. The first plans were organized by a particular hospital, but such plans were soon largely supplanted by community-wide plans. With few exceptions, Blue Cross plans are incorporated as non-profit organizations under special legislation.

This legislation exempts non-profit hospital service corporations from the provisions of state insurance laws, sets certain standards and recognizes the associations as charitable and benevolent institutions exempt from most state and local taxes.

As "non-profit" organizations, Blue Cross plans are generally exempt from regulation as insurance companies and most of them enjoy a tax exempt status. However, they usually are under the supervision of the state insurance departments. There are 78 such plans in operation in the United States, of which 76 are members of Blue Cross Association, and coverage is available in every state but two. The areas covered range from a single city to about one and one-half states. The typical plan has a board of directors or trustees who represent the hospitals, the physicians of the area, and the general public. Frequently, the sponsoring hospitals guarantee the financial soundness of the plan. In any event, the hospitals represent the ultimate risk bearers.

Independent plans have a longer history than do Blue Cross Associations. However, they represent a very heterogenous group, and generalizations are difficult. Most of them are industrial plans sponsored by an employer or union and limiting enrollment to employees or members. Most of these plans emphasize medical and/or surgical benefits.

Organizationally, the Blue Shield plans are more heterogenous than Blue Cross. There are four general methods or organization: special, enabling legislation, general legislation, underwriting by regular insurance companies and provision of supplementary benefits in Blue Cross coverages.

Usually the Blue Shield and Blue Cross organizations in an area work very closely together. Frequently, the Blue Cross organization handles administration, enrollment, record keeping, and claims administration for Blue Shield on some type of reimbursement basis.

The term "independent" has been used to denote a health insurance plan which is neither a conventional insurance company nor is affiliated with the Blue Cross or medical society approved.

The majority of these plans were industrial. Others were consumer sponsored, community sponsored, fraternal and private group clinics. The majority of these offered more or less comprehensive benefits; the balance were limited to hospital and/or surgical coverage.

In the broad sense, the majority of persons enrolled in all types of independent plans are developed with consumer including union backing.

G. Extent of Losses

Almost three-fourths of the population is covered by medical expense insurance, but such plans meet only about half of the insurable expenses. Almost two-thirds of the employed have some form of formal income protection. This covers about two-thirds of the short-term insurable income loss, but only about 15% of the long-term loss, even after considering social insurance. Thus, long-term disability losses are still met largely, if at all, by public assistance. It is in this area that private insurance faces its greatest challenge and its greatest opportunity for further growth.

VII. Underwriting the Risk

Underwriting concepts—A thorough understanding of the underwriting process—the way in which it "gets on the books"—will provide a useful foundation for the study of other operational aspects of the total process of insuring the health risk.

Underwriting is the initial step on the total process of insuring health risks. It involves selection, classification, and rating of risks. Fundamentally, its purpose is to be certain that the individual or group insured has the same probability of loss, within reasonable limits, as the universe on which premium rates were based initially. The underwriting process involves analysis to determine if the individual or group is to be accepted or declined for insurance under a proposed or a modified plan of insurance.

In both individual and group insurance, the field underwriter is the important link with the information surrounding it. Consequently, his initial appraisal of the quality of the risk is an important consideration in the total underwriting process. Based upon this and other valid sources of additional information, the Underwriting Department of a health insurance company determines the acceptability of the risk, and if acceptable, the particular basis upon which insurance will be issued.

Elements of Selection — Selection seeks to obtain a body of insured persons in each premium class whose individual prospects of suffering the loss insured against does not differ widely from the norm for that class. **Insurance is one service which must be procured before it is needed and the tendency of persons to defer purchasing health insurance is well known.** These facts require underwriters to be alert against efforts to secure coverage after the applicant has become ill or suspects that he is about to be disabled. The natural inclination of people in good health to put off buying insurance and the eagerness of those in ill health to obtain coverage is called **anti-selection** or **adverse selection.**

An important part of the underwriting process is designed to safeguard the company from the effects of anti-selection and in properly classifying applicants for health insurance, in pricing the benefits, and in avoiding anti-selection, the underwriter must consider the several factors that determine insurability.

The factors determining insurability are age, sex, race, physical condition, previous health history, occupation, moral and financial standing, other insurance, types of contract and amount of benefits applied for, insurance record, and to a small degree, family history. When all these factors have been examined, it will be found that some few applicants are uninsurable because the hazard involved is too great to be underwritten successfully. These must be culled and rejected. Some will be found to be insurable subject to special conditions and increased premiums, or a less liberal plan of benefits than applied for. For most insurers, an excess of 90% of the applicants will be acceptable for the coverage they desire and it can be issued at the standard rate for their class.

Group Insurance — Group health insurance underwriting varies in important particulars from that of individual health insurance. The purpose is the same — evaluation of the inherent hazard and assignment of the appropriate class and premium rate — but the techniques and standards for evaluation are decidedly different. The group underwriter has the responsibility not only of deciding whether and on what basis the group may be insured, but of so drawing the contract as to prevent selection against the company by individuals eligible for coverage. It is a rare thing for an application of group insurance to be rejected if it complies with any applicable statutory definition of a group eligible for this type of coverage. Insurers are eager to extend the protection of health insurance as widely as possible in order to build the volume of their business and to satisfy the social need for it.

Although group insurance is underwritten with care, the underwriter's attitude toward group risks can be less restrictive than with individual contracts in part because the yearly renewable term contract under which the insurance is written contemplates annual re-evaluation of the risk and adoption of remedial measures if the initial evaluation proved to be incorrect. On each contract anniversary date, the underwriter has the opportunity to adjust the premium rate, conditions of the contract, and the benefits provided. Through experience rating, each group tends to find its proper rate level over a period of time. In the initial evaluation and the annual re-evaluation of these risks, underwriters consider the following factors: statutory requirements, composition of the group, occupational hazard, economic and environmental influences, and plan of insurance.

A group is usually considered acceptable if it meets the legal and insurer requirements as to type, minimum size, and minimum participation. Group health insurers establish their own underwriting rules which are modified from time to time to keep abreast of developments in coverage and the changing needs of the market. Generally, they are accorded greater discretion than the underwriters of individual risks. Most group contracts are tailor-made to fit the needs of the particular applicants. Frequently, they must be adapted to an employer's overall personal program or the exigencies of collective bargaining with trade unions. Hence, there is need for greater underwriting flexibility.

Types of Underwriting Action — Basically, there are four types of action which can be taken by the underwriter for the **individual** cases: (1) rejection, (2) issue standard as applied for, (3) issue as applied for with a rating, and (4) issue with an exclusion rider.

There are presently being introduced other forms of action, such as offering an alternate policy form, increased waiting periods under disability policies, and to impose a rating, and also in disability policies to

reduce the period of benefit payment. Other underwriting actions will be developed as the time progresses, as this is a procedure of utmost importance.

The Underwriting Process — The sources of information which a company may utilize in underwriting include the application, agent's report, inspection report, physical examination, intercompany data, reports from attending physicians, and in renewal underwriting and in some group cases, the previous insurance experience of the risk.

Since the agent originates the business, he is often called a field underwriter. He represents the company, but must keep his actions within his authorized power. Verbal statements between the agent and the applicant are not binding upon the company. The agent has no authority to alter the application or to waive the answer to any question.

Probably no other business where perhaps tens of thousands of dollars are involved, must the company rely more heavily on the representative. He is the important contact, often the only personal contact a company has with its policyholders. Because the field man is so essential to efficient operations, all companies set up special instructions for their agents. Printed in a separate manual or contained in the rate book itself, these instructions guide the field man in conducting his activities in conformance with company practices. It is important that you become thoroughly familiar with your company's manual. Much of the information has to do with the selection of risks, with submitting trial applications in doubtful cases, and handling applications in normal situations.

All applications are not alike. The broader and more liberal the contract, usually the more detailed the information required in the application. Frequently, the first question asks for the applicant's name. Some applications state with health questions. All applications, however, commonly require certain information essential to sound underwriting. They are as follows:
applicant's name, date of birth, sex, marital status, occupation, physical condition, present health, air travel, other insurance, moral hazard, the beneficiary designation if any, signature and authorization.

VIII. Claims

The purpose of insurance is to provide protection and security. In the last analysis, this is accomplished by the payment of claims to insureds (policyholders) who suffer covered losses. The payment of claims represents the delivery of the product of the insurance industry. The primary function of claim administration is to deliver this product by paying all legitimate claims promptly, pleasantly and in accordance with the provisions of the policy. This should be done in such a way that the claimant (policyholder) remains a satisfied customer who will influence future sales favorably. The record of a company in paying claims is probably the most important single determinant of good will.

There are four main steps in claim settlement: **notice of loss, proof of loss, investigation,** and **payment.** The details of these steps vary with the type of insurance.

Notice: The first step in the claims process is the furnishing of notice of injury or disease to the company. The Uniform Provisions state that such notice must be furnished within a specified period of time or as soon thereafter as is reasonably possible.

Proof of Loss: Upon receipt of notice of claim, the company must furnish claims forms for proof of loss to the insured within 15 days according to Uniform Provision Number 6. Uniform Provision 7 requires the insured to furnish the proof of loss to the company in writing within 90 days of the occurence of loss other than disability income and within 90 days of the termination of the period for which the company is liable for income losses.

The agent may have a great deal, a little or nothing to do with the claim settlement, depending on the practices of his company. Many agents, even if they take no part in the actual claim adjustment process, still make it a point to deliver claim checks whenever possible. This builds good will and often leads to future sales.

Uniform claim forms for the proof of loss for medical care coverages are in general use. The Health Insurance Council (Federation of eight Insurance Associations) has developed a standard claim form and a standard hospital admission system for individual insurance.

Short period disability income (claims of 3-4-5 weeks' duration) forms usually are not filed until disability has terminated and usually are limited to brief statements from the insured and his physician. Sometimes a statement is required from the employer certifying to actual loss of time. Long period disability income forms are similar, but usually more extensive. Generally there is a preliminary statement similar to the short benefit period form, one or more reports as to continuous disability, and an affidavit from the insured and the physician as to when disability ends. For most cases the preliminary claim blank serves as the proof of loss, but for more severe cases a formal proof may be required upon termination of liability.

Investigation: The process of investigation takes place between the initial notice and the final payment. Frequently a good deal of the process is carried out before the insured files final proof of loss. In addition to the notice and proof, there are a number of sources of information open to the company.

The diagnosis of illness or injury is sufficient, in connection with the information as to treatment and time of disability, to establish the validity of most claims. Industry records of past experience will indicate the pattern of treatment and probable duration of most disabilities, and where the case fits the pattern, the claim rarely will be questioned. Where the claim deviates markedly from the norm, where questions of pre-existing conditions or misrepresentations arise, further investigation is called for.

Inspection reports may be obtained from company representatives, independent adjustors or mercantile inspection agencies. Inspectors check on the insured's residence, date of birth, employment, and nature and extent of disability. It is necessary to inquire into the insured's activities during the period of claimed total disability to make sure these activities are not inconsistent with claims of total disability. Logical sources of information include neighbors, business associates, and competitors. Where conflicting information is revealed or where the company suspects malingering or misrepresentation, it may have the claimant examined by its own physician. This may vary from a routine examination to a very detailed in process. Where a pre-existing condition is suspected, it may be necessary to obtain information from other physicians who have treated the patient in the past.

It should be noted that the investigation is concerned with more than just the facts surrounding the current claim. Many policies exclude coverage of pre-existing disease for a limited period of time, and some exclude named pre-existing diseases during the entire period of coverage. Thus, the claimant's health history should be checked on the statements in the application. If there have been material misrepresentations, these may serve as grounds for rescission of the policy.

Payment: This may be paid in full or adjusted or prorated according to policy provisions. For benefits payable periodically, the policy must stipulate the time interval for payment, which may not be less frequent than monthly.

Payment ordinarily is made to the insured, if living, otherwise to the beneficiary, if any, or the insured's estate.

The procedure in group insurance is essentially similar to that discussed before, but differs in detail. Payments must be made promptly. Procedures, therefore, are designed with punctuality in mind and generally forms are simpler than in individual insurance. Claim forms are usually available from the employer.

The group contract may provide for administration of claims by the insurer or by the employer. Self-administration of claims is less common than self-administration of coverage and accounting records because of the need for greater specialized training for claims work. Self-administration of claims will require the services of at least one trained full-time employee.

Blue Cross-Blue Shield: Many independent plans are sponsored by the purveyors of medical services, claim procedures differ somewhat from insurance company practices. The claim usually is presented to the physician or hospital, who maintains a supply of claim forms. The insured may fill out the form, but more commonly this is handled by the physician or hospital. The insured merely submits evidence of coverage and the purveyors of service do the rest. Payment of insured amounts is made directly by the association to the physician or hospital and the insured is billed by them for any excess.

Courses of action in claim settlement — Payment: There are two basic courses of action open to the company when confronted with a claim; pay or contest. About 95% of all claims presented are paid.

Payment of incurred loss in full according to policy benefits is the most common procedure followed in payment of losses. The main problem in handling claims in this category is to make sure the payments are prompt and handled in a courteous manner.

Contest: Where the company does not feel that a claim should be paid, it will deny liability and thus contest, to some extent, the claim. There are two basic grounds for contest: the claimant did not suffer the loss, or the policy does not cover the loss. The policy may not cover for two reasons: because the particular type of loss is excluded or because the policy was not in force at time of loss.

The occurrence of the loss insured against depends upon the claimant's being disabled within the meaning of the policy or incurring expenses for covered medical care. Determining the existence of disability is sometimes difficult because of an impairment that another virtually would ignore. The fact that the insured did remain at home is significant, but not conclusive. Whether disability exists and, if so, whether it is total will be determined according to the statements of the insured, the opinion of the insured's physician, the actual record of absence from employment. The nature of the disability in relationship to the duties of his occupation are vitally important. Determination of disability and of a self-employed claimant is especially difficult to tell whether he actually is active in his business. This is especially true for a family business.

Summary: The function of claim handling is to pay all legitimate claims promptly, pleasantly and in accordance with the terms of the policy.

The four main steps in claim settlement are **notice of loss, investigation, proof of loss,** and **payment.**

Most claims are paid. Payment may be in full, adjusted to conform to policy limits, or prorated in accordance with policy provisions. If the claim is to be contested, it may be on grounds of non-existence of disability or non-coverage of the policy.

Claim administration involves almost everyone connected with the insurance policy. The various parties should understand their responsibilities and exercise restraint and good judgment. If this is done, misunderstandings over claims can be kept to a minimum and public relations can be greatly improved.

IX. Regulation

In recent years newspaper and magazines have carried numerous articles about health insurance and some of these articles have presented health insurance in an unfavorable light. Some regulatory actions taken by state legislators may have been reactions to this public criticism of health insurance. With a better understanding of the program being made through inter-

company cooperation, self-regulation and state regulation, the salesmen of health insurance will be able to take more pride in private health insurance and better defend it against unwarranted criticism.

Furthermore, an understanding of the nature and extent of regulation of health insurer operations provides an appreciation of the soundness of the private health insurance and the extent to which the policyholder's interest is protected through such regulation.

Background of State Regulation — Regulation of the insurance business by the states and territories has long been accepted. In 1868 this was established constitutionally in the historic case of Paul vs. Virginia. The broad pattern of this regulation — watchfulness over solvency of insurers, licensing and establishing qualifications of producers and protection of the public from unfair practices is now recognized as necessary and proper. In 1944 the equally historic case of United States vs. Southeastern Underwriters Association, the Supreme Court of the United States questioned this long established principle of state supervision. The opinion developed that the business of insurance was subject to a series of Federal acts and that it was also subject to the judicial decision under the "commerce clause" of the constitution. In 1945 Congress enacted the "McCarran Act" or "Public Law 15". This made it clear that continued regulation of insurance by the states was in public interest. The same law made it clear, however, that Federal anti-trust laws would apply to the business of insurance "to the extent that such business is not regulated by State law." The states then made the necessary and desired adjustments in their statutes.

Objectives of Regulations — The objectives of state regulation include policyholder protection, production of revenue for the states, and retaliation against discrimination by other states against domestic companies. The most important element of policyholder protection is maintaining the solvency of insurers. The retaliation objective is not so important as it formerly was in view of the efforts of the National Association of Insurance Commissioners in developing uniform state laws. The goals of the regulatory powers could be described as maintaining insurer solidity and solvency, responsibleness, equity and fairness.

Areas of States Regulation — Area — The areas of state regulation coming under the general category of policyholder's protection include regulations concerning the formation and incorporation of insurers; admission of out of state (foreign) companies; standard of solvency in terms of size of capital and surplus; adequacy of reserves; permissible media for investment; requirements of periodic reports and examination; and provision for means for conservation and liquidation of companies whose solvency is endangered. The public is further protected by laws regulating the qualifications of agents and brokers and prohibiting certain practices; prohibiting misleading and false advertising and representations; defining standards of fair competition; prescribing policy forms or requiring approval; limiting company expenses; and regulating various activities of intercompany organizations.

Mechanics — The mechanics of state regulation are handled by an insurance department under a state official titled "Insurance Commissioner." The Commissioner has power to grant or withhold licenses to do business, examine financial condition and practices of carriers; require periodic statements; act as a depository of securities and a conservator or liquidator of companies when necessary; investigate complaints and initiate investigation, and undertake activities whcih are necessary and incidental to these. His duties involve the enforcement of all the insurance laws of the state and the administration of his department.

National Association of Insurance Commissioners — This organization was founded in 1871 as the National Convention of Insurance Commissioners and membership consists of the Insurance Commissioners of the states and territories. It operates through an executive committee, other standing committees and a number of special committees.

Its decisions have no legal status but are merely recommendations to the insurance department. However, its persuasive powers have been quite effective and a great deal of uniformity has resulted. Often the NAIC recommendations serve as a model for legislation and administrative standards in the various states and give the individual states the advantage of a thorough study which many of them would not have been able to provide themselves.

Specific Regulatory Provisions — Insurance companies, in order to transact business in a state, must first be licensed or "authorized" by that state. Generally the requirements for licensing a **domestic company** are the same as for its organization. Sometimes the licensing requirements, unlike the organization requirements, are the same for stock and mutual companies. Requirements for licensing out of state (foreign) insurers are essentially similar to the standards required for domestic companies. The states requires deposits of securities by insurers. Regulation of reserves, investments and methods of valuation all contribute toward insurer solvency. In addition, Insurance Commissioners have the power and duty to take steps to conserve the assets of companies who are on dangerous financial ground. They may and do examine the company statements and actual operations and, in case of actual or impending insolvency, may limit writing of new business or actually step in as conservator, liquidator or rehabilitator of the company involved.

Policy Provision and Filings — Each state requires that policy forms for individual health insurance must be approved by the state before the policy can be sold to its public. The Uniform Individual Policy Provision Law recommended by the NAIC in 1950 has been enacted in all states. These provisions will be listed later; however, it should be pointed out the law requires 12 provisions which are designed primarily to protect the

interests of an insured after a loss. In addition, the law provides for 11 optional provisions. These need not be included unless the company so desires. In addition to prescribing the Uniform Provisions, the law contains certain other requirements. These relate to typography, to the application, to who may be covered (individual and family only) and the like.

Uniform Provisions — The accident and health committee of the National Association of Insurance Commissioners, with the cooperation of a committee representing the Health Insurance Industry, created the Uniform Individual Accident and Sickness Policy Provision Law and was approved by the National Association of Insurance Commissioners in 1950. This law provides that policies submitted to state Insurance Departments for approval must be drafted according to the new Uniform Provisions (replaced Standard Provisions of 1912), and meet certain other requirements. Some requirements of the law have to do with the style, arrangement and size of type. Others specify that the policy must state the amount of premium, as well as the time insurance takes effect. There are 23 Uniform Provisions. Twelve of these are required and must be included in every contract. The other 11 are optional and in some cases may be omitted. An insurance company may reword any of these provisions provided it is not less favorable in any respect to the policyholder or the beneficiary. The purpose of these provisions is to define the terms of the contract and to clarify the rights and duties of both the company and the policyholder.

Provision 1 — Entire Contract; Changes

This first provision is important to the policyholder because it guarantees that his contract cannot be altered or changed or modified unless the change is authorized by an officer of the company and notice is attached to the contract.

A copy of the application is generally attached to and made a part of the policy. Other papers which may be attached include riders providing additional benefits and waivers excluding specific impairments.

> **Provision 1 — Entire Contract:** — Changes — This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

Provision 2 — Time Limit on Certain Defenses

Here is further evidence that sickness and accident contracts, like life insurance contracts, are unique in the business world. The policyholder has the right to know that when he is disabled, the company will not refuse to pay the benefits which the policy promises. It is, of course, necessary for the protection of the company and other policyholders that a short period of time, three years or less, be allowed to avoid payment on policies obtained with misstatements. This does not mean, however, that a claim can be avoided during the early policy years in event of misstatement of age, occupation or other insurance.

> **Provision 2 — Time Limit on Certain Defenses:**
>
> (a) After three years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such three-year period.
>
> (b) No claim for loss incurred or disabiltiy (as defined in the policy) commencing after three years from the date of issue of this policy shall be reduced or denied on the grounds that a disease or physical condition, not excluded from coverage by name or specific description effective on the date of loss, had existed prior to the effective date of coverage of this policy.
>
> Policies guaranteed renewable at least to age 50, or for at least five years if issued after age 44, may, in place of (a) above, contain the following under the caption "INCONTESTABLE":
>
> After this policy has been in force for a period of three years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application.

Provision 3 — Grace Period

Years ago insurance policies expired at noon on the day the premium was due if not paid. If the policyholder became disabled that afternoon, he received nothing. Now, policies must allow extra time beyond the due date in which the policyholder may pay his premiums. The number of days specified in the Uniform Policy Provisions Law is not less than seven for weekly premium policies, ten for monthly policies and 31 for all other policies.

> **Provision 3 — Grace Period:** A grace period will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force. (The length of the grace period may vary depending upon mode of premium payment and company practice.)
>
> A policy which contains a cancellation provision may add, at the end of the above provision:
>
> subject to the right of the insurer to cancel in accordance with the cancellation provision hereof.
>
> A policy in which the insurer reserves the right to refuse any renewal shall have, at the beginning of the above provision:
>
> unless not less than five days prior to the premium due date the insurer has delivered to the insured or has mailed to his last address as shown by the records

of the insurer written notice of its intention not to renew this policy beyond the period for which the premium has been accepted.

Provision 4 — Reinstatement

Although a policy has lapsed for non-payment of premium it can be reinstated by the acceptance of an overdue premium by the company or one of its agents unless a reinstatement application is required and a conditional receipt for the premium given. Then it will be reinstated on approval, or within 45 days without approval except when the applicant has been notified that reinstatement has been refused. The reinstated policy covers accidents occurring only after the reinstatement date and sickness originating ten days or more after that date. Otherwise the policy is exactly the same as it was before, unless the company has required any modification in order to justify reinstatement.

The last sentence of the above may be omitted from the policies guaranteed renewable to age 50, or if issued after age 44, guaranteed renewable for at least five years.

Provision 5 — Notice of Claim

Under this provision, the policyholder must furnish the company with a notice of claim within 20 days, or as soon as reasonably possible. Notice to an agent is considered sufficient. An additional requirement may be inserted in policies paying benefits for more than two years, which states that the insured should give the company notice of claim every six months, unless he is legally incapacitated.

> **Provision 5 — Notice of Claim:** Written notice of claim must be given to the insurer within twenty days after occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or in behalf of the insured or the beneficiary to the insurer at .... (insert the location of such office as the insurer may designate for the purpose), or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer.

Policies providing loss-of-time benefits payable for at least two years may insert the following between the first and second sentences of the above provisions:

> Subject to the qualifications set forth below, if the insured suffers loss of time on account of disability for which indemnity may be payable for at least two years, he shall, at least once in every six months after having given notice of claim, give to the insurer notice of continuance of said disability, except in the event of legal incapacity. The period of six months following any filing of proof by the insured or any payment by the insurer on account of such claim or any denial of liability in whole or in part by the insurer shall be excluded in applying this provision. Delay in the giving of such notice shall not impair the insured's right to any indemnity which would otherwise have accrued during the period of six months preceding the date on which such notice is actually given.

Provision 6 — Claim Forms

This places the burden on the company, once it has been notified of a claim, to furnish claim forms promptly within 15 days. If claim forms are not furnished, then the policyholder shall be deemed to have complied with all requirements of Provision 7, Proofs of Loss.

> **Provision 6 — Claim Forms:** The insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within fifteen days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing of proofs of loss, written proof covering the occurrence, the character and extent of the loss for which claim is made.

Provision 7 — Proofs of Loss

This provision sets forth that within 90 days after the termination of the period for which the company is liable, the policyholder must furnish written proof of loss, if reasonably possible. Except in instances of legal incapacity, proofs of loss must be furnished the company within one year.

> **Provision 7 — Proofs of Loss:** Written proof of loss must be furnished to the insurer at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within ninety days after the termination of the period for which the insurer is liable and in case of claims for any other loss within ninety days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give such proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

Provision 8 — Time of Payment of Claims

This provision states that as soon as proof of loss is received by the company, benefits are payable. Income benefits are payable at specified intervals not less frequently than monthly.

> **Provision 8 — Time of Payment of Claims:** Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be made immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid .... (insert period for payment which must not be less frequently than monthly) and the balance remaining unpaid upon

the termination of liability will be paid immediately upon receipt of due written proof.

Provision 9 — Payment of Claims

Broadly speaking, this provision designates to whom benefits will be paid so that settlement of claims can be made promptly by the company without costly legal investigation. Payment of loss of life will be made to the insured's estate if no beneficiary has been named or is alive. Either or both of two optional paragraphs may be added. One is a "facility of payment clause" which enables a company to pay up to $1,000 to any relative by blood or marriage of the insured or beneficiary who the company believes is entitled to receive it. The other clause permits the company to make payment promptly and without red tape directly to a person or hospital rendering service.

> **Provision 9 — Payment of Claims:** Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured.

Either or both of the following paragraphs may be included in this provision:

> If any indemnity of this policy shall be payable to the estate of the insured, or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, the insurer may pay such indemnity, up to an amount not exceeding $................................ (insert an amount which shall not exceed $1,000), to any relative by blood or connection by marriage of the insured or beneficiary who is deemed by the insurer to be equitably entitled thereto. Any payment made by the insurer in good faith pursuant to this provision shall fully discharge the insurer to the extent of such payment.
>
> Subject to any written direction of the insured in the application or otherwise all or a portion of any indemnities provided by this policy on account of hospital, nursing, medical or surgical services may, at the insurer's option and unless the insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services; but it is not required that the service be rendered by a particular hospital or person.

Provision 10 — Physical Examinations and Autopsy

This provision entitles a company at its own expense to make physical examinations of the policyholder at reasonable intervals during the period of a claim, and the right to make an autopsy when death benefits are payable, provided it is not forbidden by law.

> **Provision 10 — Physical Examinations and Autopsy:** The insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

Provision 11 — Legal Actions

Under this clause the company has 60 days in which to investigate a claim during which time the policyholder cannot take legal action.

> **Provision 11 — Legal Actions:** No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

Provision 12 — Change of Beneficiary

Unless the policyholder has specifically denied himself in his application the right to change beneficiary, he may change his beneficiary or assign the contract as he wishes. The company may, if desired, omit the first part relating to irrevocable designation of beneficiary.

> **Provision 12 — Change of Beneficiary**: Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy.

THE OPTIONAL PROVISIONS

All of the twelve preceding provisions are required by the Uniform Policy Provisions Law. There are 11 additional provisions, any or all of which may be included in policies. A company may change the wording provided the rewording is not less favorable to the policyholder. A general knowledge of these provisions is also important.

Optional Provision 1 — Change of Occupation

When this optional provision is contained in a policy, if a policyholder becomes disabled after changing to a more hazardous occupation, his benefits will be on the basis of the more hazardous occupation. Or, if he changes to a less hazardous occupation, his premium rate will be reduced accordingly and any overpayment will be refunded to him upon request.

> **Provision 1 — Change of Occupation:** If the insured be injured or contract sickness after having changed his occupation to one classified by the insurer as more hazardous than that stated in his policy or while doing for compensation anything pertaining to an occupation so classified, the insurer will pay only such portion of the indemnities provided in this policy as the premium paid would have purchased at the

rate and within the limits fixed by the insurer for such more hazardous occupation. If the insured changes his occupation to one classified by the insurer as less hazardous than that stated in this policy, the insurer, upon receipt of proof of such change of occupation, will reduce the premium rate accordingly, and will return the excess pro rata unearned premium from the date of change of occupation or from the policy anniversary date immediately preceding receipt of such proof, whichever is the more recent. In applying this provision, the classification of occupational risk and the premium rates shall be such as have been last filed by the insurer prior to the occurrence of the loss for which the insurer is liable or prior to date of proof of change in occupation with the state official having supervision of insurance in the state where the insured resided at the time this policy was issued; but if such filing was not required, then the classification of occupational risk and the premium rates shall be those last made effective by the insurer in such state prior to the occurrence of the loss or prior to the date of proof of change in occupation.

Optional Provision 2 — Misstatement of Age

Under this provision the policyholder is protected when an error is made regarding the age. Instead of the policy being void, benefits are paid in the amount which his premium would have purchased at the correct age. Of course, if coverage would not have been available at his correct age, the policyholder is entitled to a refund of those premiums.

Provision 2 — Misstatement of Age: If the age of the insured has been misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the correct age.

Optional Provision 3 — Other Insurance in This Insurer

This provision protects a company against excess insurance by limiting the amount of coverage which will be carried by the company. If a policyholder already has coverage with the company which, with this policy, provides benefits in excess of the maximum allowed by the company, only the maximum is payable and excess premiums will be returned to the policyholder or his estate. An alternative wording of this optional provision is permitted which limits the company's liability to the one policy selected by the insured.

Provision 3 — Other Insurance in This Insurer: If an accident or sickness policy or policies previously issued by the insurer to the insured be in force concurrently herewith, making the aggregate indemnity for .... (inserting type of coverage or coverages) in excess of $................................. (insert maximum limit of indemnity or indemnities) the excess insurance shall be void and all premiums paid for such excess shall be returned to the insured or to his estate.

Or,

Insurance effective at any one time on the insured under a like policy or policies in this insurer is limited to one such policy elected by the insured, his beneficiary or his estate, as the case may be, and the insurer will return all premiums paid for all other such policies.

Optional Provision 4 — Insurance with Other Insurer

This provides that if a policyholder has duplicate coverage on an "expense incurred basis" with other companies and a company accepts the risk without being notified of the other coverage, its liability will be a proportionate share of the expenses incurred, and premiums for the unused portion are refunded.

Provision 4 — Insurance With Other Insurer: If there be other valid coverage, not with this insurer, providing benefits for the same loss on a provision of service basis or on an expense incurred basis and of which the insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability under any expense incurred coverage of this policy shall be for such proportion of the loss as the amount which would otherwise have been payable hereunder plus the total of the like amounts under all such other valid coverages for the same loss of which this insurer had notice bears to the total like amounts under any valid coverages for such loss, and for the return of such portion of the premiums paid as shall exceed the pro rata portion of the amount so determined. For the purpose of applying this provision when other coverage is on a provision of service basis, the "like amount" of such other coverage shall be taken as the amount which the services rendered would have cost in the absence of such coverage.

If the foregoing policy provision is included in a policy which also contains the next following policy provision, there shall be added to the caption of the foregoing provision the Phrase " . . . EXPENSE INCURRED BENEFITS." The insurer may at its option include in this provision a definition of "other valid coverage," approved as to form by the commissioner, which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, and by hospital or medical service organizations, and to any other coverage, the inclusion of which may be approved by the commissioner.

In the absence of such definition such term shall not include group insurance, automobile medical payments insurance, or coverage provided by hospital or medical service organizations or by union welfare plans or employer or employee benefit organizations.

For the purpose of applying the foregoing policy provision with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute (including any workmen's compensation or employer's liability statute) whether provided by a governmental agency or otherwise shall in all cases be deemed to be "other valid coverage" of which the insurer has had notice. In applying the fore-

going policy provision, no third party liability coverage shall be included as "other valid coverage."

Optional Provision 5 — Insurance with Other Insurers

This option is the same as the preceding, except it relates to all benefits other than expenses incurred.

Provision 5 — Insurance with Other Insurers: If there be other valid coverage, not with this insurer, providing benefits for the same loss on other than an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability for such benefits under this policy shall be for such proportion of the indemnities otherwise provided hereunder for such loss as the like indemnities of which the insurer had notice (including the indemnities under this policy) bear to the total amount of all like indemnities for such loss, and for the return of such portion of the premium paid as shall exceed the pro rata portion for the indemnities thus determined.

If the forgoing policy provision is included in a policy which also contains the next preceding policy provision there shall be added to the caption of the foregoing provision the phrase " . . . OTHER BENEFITS." Note: The remaining part of this parenthetical comment is the same as that which follows "Expenses Incurred Benefits" in the comment following Provision 4.

Optional Provision 6 — Relation of Earnings to Insurance

This is generally known as the "average earnings clause" and may be used only in non-cancellable and guaranteed renewable contracts. It protects the company and its policyholders against the individual who delays recovery because his disability income is greater than his earned income. At the time disability commences, should his total disability income exceed his earned income, or his average earned income for the preceding two years, whichever is greater, his income benefits under the policy will be reduced proportionately. In no case, however, will monthly benefits under all policies be reduced to less than $200. Premiums for excess insurance are returned to the policyholder.

Provision 6 — Relation of Earnings to Insurance: If the total monthly amount of loss of time benefits promised for the same loss under all valid loss of time coverage upon the insured, whether payable on a weekly or monthly basis, shall exceed the monthly earnings of the insured at the time disability commenced or his average monthly earnings for the period of two years immediately preceding a disability for which claim is made, whichever is greater, the insurer will be liable only for such proportionate amount of such benefits under this policy as the amount of such monthly earnings or such average monthly earnings of the insured bears to the total amount of monthly benefits for the same loss under all such coverage upon the insured at the time such disability commences and for the return of such part of the premiums paid during such two years as shall exceed the pro rata amount of the premiums for the benefits actually paid hereunder; but this shall not operate to reduce the total monthly amount of benefits payable under all such coverage upon the insured below the sum of $200 or the sum of the monthly benefits specified in such coverages, whichever is the lesser, nor shall it operate to reduce benefits other than those payable for loss of time.

The insurer may, at its option, include in this provision a definition of "valid loss of time coverage", approved as to form by the commissioner, which definition shall be limited in subject matter to coverage provided by governmental agencies or by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, or to any other coverage, the inclusion of which may be approved by the commissioner or any combination of such coverages. In the absence of such definition such term shall not include any coverage provided for such insured pursuant to any compulsory benefit statute (including any workmen's compensation or employer's liability statute), or benefits provided by union welfare plans or by employer or employee benefit organizations.

Optional Provision 7 — Unpaid Premium

This clause states the right of the company to deduct from a claim any unpaid premium which is due.

Provision 7 — Unpaid Premium: Upon the payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

Optional Provision 8 — Cancellation

The cancellation clause gives the company the right to cancel at any time with at least five days' notice. After the policy has been in force beyond its original term, the insurer may cancel at any time. Excess premiums are refunded. Cancellation does not affect any claim originating before cancellation.

Provision 8 — Cancellation: The insurer may cancel this policy at any time by written notice delivered to the insured, or mailed to his last address as shown by the records of the insurer, stating when, not less than five days thereafter, such cancellation shall be effective; and after the policy has been continued beyond its original term, the insured may cancel this policy at any time by written notice delivered or mailed to the insurer, effective upon receipt or on such later date as may be specified in such notice. In the event of cancellation, the insurer will return promptly the unearned portion of any premium paid. If the insured cancels, the earned premium shall be computed by the use of the short-rate table last filed with the state official having supervision of insurance in the state where the insured resided when the policy was issued. If the insurer cancels, the earned premium shall be computed pro rata. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

Optional Provision 9 — Conformity with State Statutes

Although this is an optional provision, some states require that it be included. It amends the policy, if necessary, so that it will conform to minimum state requirements.

Provision 9 — Conformity with State Statutes: Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which the insured resides on such date is hereby amended to conform to minimum requirements of such statutes.

Optional Provision 10 — Illegal Occupation

This provision states that the company is not liable if the loss results from any felony or illegal occupation.

Provision 10 — Illegal Occupation: The insurer shall not be liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation.

Optional Provision 11 — Intoxicants and Narcotics

This provision is similar to the preceding clause, and relieves the company of liability for losses while the policyholder is under the influence of liquor or narcotics.

Provision 11 — Intoxicants and Narcotics: The insurer shall not be liable for any loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.

SUMMARY

Now that you have a general understanding of the 12 policy provisions which are required and the 11 which may be included at the option of the company, it is suggested that you study carefully the provisions in your company's contracts.

You will note that most of these clauses outlines the rights and privileges of the policyholder.

The others, in protecting the company against the unreasonable or uninsurable claims of a few unscrupulous individuals, make it possible to establish a favorable rate for the large majority of honest people who need sickness and accident protection.

LIFE INSURANCE

Although it is probable that something similar to insurance was used by the Babylonians, Greeks and Romans, insurance as we know it today began more recently. It is thought to have had its origin in 14th century Italy. During this period sea voyages were both hazardous and expensive, and a ship's captain and cargo were insured against death or capture by pirates.

At that time insurance was financed by wealthy citizens. A shipowner requiring money to finance a trip would post a document on the wall of a meeting place stating the conditions under which he would borrow money. Individuals willing to accept any portion of this loan or risk would sign their name to the bottom of the contract stating the risk they were assuming. These men became known as "underwriters." (Even today this term is used to designate those insurance men in the home office and field that determine the risks a company will accept.)

As late as the 1800's, this type of risk acceptance was still in existence. In England it became known as coffee house underwriting because it was in the coffee houses that the underwriters gathered. One of the most famous of these coffee houses was Lloyd's. Lloyd's did so much underwriting and so little "coffeeing" that eventually the organization we know as Lloyd's of London was established.

The Friendly Societies of Great Britain and the Fraternal Societies of the United States were next in the order of development of modern life insurance. These societies were the forerunners of today's fraternal life insurance companies. Bound together by membership in some organization, the societies sought to provide protection for their members and eliminate some of the misuse of insurance during the period. For example, by providing for the aged, the societies kept many oldsters from auctioning their insurance policies to have enough money to live. Two of the earliest fraternal societies in the United States were the Odd Fellows and the Grand Army of the Republic.

It was not until the nineteenth century that modern life insurance was really born. For until this time two factors hindered the growth and development of existing companies and discouraged the formation of new companies. The first was the lack of scientifically developed and reliable mortality tables. The second was the overwhelmingly rural nature of society.

The first problem was solved by accurate record keeping and extensive research. The second was corrected by the Industrial Revolution. Industrialization caused people to leave the country and congregate in cities. Here, away from the security of land ownership and close family ties, the need for insurance was more easily developed.

In the early 1800's many new life insurance companies were formed. These were the first stock companies, and were the first to put life insurance on a really organized, systematic, and businesslike basis. It was in the 1840's that the first mutual life insurance company began doing business in the United States. At this time there were less than $10,000,000 of life insurance in force in this country.

During this period some "new" sales techniques were developed that helped to spark a real mid-century growth in the volume of insurance coverage. The agency system developed rapidly, and there was a start toward the use of advertising media in promoting the sale of life insurance.

The mortality experience of United States companies between 1843 and 1858 was used to develop the first reliable mortality table, known as the American Experience Mortality Table. Many policies in force today are based on this mortality experience; in fact, this table was the basis for most policies issued until the 1941 Commissioners' Standard Ordinary mortality table was published.

During the period shortly before, during and after the Civil War, many life insurance companies were operated in a precarious manner. Unsound business practices abounded and advertising claims were grossly inflated. During the depression period of the 1870's, many of these poorly managed companies went out of business.

This poor management and their poor record during the depression period spurred many states to begin regulating insurance. Regulation had begun at an earlier date through the efforts of Elizur Wright. A former school teacher and mathematician, he had campaigned in the Massachusetts Legislature and obtained passage, in 1861, of his version of the Legal Reserve Principle. After his campaign other states began establishing insurance departments and regulated the industry within their states. Because of his pioneering efforts, Wright has become known as the "Father of Modern Life Insurance."

The end of the century found an increasing liberalization of the life insurance contract and its benefits. Cash and surrender values were written into ordinary life policies, as were provisions providing for grace periods and incontestability.

In 1905 the Armstrong Investigating Committee was charged with investigating the life insurance industry in New York. During this period of time big business was being investigated and the growth of the life insurance industry had attracted attention. The Armstrong Investigation turned out to be a sober, responsible examination and a benefit to both the public and to life insurance.

Even though the Armstrong Investigation caused a

temporary loss of confidence among the buying public, the period during World War I and the '20's was a time of growth in the industry. During these years, many advances were made in insurance, including the development of settlement options, group insurance, disability income and double indemnity benefits.

The great depression of the 1930's was an extremely difficult one for the life insurance industry. Mortality and disability claims were up, resulting in increasing underwriting costs. The amount of insurance in force decreased, interest rates were lower, and many mortgages were in default causing investment income to decrease. In spite of all this, the industry managed to ride out the depression with flying colors. Only 20 of the 350 companies failed; and these, because of their size, accounted for only slightly more than 1% of the total insurance in force. Even this 1% was reinsured by those companies that were solvent and the actual loss to policyholders was almost nothing. It was 1937 before insurance in force regained the 1930 level.

The tribulations of the depression caused many people to seek security. This quest for security, improvement of products and the development of more skilled agents has resulted in a continued growth of insurance in force. This growth has been so steady and so spectacular that by the end of 1967, in approximately 1,700 companies, there was an estimated 1.08 trillion dollars of life insurance in force in the United States.

It is difficult to know exactly where to begin in the study of life insurance. In order to understand the various types of insurance policies, it is necessary to know something about the manner in which rates are computed, but to understand the difference in the rate computations between various types of policies, it is necessary to know something about the policies.

Unique Function of Life Insurance

Life insurance is unique as a means of creating an estate for one's dependents. There is no legal method, other than life insurance, whereby one can create an immediate estate.

Some Unique Characteristics of Life Insurance

Life insurance is a risk-pooling plan—an economic device through which the risk of premature death is transferred from the individual to the group. However the contingency insured against has certain characteristics that make it unique; as a result the contract insuring against the contingency is different in many respects from other types of insurance.

The event insured against is an eventual certainty No man lives forever. Yet we do not violate the requirements of an insurable risk in the case of life insurance, for it is not the possibility of death itself that we insure against, but rather "untimely" death. The uncertainty surrounding the risk in life insurance is not whether or not the individual is going to die, but rather when he will die.

The hazard increases from year to year. The chance of loss under a life insurance contract is greater the second year of the contract, as far as the company is concerned, than it was the first year, and so on until the insured eventually dies. Yet through the mechanism of the law of large numbers as we shall see, the insurance company can promise to pay a specified sum to the insured no matter when he dies.

There is no possibility of partial loss in life insurance as there is in the case of property and casualty insurance. Therefore, all policies are valued policies. In the event that a loss occurs, the company will pay the face of the policy.

Life Insurance Not a Contract of Indemnity

The principle of indemnity does not apply in the case of life insurance. In most lines of insurance, an attempt is made to put the individual back in exactly the same financial position after a loss as he was in before the loss. For obvious reasons this is not possible in life insurance. The simple fact of the matter is that it is not possible to place a value on a human life. There is no legal limit to the amount of life insurance that an individual may purchase on his life. While there is no **legal limit,** insurance companies impose limits for underwriting reasons. Not only is the amount of insurance which a company will be willing to write on a life limited, but companies are also reluctant to issue a policy with a beneficiary where there is no apparent insurable interest.

Insurable Interest in Life Insurance

As a legal principle, every contract of insurance must be supported by an insurable interest, but in life insurance the requirement of insurable interest is applied somewhat differently than in property and casualty insurance. When the individual taking out the policy is also the insured, there is no legal problem concerning insurable interest. The courts have held that every individual has an unlimited insurable interest in his own life, and that he may assign that insurable interest to anyone.

The important question of insurable interest arises when the person taking out the insurance is someone other than the person whose life is concerned. In such cases the law requires that an insurable interest exist at the time the contract is taken out. There are many relationships which provide the basis for an insurable interest. Husbands and wives have an insurable interest in each other, likewise partners, and a corporation may have an insurable interest in the life of one of its executives. In most cases a parent has an insurable interest in the life of a child. A creditor has an insurable interest in the life of the debtor, although this is usually limited by statute to the amount of the debt or slightly more.

The question of insurable interest seldom arises in life insurance, because the bulk of life insurance policies sold are purchased by the person whose life is insured. In addition the consent of the individual insured is required in most cases even when there is an insur-

able interest. The exception to this requirement exists in certain jurisdictions where a husband or wife is permitted to insure a spouse without the consent of the spouse.

Effective Date of Coverage

Coverage under the life insurance policy is effective as soon as the contract comes into existence. The fundamental question then is when does the policy come into existence. The answer to this question hinges on a relatively small detail in the eyes of the insured whether the first premium accompanies the application for insurance. If the application is sent to the insurance company without the premium, the insurance company draws the contract and offers it to the insured. It is not a contract until it has been accepted by the insured, which the insured does by accepting the policy and paying the first premium. If the insured should die during the period between making the application and receiving the policy and paying the first premium, no benefits will be paid, for the policy had not yet come into existence.

Normally the premium accompanies the application for insurance. The company acknowledges receipt of the premium with a conditional receipt. The typical receipt puts the policy in force at the time of the application, provided that the applicant is found to be insurable according to the underwriting rules of the company. The situation might arise in which the underwriter is forced to determine whether a deceased person would have qualified for insurance had he not died. If the applicant would have qualified, then the company is bound to pay the death benefit since the policy went into effect conditionally at the time of the application.

Right of Creditors to Life Insurance Proceeds

The proceeds of life insurance policies have long been exempted from the claims of the deceased insured's creditors. While it has sometimes been maintained that this represents discrimination against creditors, it seems justifiable since the insured also has certain obligations to his dependents which are even more fundamental than his obligations to his creditors. In some states the exemption applies only if the benefits are payable to certain beneficiaries, such as a wife or children.

In some states the exemption laws are extremely broad, exempting the proceeds of a life insurance policy not only from the claims of the insured's creditors, but also from the claims of the beneficiary's creditors. For example, Section 511.37 of the Insurance Laws of Iowa states:

> A policy of insurance on the life of an individual in the absence of an agreement or assignment to the contrary shall inure to the separate use of the husband or wife and children of said individual, independently of his creditors.
>
> The proceeds of an endowment policy payable to the assured on attaining a certain age shall be exempt from liability for any of his debts.
>
> Any benefit or indemnity paid under an accident, health or disability policy shall be exempt to the assured or in case of his death to the husband or wife and children of the assured, from his debts.
>
> The avails of all policies of life, accident, health or disability insurance payable to the surviving widow shall be exempt from liability for all debts of such beneficiary contracted prior to the death of the assured, but the amount thus exempted shall not exceed $15,000.

TYPES OF LIFE INSURANCE POLICIES

Strictly speaking, there are only three types of life insurance policies:

1. Term Insurance
2. Whole Life Insurance
3. Endowment Life Insurance

Often a fourth type is included as a separate form, the Limited Pay Whole Life Policy, but as we shall see, the limited pay policy is simply a form of whole life.

The Term Insurance Policy

Term life insurance is protection against financial loss resulting from death during a specified period of time. It pays only if the insured dies within the given period, which may be 1 year, 5 years, 10 years, 20 years, until the insured is 65 years of age, or any one of a number of other periods. At the end of the policy period the protection ceases.

In its purest form, a term policy is purchased for a specified period and the face of the policy is payable only if the insured dies during this period. Nothing is paid if the insured survives the term period. It is customary, however, for term policies to contain the features of renewability and convertibility.

In the first, the renewable feature, the insured is provided with the option to renew the policy for a limited number of additional periods, usually of the same length as the original term period. For example, if an insured purchases a $10,000 ten-year term policy at age twenty-five and he survives this period, he has the option of renewing the policy for an additional ten years without the necessity of proving insurability. The level-premium rate for this ten-year period will be higher than the premium rate for the first ten years. The insured may renew the contract at age forty-five and perhaps also at age fifty-five. However, all insurance carriers, because of the element of adverse selection, impose an age limit beyond which renewal is not permitted. The most important advantage to the insured is the right to renew even if he becomes uninsurable.

The convertible feature is also an important aspect of term insurance. In addition to the right of renewal, the policy provides the insured with an option to exchange the term contract for some type of permanent life insurance without the necessity of providing evid-

ence of insurability. An insured with a $10,000 term policy could, if he so desired, convert this contract prior to expiration into a $10,000 whole life policy or some other form of permanent insurance, such as a limited payment or endowment policy, and the conversion would be accomplished even though the insured were uninsurable at the time. The conversion is generally effected at the insured's attained age, although in some cases it may be made retroactive to his original age.

In summary, term insurance is pure protection. It does not develop cash values and there is no savings element in the contract. (On some long term policies a slight cash value may develop, but it disappears before the end of the policy). Because it is temporary insurance, it is suited for only those needs that are also temporary.

The Whole Life Policy

The whole life policy (also known as the straight life policy, or "ordinary life") is the basic type of lifetime policy. It provides insurance protection at a level premium for the entire lifetime of the insured. Under the straight whole life policy, the insured pays premiums for his entire lifetime, and as long as he continues to pay premuims he enjoys protection equal to the face amount of the policy. If he lives to age 100, (Age 96 on older policies) the age at which the insurance company's mortality tables say he should be dead, they will pay him the face amount of the policy.

Limited Pay Whole Life

The limited payment whole life policy is similar to the straight whole life policy, in that it provides protection for the entire lifetime of the insured. The difference between the two policies is the manner in which the premiums are paid. Under the limited pay contract the protection extends to age 100, but the premium payments are made for some shorter period of time. Thus, under a 20 pay life policy, the insured pays premuims during the payment period that are high enough ot permit him to stop payment at the end of twenty years, and still enjoy protection equal to the face amount of the policy for the remainder of his life.

Endowment Life Insurance

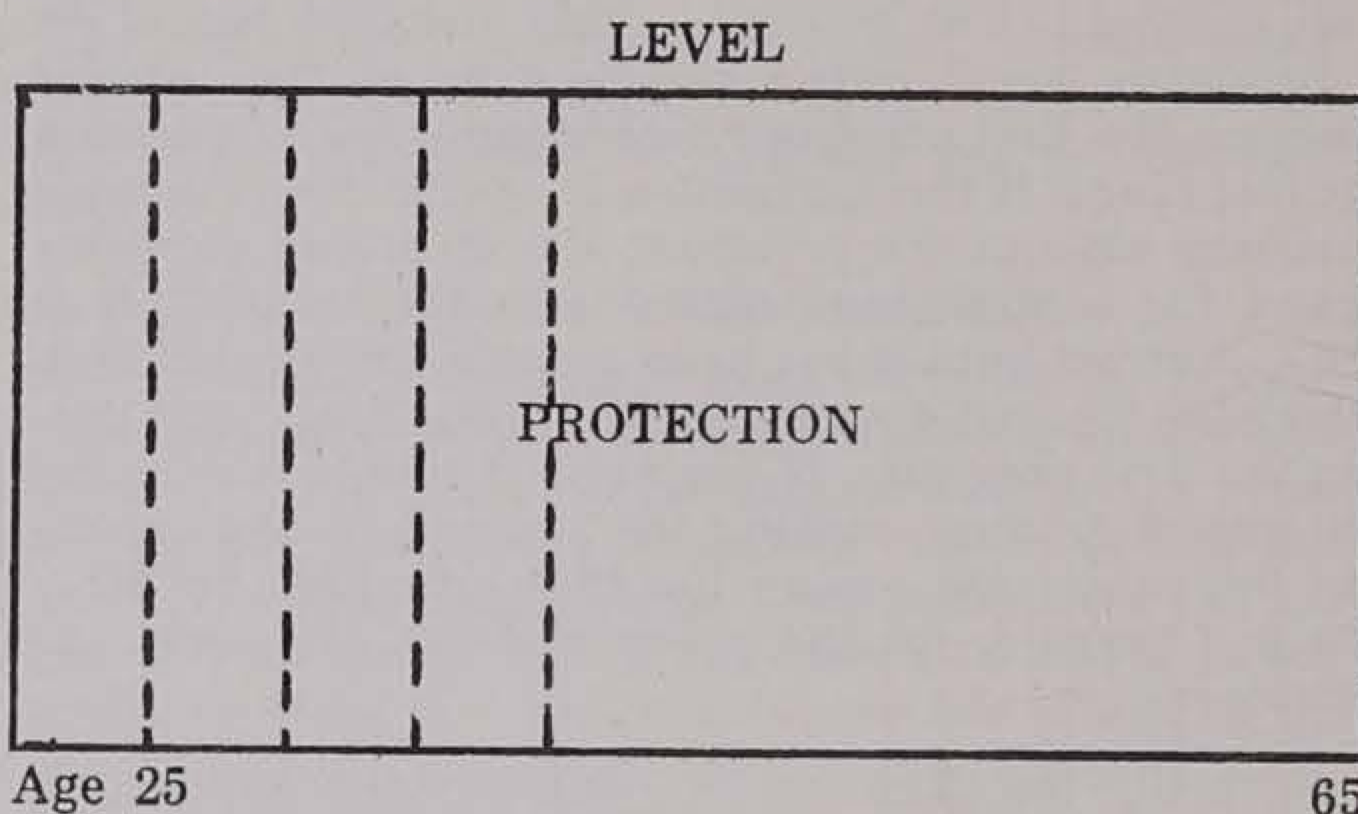
In endowment life insurance, the company promises to pay the face amount of the policy if the insured dies within the policy period, or to pay the face amount if the insured lives to the end of the specified period, which is known as the endowment period.

For example, a twenty-year endowment policy provides for the payment of the face amount of the policy to the beneficiary of the insured, if the insured should die during the twenty-year period, or for the payment of the face amount to the insured if he should survive to the end of the twenty-year period.

LEVEL AND DECREASING TERM

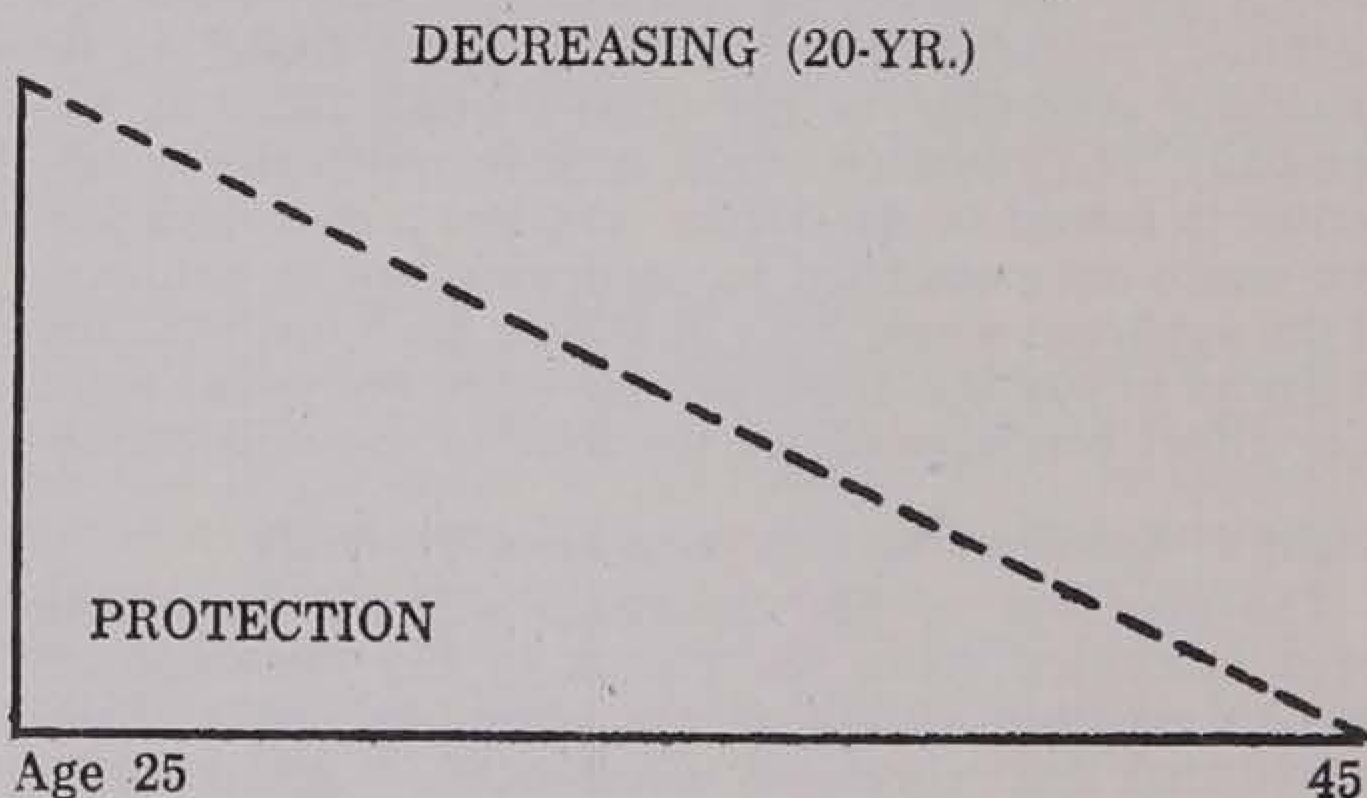
Term insurance—protection only—no cash value or very little cash value.

LEVEL



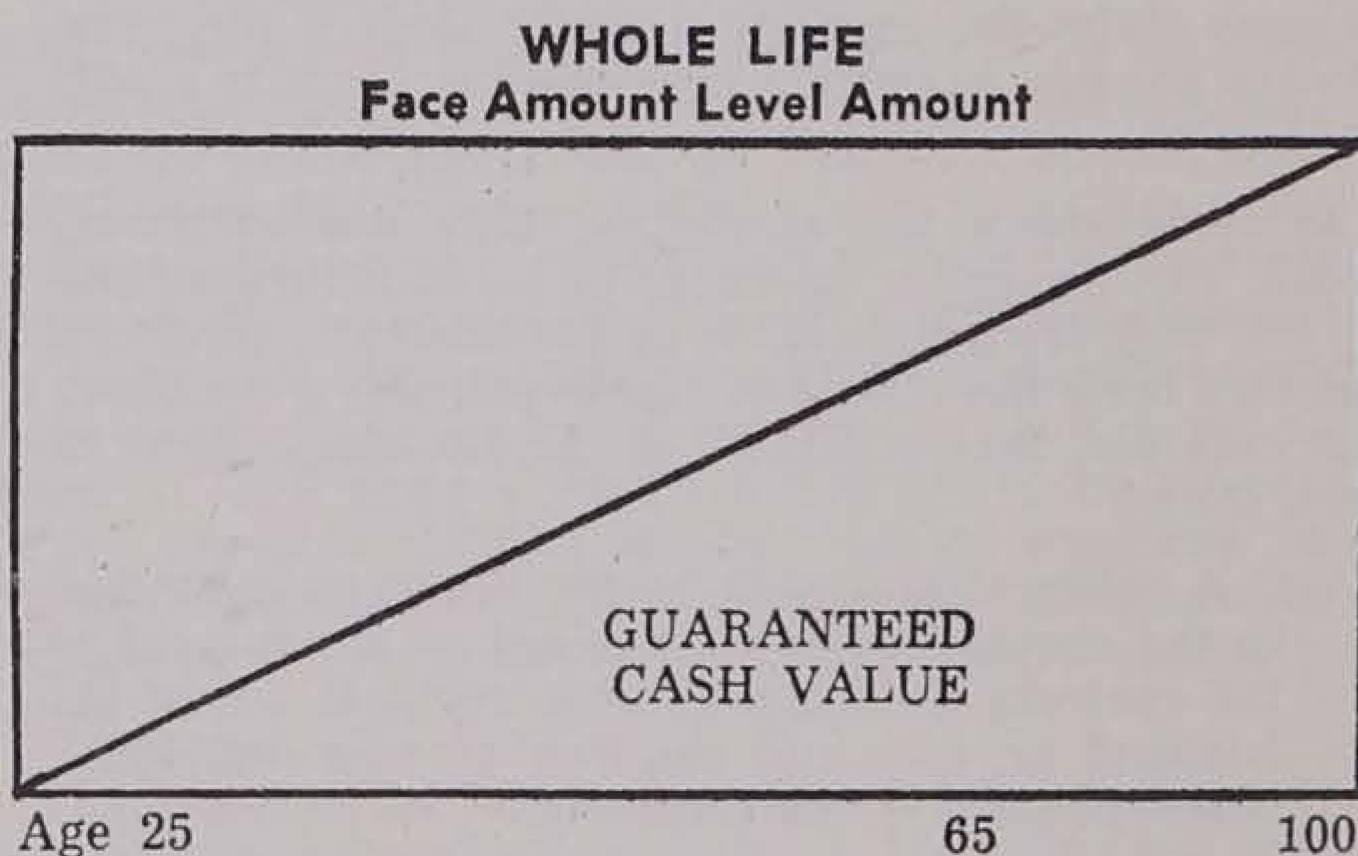
Level premium and level amount of coverage for periods of 5, 10, 15, 20 or to age 65.

DECREASING (20-YR.)



Lower premium than level term.
Decreasing coverage for 10-15-20-25 year periods.

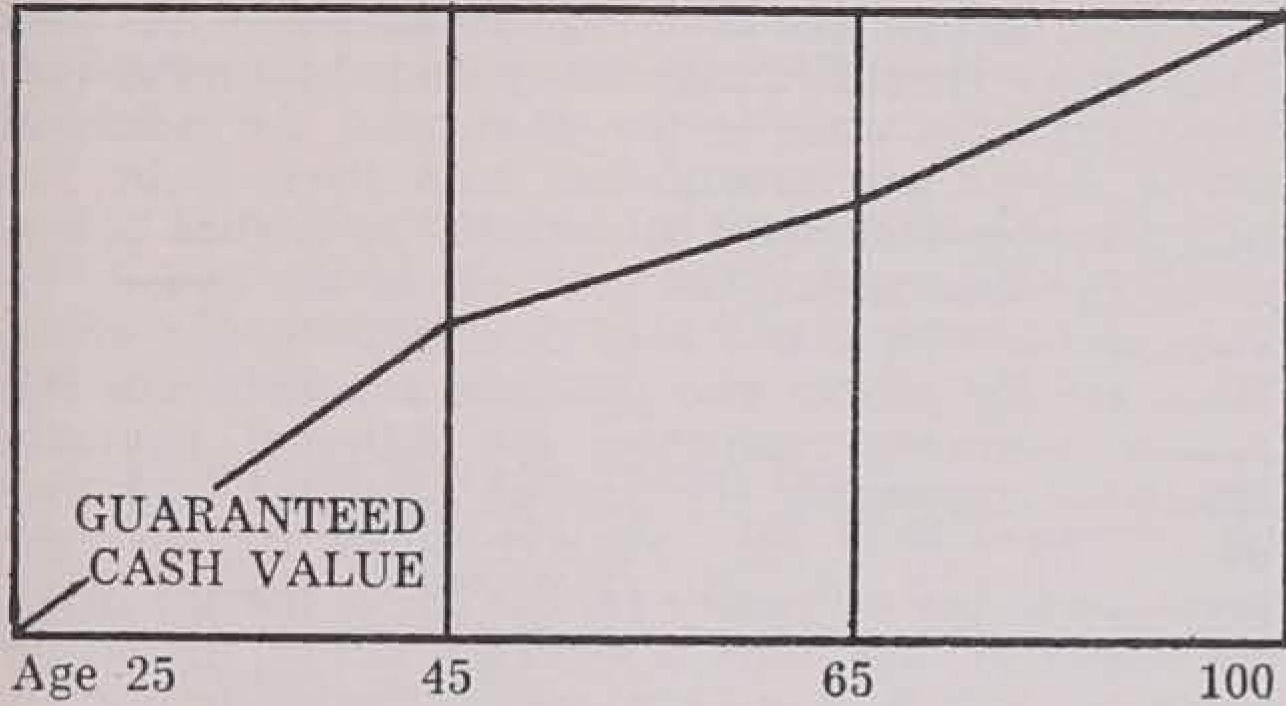
WHOLE LIFE
Face Amount Level Amount



Level premiums for life
Guaranteed cash value equal to face amount at age 100.

LIMITED PAYMENT (20 pay life)—Same as whole life, but Premiums for 20 years only.

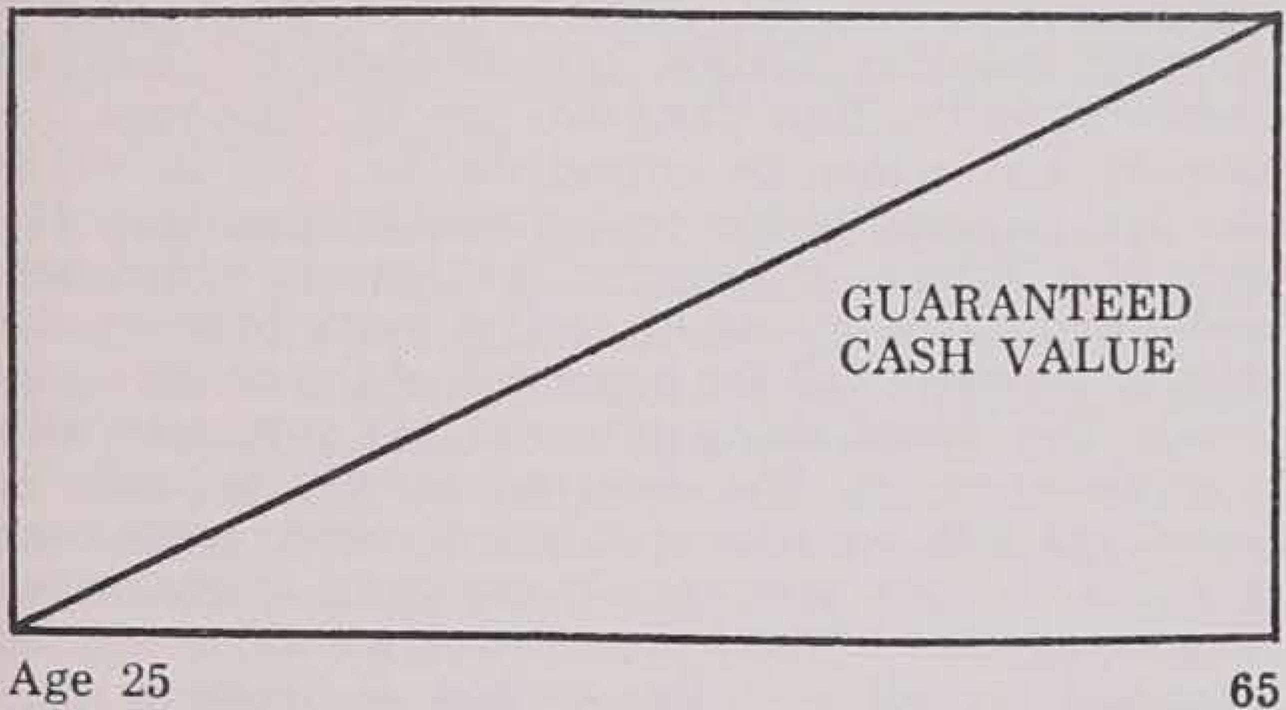
Face amount
(protection)



Emphasis on protection—but
more cash value than whole life.
Premiums payable for 20 years.
Matures at age 100.

ENDOWMENT AT 65—High cash values with more Protection—Premiums to Maturity

Face amount
(Protection)



Cash value equal to face amount at maturity date.
Premiums to maturity age.

Why Different Forms?

The simplest form of life insurance, but one rarely offered by life-insurance companies today except in connection with group life insurance, is yearly-renewable-term. This type provides protection for a period of one year only, but permits the insured to renew the policy for successive periods of one year, at a higher premium rate each year, without the necessity of furnishing evidence of insurability at the time of each renewal. This is life-insurance protection in its purest form.

Because of the difficulties of yearly-renewable-term insurance, it has been found that the most practical method of providing life insurance is one in which the premiums do not increase from year to year, but remain constant throughout the premium-paying period. This is known as the level-premium plan. Here the size of the premium will depend upon the age of the insured at the time the policy is purchased, and this amount will continue to be the premium paid by the insured as long as the policy continues.

The level-premium plan will be much more practical for most individuals because the relatively low premium in the older ages will make it more possible for an individual to continue his life insurance until his death.

The level-premium plan introduces features that have no counterpart in term insurance. Death is bound to occur at some time, and in a whole-life policy the insurance carrier knows that a death claim must be paid at some future time. Under the level-premium plan the insured pays more than the cost of pure life-insurance protection during the early years the policy is in force. The additional premium is necessary so that the excess portion, when accumulated at compound interest, will be sufficient to provide for the deficiency in the later years of the contract. These premiums create a fund which is held by the insurance company for the benefit and the credit of the policyholders. The fund is the reserve and it must be accumulated and maintained by the insurance carrier if it is to be able to meet its future obligations on the policies in force. Not only will the excess premiums in the early years completely offset the deficiency in the later years, but with the aid of compound interest, the reserve will continue to accumulate throughout the term of the policy and be equal to the face of the contract at the terminal age in the mortality table.

The level-premium plan introduces the features of the excess premium during the early years of the contract and the creation of the reserve fund. The insured has the right to withdraw these excess payments at any time through the use of the cash-surrender or loan privilege in his contract. As a consequence a contract under the level-premium plan provides more than pure life-insurance protection. It is actually a combination of decreasing insurance, the net amount at risk, and increasing savings, the growing reserve, and the two amounts are calculated in such a manner that in any year their sum is equal to the face of the policy. If a policyholder dies, the death claim is composed partly of the reserve on the policy, and the balance, the net amount at risk for the insurance carrier, is obtained from the current premiums paid by the other policyholders in the insured's age and policy classification.

It should be stressed that the policy reserve is not solely the property of the insured. It is his property only if he surrenders the policy. If he does so, the contract no longer exists and the insurance carrier is relieved of all obligations on the policy. As long as the contract is in full force, the reserve belongs to the insurance carrier and must be used to help pay the death claim if the insured should die. As mentioned above, the reserve must be accumulated by the company to take care of the deficiency in the level premium during the later years of the contract.

From the above analysis it is obvious that there are two distinct advantages in the use of level-premium insurance. First, by paying an amount in excess of the cost of pure life insurance during the early years of the contract, the insured avoids a rising premium in the later years. This will make it financially possible to maintain the insurance until his death, even though it occurs at an advanced age. Second, if the insured survives, he is in the process of accumulating a savings fund which can be utilized for his income needs in his old age.

ANNUITIES

The Nature of Annuities

Annuities in a sense are a reverse application of the law of large numbers as it is used in life insurance. While life insurance is a method of scientifically accumulating an estate, an annuity is a device for the scientific liquidation of a principal sum.

The annuity may be defined as a periodic payment to commence at a stated or contingent date and to continue for a fixed period or for the duration of a life or lives. The person whose life governs the duration of the periodic payments is called the annuitant and the payment is called the annuity. If the payments are to be continued for the duration of a designated life or lives, the contract is called a life annuity.

The basic function of a life annuity is that of liquidating a principal sum, regardless of how it was accumulated,[1] and it is intended to provide protection against the risk of outliving one's income. Each payment is composed partly of principal and partly of interest earned on the unliquidated principal, and the payments will continue as long as the annuitant lives, even though his life span is much greater than his life expectancy at the time of the purchase of the annuity. The life annuity is unique in that it will guarantee an orderly liquidation of a principal sum over the balance of a lifetime. There is no other arrangement whereby this type of liquidation can be accomplished.

For the insurance company, it makes absolutely no difference how long the individual lives. For the insurance company the average life expectancy is the important factor. Some men who reach age 65 will die before they reach 66. Others will live to be 100. On the average they will live 15.9 years and on this basis the insurance company can promise to pay a certain amount to each annuitant for life, basing the amount which it promises on the average life expectancy. Those who live longer than the average will offset those who live for a shorter period than the average. Every payment which the annuitant receives is part interest and part principal. In addition each payment is part "survivorship benefit," in that it is composed in part of the funds of members of the group who have already died.

Insurance companies have found that annuitants live longer than most people. This is simply a result of selection against the company. People who feel that they have a short life expectancy do not normally purchase annuities, while on the other hand, the individual whose father and grandfather both lived to be 115 will probably look upon an annuity as a good investment. In other words, the principle of the annuity favors people who live a long time, and on the whole, these are the people who purchase annuities. For this reason insurance companies use different mortality tables for computing the cost of annuities than they do for the cost of life insurance. Since the company promises to pay an income for the life of the annuitant, the longer the annuitant is expected to live, the higher will be the cost for a given amount of annual or monthly income. The higher the age of the annuitant, the lower the cost for a given amount of monthly income. Obviously, there is no requirement that the annuitant be in good health.

Classification of Annuities

Annuities may be classified in various ways. **First,** the annuity may be paid for the duration of a single life or for the duration of two or more lives. This classification involves the single-life and the joint-and-survivor annuities. **Second,** annuities may be classified according to the time payments are to commence. An annuity may either be immediate, **i.e.,** one in which the first payment is due on payment-interval from the date of purchase, or deferred, **i.e.,** one in which normally there is a spread of several years between the date of purchase and the beginning of the annuity payments. The immediate annuity is always purchased with a single premium. The deferred annuity normally is purchased with periodic premium payments made over a period of years, with annuity payments to commence at some specified future date. **Third,** annuities may be classified according to the method of premium payment. They may be purchased with a single premium, with the annuity to begin immediately or at some future date, or they may be purchased on an installment basis over a period of years. **Fourth,** annuities may also be classified according to the nature of the insurance carrier's obligation. Under a pure, single-life annuity, payments are made only for the balance of the annuitant's lifetime, regardless of how long or how short this period might be. The annuity is considered fully liquidated at the annuitant's death, with nothing payable to the annuitant's estate. The annuity may contain some sort of a refund feature, with a specified amount to be paid to the annuitant's estate if he should die shortly after the commencement of annuity payments. The difference between the total annuity payments and the purchase price of the annuity, for example, could be paid to the annuitant's estate. Each of these classifications will be discussed briefly.

The life annuity that provides the maximum income per dollar of premium expenditure is the pure-life an-

[1] It could involve the liquidation of a sum of money derived from a person's savings. This sum could be used as a single premium to purchase an immediate-life annuity. It could also involve the liquidation of the cash values of life-insurance contracts, or the liquidation of the proceeds of a life-insurance contract after the death of the insured in the form of a life income for the beneficiary of the policy.

nuity. This annuity may be immediate, or it may be deferred. It may be purchased on a single life, or jointly on two or more lives. Its outstanding characteristic is that the annuity is payable only for the balance of the lifetime of the annuitant; or in the case of Joint Life, benefits cease upon the death of the first in the group to die.

The pure-life annuity is perhaps most attractive for the single individual who has no dependents and who desires the maximum income that is possible on a life-annuity basis.

Since on the average women live longer than men, this means that life annuities are more expensive for women. Thus, in calculating the costs of life annuities, insurance carriers do in fact what women so frequently do in imagination: they rate the age of a woman back by at least five years. Hence, the amount of monthly female of age sixty-five, will be that income for a male income to be produced by a given principal sum for a who is age sixty.

There are many instances when retirement occurs, however, that the male has one dependent, his wife. If he should choose a single-life annuity, the chances are great that he will die before his wife. This could leave her in rather straitened circumstances. The best solution to this problem is perhaps the joint-and-survivor annuity. Here annuity payments will continue as long as either is alive.

A joint-and-survivor annuity could be subject to criticism if it provides the same income after the death of one of the annuitants as was provided while both were alive. In order to eliminate this criticism, a number of modifications exist with respect to the amount of each payment. A common modification provides that the income of the survivor will be reduced one-third after the death of the other annuitant. This is known as a joint-and-two-thirds-survivor annuity. Another somewhat less common modification is the joint-and-one-half-survivor annuity. A modification of this type in many cases is desirable. It exists on a principle that more income is needed while both are alive, which is logical.

Even though the pure-life annuity provides the maximum income per dollar of principal sum, many people have strong objections to placing a substantial sum into a contract that promises no return if death should occur shortly after the annuity payments begin. As a consequence, insurance carriers have found it necessary to add some sort of a refund feature to annuities in order to make them more salable.[2]

[2]It appears that most persons are willing to reduce their income while alive in order to leave some estate for distant relatives. It should be obvious that these refund features will increase the cost of the annuity, or what amounts to the same thing, will reduce the amount of the periodic income purchasable with a given principal sum. If the refund feature is used because of the fear that dependents will be left without income in the event of the early death of the annuitant, then an annuity should not be purchased at all or an approach such as the joint-and-survivor annuity should be used.

Industrial Life Insurance

One of the most common of the refund features involves an annuity with a certain number of payments guaranteed, whether the annuitant lives or dies.

Today guaranteed periods are available for five, ten, fifteen, or twenty years. The longer the period of guaranteed payments, logically the greater will be the cost of the annuity.

Another popular type of refund feature is one that provides for annuity payments at least equal to the purchase price of the annuity, the balance will be paid to a beneficiary or to the annuitant's estate either on a lump-sum basis or in continued installments. If the balance is paid in continued installment, the contract is referred to as a "refund annuity." If the balance is paid in a lump sum, the contract is a "cash-refund annuity."

General Classifications of Life Insurance

There are four basic classes of life insurance, distinguished on the basis of the manner in which they are marketed:

1. Ordinary
2. Industrial
3. Group
4. Franchise

Our treatment thus far has been concerned with ordinary life insurance. The discussion would not be complete without at least a brief description of the other three. Group life and its specific function and characteristics are so different from those of ordinary life that it has become a separate branch of the industry. Industrial life insurance has also had a tremendous popularity and growth, although it has declined in relative importance in recent years.

Ordinary Life Insurance

Ordinary life insurance constitutes the oldest and largest of the classes. In ordinary life individual policies are marketed with a face amount of over $1,000. The premiums on these policies are paid annually, semi-annually, quarterly, or monthly. The main characteristics of ordinary life are the purchase on an individual basis and the policy amounts in excess of $1,000.

The second branch of life insurance is known as industrial insurance. It is a type that was designed to provide for the burial expenses of persons in the lower income groups, the industrial wage earners, and to provide the insurance on a basis whereby it would be simple and convenient for some persons to keep insurance in force.

By definition, industrial life insurance is a form in which the face value of the policy is less than $1,000 and one in which the premiums are payable as frequently as weekly. The most distinctive feature is, premiums are collected by a representative of the insurance company at the home of the insured. The weekly premium and its collection by a company representative at the home of the insured are important factors in keeping the policies in force.

In most instances industrial insurance is sold in premium units and not in units of face amount. Generally it is decided how much weekly premium the insured can pay. The amount of the insurance will then depend upon the amount this premium will purchase under the plan selected at the attained age of the insured. Generally the weekly premium will vary from 5¢ to as much as $1.00 per week. The types of policies available include whole life with premiums payable to a specified age such as sixty-five or seventy, twenty-payments life, and twenty-year endowment. Term insurance is not available. The insurance may be provided for all family members from birth to a specified age such as seventy. As a general rule, the insurance is provided without medical examination.

Industrial policies have a number of provisions that are different. **First,** when the insured purchases the policy, he has the right to surrender the contract within a specified period, usually two weeks, and receive a return of the full amount of the premium. **Second,** the policies contain incontestable clauses which in most instances provide for incontestability after the policy has been in effect during the lifetime of the insured for one year from date of issue. However, the application normally is not made a part of the contract, as in ordinary life insurance, and as a consequence the statements in the application cannot be used as evidence for voiding the contract. However, a safeguard does exist. It is usually provided in the policy that if the insured had medical treatment for a serious mental or physical condition within two years prior to the issuance of the policy and did not disclose this fact to the carrier, the policy would be voidable if the misrepresentation was discovered within the one-year contestable period. The **third** unique feature of industrial life insurance is a provision known as the **facility-of-payment clause.** The insured may designate a beneficiary in the contract. However, under the facility-of-payment clause, if the beneficiary predeceases the insured, or if the beneficiary fails to make a claim under the policy within sixty days after the death of the insured, or if the beneficiary is a minor, an incompetent, or the estate of the insured, the company shall have the right to pay the proceeds to the insured's executor or administrator or to any relative by blood or marriage appearing equitably to be entitled to the proceeds.

The assignment of an industrial policy generally is prohibited. The same types of surrender values as in ordinary contracts are provided in industrial policies. However, in many instances the surrender values are not available until the contract has been in force for five years. Because of the low values, loan values are generally not available. Dividends are paid on participating policies, but the insured normally has no choice as to the form in which the dividends are to be paid. Some companies provide for their use in making future premium payments; others utilize the dividends to purchase paid-up additions to the policy. Settlement options are not available in these contracts primarily because of the small amounts involved. And for the same reason, industrial policies do not contain a suicide restriction.[3]

Group Life Insurance

Group life insurance is a plan whereby coverage can be provided for a number of persons under one contract, the insurance on each life, however, being independent of that on the other lives. Normally it is provided for the employees of a specified employer and is provided without evidence of insurability.

In most states group life insurance is subject to certain requirements established by law. It is customary to require that it be written on not fewer than 25 employees, under a master contract issued to the employer, the premium to be paid by the employer or by the employer and employees jointly, and with the insurance to be provided for all or any class of employees in an amount to be determined by conditions pertaining to the employment. The amount of the insurance must be based upon some plan which will preclude individual selection, and the insurance must be for the benefit of some person other than the employer. If the premium is to be paid in its entirety by the employer, 100% of the eligible employees must be included. However, if the premium is to be paid jointly by the employer and the employees, then not less than 75% of the eligible employees must be insured.[4]

The cost of group life insurance is comparatively low. The reasons are quite simple. **First,** the basic plan under which most group life insurance is provided is year-renewable-term insurance. The student has already learned that term insurance provides the lowest dollar of premium outlay of all the types of life insurance. **Second,** the expenses of medical examinations and of other methods of determining insurability have been largely dispensed with. **Third,** group life insurance involves mass selling and mass administration. As a result, the expenses per life insured will be less under group than under the marketing of individual policies.

The major problem of the insurance carrier in the underwriting of group life insurance is that of holding the factor of adverse selection to a minimum. It should be obvious that if group life insurance were provided without any required minimum number of percentage of employees, and if the employees could choose to enter the plan or stay out, only the impaired lives would take the insurance. And if the employee could choose the amount of insurance, the impaired lives naturally would take large amounts while those in good health would take only small amounts. The problem would, of course, be compounded by the elimination of the

[3]Can you imagine someone committing suicide in order that $300 would be paid to a beneficiary?

[4]Some states permit group life insurance to be written on groups of as few as ten employees. In addition, many State laws do not limit the use of the group principle merely to groups involving employer-employee relationships. Provision is made for the use of the principle to insure members of other closely-knit groups such as labor unions and even professional and trade associations. It may be used by creditors to insure the lives of installment debtors.

medical examination and other evidence of insurability. If group life insurance is to be a practical possibility, safeguards must be provided for the prevention of minimizing of the element of adverse selection.

In the underwriting of group life insurance, the contracting parties are the employer and the insurance carrier. The policy issued to the employer is called the **master contract.** Each participating employee will receive a certificate which stipulates the amount of insurance coverage he has under the plan, the designation of his beneficiary, and any rights and privileges he may have under the plan. The coverage is applicable to the employees so long as they remain in the service of the employer, and also applies for thirty-one days after termination of the employment. The employee may, during the thirty-one days after termination of employment, convert all or a portion of the insurance to any form of individual policy currently offered by the insurance carrier, with the exception of term insurance. Conversion would be at the attained age of the employee and could not be refused by the insurance carrier because of uninsurability of the employee.

There are no exclusions in group life insurance. The proceeds of the insurance will be paid for death arising from any cause, including suicide, without any restriction as to time.

Group life insurance has become an important branch of life insurance today, and its importance undoubtedly will continue to increase. For some persons it may be the only insurance. And for many persons who would not be insurable for ordinary-life insurance, it provides the only means whereby life insurance can be obtained. For others the group life insurance is an excellent supplement to the individual life-insurance program, and should always be taken into consideration in the formulation of one's individual life-insurance program, in the same manner as consideration of coverage under the social security program.

Group Annuities

The group principle is also applicable in the operation of the industrial pension programs in industry today. However, the subject of group annuities and industrial pension plans is too extensive and complicated to warrant more than mere mention in a textbook of this kind. It is important, though, for the student to recognize that group annuities can be an important and highly attractive means of operating an industrial pension program.

Since most pension programs provide a lifetime income for the retired employee, the group-annuity principle can be a highly attractive means of funding and administering a pension program. A master contract will be issued to the employer, as in group life insurance, and each participating employee will receive a certificate outlining his rights and benefits. The vast majority of the group annuities are contributory, with the employee's contribution being subject to payroll deduction.

Franchise Life Insurance

Groups which are not large enough to meet the requirements for a group policy may purchase a different form of wholesale insurance called franchise insurance. Basically, franchise life insurance is a mass marketing plan similar to group life insurance. However, franchise plans may be written on a group composed of five lives or more. Individual policies are issued in franchise insurance programs instead of a master policy and certificates as in the case of group insurance. Each policy may vary as to the kind of insurance, the amount of coverage, and the premiums.

The most important distinctions between franchise life insurance and group life insurance are that the minimum size of the group is smaller in franchise insurance and that the contract is between the individual insured and the insurance company in franchise insurance, while it is between the employer and the company in group life insurance.

USES OF LIFE INSURANCE

Family Uses of Life Insurance

Life insurance is designed to provide MONEY when a family needs it most. For example, the death of the wage earner, retirement or financial emergencies such as loss of job, depression, or other crisis. Life insurance provides not only death benefits but also the cash values can be used by the insured. He can, while living, use it as a reserve fund in time of emergencies or to borrow against when an investment opportunity presents itself such as going into business for himself or purchase of a home where he needs cash for the down payment and does not want to assume an additional regular monthly obligation. There are several areas of family need or use of life insurance.

1. Guaranteed Savings Plan (Portion of premium going to cash value)
2. Final Expenses
3. Mortgage Liquidation
4. Readjustment and Emergency Fund
5. Family Income
6. Educational Fund
7. Widow's Income
8. Estate Liquidity
9. Retirement Income for the Insured and Wife
10. Wife Insurance
11. Children's Insurance
12. Charitable Bequests

1. **Guaranteed Savings Plan** — Permanent life insurance provides an unequaled method for accumulation of emergency fund and cash reserve for the insured. By including the waiver of premium feature on a policy, the insured has the guarantee that if he becomes disabled and can't work the premiums will be paid. The cash value grows at a guaranteed rate. This allows the insured to plan ahead to determine how much he wants to have accumulated at a given time and simply purchase sufficient life insurance to reach this

amount. The insured can then draw on this fund at any time regardless of reason or need. He can borrow it, usually at a guaranteed low rate of interest, or surrender the policy and withdraw the cash value.

If the policyholder borrows the cash value, the policy still remains in force and will be reduced only by the amount of the loan in the event of the insured's death. The loan does not have a due date. This allows the insured ample time in which to repay the loan. For example, if he borrowed the cash value to use as down payment on a home, he would not immediately have to start making payments on the cash value loan as well as payments on his home mortgage. Where the insured uses the cash value loan to establish his own business, he has ample time to operate before he needs to repay the loan.

2. **Final Expenses** — These are the expenses incurred by a person's death. They include funeral expenses, final medical bills not covered by hospital insurance, miscellaneous charge accounts, and outstanding debts and estate administration costs and taxes. This fund may be relatively small for the man with a small estate and little or no outstanding bills. In the case of a man with a large estate, the final expense could run into thousands of dollars with Federal Estate Taxes and States Inheritance Taxes due.

3. **Mortgage Fund** — This is the amount of money needed to pay off a mortgage, leaving the widow and family a home free and clear. This can be just as essential a need for the family which does not own a home since the proceeds can be used to pay rent or purchase a home.

4. **Readjustment and Emergency Fund** — This fund is used by the family immediately following the death of the wage earner. It gives them an opportunity to adjust their standard of living to a reduced level. It also is designed to provide a cash sum that would be held at interest for future emergencies such as serious illness or major house or auto repairs.

5. **Family Income** — This is a regular monthly income for the widow and children that, together with Social Security, will be their subsistence. This may vary greatly depending upon the ages and number of children as well as the family's standard of living.

6. **Education Fund** — This is an amount of money which the insured needs to provide for the purpose of educating his children. By using permanent life insurance to assure this fund, he can be certain that his children will have this money whether he lives or dies. If he lives, the cash value can be withdrawn to assist in paying the college costs. If he dies before the children complete their education, the face amount will be paid to his family; and can be used to pay the cost of tuition, books, and room and board for schooling.

7. **Widow's Income** — This is a lifetime income to the widow after the last child has left home. This usually requires a large amount of insurance since she has no Social Security income from the age 18 of her youngest child to her age 60. This period is commonly known as the "black-out" period and could be most difficult for a widow who may not have worked since before her marriage and, consequently, possesses no particular or relevant experience with which she can earn a respectable living.

8. **Estate Liquidity** — This high sounding term simply refers to the need for cash in a person's estate with which to pay estate taxes and administration costs, especially in a large estate where the Federal Estate Tax can be a substantial amount. For example, if a man's estate consists of his ownership in a business which he wants to be continued after his death for the benefit of his family; and if his estate does not have cash to pay these expenses, the family may be forced to sell the business. This "forced sale" can result in a loss to the family two ways; through reduced sale price and loss of an income producing property.

9. **Retirement Income For Insured and Wife** — By saving money through ordinary life insurance through cash values and dividends (in participating policies), a man is able to accumulate savings toward use during his retirement. When he reaches retirement age, he may choose any one of several life income options, contained in his life policies, under which the cash values he has accumulated will be paid to him as a regular monthly income for his life or for the life of him and his wife. The policies will then be turned into what is known as an annuity. (See the section in this text on annuities for further information.)

10. **Wife Insurance** — This is probably the most neglected market for the life insurance industry. While many wives do not work outside the home; nonetheless, they have considerable value in their function of housekeeper, babysitter, cook, chauffeur, laundress, and so on. In most cases, a family with small children would be financially unable to hire similar services in the event of the death of the wife at a young age. Additional reasons for a wife being insured include loss of the marital deduction, from an estate planning and tax saving standpoint.

11. **Children's Insurance** — Normally insurance is purchased for children for two reasons. The first is to provide for funeral expenses through a small policy. The second reason for purchasing life insurance for children is to give them a start in their life insurance program by buying at a young age when premiums are low. Through the use of guaranteed insurability clause, the child can be guaranteed the right to increase his insurance program at later ages regardless of health or occupation. The amount may vary depending upon the parent's ability to pay premiums and, in many cases, whether it is a boy or girl.

These, briefly are the primary uses and needs for life insurance within the family. You will note that we referred to this as life insurance not death insurance. The reason, of course, is that we are talking about living needs and benefits for the family or for the insured. The needs were not created by the death of

someone, they were always there and would have been met through the earnings of the insured if he had lived. Life insurance is the way to provide these same benefits in the event he dies. There are many ways and variations of providing this insurance such as through gifts from grandparents to grandchildren or parents to children.

12. **Charitable Bequests** — One of the more attractive approaches in this area is the use of life insurance to provide for a gift to a charitable institution. The individual purchases insurance in the amount which he desires to give, naming the institution as the beneficiary. While it might be impossible for the individual in question to make an outright gift of, say $5,000, to his church, he could probably afford the annual premium which the purchase of a whole life contract would require.

BUSINESS USES OF LIFE INSURANCE

Business Continuation Insurance

The death or disability of the owner of a business, the member of a partnership, or a stockholder of a close corporation may create serious problems for that business. If the business is a sole proprietorship, it may be necessary to liquidate and sell the specific assets, rather than the going business. Any value based on goodwill or earnings may be wiped out. In the case of a partnership the executor of the estate of a deceased partner may find it necessary to sell the estate's interest at the best offer he can obtain from the surviving partners. Finally, in the case of the corporation, the corporation will continue, but either the heirs of the deceased stockholder may not desire to continue their ownership, or the remainnig stockholders may not wish to share the ownership and control of the corporation with the heirs.

The ideal solution to these problems is to make prior arrangements for the sale of the individual's interest in the business prior to his death through a buy and sell agreement, under the terms of which each owner agrees that his share of the business is to be sold to the remaining owners at his death, and each owner agrees to buy the share of a deceased owner. In the case of a proprietorship, the parties to the purchase agreement may be the owner and an employee or the owner and a competitor. The agreement may contain a formula to be used in setting the value of the business at the time of sale, thus eliminating difficulty at the time of the sale.

It is possible to have a business purchase agreement without a funding arrangement. The partners may have sufficient cash or liquid assets which would enable a survivor to purchase the interest of the decedent for cash. But this would be a very unusual situation, particularly in a growing business, where the partners have been plowing back the profits into the business.

The most satisfactory method of funding is to purchase business life insurance on the lives of the owners; the partners, partnership, stockholders, or the corporation, whoever is to be the purchaser to pay the premiums and own the policies on the life of the party whose interest in the business is to be purchased upon his death. By this method it is possible to have the business purchase agreement fully funded at all times.

The operational aspects of the funding may vary, depending on the circumstances. Under the arrangement known as a "cross-purchase plan," each of the partners or stockholders carries enough life insurance on the lives of the others to permit the purchase of a proportionate share of a deceased member's interest. For example, If Abner, Baker and Cole each own one third of a business valued at $300,000, Abner would buy $50,000 in life insurance on Baker and Cole, Baker would buy a $50,000 policy on both Abner and Cole, and Cole would buy $50,000 on each of Abner and Baker. If one of the partners dies, the remaining two will receive sufficient proceeds from their policies on his life to permit them to purchase his interest.

As an alternative, the policies on each of the owners could be purchased by the firm itself. Under this arrangement, known as the "entity plan," the firm owns the policies and is the beneficiary. The premiums paid on such insurance is not deductible as an expense for tax purposes. On the positive side, the exemption of life insurance proceeds payable by reason of death from the income tax applies whether the beneficiary is an individual, a partnership, a trustee or a corporation. Under the entity plan, the partnership or corporation purchases the interest of the deceased owner, and the interest of the survivors is increased proportionately.[5]

Key Man Insurance

One of the most valuable assets of any business is the skill of its employees. Since every employee contributes to the success of a business, the death of any employee is a source of loss to the firm. The extent of this loss varies with the contribution of the individual to the success of the firm. Those employees who make a critical contribution to this success are key employees, and in the case of these employees the risk of loss to the firm may be sufficiently great to warrant insurance protection. The key man may be a crucial factor in sales, in production, in finance, in management, or in some combination of these functions. The determining characteristic is that the success or failure of the firm depends to a great degree on his continued efforts. In many cases this key man will be the owner; in some it will be a partner or employee; it may even be a stockholder. In any case, when the loss of an individual connected with the business would cause a financial loss through imperiled credit, loss of leadership, re-

[5]There is a distinction between a Stock retirement agreement and a Stockholders Buy and Sell Agreement. A Stock Retirement Agreement is an agreement between stockholders and a corporation whereby the corporation agrees to purchase the stock of the corporation owned by the stockholder upon his death. There is usually no agreement that the stock will be retired. Such stock may be held in the treasury or canceled. The term, "Stockholders Buy and Sell Agreement," is generally used to describe an agreement for purchase and sale between stockholders, the survivors to buy the stock of the deceased stockholder.

duced profits, or reduced ability to secure new business, the firm has an insurable interest in that individual.

One of the most difficult aspects of insuring a key man is the determination of his value. The valuation may be based on an estimate of the probable loss of income that might result from his loss, based on esimates of the decline in sales or general slow-down of operations. Additionally, it may be based on an estimate of the additional expense that would be involved in obtaining a replacement, including the costs of finding, hiring, and training a comparable individual. In the last analysis the determination of the value of the key man will be an educated guess, based on a combination of the above factors.

The type of insurance that is used to insure the life of the key man will vary. But generally whole life is purchased.

The Split Dollar Plan

Split-dollar insurance is the name given to an arrangement whereby an employer and an employee share the premium cost of an insurance policy on the life of the employee.

The employer and employee usually enter into an agreement which provides that the employer will contribute a portion of each annual premium equal to the increase in the tabular cash value which will result from such premium payment. The employer will collect the balance of such premium from the employee. The employer as owner of the policy, is responsible for paying the full premium to the life insurance company.

The employer is usually the owner of the policy. The employer is also the beneficiary of the policy to the extent of an amount equal to the cash value as of the date to which premiums have been paid at the time of the employee's death less any indebtedness. The employee's wife or other personal beneficiary is designated as beneficiary to the extent of any balance of the death proceeds. Under the basic split-dollar plan, it is provided that the employer may not change the portion of the beneficiary designation dealing with the insured's personal beneficiary without the consent of the insured. Where the parties wish to have the proceeds of the policy excluded from the insured's gross estate for Federal estate tax purposes, it is usually provided that the designation of the insured's personal beneficiary may not be changed without the consent of such beneficiary.

Many concrete benefits accrue to an employee under a split-dollar plan. First of all, the employee is afforded the opportunity of obtaining additional life insurance with a minimum outlay of his own funds. In addition split-dollar insurance has the additional advantage of being permanent insurance—not term insurance—and can be continued beyond retirement age. Finally, split-dollar insurance provides an incentive and an inducement for the employee to remain with the firm.

One drawback to the basic split-dollar plan is that the amount which is payable to the insured's personal beneficiary decreases year by year as the cash value of the policy increases.

Deferred Compensation

Deferred compensation is an arrangement in which the employer agrees to make future payments to the employee after retirement or future payments to the employee's widow if he should die before retiring. Such an arrangement usually involves a desire on the part of the employer to retain the services and loyalty of his key personnel. The employee also derives a benefit from such an arrangement, because it defers the receipt of income until a time when the tax burden is usually not as great. Ordinarily, a person's income after retirement is lower in amount and the employee is in a lower income tax bracket. The employee incurs no current Federal income tax liability prior to retirement under an orthodox deferred compensation agreement, because the employer's mere promise to pay, not represented by notes or secured in any way, is not regarded as the receipt of income by a cash basis taxpayer.

If the employee lives to retirement age, the employer will use the cash surrender value of the policy to make monthly payments to the employee. When the employer surrenders the policy, the amount received by the employer is subject to the Federal Income Tax to the extent that it represents a return over the employer's contribution. Amounts payable to the employee are fully taxable when received.

If the employee dies before he retires, the proceeds of the policy on his life provide the amount which will be paid by the employer to the employee's widow. The death proceeds received by the employer are free from the income tax but the amounts paid by the employer to the widow are generally taxable, subject to a $5,000 employee death benefit exclusion. The employer may not deduct the premiums paid for the policy as a business expense, but the amount paid out to either the employee or his widow are deductible if reasonable in amount.

THE LIFE INSURANCE CONTRACT

Unlike many insurance contracts, there is no standard policy form that must be used in life insurance. However, while there is no standard contract, the states have enacted legislation which requires that all life insurance contracts include certain mandatory provisions. The most commonly required provisions include the following:

1. The policy shall constitute the entire contract.
2. There must be a grace period of 30 days or one month.
3. The policy shall be contestable only during the first two years.
4. Misstatement of age shall adjust the amount of insurance.
5. Reinstatement must be permitted.

6. Participating policies shall pay dividends on an annual basis.
7. Non-forfeiture values must be listed for at least 20 years.
8. The non-forfeiture values to which the insured is entitled must be listed after the payment of three premiums.
9. A policy loan provision must be included on policies that develop cash values.
10. Installment or annuity tables shall show the amount of benefits to which the beneficiary is entitled if the policy is payable on installments or as an annuity.

In many cases the exact wording of the provisions is not spelled out, but the final wording adopted must be approved by the commissioner. In addition to those provisions prescribed by law, there are other general provisions which are necessary to complete the structure of the contract. Competition generally requires substantial similarity in these provisions. So, while there is no "standard" life insurance contract, the provisions discussed in this chapter are more or less common to all life contracts. It is suggested that you study a sample contract of your company.

GENERAL PROVISIONS

The Entire Contract Clause

When the application is incorporated as a part of the policy contract, the representations of the insured then become contractual provisions and can be used as evidence in a contest of the validity of the contract. In order to prevent the use of other evidence, most states require the inclusion of a clause in life insurance policies stating that the policy and the application attached to the policy constitute the entire contract between the insurer and the insured.

The clause states that the statements of the insured are to be considered representations and not warranties, thus requiring the insurer to prove the materiality of any misrepresentations by the insured. This provision is clearly beneficial to the insured.

The Ownership Clause

A life insurance policy is a piece of property. The owner of the policy may be the individual on whose life the policy is written, it may be the beneficiary, or it may be someone other than either the insured or the beneficiary. The person designated as the owner has vested privileges of ownership, including the right to assign or transfer the policy, receive the cash values and dividends, or borrow against the policy.

The Beneficiary Clause

The beneficiary is the person named in the life insurance contract to receive all or a portion of the proceeds at maturity of the policy. The designation of the beneficiary is an important aspect of the policy and is designed specifically to reflect the insured's decisions concerning the disposition of his insurance. The beneficiary may be the insured with respect to an endowment or retirement-income policy, or may be his estate or a third-party beneficiary with respect to the proceeds in the event of his death. In most instances it is best not to name the estate as beneficiary, particularly when it is intended that the proceeds will go to certain individuals. If a specific beneficiary is named, the proceeds will be paid to the designated person or persons directly after the death of the insured and they will not be delayed until the settlement of the entire estate has been completed.

The customary type of beneficiary designation is the donee or third-party beneficiary. Here the beneficiary may be a specific individual or a class designation. In order to make certain that his intentions will be accomplished, the insured should designate the beneficiary or beneficiaries with care. For example, his desire may be that his wife be the primary beneficiary and that his children by his wife are to be the class-contingent beneficiaries. Proper identification could be accomplished in this case by the designation of "My wife, Elizabeth Hallquist Jones, and our children." The wife would perhaps be named the primary beneficiary and the children contingent. The children then, would receive and share equally the proceeds if the wife should predecease the insured.[6]

There are many classifications of beneficiaries, but for our purpose the most important involves that in which the insured may or may not reserve the right to change the designation. In this classification beneficiaries may be **revocable** or **irrevocable.**

If at the inception of the contract, the insured designates a beneficiary and reserves the right to change this designation, then the change may take place any time and any number of times during the term of the policy.

If the insured designates an **irrevocable** beneficiary, he then loses his right to exercise the privilges granted by the contract, except with the consent of the beneficiary.

The Incontestable Clause

The usual policy provision reads as follows: "This policy shall be incontestable after it has been in force during the lifetime of the insured for two years from

[6]There are many reasons for the use of care in the designation of the beneficiary. For example, if the insured designates as beneficiary "My wife, Mrs. Jones," to whom does he have reference? Is this his present or a former wife? Or if he designates "My children" as a class beneficiary, which children does he desire to include? Would adopted or illegitimate children be included? And what about children of a former wife? These difficulties may be avoided with a little intelligent care. Otherwise a disgruntled former wife or an illegitimate child may cause considerable difficulty.

the date of issue.[7] This means that the validity of the contract cannot be questioned for any reason whatsoever after it has been in force during the lifetime of the insured for two years. The fundamental reason for this restriction is based on the long-term nature of the life-insurance contract. It is to assure the person insured and his beneficiary that they will not be harassed by lawsuits long after the original transaction and at a time in which all evidence of the original transaction has disappeared and original witnesses have died.

The clause is applicable for only two years **during the lifetime of the insured.** This means that the death of the insured during the contestable period will suspend the operation of the clause. If it so desires, the company may then contest the validity of the contract without the limitation of the two-year interval. If this were not the case, should the claimant know that the insured had purchased the contract and had made many material misrepresentations in the application, he could wait until the termination of the two-year period before submitting his claim, and thus would be protected against voidance of the contract because of the insured's fraudulent acts.

Misstatement of Age Clause

The incontestability clause does not apply to the misstatement of his age by the insured. The misstatement of age clause provides that in the event that the insured has misstated his age, the face of the policy will be adjusted to the amount of insurance that the premium which he paid would have purchased at his correct age. In other words, the amount of the policy is **adjusted;** the contract is not voided.

The Grace Period

We have already learned that the consideration for the insurance company's promise is the payment of the first premium by the insured. While subsequent premiums are not a part of the legal consideration, they must be paid when due or the contract can no longer exist. A premium-due date is designated in the policy and the premium should be paid on or before that date if the contractual promise of the insurance carrier is to continue. The insured may pay his premiums on an annual basis, or in semi-annual, quarterly, or monthly installments.

[7]By statute in most States, the incontestable clause must be a provision in all life-insurance contracts, and no State permits the period to exceed two years from the date of issue of the contract. Some carriers, perhaps for competitive reasons, have shortened the contestable period to one year, and this is permissable under the law. However, courts have generally refused to uphold a provision that makes the contract incontestable from date of issue, particularly in those cases in which fraud is involved.

If the insured does not pay the premium on the due date, technically the contract will lapse. The time of lapsation, however, is subject to a modification which is in the nature of a "grace period," and is required almost universally by statute.

The purpose of this clause is not to encourage procrastination in the payment of premiums (although it does), but rather to keep the policy from lapsing when the owner of the policy inadvertently neglects to pay the premium.

Reinstatement

Practically all permanent life-insurance contracts today permit reinstatement of a lapsed policy. However, the reinstatement is subject to certain specific conditions.

It is apparent that reinstatement is not an unconditional right of the insured. It can be accomplished only if the risk has not changed for the insurance carrier and only if, by payment of the back premiums with interest, the reinstated policy would have the same reserve as it would have had if the policy had not been lapsed. The conditions necessary are quite specific. First, reinstatement is possible only if at the time of lapsation the insured did not withdraw the cash value of the policy. Withdrawal of the surrender value in cash terminates the contract forever. Second, reinstatement must be effected within a specific time period, normally five years after lapsation. Third, the insured must provide proper evidence of his insurability. Fourth, it is obvious also that reinstatement can be effected properly only if the insured pays the overdue premium plus interest and pay or reinstates any indebtedness that may have existed.

Suicide Exclusion

Life-insurance contracts have few exclusions. Almost universally, however, suicide during a stipulated period after inception of the contract is excluded. A typical exclusion reads as follows: "If within two years from the date of issue the insured shall die by suicide, whether sane or insane, the amount payable by the Company shall be the premiums paid." Some companies, however, limit the suicide exclusion period to one year. The reason for the exclusion is, of course, that of protecting the carrier against a person who might purchase the insurance with the deliberate purpose of committing suicide. After the exclusion period is over, death by suicide becomes just another cause of death, and coverage is justified on the assumption that it should be provided for a hazard of life to which practically all people are subject.

NON-FORFEITURE VALUES

If the insured does not pay the premium within the grace period, the policy will lapse. Years ago life insurance contracts did not contain non-forfeiture values and in the event of a missed premium the policy was terminated with no return to the insured. Because of the overpayments which the insured had made under the level premium system, this was extremely unfair to the policyholder and resulted in unjust enrichment of the insurance company.

Under the Standard Nonforfeiture Law today, at any time after the policy has begun to develop a cash value the insured may discontinue premium payments and obtain the return of a part of the overpayment which he has made. Normally policies do not begin to accumulate a cash value until after the end of the second policy year, and although there is a relationship between the policy reserve and the cash value, the cash value of the policy rarely equals the full amount of the policy reserve until the policy has been in force for 10 to 15 years.

When the insured decides to stop payment of premiums, he is entitled to the cash value of the policy, which he may take in one of three ways:

1. He may take the cash listed in the Table of Nonforfeiture values.
2. He may take a paid-up policy in some reduced amount. The amount of the reduced policy will be the amount that the cash value would purchase as a net single premium.
3. The third option permits the insured to continue the policy in force as term insurance for as long as the cash value will permit. The cash value is used to make a net single premium purchase of a term policy in the face amount of the policy with the non-forfeiture value. If the insured does not request another option, the company will normally provide extended term insurance.

A typical table of non-forfeiture options is reproduced below. It lists the guaranteed values at the end of each policy year. The law requires that these values be listed for at least the first twenty years of the policy, but they are commonly given for advanced ages of the insured in addition.

The Standard Nonforfeiture Law requires that a surrender value be made available in cash, but also permits a company to delay or postpone payment of the cash value for a period of six months after surrender of the policy. This is known as a **delay clause** and is mandatory in all policies today. Its purpose is to prevent substantial investment losses in the event large numbers of insureds cash in their contracts in a relatively short period of time, as might occur during a major economic recession. Insurance carriers pay little attention to the clause and perhaps would use it only under the most unusual circumstances. If the insured surrenders the policy for its cash value, the entire contract is terminated and the company will have no further obligations.

Paid Up Reduced Amount

The second surrender option is paid-up whole-life or endowment insurance. Here, in lieu of obtaining the cash-surrender value in cash, with complete termination of any insurance, the insured will receive a reduced amount of paid-up insurance which will be payable under the same conditions as the original policy. The paid-up contract will have a cash-and-loan value

TABLE OF NONFORFEITURE VALUES

At End of Policy Year	Tabular Cash Value or Loan Value	Paid-up Life Insurance	Extended Term Insurance		At End of Policy Year	Tabular Cash Value or Loan Value	Paid-up Life Insurance	Extended Term Insurance	
			Years	Days				Years	Days
1	$ 0.00	$ 0	0	0	13	$185.72	$413	15	138
2	0.40	2	0	41	14	204.50	443	15	219
3	15.53	46	3	294	15	223.54	472	15	274
4	31.02	89	6	212	16	242.84	500	15	307
5	46.87	130	8	263	17	262.38	527	15	321
6	63.06	170	10	136	18	282.16	553	15	317
7	79.59	209	11	244	19	302.17	578	15	299
8	96.46	246	12	255	20	322.39	602	15	269
9	113.66	282	13	189	Age 60	414.55	691	14	211
10	131.19	316	14	62	Age 62	451.41	722	14	12
11	149.06	350	14	248	Age 65	506.00	763	13	63
12	167.24	382	15	29					
Nonforfeiture Factor	FIRST 20 YEARS 17.31369 - THEREAFTER 15.29869								

on the same general terms as those of the original policy. If the original policy is a limited-payment contract, the paid-up insurance of reduced amount will be whole life. But if the original contract is endowment insurance, protection in a reduced amount will be granted only for the remainder of the endowment period. If the insured survives the endowment period, the payment at that time will also be in a reduced amount.

Extended Term Insurance

The third surrender option is paid-up term insurance and the benefit is commonly referred to as "extended-term insurance." Here the amount of the term insurance will be the same as the face value of the original contract. The variable will be the length of the term period, rather than the amount of the insurance, and the period will be of that length which the cash value used as a net single premium will purchase at the insured's attained age. If he should die during this term, the carrier will pay the face amount to his beneficiary. But if he outlives the term, the commitment of the insurance carrier will be terminated. If this option is selected where the original contract was endowment insurance, the paid-up term insurance will not extend beyond the maturity date of the original contract. Usually after the endowment contract has been in effect for a few years the surrender value will exceed that amount necessary to purchase term insurance for the balance of the endowment period. So rather than extend the term period beyond the original endowment maturity date, the insurance carrier will use the excess to provide for the payment of a pure endowment should the insured survive the endowment period. This amount, however, will be substantially less than the face amount of the extended-term contract.

Policy Loan Provisions

One of the most important secondary benefits of a life-insurance contract involves the policy-loan provisions. The insured at any time may obtain a loan from the insurance carrier, using the policy as collateral for the loan. The loan will bear interest at some percentage stipulated, and if not paid, will be added to and become a part of the loan. If the insured dies while the indebtedness exists, the loan plus interest will be deducted from the proceeds of the policy.

Automatic Premium Loan. Most policies today contain an automatic-premium-loan provision. If this provision is included in the contract and the insured does not pay the premium on the due date, the company automatically will pay the premium and charge it against the cash value of the policy. The loan will bear interest at the rate applicable to policy loans as stipulated in the contract.

This provision may be very beneficial for the policyholder, particularly for one who inadvertently forgets to pay the premium within the grace period and for one who cannot pay the current premium because of financial difficulties. The most important aspect is that the policy does not lapse. Advantages are that any special coverages such as double indemnity and disability coverages will remain in force, and no medical examination must be passed to reinstate the policy.

Most companies now offer this provision, but the provision is optional and an election must be made at the time that the policy is taken out or at least before the premium is in default. Various companies handle the option differently; some specify that the insured most notify the company if he wants the provision to apply, while other companies make the provision automatic and the insured must notify the company if he does not want it to apply.

DIVIDEND PROVISIONS

Because of the long-term nature of life-insurance contracts, companies must calculate premium charges on a conservative basis. The gross premium for a life-insurance contract is composed of three factors: mortality costs, plus the anticipated expenses of operating the company and minus an assumed rate of interest earned on invested funds. Once the premuim rate is established, it must be guaranteed for the entire term of the policy. It is not subject to change, even though the basic factors used in determining premiums change substantially. Over a long period of time substantial changes in the premium factors could occur. Mortality rates may change. The expenses of operating the business may increase substantially, particularly if the long-run trend of prices is upward. Interest rates may also change, and the change could be down as well as up If current premium rates are to be sufficient to enable insurers to fulfill their obligations on contracts that may exist for many decades in the future, a safety margin must, then, be used in the calculation of the premiums, in order to provide a relative degree of assurance of their adequacy.

Life-insurance contracts may be participating or non-participating. A participating policy is one on which annual dividends are paid to the policyholder. In this type a substantial margin of safety is built into the gross premium, sufficient to constitute a willful overcharge but justified on the assumption that if the extra premium is not needed, it will be returned to the policyholder in the form of a policy dividend. This means that policy dividends are not profits, as the term is normally used, but merely the return of the excess premium. The overcharge, however, does have a substantial justification. It will provide the company with a margin of safety which will assure that its obligations will be fulfilled even in the distant future when underlying conditions affecting premium rates may have changed substantially and adversely. The policyholder is assured of a return of the overcharge as well as the ability of his insurance company to meet its obligations.[8]

[8]The safety margin on non-participating contracts is much narrower than on participating. This is necessary because the cost of the insurance to the policyholder will not be adjusted by the payment of dividends; hence the gross premium charged must reflect closely, at least for competitive reasons, the actual cost of providing the insurance. Any profit realized in the operation will be used to provide dividends to stockholders and to provide surplus funds that may be used as a buffer for adverse experience.

Favorable deviations from the assumptions entering into the calculation of the gross premium are the source of surplus from which policy dividends are paid. The current death rate may be less than anticipated, the rate of interest earned on invested funds may be higher than that assumed, and company expenses may be substantially less than anticipated. The savings in mortality, the excess interest, and the savings in expenses will yield a surplus each year. A portion of this gain will be transferred to company surplus or to a special contingency reserve to be used, if necessary, for future losses arising from adverse mortality experience, extremely low interest earnings, and unusually high operational expenses. The balance will be distributed as policy dividends.

In a participating life-insurance contract the policyholder is provided with several dividend options. He may take the dividend in cash, he may apply it toward the payment of the current premium on his policy, he may apply it to the purchase of paid-up additions to the policy, or he may leave the dividends on deposit with the insurance company to accumulate at interest. The policyholder normally makes an election as to the disposition of the dividends at the time he purchases the policy. However, a new election may be made at any time with just one possible qualification: if the insured does not elect to use the dividends to purchase paid-up additions to the face of the policy at the inception of his contract, he must then file evidence of insurability if this option is selected at some later date. In most contracts, if the policyholder does not choose an option at the time of issue of the policy, the dividends automatically will be used to purchase paid-up additions to the policy amount.

Several of the options are so simple as to require little explanation. If the insured chooses to receive the dividends in cash, the company will send him a dividend check on each anniversary of his contract. If the dividend is to be applied toward payment of the next premium, the company will indicate the amount of the dividend on the premium-due notice and the insured will remit only the difference between the gross premium due and the amount of the dividend.

If the insured choose to use the dividend to purchase paid-up additions to his policy, the dividends will be used as a net single premium at his attained age to purchase whatever amount it could purchase at that age. The additions will be payable under the same conditions as the basic policy, i. e., as a whole- life or endowment insurance.

The insured may also choose to leave the dividends on deposit with the insurance company. Interest at some guaranteed rate will be paid on the deposit and the insured will also share in the excess interest earnings of the company.[9] If the insured should die, the accumulated deposits will be paid in addition to the face of the basic contract. If he should surrender the policy, the deposits will be added to the surrender value and may be added to the face amount of the paid-up policy of reduced amount or to extended-term.

If the dividends are left with the company either as deposits or to be used to purchase paid-up additions, it is possible for the insured to convert the basic contract into a fully paid-up policy at an earlier date than that called for by the terms of the basic contract.

SETTLEMENT OPTIONS

The average person, in thinking about the settlement of life insurance policies, normally thinks of a lump sum being paid to the beneficiary of the insured. As a matter of fact, while a great many life insurance policies are paid in this manner, most are not. In addition to the lump sum settlement, there are certain optional methods of settlement which may be used to pay out the proceeds of the policy.

Normally the owner, (who in most cases is also the insured), selects the option under which he wants the proceeds of the policy paid. If no election is in force when the policy becomes payable the beneficiary is entitled to select the option desire. Unless the insured (owner) has made provision which denies the right, the beneficiary may also change to some other settlement.

The Interest Option

The proceeds of the policy may be left with the insurance company under the interest option, in which case only the interest on the principal amount is paid to the beneficiary. At some later date the principal may be paid out in a lump sum or paid out under one of the other options.

Installments for a Fixed Period

The insured may specify, (or the beneficiary may elect) to have the proceeds of the policy paid out over some specified period of time. The insurance company simply computes how much it can pay out of the policy proceeds and the interest on the proceeds during each of the required periods so that the entire principal and interest will be gone by the end of the period. The longer the period of time for which the company promises to pay the installments, the smaller each installment must be.

Installments of Fixed Amount

The owner of the policy (or the beneficiary) may elect to have the proceeds of the policy paid out in payments of some fixed amount ($50, $100, $200, etc.) per month for as long as the principal plus interest on the portion of the principal which has not been paid will last. Since the amount of each installment is the controlling factor under this option, the length of time for which the payments will last will vary with the amount of the policy.

Life Income Options

In addition to the options listed above, the policy gives the insured's beneficiary the option to have the proceeds of the policy paid out as a monthly life in-

[9]This interest will be taxable as income to the insured. The dividends themselves are obviously not taxable, for they are not income, but merely the return of an overcharge.

come. In such cases the proceeds of the policy are used to make a single premium purchase of an annuity. Although the various life insurance companies list many life income options, they may be classified into four basic categories.

1. **Straight life income. (Life Annuity).** Under a straight life income option the proceeds of the policy are paid to the beneficiary on the basis of his or her life expectancy. The beneficiary is entitled to receive a specified amount for as long as he or she lives, but nothing more. If the beneficiary dies during the first year of the pay period, the company has fulfilled its obligations and no further payments are made. Beneficiaries who live longer than the average are offset by those who live only a short time.

2. **Life income with period certain.** Under this option the beneficiary is paid a life income for as long as he or she lives, but a minimum number of payments are guaranteed. If the beneficiary dies before the number of payments guaranteed have been made, the payments are continued to a contingent beneficiary. Normally the "period certain," as the time for which payments are guaranteed is known, is 5 years, 10 years, 15 years, or 20 years.

3. **Life income with refund.** Under the life income with refund option the beneficiary is paid a life income for as long as he or she lives, and if the proceeds of the policy have not been paid out by the time that the beneficiary dies, the remainder of the proceeds will be paid to a contingent beneficiary. The Life Income With Refund may be either a life income with installment refund, in which case installments are continued until the contingent beneficiary has received the difference between the original policy proceeds and the amount received by the direct beneficiary, or it may be a cash refund. Under the cash refund installments do not continue to the contingent beneficiary, but instead a lump sum is paid to the contingent beneficiary.

4. **Joint and Survivorship Life Income Option.** The joint life income option is a somewhat specialized option, designed to provide income to two people. The joint life income option may provide for payment of a given amount of income during the time that either of the two people are alive. Under this type of provision the payments continue after the first of the two people has died and does not stop until the second has died. A modification of this plan provides that the amount of the benefit will be decreased when the first of the two payees dies. The benefit to the remaining payee will then be either two-thirds or one-half (or possibly some other fraction) of the original income amount. This benefit is computed on the basis of two lives and the amount of the benefit depends on the age of both beneficiaries.

The amount payable under any one of the life income options depends on the age and sex of the beneficiary plus the option selected. For obvious reasons, the company cannot afford to pay as high a monthly income if it also guarantees to pay it for at least some guaranteed period of time. When a period certain is selected, the mortality gains under the annuity are eliminated for whatever length the period certain is.

IMPORTANT OPTIONAL PROVISIONS

The Disability Waiver of Premium Provision

The disability waiver of premium provision is one of the most important options available to a person purchasing life insurance. Under the provisions of this coverage the company agrees to waive all premiums coming due after the insured has become totally and permanently disabled. Once an individual has become disabled, it will undoubtedly be difficult if not impossible for him to obtain insurance coverage, and it is therefore essential that he be able to continue the coverage which he has. In essence, this benefit provides for the waiving of all premiums on the contract during the period of disability, and the continuation of the contract as if the premiums were paid. This means that the cash value will increase and the dividends will be paid to the insured just as if the insured were paying the premiums. This provision is so important and at the same time so inexpensive that many companies automatically include it in their policies. If it is not automatically included, the insured should certainly elect to have it added.

Although the details of the provision may vary slightly from one company to another, it usually provides for waiver of premiums coming due during a period of total disability which has existed continuously for a period of at least six months. Furthermore, the provision generally requires that the disability commence prior to a specified age, usually 60. However, the reader should not confuse the time at which the disability must begin with the duration of the benefits. If the disability commences before the limiting age, waiver of premiums may continue for the entire lifetime of the insured.

Accidental Death Benefit

Another coverage that may be added to a life insurance contract is the Additional Death Benefit, which provides for the payment of a specified sum in addition to the face of the policy if the death of the insured is caused by accident. Typically, this additional amount is equal to the face of the policy, and for this reason the benefit is often referred to as "Double Indemnity". However, the added amount is not always equal to the face of the policy. In some instances it is a lesser amount, and in some cases companies provide "Triple" or even "Quadruple" Indemnity. In any case, the insuring agreement usually provides that the additional Accidental Death Benefit is payable under the following conditions:

1. Death results directly and independently of all other causes from accidental bodily injury.

2. Death occurs within 90 days of the injury.

3. The accidental bodily injury or death occurs before a specified age (such as 65 or 70).

There is a small additional charge for this benefit, usually payable until the limiting age specified in the endorsement.

Guaranteed Insurability Option

Many companies now permit an insured at stated intervals to purchase additional amounts of insurance without providing evidence of insurability. The option under which this is possible is known as "guaranteed insurability" or "additional purchase option," or by some similar designation, and is applicable only to the permanent types of contracts such as whole-life and endowment. The insured has the option of purchasing additional insurance, regardless of his insurability, at three-year intervals and up to a specified age, the most common maximum being age forty. In many cases the amount of the additional insurance is limited to the face of the basic policy, or $10,000, whichever is the smaller. An extra premium is required for the option that is based on the company's estimate of the extra mortality that will be experienced on policies issued without evidence of insurability. The premium is payable to the last option date and, for the insured, is the cost of insuring his insurability.

The option is not standardized, which means that some variation exists in the provisions in use by different insurance carriers. One of the most important variations involves the waiver-of-premium and the accidental-death-benefit provisions. Naturally the question must arise as to whether the additional insurance will contain these benefits if they are included in the original contract. If the answer is "Yes," will the waiver-of-premium benefit be applicable to the additional insurance should the insured become totally disabled at the time the additional insurance becomes effective? The most liberal options do provide automatically for the inclusion of the waiver-of-premium benefit if it exists in the original contract.

The Common Disaster Clause

The insured and the beneficiary rarely die simultaneously, but when both are killed in the same accident, it is often of considerable importance to determine the order in which death occurred. For example, if the insured survived the beneficiary, the policy proceeds would be payable to a contingent beneficiary or, in the absence of a contingent beneficiary, to the estate of the insured. On the other hand, if the beneficiary survived the insured, the policy proceeds become payable to the beneficiary, and upon the subsequent death of the beneficiary, to the beneficiary's estate. Such an arrangement may be totally contrary to the interest of the insured, and may in addition subject the proceeds to unnecessary probate and estate tax costs.

Some states (including Iowa) have attempted to partially solve this problem through a statute known as the Uniform Simultaneous Death Act, which provides that where the insured and beneficiary have died and there is no evidence that they died other than simultaneously, life insurance proceeds are distributed as if the insured survived the beneficiary. This does not totally solve the problem, since in some instances it is known that the beneficiary did survive the insured, if only for a short time.

The contingency is dealt with far more effectively in the life insurance policy itself through the use of a provision called the Common Disaster Clause. Under the terms of this provision, settlement of the policy proceeds are withheld for a designated number of days after the death of the insured (usually 30) and for the purpose of making settlement, any beneficiary surviving the insured but dying within the number of days designated is considered to have predeceased the insured.

The Spendthrift Clause

It is sometimes a practice to include a provision in the policy called the "Spendthrift Clause", which denies the beneficiary the right to commute, alienate, or assign his or her interest in the policy proceeds. In addition to providing some protection against extravagance of the beneficiary which might result in the dissapation of the policy proceeds, the clause also provides some protection against claims made by creditors of the beneficiary. A typical Spendthrift clause reads as follows:

> Unless otherwise provided in this settlement option agreement, no beneficiary may commute, anticipate, encumber, alienate, withdraw, or assign any portion of his share of the proceeds. To the extent permitted by law, no payments to a beneficiary will be subject to his debts, contracts, or engagements, nor may they be levied upon or attached.

As the reader will recall, Iowa law exempts life insurance policy proceeds payable to a surviving widow from liability for debts of the beneficiary contracted prior to the death of the insured, up to $15,000.

SPECIAL LIFE INSURANCE FORMS

As we have seen, there are three basic types of life insurance contracts:

1. Term insurance
2. Whole Life
3. Endowment

In addition to the basic life insurance contracts listed above, life insurance companies offer a wide variety of policies that combine two or more of the basic types into one contract, or which provide for an unusual pattern of premium payments.

These special types are designed to fit special situations, and while they may or may not offer the same degree of flexibility as do the basic contracts, they may possess advantages that make their use attractive in many situations. The important point to remember is that the forms that will be discussed are nothing more than combinations or modifications of the three basic

forms, and the manner in which they may be combined is limited only by the imagination of the policy writers.

Mortgage Redemption Policy

Although technically we might call any policy purchased for the purpose of retiring a mortgage in the event of the borrower's death "mortgage insurance", as the term is generally used it refers to a policy designed to provide protection in some amount that will be sufficient to pay off a declining mortgage balance at any time. The principal of a mortgage usually reduces on a gradual basis over time, so a policy designated to pay off that mortgage may also reduce over time. A Mortgage Protection policy is written on a decreasing term basis for the term of the mortgage. If the policyholder lives to pay off the mortgage himself, the policy expires without value at the same time that the need for the protection disappears. On the average, the amount of risk facing the insurance company is about one half the initial face amount, so the cost of such a policy is considerably less than a level term policy for the same period of time. Normally, the premiums on the mortgage protection policy are payable only for a portion of the term of the policy (e.g., 16 years on a 20 year policy).

The Family Income Policy

The Family Income Policy utilizes the concept of decreasing term insurance to fit a need for a decreasing amount of insurance. The family income policy is a combination of some form of permanent insurance (e.g., whole life) with decreasing term insurance. The term insurance makes provision for the payment of some stipulated amount per month from the date of the insured's death until some specific date in the future. The amount payable per month is typically $10 for each face of permanent insurance, although many companies offer other options.

To illustrate the operation of the family income policy, let us assume that the insured in question purchases a $10,000 whole life policy with a 1% family income benefit. The insuring agreement of the family income rider promises to pay $100 per month to the beneficiary of the policy from the date of death of the insured until a date 20 years from the inception of the policy. The amount of insurance under the decreasing term is always sufficient to pay the monthly income from the date of the insured's death until the expiration date of the term. If the insured outlives the period specified as the family income period, the decreasing term portion of the policy ceases. The insured then has the basic amount of permanent insurance on which he continues to pay premiums.

The figure below illustrates graphically the family income policy. The amount of whole life insurance in this illustration is $1,000. The $1,900 represents the amount which the life insurance company must have in policy proceeds at the beginning of the policy in order to pay the 1% of the basic amount per month for a period of 20 years. As time goes by, the amount of insurance needed to make the $10 monthly payment for a period of 20 years in the future declines. In our illustration we have assumed that the policy was purchased on January 1, 1970. The $10 per month will be paid from the date of the insured's death until January 1, 1990.

The Family Income Rider

The family income rider is merely a variation of the family income policy, but with somewhat more flexibility. The family income rider is simply a decreasing term rider that is attached to some permanent form of insurance such as whole life or endowment. Some companies will even permit the use of the family income rider with a form of long duration term such as term to age 65 or term to expectancy.

One of the major differences between the family income rider and the family income policy is the amount of term insurance involved. While both the family income policy and the family income rider may provide for the payment of a specified amount (e.g., $100 per month), the actual amount of term insurance required to provide this amount may differ. The determining factor is the time at which the basic policy is payable. It is common under the family income policy to provide for the payment of the basic policy at the end of the income period. Thus the income from the basic policy helps to provide the monthly income payments. In the case of the family income rider, the term insurance is frequently sufficient to provide the full amount of the monthly benefit, without the interest from the basic policy. This means that the amount of the basic policy may be paid immediately at the death of the insured, it may be left at interest to increase the amount of the monthly benefit above the designated amount, or it may be left to accumulate at interest until the end of the income period.

FAMILY INCOME
(20 Year)

$1,900—Initial Value
(Term Insurance)

$1,000—Basic Policy

Age 25 | 45 | 65

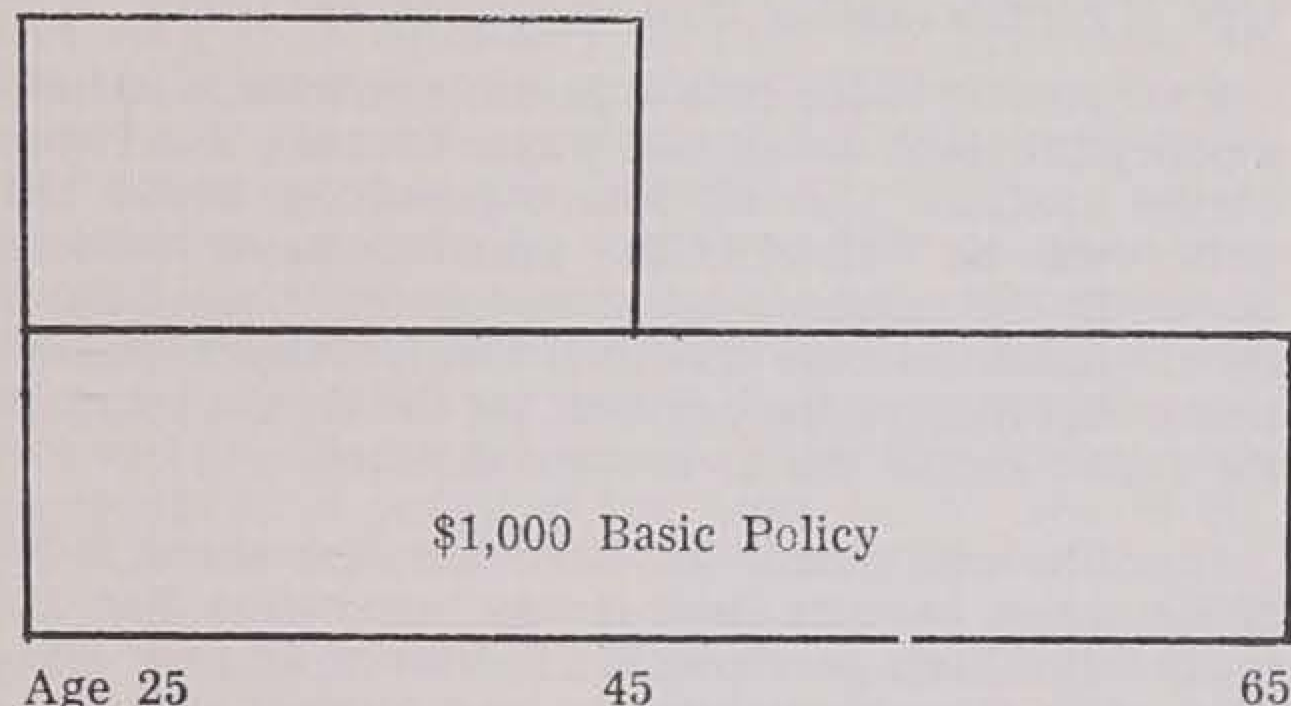
The Family Maintenance Policy

Instead of paying a monthly income from the date of the insured's death until some dates 10, 15, or 20 years from the inception of the policy as does the family income policy, pays the monthly income for a period

of 10, 15, or 20 years from the date of the insured's death, provided that the insured dies during a specified period.

The family maintenance policy is a form of permanent insurance, plus level rather than decreasing term. The term portion of the policy will provide income for the number of years specified.

FAMILY MAINTENANCE



The Family Protection Policy

This special form is known by many names; most companies offer it in one form or another and many of the companies refer to it by their own special trade name. The family protection is a package policy approach to providing insurance on all members of the family. Perhaps the most outstanding characteristic of all is that insurance in predetermined proportions is provided for each member of the family. For example, the unit on the husband may be $5,000 on an ordinary-life basis, with $1,000 term insurance on the wife (the term extending to the time the husband is sixty-five), and the $1,000 term coverage on each child, with coverage to a specified age such as twenty-one. Children born after the inception of the contract are covered automatically without notice to the insurance carrier, upon the attainment of a specified age, **e. g.,** fourteen days. The contract may include a waiver-of-premium benefit which provides that if the husband dies or becomes totally disabled, further premium payments on the contract will be waived. In addition, an accidental-death benefit providing for double indemnity on the life of the husband only may also be included. Surrender and loan values are provided, but paid-up insurance normally is provided only on the coverage applicable to the husband. It is also customary to permit conversion of the term insurance on the lives of the dependents upon the expiration of the specified term. For example, many contracts provide for conversion of the coverage on the children up to as much as $5,000 of permanent life insurance for each $1,000 of term coverage and without evidence of insurability.

The husband is considered to be the owner of the policy. However, his freedom in disposing of the insurance is normally limited by specific provisions in the contract.

The premium on this form of insurance is based on the age of the husband, with an adjustment made for the additional risk which the company accepts.

All members of the family must be insurable if the contract is to be issued. If the husband or the wife should be uninsurable, the contract cannot be issued at all. In some companies a "parent's policy" covering one parent and the insurable children may be employed. A possible exception involves the children. If one child is uninsurable, the family policy may be issued, but with the uninsurable child excluded from coverage.

It can be, and often is written with a family income rider which provides 1% of the amount of coverage on the father as monthly income during the family income period. One of the more attractive features of the policy is that it guarantees the insurability of the children in the family. In the event that a child should become uninsurable before reaching the conversion age, or if a child were born to the marriage who was uninsurable this contract would guarantee that the child would be able to purchase at least some minimum amount of permanent insurance upon reaching the conversion age. The conversion does not require the evidence of insurability.

Return of Premium or Cash Value

Some individuals who lack an understanding of the level premium concept feel that the insurance company should pay the face of the policy when the insured dies, plus the cash value. They reason that since the cash value is the insured's saving fund, it is inequitable to pay this to the beneficiary and call it a part of the death benefit. These individuals feel that if the insured dies before the policy matures, the company should be obligated to pay the face amount of the policy plus the cash value. Some insurance companies attempt to create a product that is saleable, and if people want a policy that will pay the face amount plus the cash value, they are certainly going to get it.

Policies have been issued which purport to pay, in addition to the face of the policy, the cash surrender value at the time of death. It should be obvious from what we have learned about the cash value and its relationship to the level premium that this is impossible unless an additional premium is charged. The policies that agree to pay the cash value plus the face of the policy are nothing more than a combination of two contracts. One of the policies pays the face amount in the event of death of the insured. The second portion of the policy is an increasing amount with a face value equal to the cash value of the base policy.

Modified Whole Life

Modified whole life is another combination plan. This form is actually "automatically convertible term." The main characteristic of the policy is the premium level, which changes as the policy becomes three or five years old. The premium for the first three or five years is slightly more than the premium on the same amount of

term insurance. After the end of the three- or five year period, the premium increases to a level that is slightly more than the whole life premium at the age at which the policy was taken out, but also slightly less than the premium on permanent insurance at the attained age of the insured. The policy is particularly attractive to individuals who feel that their income will increase within a short time. They would like to purchase permanent insurance at their present age, but cannot afford to do so. If they wait until they can afford to do so, or if they purchase convertible term, the premium on the permanent insurance will be based on the age at conversion. The modified whole life policy helps to solve this problem.

If the insured knows he will be converting to permanent insurance with a short period of time, he could save on the total premium outlay by purchasing a modified whole life contract rather than convertible term.

The Graded-Premium contract is a slightly different contract with non-level premiums. The premium increases each year during the early years of the contract (usually five years) and remains level thereafter. The initial premium is less than the equivalent premium at the age of issue and the final level premium is more, but less than the ordinary life premium at the then insured's attained age.

Modified Life and Graded-Premium life contracts are useful compromises between whole life insurance and convertible term insurance. The premium is less than that for whole life insurance in the early years. However, the insured is accumulating some cash values and he need not decide to convert term insurance or act upon this decision and furthermore the premium increase is not as great as it would be with convertible term insurance.

Preferred Risk and "Special" Whole Life Policies are examples of changing underwriting requirements to produce different kinds of whole life policies. Presumably, the preferred risk type policy is issued only to persons meeting superior underwriting standards, this is the major justification for the reduced premium.

Juvenile Insurance

The idea of purchasing insurance on children is especially attractive to many individuals. Often grandparents or friends make a gift of a life insurance policy to a child. The primary intent of most juvenile policies is thrift. Juvenile insurance policies are widely used by parents to provide a college fund for the child when he grows up. The forms of insurance often written to cover children are:

1. Twenty-year endowment
2. Educational endowment at age 18
3. The Jumping Juvenile
4. Limited pay whole life policies

The educational endowment at age 18 is quite similar to the twenty-year endowment. The only difference is that the maturity period is shorter, making the face of the policy payable at age 18 so that the benefits can be used for the college education of the child.

The Jumping Juvenile is a specially designed policy which is written for a basic amount of insurance (say $1,000) which automatically increases to some multiple of the basic amount when the child reaches age 21. The premium on the contract remains level throughout the life of the policy. It is normal to limit the face of the basic policy to $5,000. Some parents purchase this type of contract rather than an endowment policy.

It is common in the case of juvenile policies to include a policy provision called the "Payor Clause". The Payor Clause specifies that all future premiums under the policy will be waived if the premium payor, who is named in the endorsement attaching the Payor Clause, should die or become disabled. This provision guarantees completion of the payment on the child's policy if the father should die or become disabled.

Juvenile insurance is an extremely specialized form of insurance. In some cases it may be misused. For too many individuals purchase life insurance on their children when they themselves are inadequately protected. In these cases the premium dollars spent to purchase insurance on children would be better spent in providing protection on the head of the family. Adequate life insurance programming requires a substantial amount of protection on the wage earner. While the death of a child is certainly a tragedy, it does not bring with it the horrendous consequences for the family that the death of the wage earner brings. Dollars spent to provide educational funds for the child can accomplish this purpose as well when they are spent to insure the father's life.

Split-Life

Another recent innovation is split-life insurance. Fundamentally, split-life insurance involves a combination of two contracts, an annual premium retirement annuity and yearly renewable term insurance. Under a split-life package, the purchase of an annuity policy gives the purchaser the right to purchase low cost term insurance up to some maximum which varies with the amount of the annuity. Generally, the insured may purchase up to $10,000 of term insurance for each $10 of annual annuity premiums. The annuity and the life insurance need not be purchased on the same life and can even be spread among several lives. Although the annuity rates are typically high, the term insurance rates are quite low, creating an alternative package. The contract has met with opposition from some regulatory authorities, who hold that the low term insurance rates represent a form of discriminatory pricing in favor of the annuity purchasers. Split-life insurance has not been approved in Iowa.

SPECIAL ANNUITY FORMS

The Retirement Annuity

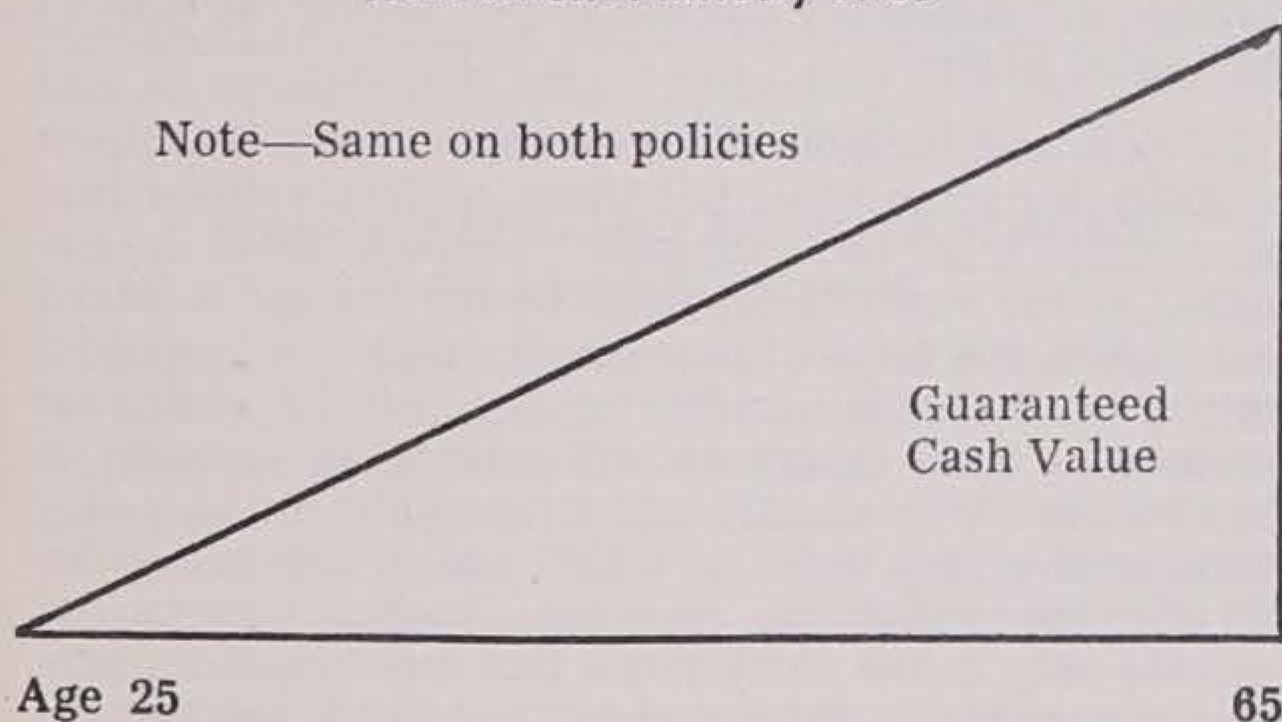
In our earlier discussion of annuities we noted briefly that annuities may be purchased on a deferred basis;

under this plan the insured pays for the annuity prior to the time at which benefits are to begin. A deferred life annuity is normally purchased in premium installments over a period of years. Premium payments are to terminate and annuity payments are to commence a stipulated age. The most popular of the deferred-life annuities sold by life-insurance carriers today is one that goes under the name of a **retirement annuity.**

In most instances the premium for this contract is quoted as the amount necessary to provide a monthly lifetime income of $10 at a designated age such as sixty-five, and it is customary to base the premiums on the assumption that the annuitant will receive the income with payments guaranteed for ten years. So if "X," age twenty-five, should decide to purchase a retirement-income annuity, he could pay $250 per year, and at 2½% guaranteed compound interest, accumulate a fund over a period of forty years which would provide approximately $100 per month beginning at age sixty-five and payable for the balance of his lifetime but with payments for a period of ten years. If "X" should die prior to the selected retirement date, i.e., within the deferred period, the company will pay the accumulated gross premiums, without interest, or the cash value, whichever is the larger, as a death benefit. The purchaser may also surrender the policy and withdraw the cash value at any time. The retirement annuity policy then is a method of accumulating a principal sum through the use of the investment facilities of an insurance company.

At the maturity date of the contract "X" is not obligated to accept a life annuity, but may withdraw the accumulated cash value instead. This is known as the **cash option** and its existence exposes the insurance company to a substantial element of adverse selection. Logically those in good health will choose the annuity and those whose health is impaired will choose the cash sum. This is an obvious advantage to the insured.

Retirement Annuity at 65



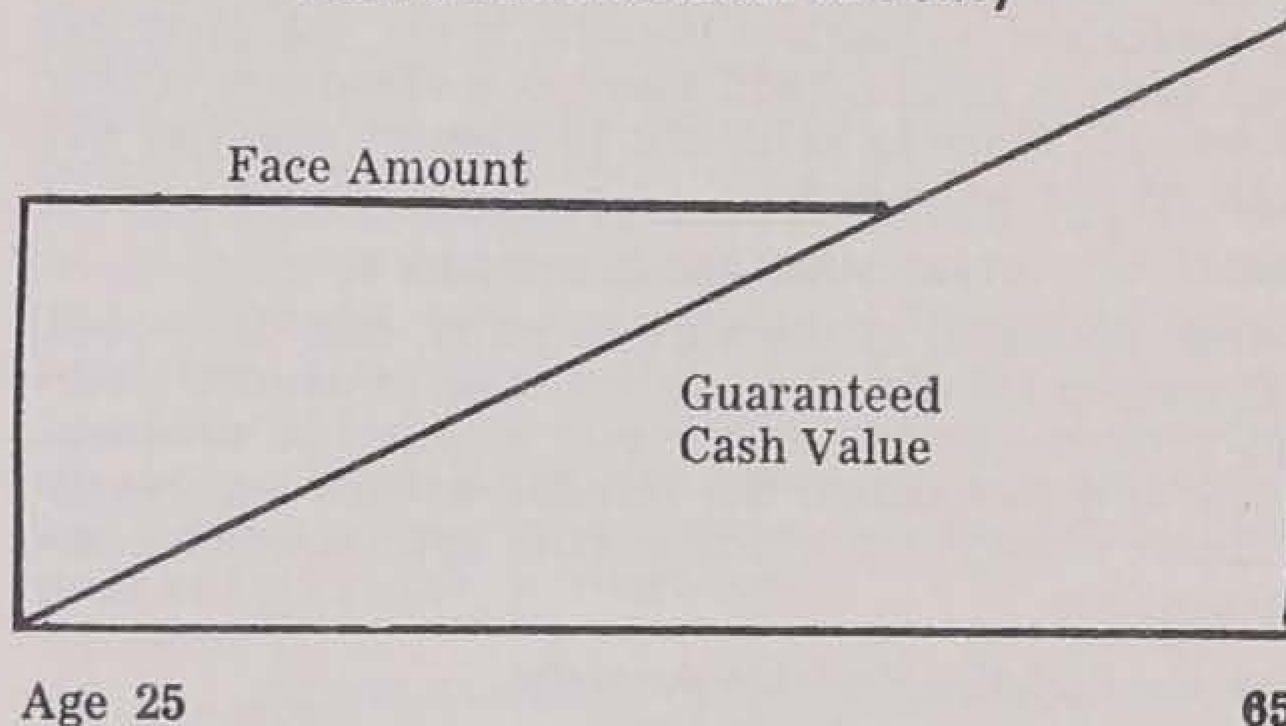
$1,500-$1,900 cash value for each $10/mo. life income at 65.
Death Benefit—total premium paid or cash value whichever is higher.
Premium paid for full period.

The Retirement Income Policy

Most insurance companies also sell another type of deferred annuity known as a retirement-income contract, an endowment annuity, or a retirement endowment. It is similar to the retirement annuity discussed above, except that it provides a rather substantial life insurance during the deferred period. The death benefit in the retirement annuity, as will be recalled, is a return of premiums or the cash value, whichever is larger. Under the retirement income policy, there is $1,000 in life insurance for each $10 of monthly income.

Then if "X", at age twenty-five, purchases this contract with the objective of $100 per month life annuity

Retirement Income at 65 Policy



$1,500-$1,900 cash value for each $1,000 face amount.
Death Benefit—face amount or cash value, whichever is higher.
Premiums paid for full period.

at age sixty-five, the amount of the life insurance would be $10,000. In the event of his death during the deferred period, the insurance carrier would pay either the $10,000 or the cash value, whichever is the greater. The cash value of the contract probably would exceed $10,000 at approximately age 55. If "X" should die after age 55, the carrier will then pay the cash value as a death benefit.

The retirement-income contract is a combination of a retirement annuity and decreasing-term insurance. The term insurance, at any age, is the difference between the face amount of the contract, the $10,000 in the above example, and the accumulated cash value. And the term element reaches zero at that point at which the cash value equals the face amount of the insurance. In all other respects the contract is identical with the retirement annuity.

Joint and Last Survivor Annuity

Annuities may be designed for special purposes, just as life insurance contracts have been. One of the specialized annuity forms in the **Joint and Last Survivor Annuity.** This is an annuity which is computed on the basis of two lives. Annuities normally cover only one life, but situations arise in which it is desirable to make the payments on the basis of two lives. Under the Joint and Last Survivor Annuity the insurance company

promises to make payments until both annuitants have died. This is an especially attractive form of annuity for a retired couple. If, as is likely, one predeceases the other, annuity payments will be continued until the other had died. A variation of this form provides for a reduction in the income payments at the death of the first annuitant, with annuity payments being continued in the reduced amount (usually 2/3 of the original income payments) until the death of the second annuitant.

Joint Life Annuity

The Joint Life Annuity is similar to, but should not be confused with the Joint and Last Survivor Annuity. Under the joint life annuity payments cease upon the death of the first annuitant to die. The other annuitant then receives no further benefits under the program. This form is useful when there is a secondary source of income which is sufficient to support one, but not both of the annuitants.

THE VARIABLE ANNUITY

Our discussion of the various forms that have been designed to fill special needs would be incomplete without a discussion of the variable annuity. A comparatively new innovation, the variable annuity represents a classic example of an imaginative approach to a critical problem.

The Need of the Variable Annuity

The conventional fixed dollar annuity was developed and is based on the assumption that the value of the dollar is relatively stable. Under this assumption the fixed dollar annuity is a good investment for retirement purposes and is the only investment which will guarantee the investor that his income will continue for his entire life. However, since early in the 1940's this country has witnessed a steady increase in the cost of living and a decline in the purchasing power of the dollar.

The Nature of the Variable Annuity

The variable annuity is an attempt to cope with the problem resulting from changes in the price level over time to the detriment of persons who are retired or who are attempting to accumulate funds for retirement. Under a fixed dollar annuity, the annuitant is guaranteed a fixed number of dollars at each pay out date. Under the variable annuity there is no such guarantee, and the number of dollars that will be paid to the annuitant may vary. The basic intent is to provide a varying number of dollars with constant purchasing power rather than a constant number of dollars with varying purchasing power. This is done by linking the retirement income to the level of stock prices. The basic rationale of the variable annuity is based on the assumption that the value of the dollar will vary from time to time and that the value of a diversified portfolio of common stocks will change in the same direction as the cost of living. While the cost of living has neither remained stable nor increased at a predictable rate, we have seen that the value of common sotcks has generally moved in the same direction as the cost of living. There have been times, during periods of accelerated inflation, when the price of common stocks has moved in the opposite direction from that of the cost of living, but there has been no extended period in which the price of common stocks has not moved in the same general direction as the cost of goods and services.

Although individual variable annuity contracts may differ somewhat, the general nature of the variable annuity is the same. Under a variable annuity the annuitant's payments purchase units in a fund of securities, very much like an open end investment company. The value of these units is valued at retirement, and the insurance company promises to pay him a variable income based on the value of these units as they fluctuate over time. The number of annuity units to which the annuitant is entitled remains constant, but as the value of these units fluctuates, the number of dollars which he receives also fluctuates.

Variable annuities may work in several different ways. Most frequently the variable annuities include both a variable pay-in and a variable pay-out as described above. As an alternative, the annuity may provide for a variable accumulation, with a fixed pay-out. Under this plan the accumulation fund increases or decreases in value prior to retirement, but at retirement the fund is converted to a conventional annuity and provides a guaranteed income to the annuitant for life. The plan may also provide for a fixed value pay-in with a variable pay-out, under which the fund is accumulated on a fixed dollar basis and does not fluctuate prior to retirement, but is converted at retirement to a variable pay-out.

VARIABLE LIFE INSURANCE

Like the concept of the variable annuity, the idea of a life insurance policy constructed so that the face amount of insurance would increase with inflation has considerable appeal. However, while variable annuity contracts have been available on a group basis since 1952, and on an individual basis for well over a decade, variable life insurance has developed slowly, at least in the United States.

Index-linked variable life insurance policies have been available for some time, but these contracts differ fundamentally from the "variable" concept as it is embodied in the variable annuity. Under the index-linked contracts, some form of permanent insurance is written with a cost-of-living rider, under which additional amounts of term insurance, reflecting the increase in the CPI are automatically added annually to the policy at the anniversary date. An additional premium is charged for the additional coverage. Such contracts are variable only in the same sense that any insurance program is variable — the insured can increase the amount of insurance. It can be argued that since the insured pays the premiums on fixed dollar life insurance with cheaper dollars during periods of inflation, he or she should purchase additional amounts of insurance as prices increase. However, this is a clumsy arrangement

at best. Even when the increased amount of insurance is automatically added, as in the cost-of-living policies, insurance buyers have been able to restrain their enthusiasm.

Although variable life insurance is still in its embryonic stage, and the final form it will take it still undecided, there are at least two features that will probably be included in the final version of the product: a fixed premium and a minimum guaranteed death benefit. Experience with the index-linked cost-of-living contracts seem to indicate that variable premium contracts have little appeal to the consumer. The desire for a fixed premium and a variable benefit means that the contracts will probably be basd on equity investments, much the same as in the case of variable annuities. In addition, the historical commitment of the U.S. life insurance industry to the fixed dollar benefit contract is likely to result in the incorporation of a minimum guaranteed death benefit.

Several designs for equity-linked variable life policies have been proposed. The most widely discussed of these is called the "ratio plan," a design originally suggested by New York Life. Under this plan, the face amount of the policy would vary over time with the performance of a fund invested in equities, but the amount of insurance would at all times bear the same ratio to the reserve as in a fixed dollar policy. At the same time, the face amount of the policy would never decline below the original amount of insurance. This means that unlike the variable annuity, under a variable life policy the face amount would vary upward, but not below the original amount of insurance.

The slow development of variable life insurance has been due, at least in part, to the litigation and other difficulties that accompanied the development of the variable annuity. Although the NAIC approved model legislation providing for the sale of variable life policies in 1969 and recommended this legislation to the states, there remained the problem of the SEC. In 1972, seeking to avoid some of the difficulties that have been encountered in connection with the variable annuity, the insurance industry petitioned the SEC for an exemption on variable life. After conducting hearings, the SEC ruled that variable life would be treated as a security.[10]

ADVANTAGES AND DISADVANTAGES OF SPECIAL FORMS

The special policy forms have certain advantages and certain disadvantages. Both the advantages and the disadvantages arise from the fact that these policies are designed to fit special needs. Since they are designed to fit certain needs, these special policy forms may meet those needs better than any other policy. By the same token, since they are designed to fit special needs, they are often quite inflexible and cannot be used effectively to meet other needs. Unfortunately not all needs are the same. Each individual faces different circumstances and the danger exists that one of the special policy forms may be used to fill a need for which it was not designed. There are, of course, certain almost universal needs. There is little chance of the family income policy being misused, for the need for protection during the child-raising years is quite general. On the other hand, the juvenile insurance policies could be misused, eating up premium dollars that would be better spent on the father.

In addition to the special policy forms discussed in this chapter, there are a number of other more specialized contracts. A number of the more specialized contracts are unique with a certain company. In addition, many companies modify the basic provisions of the policy form discussed here. The point is that the variety and type of special policies is limited only by the imagination of the marketing directors of the insurance companies. When properly used, the special policy forms are extremely useful tools for protecting the members of the insured's family against the financial consequences of premature death, or for accumulating a fund of money for some specific future need such as retirement or education.

PROGRAMMING LIFE INSURANCE

Life insurance programming consists of a study of the individual's needs for capital resources. It includes an assessment of the person's present financial position and future obligations, and the life insurance that should be used to meet these obligations. It is an approach to life insurance buying which places the emphasis on planning.

It takes a substantial amount of life insurance to provide adequate protection in most cases. The vast majority of the families in the United States today are inadequately insured. If total life insurance in force in the United States were divided equally among all American families, each family would have only slightly over $21,000 of protection.

The first and most obvious step in programming life insurance is to determine the amount to be purchased. The willingness of the individual to spend hard earned dollars will depend on his subjective orientation and his desire to provide protection for his family. This is an individual matter, and in the last analysis the decision must rest with the individual. However, there are at least two generally accepted approaches which can be of assistance in determining the amount of life insurance needed.

The Human Life Value

The human life value is the insurable value of the individual's income earning ability. The insurable value of the income producing capacity of an individual may be viewed as the maximum potential earnings of the

[10]The SEC granted an exemption from the provisions of the Investment Company Act of 1940 with respect to the separate funds in which the insurer invested the assets related to variable life policies, but the variable life policy itself must be registered under the Securities Act of 1933 and agents selling variable life must be registered as a broker-dealer under the Securities Exchange Act of 1934.

individual that would be lost if the individual died.[11]

In other words, it is the present value of the income lost by his dependents as a result of his death. We can estimate this insurable value by discounting the expected stream of income that would accrue to the dependents as a result of continued employment. If we deduct the amount of the income earned which would be consumed by the producer himself, and discount the remainder, we have a notion of the present value of the stream of income that will be lost. The emphasis here is on the income that would be lost by the dependents.

The Needs Approach to Life Insurance

Another method, and one that is perhaps more practical than the use of the economic-value concept, is commonly called the "needs" approach. Here the amount of life insurance purchased is based on an analysis of the various needs that would be experienced by the family should the income producer die.

In reality, the needs approach is directly related to the life value concept. In summarizing the needs which would exist in the event of the wage earner's death we are merely looking at the other side of the family income-expenditure equation. While the life value concept focuses on the income that would be lost, the needs approach attempts to identify the allocation of that income and summarize those prospective expenditures which are most critical. In addition, the needs approach attempts to recognize unusual or non-regular expenditures which may result from the death of the wage earner and the additional expenses which may accompany the period of readjustment following the wage earner's death.

There are various ways in which the needs may be classified; the traditional approach includes the following

Fund for last expenses
Funds for readjustment
Dependency Period Income
Mortgage Payment Funds
Educational Funds
Life Income for the Wife

Under the needs approach these income requirements of the family are usually listed on a month-to-month basis over time, in a graphic presentation indicating the amount of income needed, the amount available from social security and other sources, and the extent of the unfilled need. The chief benefit of this graphic analysis is that it helps the individual to visualize the amounts needed as a flow of income.

A Continuing Task

The major defect of both the life value approach and the needs approach as they are most frequently used is that they rely on static analysis, determining the amount of insurance at a specific point in time. This results in the purchase of an amount of insurance that may be correct at that point in time, but which will be inaccurate as time goes by. Because the life value of the individual decreases over time and the individual approaches the end of his income earning years, the fixed amount may be excessive.

Obviously, the needs of each individual will vary, depending on age, the number of children, responsibilities, and financial assets. In addition, the needs of the individual may change over time, for during each period of life there are different needs that appear to be more crucial. We can subdivide the average person's life into the following four periods: The premarital period, the pre-child-raising years of marriage, the child-raising years, the years approaching retirement. For most individuals needs will vary with each of these periods.

ESTATE PLANNING

There are advantages to both the life value concept and the needs approach to the determination of the amount of life insurance to be purchased, but regardless of which approach is used, the result is usually that substantial amounts of insurance are indicated.

Estate planning is the process of arranging a person's affairs so as to produce the most effective disposition of his capital and income, planning so as to reduce the shrinkage of the estate and provide that the maximum number of dollars will be transferred from the decedent to the survivors. At one time it was felt that estate planning involved nothing more than making out a will, but today most people recognize that making a will is just one part of a more elaborate process. While the will is certainly one of the more critical tools in the estate-planning process, there are other tools as well, including life insurance, outright gifts during the lifetime of the individual, gifts in trust created during the owner's lifetime, and trusts created at death.

The purchase of life insurance has become more and more complex as a result of its ever-increasing relationship to wills, trusts, and taxes; and the stern practicalities of law, taxation, and other factors require the individual to make far-reaching decisions in this area which are often irrevocable. It should be apparent that the entire field of estate planning is a complicated and highly specialized area. The complexity dictates that the individual seek not only expert insurance advice, when setting up his insurance program, but skilled legal guidance as well, so as to guarantee that his intentions will be realized.

Advantages of Life Insurance

The outstanding characteristic of cash value life insurance as an investment is the compulsion which it entails. Most individuals do not have the self-discipline and determination required to follow through with their plans for the regular accumulation of a savings fund. Once a policy is taken out, the individual will pay the premiums rather than deprive his family of

[11] S. S. Huebner, The Economics of Life Insurance, 3rd ed. (New York: Appleton-Century-Crofts, Inc. 1959).

the protection involved in the policy, and in paying the premiums he makes regular contributions to the saving element of the contract. History indicates that even in the depths of the Great Depression of the 1930's, men gave up almost every kind of obligation before they stopped paying their life insurance premiums.

In addition, there are certain tax advantages under life insurance which some other forms of investment do not enjoy. Increments to the cash value are not taxable until they are actually received by the insured. At the time that the policy is surrendered, the excess of the cash surrender value over net premiums paid is taxable as ordinary income. In order to earn a net return on alternative investments equal to that under a life insurance contract, the gross rate of return on the alternative investment must be higher than that available under the life contract.

Finally, there is a safety of principal that does not exist in certain other investments. The major criticism levied at life insurance as an investment is the relatively low rate of return—usually between 4 and 5 percent, and perhaps the rate of return is low, but low relative to what? Common stocks represent a risk form of investment. The investor hopes to have gains, but on the other hand he may suffer losses. Life insuranc cash values are a guaranteed form of investment, with both safety of principal and a guaranteed rate of return. For this reason, and the other reasons cited above, life insurance may be the most attractive and dependable investment for many individuals. On the other hand, there are individuals who are not content with fixed dollar nature of the life insurance investment, preferring equity investments with their potentially greater rate of return. The choice, however, is a matter of finance rather than an insurance decision.

SELECTION OF RISKS

The selection of risks is a most important job of the underwriting department of an insurance company and of the agent. Only by selecting good risks and rejecting bad ones can the insurance company hope to pay claims as promised and have the financial stability to provide a good long-term career for you.

Sources of Information Concerning Life Risks

In selecting risks the insurance company gets its information from a number of sources. Let's talk about a few of them in some detail.

(1) Application

The application is the most important source of information concerning the applicant's identity, age, marital status, past, present and contemplated occupations. It also reveals information about where the applicant lives, his military status (possible aviation hazards), amount of insurance he has, amount he wants to buy and who he wants to have for his beneficiary. It covers all of the most important items of information needed by the insurance company and it becomes a part of the insurance contract. Because it is photostated and made a part of the insurance contract, it should always be filled out carefully and completely. Abbreviations, if any, should be used sparingly; and all questions should be answered in such a way that they can be understood many years after completion by someone unfamiliar with the situation.

(2) Agent's Report and Certification

The Agent's Report affords the agent an opportunity to provide information to the insurance company in a confidential manner which will not generally be included in the application or made a part of the contract. Here the information such as how long the applicant has lived at his present residence and where he lived previously; what are his exact employment duties; whether he engages in any hazardous sports and any explanatory remarks which the agent feels would be helpful to a Home Office underwriter in understanding the situation more completely. It is on this agent's report and certification that any information not listed on the application itself is furnished. This report should probably be completed without the applicants direct help and presence.

(3) Medical Examination

The medical history portion of the medical examination is photostated and made a part of the insurance contract. Because of this, the medical examiner should do a complete job in listing the applicant's medical history as well as the names and addresses of attending physicians which have been seen by the applicant. On the back side of the medical report, the doctor lists his findings concerning the applicant's general physical condition.

(4) Non-Medical Examination

The non-medical form completed by the agent is also a part of the application to take the place of the part completed by the doctor. It is also photostated and becomes a part of the insurance contract. For this reason, due care must be taken in completing all of the questions concerning the prospect's health. Names and addresses of doctors who have been seen by the applicant should be listed in detail. Home Office medical departments have medical directories but these are often out of date and it will save a lot of time and trouble if the information given them on the application is complete and accurate. Care must be taken to distinguish medical factual answers from mere opinions if the information is to prove beneficial to the home office underwriter.

(5) Attending Physician's Statement

At the time the applicant applies for an insurance policy, he is normally required to sign a statement permitting the company to make inquiry with any physician who has attended the applicant

in the past. The company may feel it is necessary to contact physicians who have checked or treated the applicant in order to obtain pertinent medical information. This information is then used to determine current insurability of the applicant.

(6) **Inspection Report**

Insurance companies may require an independently furnished inspection report on a risk to help them better evaluate the insurability of the applicant. This is particularly true when significant amounts of coverage are requested. Factual reports help the industry maintain fair premium rates, which in turn keeps insurance widely salable. An inspection report, supplied by a neutral inspection company, frequently furnishes facts unknown to, or withheld from, the agent — facts covering such areas as health, habits, finances, employment, activities, and reputation.

Classification of Risks

Most of us understand the principle that a wood house costs more to insure against fire than does a brick house. This doesn't mean that any particular wood house is more apt to burn. It does mean that if you have a thousand wood houses, your loss by fire will be proportionally greater than if you have a thousand brick houses. The same principle applies to the Classification of Risks from a life insurance point of view. When a person has high blood pressure it doesn't mean that he won't live to a ripe old age. It does mean that out of a group a thousand just like him, a greater precentage will die at an earlier age than in a comparable group of one thousand healthy people. In classifying a risk, the Home Office underwriting department will look at the applicant's past medical history, his present physical condition, his occupation, his habits and his morals. All of these things are taken into consideration in deciding whether or not he should pay an extra insurance premium. Let's discuss, now, several of the classifications.

(1) **Standard Risks**

A Standard Risk is a person who, according to a company's underwriting standards, is entitled to insurance protection without extra rating or special restrictions.

(2) **Substandard Risks**

There are a number of people who, because of a physical condition (family or personal history of disease, occupation, residence in unhealthy climate, or dangerous habits) can not really expect, on the average, to live as long as people who don't have these situations. They are called substandard risks. Perhaps the word substandard is not the most proper term, and the term "rated class" would be better but substandard is the word often used. The underwriting department of an insurance company often has a numerical rating system by which they give a point value for each type of physical disability suffered by the applicant and for each negative situation in his background or his habits or his morals. The total of all the points represents our expected mortality percentage increase over that which is expected for standard or normal risks. It's really a very fair way of arriving at a premium which is equitable both to the insurance company and/or the person to be insured.

(3) **Uninsurable**

When an applicant has a disease so rare or situation so unique that the insurance company has had very few others like it, they may decline to issue insurance at all. Not because insurance can't be issued, but just because they don't have enough experience to be able to quote a premium which would be fair to the applicant as well as to themselves. They are very interested in arriving at just the right premium a person should pay and the process of doing it is called Classifying the Risk.

SPECIAL MARKETS

In addition to the uses and markets for life insurance discussed earlier in this manual, there are many special markets which require extensive study on the part of the agent if he is to properly sell and service these markets.

Keogh Act (H.R. 10) — The tax benefits of qualified (by U.S. Internal Revenue) pension and profits sharing plans have been available to employed corporate employees for some time. Self-employed individuals have not been able to take advantage of such tax-favored programs in the past. The "Self-Employed Individuals Tax Retirement Act," of 1962, has finally corrected this tax inequity. (This act is popularly referred to as H.R. 10).

Up until 1974, the maximum annual contribution and deduction permitted to a self-employed individual was 10% of earned income or $2,500, whichever was lesser. Under the new provisions of the law, contributions and deductions for self-employed persons is limited to 15% of earned income or $7,500, whichever is lesser. Minimum provisions permit deduction of the lesser of $750 or 100% of earned income.

A self-employed individual may establish such a plan if he also covered all of his full-time employees who have been employed for at least three years and are full-time employees as defined in the law. He may contribute up to 15% of his income to this plan so long as his contribution does not exceed $7,500. The qualified employees must be treated as the self-employed treats himself. The requirements and limitations of H.R. 10 apply when the self-employed is included in the plan.

Particulars as to who may be considered as self-employed individuals and eligibility requirements for both employer and employee can not be fully covered in this manual. An agent shall be expected to know

these facts before participating in H.R. 10 sales since he will be held accountable for any possible misrepresentation to his client. The law does distinguish between **self-employed individuals and owner employees.** If, for example, a partner owns 10% or less of the capital or profit interest of the partnership, he is not an owner-employee, even though he is a self-employed individual. This distinction is important since some provisions of the law are more restrictive for self-employed individuals who are also owner-employees. Details may be found in I.R.C. 401 (c) (3); Reg. 1.401-10(d).

Basically, the funding instruments available in connection with corporate plans may also be used in conjunction with H.R. 10 plans. These funding instruments include custodial accounts, face-amount certificates, a special series of U.S. government bonds, the issuance of certain insurance and annuity contracts, and certain trusts.

The basic idea of any H.R. 10 plan is to invest untaxed monies from income, they would then be taxed when received as income at a later date when the participant would expect to be receiving a lower income). Since this would give the individual the advantage of accepting these proceeds at a time when he fits into a lower tax bracket, he would experience a more favorable retirement income from his earned dollars. Another advantage is the fact that the values of the accumulated earnings may accumulate without current tax liability.

The agent should be particularly cautious in designing an H.R. 10 plan for his client. The client should understand he is not to withdraw his proceeds before he is 59½ years old but before he is 70½ years old. The client must understand this money is not available to him during the period of savings, an insurance policy or annuity may not be assigned or borrowed on during this period. If he withdraws early he will experience tax penalties and may not be able to participate in another H.R. 10 plan for a period of 5 years.

Tax Sheltered Annuities— Certain educational institutions, which have been given the power under state law and Section 501 (c) (3) of the U. S. Internal Revenue Code, may be able to purchase tax sheltered annuities for their employees. In the state of Iowa, this power has been specifically granted by statute to the State Board of Public Instruction, the Board of Regents, school boards, county school boards, area school boards, and the Board for Educational Radio and Television Facility. These organizations may purchase non-forfeiture annuities for their employees without having the premiums treated as income to the employees as paid. The employees may receive the procéeds at a later date, normally after retirement, when they are in a lower income tax bracket, with a subsequent tax advantage.

Section 501 (c)(3) includes certain corporations, any community chest, fund, foundation, organized and operated exclusively for religious, charitable, scientific, testing for public safety, literary, or educational purposes, or for the prevention of cruelty to children or animals, no part of the net earnings of which inures to the benefit of any private shareholder or individual, no substantial part of the activities of which is carrying on propaganda, or otherwise attempting, to influence legislation, and which does not participate in, or intervene in (including the publishing or distribution of statements), any political campaign on behalf of any candidate for public office. The Internal Revenue Service must determine if an organization qualifies.

The provision relating to school districts (Iowa Code, Chapter 294.16) is typical of the statutory provisions granting permission for the purchase of tax sheltered annuities.[12] It reads as follows:

> At the request of an employee through contractual agreement a school district may purchase group or individual annuity contracts for an employee, from such insurance organization authorized to do business in this state and through an Iowa-licensed insurance agent as the employee may select, for retirement or other purposes and may make payroll deductions in accordance with such arrangements for the purpose of paying the entire premium due and to become due under such contract. The deductions shall be made in the manner which will qualify the annuity premiums for the benefit afforded under section 403b (26 USC 403b) of the federal internal revenue code and amendments thereto. The employee's rights under such annuity contract shall be nonforfeitable except for the failure to pay premiums.

Although the employer, whether public school or non-profit organization, is the applicant and purchaser, the annuitant is the owner and has control over the annuity or qualifying insurance plan except that it is non-transferable. This means that the owner will not have the right to make either a collateral assignment or an absolute assignment. When a qualifying insurance plan is used, that portion of the premium which is considered payment on the insurance shall not be granted the tax favored treatment.

All formulas for calculating the amount that the employee may deposit in such a plan called an exclusion allowance, cannot be included in this manual. In general, an employee may contribute one sixth of his income minus any amount contributed to a similar program such as the Iowa Public Employee Retirement System in the case of Iowa Public School teachers. Past service may increase his allowable input.

A participating employee's Social Security must be withdrawn on the full income of the employee before withdrawal of his amount of the premium deposited in the tax sheltered annuity.

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[12]The other organizations to which power for the purchase of tax sheltered annuities has been granted are treated under other sections of the code. See Chapters 257.10, 273.13, 280A.23, 8A, 262, with respect to the State Board of Public Instruction, county school boards, area school boards, the State Education Radio and Television Facility Board, and the State Board of Regents.

The amount of the premium placed in the tax sheltered annuity shall not be included as income on the employees W-2 form.

The employee should: (1) Sign salary reduction agreement if TSA premium is payable through a salary reduction; (2) Sign application as proposed annuitant or insured; (3) Name beneficiaries and hold policy as owner.

The employer should: (1) Adopt enabling resolution permitting employees to participate in TSA program; (2) Sign application as applicant and pay premiums; (3) Sign appropriate form if a 501 (c)(3) organization.

The agent should keep in mind that even though all employees of Public Schools and 501 (c)(3) organization may technically be entitled to this tax benefit, not all such employees should be considered prospects under sound sales standards. Thus, a teacher with heavy family responsibilities should possibly first establish his life insurance program. A young teacher who is uncertain whether he will stay in teaching, or in one school system, for more than a year or two, would perhaps be wiser to invest in some other media. He may move to a school system in which he is not permitted to continue his program as originally designed.

The agent should be very careful when setting up such a program for his client. His responsibility to the client and his industry demands that he inform his client of limitations as well as advantages of a TSA program.

AGENTS EDUCATIONAL OPPORTUNITIES

In addition to the many educations, courses developed by and used by individual life insurance companies, there are two institutional educational programs available to agents of all companies.

L.U.T.C. — The Life Underwriter Training Council (L.U.T.C.) with headquarters in Washington, D.C., was officially formed through the joint efforts of company and field organizations in 1947 as an independent nonprofit educational organization. The Council offers a two-year practical sales training program in life insurance and a one-year course in health insurance to all qualified career life insurance representatives. As set forth in its Constitution, the objective of the Council is to contribute to the constant improvement of the quality of life underwriting by (1) engaging in educational and training activities for the field underwriter; (2) cooperating in the educational and training activities of associations of life underwriters, training departments of companies, the American College of Life Underwriters, the American Society of Chartered Life Underwriters, other institutional groups, recognize educational institutions and others interested in the training of those who sell and service life insurance; (3) serving as a clearing house for information of life underwriter education and training."

C.L.U. — The Chartered Life Underwriter (C.L.U.) diploma is a professional designation awarded by the American College of Life Underwriters. The College was established in 1927 to provide advanced professional study for men and women in life and health insurance. The College, located in Bryn Mawr, Pennsylvania, prescribes a course of study which prepares a candidate for the taking of five comprehensive examinations leading to the C.L.U. designation. Study classes are usually conducted locally under the sponsorship of the local chapter of Chartered Life Underwriters or The Life Underwriters Association.

VARIABLE ANNUITIES

THE NEED FOR THE VARIABLE ANNUITY

The conventional fixed dollar annuity was developed and is based on the assumption that the value of the dollar is relatively stable. Under this assumption, the fixed dollar annuity is a good investment for retirement purposes, and is the only investment that will guarantee the investor that income will be continued for life. However, experience clearly indicates that the assumption that the value of the dollar is relatively stable is false. Over time, the price level has fluctuated widely; and with those fluctuations in the price level, the value of the dollar has also changed markedly.

When prices go down, the value of the dollar increases, since a fixed number of dollars will purchase more goods and services. Conversely, when the price level increases, the value of the dollar declines; and a given number of dollars will purchase fewer goods and services. During the period since the early 1940's, this country has witnessed a steady increase in the cost of living; and with the increase in prices, the value of the dollar has declined steadily. The extent of this decline in the value and purchasing power of the dollar is indicated by the trend in the Consumer Price Index (CPI).

CONSUMER PRICES - ALL ITEMS
1950 - 1975
1950 = 100

1950 = 100.0
1955 = 107.9
1960 = 123.0
1965 = 131.0
1970 = 161.3
1975 = 224.9

During the two and a half decades from 1950 to 1975, prices have more than doubled, cutting the value of the dollar in half, and requiring more than twice the number of dollars to purchase a given amount of goods and services.

Because their money income is fixed, people living on retirement incomes suffer more than most other groups from inflation. While the salaries of those who are employed may lag behind price changes, their incomes do rise. The money incomes of the retired remain constant during inflation, however, since there is little they can do to adjust the money income. Those who have depended on a fixed dollar retirement plan during the past three decades have found to their misfortune that they had no protection against changes in the value of the dollar.

Persistent inflation also undermines attempts to save for retirement. Even the prudent individual who makes a serious attempt to accumulate funds for retirement may see his or her efforts wiped out by inflation. When prices are increasing at 6% or 7% a year, the person investing in a program with a 5% return will eventually accumulate a fund in dollars that is worth less than half the value of the dollars that were originally saved.

Many economists feel that there are sufficient inflationary pressures in the economy to cause continued inflation, with little or no possibility of reversal in the long run. The strength of the labor unions, the acceptance by both major political parties that it is the responsibility of the federal government to maintain full employment, welfare costs, and other factors all indicate the likelihood of more inflation rather than deflation.

It was in response to these factors that the variable annuity was developed. The variable annuity is an attempt to cope with the problems associated with the impact of price level changes on retirement incomes and on funds being accumulated for retirement.

NATURE OF THE VARIABLE ANNUITY

Under a fixed dollar annuity, the annuitant is guaranteed a fixed number of dollars at each payout date; but, as noted above, these dollars may have varying purcashing power. Under the variable annuity, there is no guarantee regarding the number of dollars that will be paid out. The dollars payable to the annuitant will vary according to the market value of securities invested (usually in equity instruments such as common stocks) by the insurer. The basic intent is to provide a varying number of dollars that will provide constant purchasing power. This is done by linking the retirement income payable to the level of stock prices.

Although individual variable annuity contracts may differ somewhat, their general nature is the same. The annuitants' premiums are used to purchase units in a fund of securities, very much like an open-end investment company. These units are accumulated until retirement, and a retirement income is then paid to the annuitant based on the value of the units accumulated. The basic rationale is that the value of the dollar will vary from time to time, but that the value of a diversified portfolio of common stocks will change in the same direction as the price level. While the cost of living has neither remained stable nor increased at a predictable rate, we have seen that the value of common stocks has generally moved in the same direction as the cost of living, increasing as prices rise and decreasing as they fall. However, there have been times, during periods of accelerated inflation, when the value of common stocks have moved in the opposite direction from the cost of living.

Although there have been periods in which the performance of the stock market has brought perversity, the basic assumption on which the variable annuity is

based—that the value of common stocks will increase with the cost of living—has generally been valid. If the stock market does perform as expected, then a fixed pay-in can be converted into a variable pay-out. Although the number of dollars that the individual annuitant will differ from the amount that would have been received under a fixed dollar annuity, the varying number of dollars should provide constant purchasing power.

The Balanced Annuity

Because income payments from a variable annuity can be reduced sharply during periods of adverse economic activity, many financial advisors recommend a "balanced annuity" as a partial hedge against either inflation or deflation in the economy. A Balanced Annuity combined fixed dollar annuity monthly income payments with variable annuity monthly income payments. The annuitant specifies the allocation of the purchase payment at the time the annuity is purchased. He or she may allocate 100% of the purchase payment to variable accumulation; or it may be divided between fixed accumulation and variable accumulation, in accordance with specified percentages (for example, 50% variable and 50% fixed). Some companies permit the annuitant to change these percentages during the accumulation period, but a change does not take effect until a written request has been filed with the insurance company at its home office. Any change in the percentage stipulated applies only to payments made with the request and to payments made thereafter.

BACKGROUND AND DEVELOPMENT

The variable annuity as we know it today was developed by the Teachers Insurance and Annuity Association (TIAA), a nonprofit organization founded in 1918 by the Carnegie Foundation to provide college professors with retirement programs. The TIAA originally wrote conventional fixed-dollar annuities, until several faculty members at Harvard University, realizing how vulnerable their retirement program was to inflation, decided to invest a part of their retirement dollars in the Harvard Endowment Fund, which invested mainly in common stocks. With a part of their retirement dollars invested in TIAA and a part in the Harvard Endowment Fund, the faculty members hedged against both inflation and deflation.

Shortly thereafter, TIAA began a study of the possibility of equity funded retirement programs as a hedge against inflation. The conclusions of the study were published in 1951, and the result was the creation of a companion organization to TIAA, which was called the College Retirement Equity Fund (CREF). The first CREF variable annuity was issued in 1952. There are now over 200,000 participants in the CREF variable annuity program.

Following CREF's innovative lead, private insurance companies became active in the field. The first variable annuities written by a commercial insurer were issued in 1954 by the Participating Annuity Life Insurance Company of Little Rock, Arkansas, which operated strictly on an intrastate basis. Late in 1955, the Variable Annuity Life Insurance Company (VALIC) was formed in Washington, D.C., and became the first company (other than CREF) to operate on an intrastate basis.

The two most active companies in the early stages of the variable annuity's development were VALIC and the Prudential Insurance Company of America. The entry of these two companies into the variable annuity field prompted the Securities Exchange Commission (SEC) to intervene, leading to protracted litigation over the nature of variable annuities. The most important issue was whether variable annuities were insurance (and as such, exempt from federal regulation under Public Law 15) or whether they were, as the SEC contended, securities. The litigation lasted several years, and was eventually settled by the U.S. Supreme Court, which ruled that the variable annuity was a security and as such subject to regulation by the SEC. This decision was vital to the SEC and established the pattern for regulation of the variable annuity. Variable annuities are currently subject to regulation by both the SEC and the state insurance departments.

In addition to the long and involved litigation, the development of variable annuities was also retarded by some opposition from within the life insurance industry. The life insurance industry was originally divided on the question of the variable annuity, with some segments strongly opposing the concept. A part of the opposition came from those who considered the variable annuity to be a competing product with the main product of the industry, cash value life insurance. Others opposed the variable annuity because they were convinced that there was a danger that the public would not understand its fundamental nature.

In spite of the litigation over its status, the eventual dual regulation, and the opposition from within some corners of the industry, the variable annuity has become firmly established as a vehicle for providing for retirement needs. At the end of 1976, slightly over 750,000 persons were covered under group variable annuities, with another 500,000 persons covered under individual annuity contracts.

VARIABLE ANNUITIES IN OPERATION

While the general concept of the variable annuity has been noted, there are certain special features of variable annuities that should be explored. In addition, the actual conditions of the contracts and the manner in which the variable annuity concept is embodied in the policies are discussed below.

General Features of Variable Annuities

Although all variable annuities are based on the same

operational concept, there are differences among the various contracts, based on the differences of the companies that market them and differing demands of consumers.

Group and Individual. Variable annuities are marketed on both a group and an individual basis. Group variable annuities are sold to employers and to associations to cover employees or members of the association as participants. As in the case of group life and group fixed dollar annuities, the loading charges for group variable annuities are generally lower than those of individual contracts, because of the savings possible through the group marketing techniques.

Participating and Nonparticipating Variable Annuities. As in the case of the traditional fixed dollar life insurance and annuity contracts, variable annuities are available on either a participating or nonparticipating basis. Participating policies are issued by all mutual insurers and some stock companies. The annuitant's share of the divisible surplus of the company is determined annually by the company. However, dividends are generally lower than on fixed dollar contracts. Under fixed dollar contracts, dividends are derived from mortality savings and investment earnings in excess of the assumed rate. Since investment income under the variable annuity is already credited to the annuitants under the separate account, dividends are derived solely from mortality or expense savings, and for this reason are usually lower than dividends on fixed dollar contracts.

Operational Aspects of Variable Annuities

Under a fixed dollar annuity, the annuity benefit purchased for a given premium is determined by the annuity mortality table, expense factors, and the stipulated rate of interest assumed on investments up to and after retirement. None of these factors are subject to change after the contract has been issued. Under the variable annuity, on the other hand, the amounts payable to the annuitant vary according to the market value of securities in a Separate Account maintained by the insurer. A "Separate Account" is a special account into which the insurance company allocated funds received from the purchasers of variable annuities, along with the investment income derived from these funds. The assets in this account must be kept apart from the insurance comany's other assets, and may not be used for the benefit of the company's nonvariable accounts. Normally, the Separate Account must be registered as an Open-End Investment Company under the Investment Company Act of 1940. The assets of the Separate Account are invested primarily in common stocks. However, the assets may also be invested in real estate, preferred stock, bonds, and convertible debentures.

The Net Purchase Payment Factor. As in the case of fixed dollar annuities, the insurance company has certain expenses associated with the sale and administration of variable annuities, referred to as "loading charges." These include agents' commissions, administrative expenses, premium taxes, and so on. These loading charges are expressed as percentages of the Gross Purchase Payment, and represent a deduction from the gross premium before allocation to the Separate Account. For example, the loading charge for the first year might be 15%, and for subsequent years 7%. Using these percentages, the net purchase payment factor would be .85 for the first year, and .93 thereafter. (Many companies use a level loading charge for the entire duration of the contract, rather than a higher percentage in the first year. In either case, the net purchase payment factor for the first and each subsequent year of the contract must be disclosed in the prospectus and in the contract itself.)

In addition to the loading charges, most variable annuity contracts also include a charge for the investment management of the Separate Account. Although these charges may be levied against the purchase payments, more often they are charged against the Separate Account.

The Accumulation Unit. An accumulation unit is simply an accounting unit that is used to measure the value of each annuitant's interest in the Separate Account before the commencement of annuity payments. The value of an accumulation unit will increase or decrease, depending on the performance of the securities in which the separate account is invested.

Generally, the insurance company assigns an arbitrary value to the accumulation unit when the Separate Account is created (say, $1 or $10). Thereafter, the value of the accumulation units is recomputed daily in the same manner as the shares of a mutual fund. The total value of the holdings in the separate account, divided by the number of accumulation units outstanding, sets the value of each accumulation unit. This means that the number of accumulation units that a given net payment will purchase depends on the size of the net payment, and also on the value of the accumulation unit at that time.

The Gross premium payment allocated to variable accumulation is multiplied by the net purchase payment factor stipulated in the contract to determine the net purchase payment. The net purchase payment, divided by the accumulation unit value determines the number of units purchased at each premium payment. For the purpose of illustration, assume an annual gross purchase payment of $1,000, with a net purchase payment factor of .85 for the first year, and a net purchase payment factor of .93 for the second year. Assume also that the value of each accumulation unit is $10 at the time that the first premium is paid. The gross premium less loading (i.e., times the net purchase payment factor of .85) is $850. This means that the annuitant will be credited with 85 accumulation units. ($850 net purchase payment, divided by $10 = 85 units).

At the second premium payment date, the net payment factor is .93, which means that the net purchase payment is $930. If we assume that the value of an accumulation unit has increased from $10 to say, $12, the second net premium payment will purchase 77.5 accumulation units. ($930 divided by $12).

Fixed and Variable Payouts. At maturity of the policy, the annuitant may take a lump sum cash settlement, purchase a fixed dollar annuity contract, or purchase a variable annuity contract. If the annuitant selects a fixed dollar payout, payments are made on the same basis as under the traditional annuity in which the accumulation is nonvariable. On the other hand, if the annuitant selects a variable payout, the accumulation units are converted into a lifetime income of "annuity units" using a special mortality table for annuitants. The value of these annuity units, like the value of the accumulation units, vary over time with the value of the securities in which they are invested. The number of annuity units payable at each pay-out date does not change over the lifetime of the annuitant, but the income produced by each annuity unit will vary with the investments on which the annuity units are based. The current value of the annuity unit will thus determine the annuitant's income. Unlike the accumulation units, which are revalued on a daily basis, the value of the annuity unit is usually established on an annual basis.

The settlement options available under variable annuities are generally the same as those available under the traditional fixed dollar annuities:

1. **Straight life annuity.** Under this option, annuity payments are made for the life of the annuitant, ceasing at the death of the annuitant.
2. **Life Annuity with Period Certain.** Under the life annuity with period certain, annuity payments are also made for the lifetime of the annuitant. However, in this case, if the death of the annuitant should occur before payments have been made for the preselected period (usually 10 years, but sometimes 20 years), the balance of the payments are made to an indicated beneficiary, either in a lump sum or as monthly payments for the preselected period.
3. **Joint and Survivor Annuity.** The Joint and Survivor option is payable for the lifetime of two persons. It provides for payments until the death of the first annuitant, and thereafter to the surviving annuitant for the balance of that person's lifetime. The Joint and Survivor annuity option may also be issued with a period certain.

Immediate or Deferred. Variable annuities may be purchased on either an immediate or deferred basis, and may be paid for on either an installment basis or with a single premium. Most variable annuities are deferred annuities, purchased on an installment basis.

Death Benefit. Like traditional fixed dollar annuities, a deferred annuity generally includes a death benefit, payable if the insured should die prior to the maturity of the contract (retirement age). In most cases, this death benefit is equal to the cash value of the contract. Some contracts also contain a provision that the death benefit will be equal to the premiums paid, although an additional premium is usually required for this provision.

REGULATION OF VARIABLE ANNUITIES

The protracted litigation over the nature of the variable annuity, which ended when the U.S. Supreme Court ruled that the variable annuity was a security, and as such was subject to regulation by the Securities Exchange Commission, resulted in a system of dual regulation, under which variable annuities are regulated by both the SEC and the state insurance departments. The states consider the variable annuity to be an insurance contract, and regulate it under the state insurance laws. State regulation includes control over the design of variable annuities, mortality assumptions, and certain other facets, and also supervise the licensing of agents to sell variable annuities. However, since the variable annuity is also regarded as a security, it is subject to regulation by the Securities Exchange Commision, under the Securities Act of 1933, the Securities Exchange Act of 1934, and the Investment Company Act of 1940.

The 1933 act requires the issuers of securities to file registration statements with the SEC and to issue a prospectus to each person solicited. The SEC does not attempt to approve or disapprove the particular security being offered, but merely attempts to make certain that complete information is available to the prospective buyer. This is the basic purpose of the required prospectus. It contains pertinent facts about the variable annuity being offered, designed to encourage intelligent judgments on the part of the consumer. It is intended merely to provide full and truthful disclosure about the security offered. In addition to requiring full disclosure, the SEC also regulates the form and content of advertising and promotional material used in the sale of variable annuities. When making a sales presentation to a prospective applicant, a Broker/Dealer or registered representative must deliver a prospectus to the customer at or before the time of the sales presentation. The presentation by the agent must conform with the SEC "Statement of Policy" and with the requirement that any sales literature must have been prefiled with the SEC. The "Statement of Policy" is a booklet published by the SEC which sets forth rules and standards for adveritising and sales material which is used in connection with the variable annuity.

The Securities Exchange Act of 1934 deals with the registration and regulation of stock exchanges and securities dealers. Under the provisions of this act, any

corporation, partnership, or other entity engaged in the sale of securities must register with the SEC as a Broker/Dealer. Sales of securities are made through "registered representatives" who are associated with or employed by a Broker/Dealer. Most insurance companies that sell variable annuities have registered either a subsidiary or the parent company as a Broker/Dealer.

The SEC controls variable annuity sales in essentially the same manner as it controls the sale of other securities, by requiring all individuals and organizations involved in such sales to register with the SEC or with the National Association of Securities Dealers. Although the act permits self-regulation of over the counter securities markets by the National Association of Securities Dealers, any person associated with the marketing of securities (including variable annuities) must pass a written examination covering investments, securities laws applicable to investments, corporate finance, securities markets, and investment companies. This means that in order to sell variable annuities, the agent must hold a life insurance license from the state, and in addition must qualify as a "registered representative" (securities salesman) by passing an examination recognized by the SEC. The agent must be registered with the SEC or the NASD.

The Investment Company Act of 1940 regulates the operation of investment companies. Normally, the separate accounts used to fund variable annuities are considered investment companies under the provisions of this act, and must be registered as investment companies. An exception exists in the case of separate accounts that are used solely to fund contracts under Keogh Plans and corporate retirement plans qualified under Section 401 of the Internal Revenue Code. Such separate accounts need not be registered.

CREDIT LIFE AND CREDIT ACCIDENT AND HEALTH INSURANCE

Credit Life Insurance and Credit Accident and Health Insurance represent a unique application of the life and health mechanism. These two forms of insurance, which are often referred to jointly as "consumer credit insurance," are sold through lending institutions to short-term borrowers contemplating consumer purchases and through merchants selling on a charge account basis to installment buyers at the retail level. The insurance coverage which they provide protects both the lenders and the debtors against the financial loss that might result if the debtor should die or become disabled before completing the payments required under the debt transaction.

Credit life insurance, for example, insures the life of a borrower for an amount related to the outstanding balance of a specific loan or credit transaction, and generally provides for the payment of the scheduled balance of the loan in the event of the borrower's death. Credit accident and health insurance (often shorted to credit disability insurance) insures against the disability of the borrower through accident or illness, and provides benefits by meeting required payments for a specific loan during the debtor's disability, commonly subject to some dollar maximum per payment and some maximum number of payments.

When arranging the details of a time payment purchase or loan, the debtor usually becomes acquainted with consumer credit insurance when the salesman or loan officer suggests that he purchase the coverage. In most cases, the debtor will bear the cost of the insurance even though the creditor becomes the beneficiary. Typical loans covered by credit life and credit accident and health insurance include unsecured personal loans for general purposes and commodities purchased on time payments, such as automobiles, furniture, mobile homes, appliances, home improvements and even vacations.

The major suppliers of consumer credit, and the lenders who are also generally involved as vendor-beneficiaries of consumer credit insurance include commercial banks, sales finance companies, credit unions, personal finance companies, and retailers, such as department stores and automobile dealers selling goods or services on a charge account or installment basis.

More than 250 insurance companies offer credit life insurance, and over 200 companies also write credit disability insurance. Consumer credit insurance is written by both stock and mutual companies. Some companies specialize in writing credit insurance, while for other insurers, consumer credit insurance represents only a small part of their total business.

Two basic methods of providing consumer credit insurance currently exist: group and individual. Both consumer credit life insurance and consumer credit disability insurance are written on a group basis and an individual basis. Under the individual basis of marketing consumer credit insurance, individual policies are issued to the borrowers; under the group system, a master policy is issued to the lending institution and the individual borrowers receive certificates outlining their coverage. Approximately 85 per cent of the consumer credit life insurance is written on a group basis and slightly over 80 per cent of the credit disability insurance is on a group basis.

History and Growth of Consumer Credit Insurance

The practice of utilizing insurance to protect the lender and the borrower from financial loss resulting from the premature death or disability of the borrower is not a novel concept, but the application of this technique to short-term and unsecured consumer credit is basically a phenomenon of the Twentieth Century. The development of consumer credit insurance closely parallels the development of consumer credit itself.

Consumer credit may be said to date from 1910, when Arthur J. Morris began to offer installment credit facilities to borrowers who had no specific assets to pledge as collateral, other than their future earning power and their personal character. While Morris is widely recognized as the father of consumer credit, his role in the development of credit life and credit accident and health insurance is less well known. Almost from the inception of his consumer credit operation, Morris was convinced that some form of protection should be made available to the lender against the possibility that the debtor might die before the loan could be repaid, and the obvious solution to this problem was life insurance on the debtor. Morris conceived a plan whereby the outstanding balance of a loan on the date of the borrower's death would be paid to the lender by an insurance company, but when he approached the then existing life insurance companies with the idea, they simply were not interested. After having met with discouragement from the existing insurance companies, Morris decided to form his own insurance company, and incorporated the Morris Plan Insurance Society as a stock company under the laws of New York State. The company issued its first credit life policies in 1917, with rates based on the individual ages of the insureds.

The first policies were individual level term contracts with the face of the policy equal to the full amount of the loan over the entire period of indebtedness. In 1922, the Morris Plan Insurance Society pioneered the decreasing term policy, under which the face value of the policy declined at approximately the same rate as the unpaid balance of the loan. Until 1926, all policies continued to be written on an individual basis. The first

group credit life policy was written in that year by the Credit Life Insurance Company of Springfield, Ohio. Five years later, the credit union movement organized the Credit Union National Association Mutual Insurance Society, (CUNA) to provide both credit life and credit disability coverages to credit union borrowers.

The history of the growth of consumer credit insurance can be conveniently divided into two distinct periods: the early era, which lasted from 1917 until about the end of World War II, and which was marked by modest but continued growth, and the modern era, from the end of World War II in 1945 until the present, during which the use of consumer credit insurance has grown at a rapid rate, paralleling closely the increase in consumer debt. The early history is primarily a history of the credit life insurance field, and credit disability was added only as the industry grew.

Table I indicates the growth of all consumer credit life insurance from its inception in 1917 until 1973, the last year for which statistics are available. As the figures in the table indicate, the initial growth of consumer credit life insurance was relatively slow. Between 1917 and 1930, the number of insurers writing credit life insurance increased from one to about 30, and the total amount of consumer credit life insurance in force increased from less than $500,000 to about $73 million. By 1940, the amount of coverage in force was approximately $380 million, and at the end of World War II the amount of credit life insurance in force stood at $365 million.

The end of World War II marked the beginning of a dramatic period of growth for the consumer credit insurance field. As the data in the table indicates, the use of credit life insurance during the period since the end of World War II has mushroomed. Insurance in force increased ten-fold during the five-year period following the end of the war, from $365 million in 1945 to $3.884 billion in 1950. During this period of almost incredible expansion, the industry grew faster than any other form of life insurance, and perhaps not surprisingly, certain abuses developed in the marketing process. These abuses brought both the insurance and loan industries under the scrutiny of regulatory officials. State insurance officials and federal legislators held hearings aimed at determining the extent of such under abuses and devising legislation to curb them. Later in our discussion we will note the outcome of these hearings. At the same time, the insurance industry began efforts to clean its own house. In 1951 several consumer credit insurers banded together to form the Consumer Credit Insurance Association (CCIA), which acts as a trade association in disseminating consumer credit advertising for companies that specialize in this form of coverage, and also attempts to promote higher standards in the industry.

Throughout the post war period, the credit life insurance industry has continued its expansion. From less than half a billion dollars in protection at the end of the war, it has grown to over 100 billion in 1973. Further evidence of the increasing significance of credit life insurance is indicated by the fact that only about seven per cent of all outstanding consumer credit was protected by credit life insurance in 1945, but by 1973, over 70 per cent was covered by credit life insurance.

TABLE 1

CREDIT LIFE INSURANCE IN FORCE
In The United States (000 Omitted)

Year	No. of Policies and Certificates	Amount	Year	No. of Policies and Certificates	Amount
1917	1		1959	38,556	$24,998,000
1920	22	$ 4,000	1960	43,087	29,101,000
1925	81	18,000	1961	44,845	31,107,000
1930	363	73,000	1962	47,176	35,341,000
1935	559	101,000	1963	52,389	40,666,000
1940	2,563	380,000	1964	57,508	46,487,000
1945	2,110	365,000	1965	62,599	53,020,000
1950	10,819	3,844,000	1966	69,415	58,059,000
1951	12,368	4,763,000	1967	70,423	61,535,000
1952	14,422	6,355,000	1968	74,851	68,357,000
1953	17,810	8,558,000	1969	78,285	74,598,000
1954	20,939	10,046,000	1970	77,516	77,392,000
1955	27,900	14,493,000	1971	76,041	81,931,000
1956	32,034	16,774,000	1972	78,439	93,410,000
1957	33,836	19,366,000	1973	77,574	101,154,000
1958	34,793	20,536,000			

SOURCE: Life Insurance Fact Book, 1974

Statistics on the growth of credit accident and health insurance are not as readily available as are those with respect to credit life insurance, and the data that are available measure the growth of credit disability insurance in terms of the premium volume (as opposed to the face amount of protection as in the case of the credit life insurance statistics). The premium figures available indicate that credit disability experienced a

14-fold increase during the decade of the 1960's, increasing from about $17 million in premiums to almost a quarter of a billion at the beginning of 1970. In terms of percentage increase, this growth rate exceeds the rate of growth for credit life insurance, however the comparison is somewhat misleading. Credit disability premiums are generally more than twice as much per $100 of coverage than the premiums for credit life, so a given dollar increase in credit disability coverage generates a substantially greater increase in premiums than would the same increase in credit life insurance coverage. In spite of the difficulty in measuring growth, it nevertheless appears that the credit disability field is growing faster than the credit life insurance field.

Benefits of Consumer Credit Insurance

The rapid growth of the consumer credit insurance field is not surprising when one reflects on the various benefits that accrue to the parties involved in the credit transaction as a result of the coverage.

First of all, there are the benefits to the lenders themselves. Consumer credit insurance is advantageous to lending institutions in that they save considerable time, energy, and money. The institutions are assured of repayment of the loan even though the borrower does not live to complete the scheduled repayments or even though his ability to continue making payments on the loan is cut off by a protracted period of disability. Creditors benefit from the immediate loan repayment in the event of the borrower's death and continued payments in the event of the insured's disability, and thereby avoiding creating adverse public relations from attempts to collect during periods of family difficulty. If insurance was not available, the debtor or beneficiary might be faced with the unpleasant task of renegotiating the loan repayment schedule. Consumer credit insurance generally eliminates the need for the lender to attempt to collect from survivors or co-signers, and thereby creates a substantial element of customer good will. Not only does this create goodwill, it also reduces collection costs and losses that might result from contingencies. Finally, the coverage acts as a business getter. The borrower is assured that if he does not live to pay off the debt, he will not leave an obligation for his family to meet, and is therefore less reluctant to enter into the debt.

In addition to the benefits to the lenders, there are the obvious and well recognized benefits to the borrowers. When entering into an unsecured credit transaction, the borrower anticipates that the debt will eventually be extinguished through the periodic payments made out of his future income. If his earning power is cut off because of death or disability, credit life and credit disability insurance provide that the continued payments to the creditor will not necessarily fall on the survivors or co-signers. Although credit insurance generally covers a market that is underinsured, even people who have substantial amounts of individual life insurance or disability insurance may elect to cover their loans with credit life and credit disability insurance. These people count on the full amount of their individual insurance to provide for the future of their families, and do not want that amount reduced by obligations left after their death or outstanding in the event of disability. With credit life and credit disability insurance, they or their families will not have to meet payments or face collection or repossession at the time of a crisis. Consumer credit insurance also serves as a device to lessen the difficulties that might otherwise be experienced by co-signers.

GROUP CREDIT LIFE INSURANCE

As previously noted, over 85 per cent of all credit life insurance sold in the United States is provided on a group basis. In the State of Iowa, group credit life is usually used for single payment notes or line of credit loans to farmers, while most installment loans are covered on an individual policy basis.

The Insurance Code of the State of Iowa makes specific provision for the writing of group credit life (and accident and health) insurance. It provides that:

> ". . . a policy may be issued to a creditor, who shall be deemed the policyholder, to insure debtors of the creditor, subject to the following requirements . . ."

The code goes on to specify certain underlying conditions for the issuance of a group credit life policy. The initial size of the group is not fixed by law in Iowa, but the Code requires that the group policy may be issued only if the group is receiving or may reasonably be expected to receive new entrants at the rate of 100 a year. Furthermore, the Code sets a statutory maximum of $35,000 group credit life insurance on the life of any one debtor.

The Code provides that the premium is to be paid by the policyholder, either from the creditor's own funds, or from charges collected from the insured debtors, or both. In most instances, the insurance charges are paid entirely from charges collected from the debtors. A single rate normally applies to all insureds who elect coverage, with debtors under age 18 or over age 65 generally excluded from credit insurance coverage. Originally, there was an attempt to calculate premium rates for group credit life on the basis of the ages of the lives insured, just as in the case of traditional group plans. However, this proved impractical, and instead of attempting to obtain age data for the various members of the group (who are constantly changing), the current practice is to set the initial premium rate on the basis of the amount of indebtedness to the insured.

As a result of the unique relationship among the various parties involved in the group credit life transaction, certain modifications have been introduced into the traditional group contract to adapt the conventional group term plan to fit the needs of the creditor-debtor relationship. In general, however, the operation of a

group credit life plan is much the same as other forms of group life insurance. Under the traditional group contract (as for example, in the case of an employee benefit plan) a master policy is issued to the employer, and the individual employees receive certificates outlining the provisions of the coverage. When a group credit life insurance policy is issued by an insurer, the creditor becomes the policyholder and the borrower receives a certificate from the policyholder (i.e., the lender) describing the insurance coverage and its limitations. Normally, only loans made to natural persons are insurable, and therefore, loans made in the name of a partnership or corporation may not be covered.

The uniqueness of the group credit life policy is evident from an examination of the group credit life policy insuring clause: the creditor is both the policyholder and the beneficiary. The insuring agreement provides that upon due proof of the death of the insured debtor, the insurance company will make payment to the beneficiary-creditor in the amount for which the debtor was insured at the time of death. The insurance agreement also provides that the creditor must apply the proceeds received to the discharge of the debtor's indebtedness. Although joint life is available from some companies, only one person is normally insured in connection with each loan, and when there is more than one signer (as is usually the case of husband and wife co-signers) the first person signing or the person designated by the lender at the time of the loan is designated as the insured. Under the joint-life policy issued by some insurers, the insurance applies to two or more persons, with the benefits payable upon the death of either.

As previously noted, almost all insurers ignore age data in the calculation of the premium. This means that the traditional misstatement of age provision found in other life insurance policies (under the terms of which the amount of insurance on the individual is adjusted to the amount which the premium paid would have purchased at the correct age) has no relevance in the case of credit life.

The insurance in force on an individual debtor's life remains equal to or sometimes less than the outstanding balance of the loan. As a consequence, there is usually no mention of a secondary beneficiary in the policy since the contract rarely provides more insurance in force than what is owed to the creditor.

The situation sometimes arises in which the amount of the debt exceeds the maximum limit of coverage allowed for a single borrower. The amount of insurance in force on the life of a given debtor may be less than the outstanding balance of his loan because the loan exceeds the statutory maximum of $35,000 for group credit life under Iowa law or because the loan exceeds the insurer's underwriting limitation of the maximum allowable coverage on any one debtor. In such instances, provision is usually made for a proportionate reduction in coverage as the amount of the loan reduces. Such contracts provide that where the debt is greater than the maximum amount limit, the benefit is paid in proportion that the original amount of indebtedness bears to the maximum amount of insurance. For example, if the debtor borrows $10,000 and is covered under a policy with a $5,000 maximum per borrower, his amount of insurance will always equal one half of his outstanding indebtedness. Other companies allow the maximum coverage to remain in force until the loan is reduced to that amount, and then provide that the insurance reduces with the loan.

Although most insurers impose some broad eligibility requirements, evidence of individual insurability is not required of those who meet these general requirements, provided a substantial proportion of the eligible debtors are insured. The most common of the eligibility requirements relates to the age of the debtor, and most companies exclude debtors over 65 from eligibility. Apart from this requirement, group credit life is usually provided without evidence of insurability when a specified percentage of the eligible debtors are included, on the assumption that insuring the group reduces the tendency toward adverse selection.

As the student will recall from his study of the General Section of this manual, adverse selection is the tendency of poorer than average to seek insurance to a greater extent than do the average or better than average risks. Initially, it might appear that the very nature of consumer credit transactions serves to eliminate the possibility of adverse selection. First of all, the availability of the insurance is governed by the creditor's willingness to extend credit, and the group exists for a specific purpose other than the acquisition of the insurance. Furthermore, the insured debtors are not free to select the amount of insurance coverage on their lives. Under Iowa law, the amount of insurance on the life of any one debtor may not exceed the amount owed by him to the creditor or the face amount of the loan. In spite of these characteristics, however, the tendency toward adverse selection (which seems to exist in virtually all fields of insurance except those in which coverage is compulsory) exists in the field of group credit life insurance. In the case of credit life insurance, adverse selection might assume two basic forms. First, the less physically fit persons would consent more readily to become insured once the availability of the coverage was made known to the lender. Second, and more important, an individual might actively seek out a lender for the primary purpose of obtaining the insurance and only incidentally for the purpose of the loan. For example, in the absence of any attempt on the part of the insurer to preclude such action, seriously ill persons — particularly known terminal cases who are otherwise uninsurable — might take advantage of credit insurance to augment their estates. They could buy automobiles or other durable goods knowing that at death credit insurance would take care of the unpaid balance.

This means that if group credit life were provided without evidence of insurability regardless of the ex-

tent of participation by the members of the group, a disproportionately large number of poorer than average risks might elect the coverage. The major problem of the insurance company in underwriting any form of group insurance is that of holding adverse selection to a minimum, and this is generally accomplished by underwriting on a group basis — requiring a certain minimum percentage participation. However, because the public interest requires that credit life insurance be optional when the debtor is required to pay a part or all of the premium, a somewhat different approach has been adopted for group underwriting in the credit life field. The Iowa Code specifies the condition under which the members of the group may elect coverage without evidence of insurability.

When the premium or any part of the premium is paid by the borrowers, the insurance company must reserve the right to require evidence of individual insurability if less than 75 per cent of new entrants into the group elect to become insured. In addition, when the borrowers pay part of all of the premium for the coverage, a policy issued to cover a group of existing debtors must require evidence of individual insurability for the existing debtors unless 75 per cent or more elect coverage. If the premium is paid entirely by the lender, coverage must be provided for all eligible debtors, excluding only those who do not meet the underwriting requirements of the insurer. This means, for example, that if the insurer restricts coverage under the policy to persons under 65 years of age, persons over this age need not be insured, but all others who qualify must be afforded the coverage.

In addition to the general eligibility requirements and the requirements for evidence of individual insurability when participation falls below the specified percentage, insurers also utilize policy provisions to avoid adverse selection. Perhaps the best example of such a provision is the "Good Health Clause," which is designed to discourage adverse selection by denying coverage to the seriously ill, or at least excluding them from coverage for a period of time. The provision operates in somewhat the same manner as the incontestable clause used in individual or ordinary life insurance policies. The application asks the debtor to declare that he has not consulted a physician or been confined to a hospital within the past six months for any condition listed in the application. The "Good Health Clause" is the insured's representation to this effect. Under the provisions of the "Good Health Clause," if the insured dies within a specified period after the inception of the coverage (commonly six months) and it is subsequently discovered that the insured knowingly made a false statement in connection with the "Good Health Clause," the insurer will reject the claim for benefits and return the amount of premiums paid. However, as in the case of an incontestable clause, after the policy has been in effect for the specified period (again, six months) the Good Health Clause lapses, and any death claim will be paid even those resulting from a condition with respect to which the insured had made a fraudulent misrepresentation in the application.

A second restriction imposed by a few insurers is a suicide clause similar to that used in ordinary life insurance policies. If the debtor commits suicide within a stipulated period — commonly two years — from the inception of the coverage, a claim for benefits normally would be denied by the insurer, and the beneficiary (usually the creditor) would receive only a refund of insurance premiums paid by the debtor.

INDIVIDUAL CREDIT LIFE

Although individual credit life policies account for only about one-sixth of the total credit life coverage in force in the United States, they represent an important segment of the business. In the State of Iowa, individual credit life policies are usually used to cover installment loans, with group or blanket policies used to cover single payment loans. It has been estimated that perhaps 85 per cent of the insured installment loans in Iowa are covered on the individual credit life policy basis.

When consumer credit life insurance is written on an individual basis, the insurer normally enters into an agency agreement with the lender, who becomes an agent of the insurer rather than a master policyholder. Individual credit life policies are issued to each borrower, normally with a single premium paid by the borrower at the inception of the loan in addition to the finance charges.

Coverage is provided under two types of contracts: decreasing term and level term. Since level term contracts are generally written only in connection with single payment loans, and since more than three-fourths of the current consumer indebtedness is of the installment variety, the decreasing term plan is more widely sold than the level term plan. Under the decreasing term policy, the amount of insurance declines as the balance of the installment loan decreases by periodic payments, thus making the insurance equal to the anticipated unpaid loan balance. Since the coverage is automatically decreasing over time, a policy of a given duration costs less than level term by about 50 per cent. Normally the amount of insurance in force under the decreasing term plan declines at the same rate as does the balance of the loan. However, because individual decreasing term credit life policies are generally written to cover the principal and interest of the loan on a "normal or anticipated payment schedule," if larger payments than anticipated are made or if extra payments are made by the borrower during the loan, it is possible that the amount of insurance paid for on a single permium basis might be greater than the remaining balance of the loan at the death of the borrower. In such cases the difference would be paid to a second beneficiary or to the estate of the insured borrower.

Level term life is merely a term life policy for the period of the loan, the face of which is constantly equal to the initial amount of the loan. Level term is usually sold in conjunction with loans of the non-installment variety. One example of this type of loan is the so-called "balloon" loan in which very small periodic payments,

insufficient to amortize the loan, might be made during the loan period, or no periodic payments at all, resulting in a "balloon" or large payment at the end of the long period. Under the level term plan the full amount of insurance remains in force for the entire period of the loan. If death occurs any time within the insured period, the loan balance is paid to the creditor, any excess being paid to a secondary beneficiary on the debtor's estate.

The difference between level term credit life insurance policies and the decreasing term variety is illustrated in Diagrams 1 and 2 below.

DIAGRAM 1

LEVEL-TERM LIFE INSURANCE

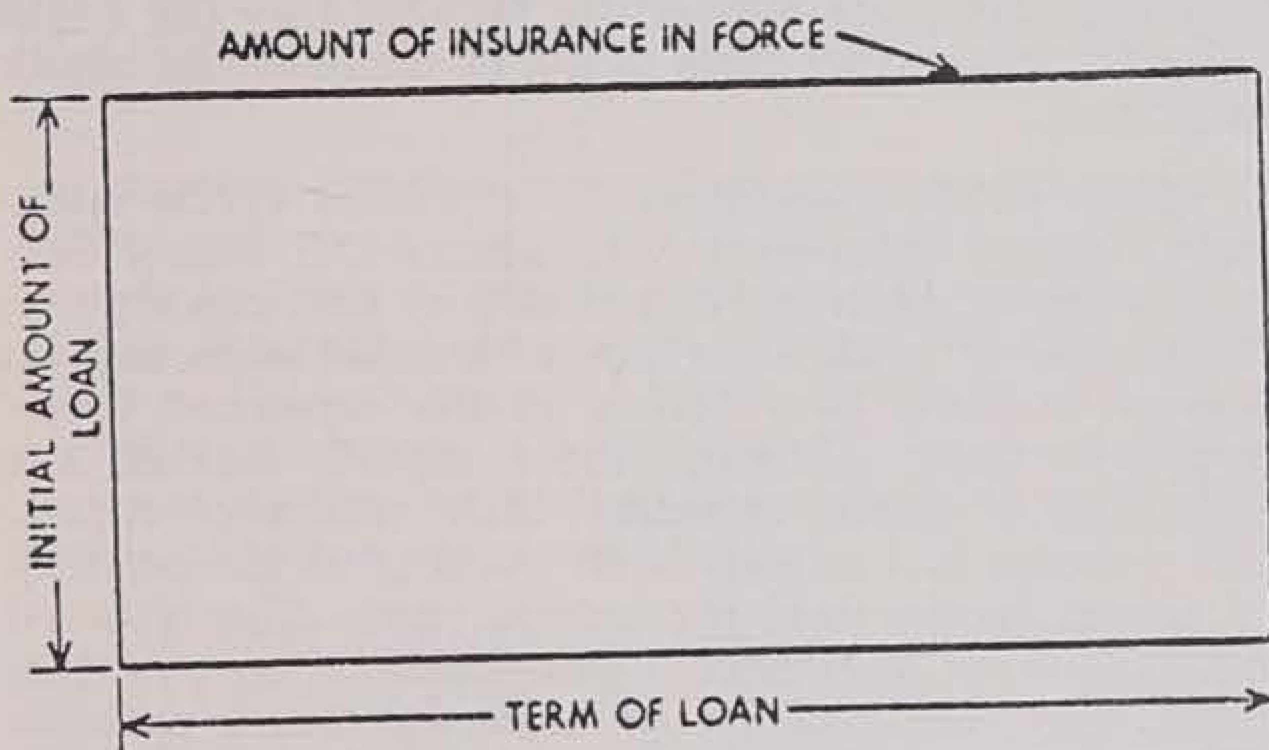
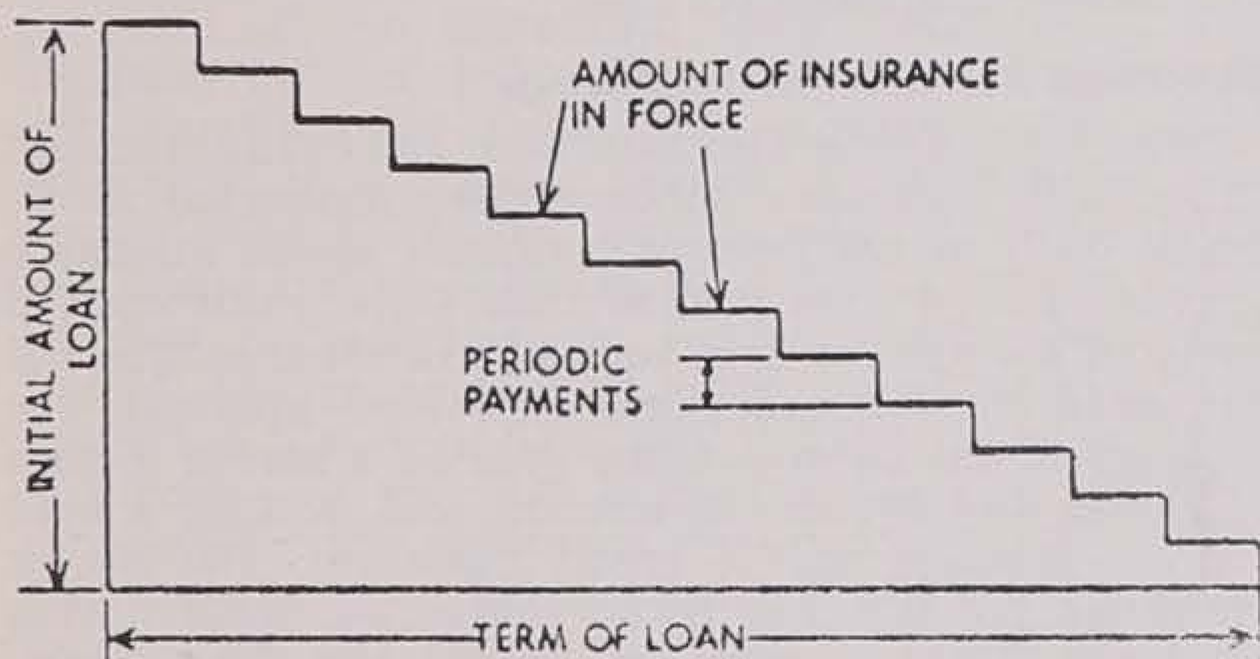


DIAGRAM 2

DECREASING-TERM LIFE INSURANCE



CREDIT DISABILITY INSURANCE

Credit disability insurance compares with credit life insurance in many respects, and many of the underwriting principles previously discussed in connection with credit life insurance also apply to credit accident and health insurance. Both forms of coverage are sold by the same institutions utilizing similar procedures and serve essentially similar functions. Under credit life insurance, you will recall, if the debtor dies, the insurer pays the creditor the face amount of the credit life insurance which is applied to the outstanding balance of the deceased debtor's loan. In the case of credit disability insurance, on the other hand, if the debtor becomes disabled (as defined in the policy), the monthly installments are paid by the credit disability insurer to the creditor for the duration of the disability, or until the maturity date of the loan, whichever comes first.

Like credit life insurance, credit accident and health insurance is written on both a group and an individual basis. As in the case of group credit life, group credit disability uses a master policy issued to the creditor, with individual certificates issued to the debtors. Like credit life insurance, both group and individual credit disability policies provide for the creditor to remit the premiums to the insurance company. Ordinarily, credit disability insurance is issued in conjunction with credit life insurance, but there are instances in which the debtor may obtain credit disability coverage without credit life insurance.

Because of the greater risk, underwriting considerations are more stringent for credit disability insurance than for credit life insurance. Normally a maximum limit (i.e., $250 per month) is placed on the amount of periodic payments by the insurer to the creditor beneficiary on each credit transaction. Furthermore, in addition to the age restriction used in credit life, the borrower may be required to be gainfully employed in order to secure credit disability insurance, on the assumption that if he is employed, he cannot at that time be disabled.

Even more important than the credit disability insurance restrictions is the pre-existing condition provision. Similar in effect to the good health declaration of credit life insurance, the pre-existing condition clause denies benefits to a debtor whose disability is due to a condition for which he consulted a physician or received treatment within a specified period prior to securing the insurance coverage. Typically, if the debtor consulted a physician for a particular condition within six months prior to obtaining the insurance protection and has a recurrence of that condition within six months after the insurance coverage began, the insurer may reject a claim for the payment of benefits. Once the stipulated period has elapsed, the insurer is obligated to make payment even if the disability results from the pre-existing condition.

Credit disability insurers also make use of the "deductible principle" by incorporating waiting periods into the credit disability policies. In simplest terms, a "waiting period" provides that the coverage will not respond for benefits unless and until the insured has been continuously disabled for a specified period of time, thereby eliminating benefits for short periods of disability. By eliminating coverage for short term disabilities, the waiting periods reduce the tendency toward fictitious losses and at the same time reduce the cost of the protection. Credit accident and health policies are usually classified according to the form of the waiting period that they contain. There are two types of waiting periods: Elimination (also known as non-retroactive) and Retroactive.

Elimination Plans. If the policy stipulates an "Elimination Period," benefits are paid only from the number of days specified after an accident occurs or the onset of an illness resulting in "disability" as defined in the policy provision. No payment is made on the debtor's behalf until he has been disabled for the specified period, fourteen days being a popular waiting period, after which payments are made by the company until the end of the disability or the loan runs out. Policies with elimination periods of from 14 to 30 days are available.[1] The purpose of the elimination period is to bring the cost of the insurance down by eliminating payment for the first few days of disability, as well as disability resulting from common short-term illnesses and accidents. Elimination Plans are also known as non-retroactive elimination plans.

Retroactive Plans. If the policy stipulates retroactivity, coverage takes effect after the end of a specified waiting period, but payments are made retroactively from the beginning of the disability resulting from an accident or illness. In other words, like the elimination period plan, the retroactive plan eliminates coverage for disabilities that do not last longer than the period specified, but once the disability extends past the time specified, payments are made on behalf of the insured debtor for the entire period of disability. As in the case of the elimination period plan, 14 and 30 day waiting periods are available.

The distinction between Retroactive Plans and Elimination Plans is sometimes misunderstood by borrowers, but actually the difference is quite simple to grasp. To illustrate the difference, let us assume that Brown and Smith are both insured borrowers under credit disability policies with 30-day waiting periods, providing $150 installment loan payments. Brown's policy includes a retroactive waiting period of 30 days, while Smith's policy includes a non-retroactive 30-day period.

	BENEFITS PAYABLE DURING A PERIOD OF DISABILITY LASTING			
	1 Month	2 Months	3 Months	4 Months
BROWN - 30 day Retroactive waiting period	0	$300	$450	$600
SMITH - 30 day Non-retroactive waiting period	0	150	300	450

As the example illustrates, if either Brown or Smith suffers a disability of less than the period of time specified as the waiting period, neither policy will provide benefits. After the elimination period, both policies will provide for the payment of the installments, but Brown's policy will provide for the payment of the installment falling due during the 30 day retroactive period, provided the disability exceeds the period specified. Smith's policy on the other hand, does not cover the installment falling due during the elimination period, and the benefits payable under his policy do not go back to pick up payment of the installment during the initial 30 days of disability.

[1] In some jurisdictions coverage is available with a waiting period as short as three days, but the Iowa Department of Insurance has ruled that coverage with a waiting period shorter than 14 days is not in the public interest, and that such policies will not be approved by the Insurance Department.

REGULATION OF CREDIT LIFE AND CREDIT ACCIDENT AND HEALTH INSURANCE

Historical Development

Originally, consumer credit insurance was subject to the same laws as those governing other forms of life and accident and health insurance. As a result, the degree of regulation was no more stringent for consumer credit insurance than it was for other forms of insurance. However, because of the uniqueness of this coverage, and its misuse by an unscrupulous few in ways to be described later, legislators and insurance regulatory officials became convinced of the need for supplementary regulation in this field. As a result, credit life insurance and credit accident and health insurance are more stringently regulated by the states today than any other form of life or accident and health insurance.

Major public interest in the consumer credit insurance industry dates from 1954, when a U.S. Senate Subcommittee on Antitrust and Monopoly first reported on tie-in sales of credit insurance with small loans and expressed concern over abuses in the consumer credit insurance field. Although these reports marked the beginning of public attention, state insurance regulatory officials had already been working on the problem of abuses in the field for several years. The National Association of Insurance Commissioners, a voluntary cooperative organization of state insurance officials whose recommendations, although advisory only, have been responsible for the most significant improvements in insurance regulation, had appointed a special subcommittee on credit life insurance and credit accident and health insurance in 1948.

The NAIC Subcommittee Findings

The NAIC Credit Life Insurance and Credit Accident and Health Insurance Subcommittee conducted an in-depth study of the field of consumer credit insurance over the period from 1948 to 1953. During this study it received the testimony of various interested parties and examined hundreds of pages of written material. The findings of the subcommittee painted a sordid picture of abuses and debtor exploitation, and dictated a need for closer regulation of credit insurance. The abuses identified fall into two broad categories: those having to do with premium rates and pricing, and those having to do with other matters. Although we will not attempt to examine the various abuses in detail, a brief discussion of some of the more common ones identified by the subcommittee will serve to emphasize the significance of certain regulatory provisions of the Iowa Code.

Abuses Involving Rates. All in all, the picture of the credit life industry relative to pricing of its products to the ultimate consumer was, according to the NAIC subcommittee, marred by a wide range of abusive practices. Among the more common abuses were overcharging of borrowers by lenders, the payment of unduly

high commissions by some insurers to their creditor representative, and excessive premium rates for both individual and group policies.

There seems to be general agreement on the fact that the majority of the abuses developed because consumer credit insurance is characterized by the existence of captive markets. Unlike other lines of insurance where the insured generally has a choice of coverages, companies, agents, and rates, the individual who secures a loan from a lender offering consumer credit insurance and elects to carry such coverage has automatically, through the selection of his creditor, chosen his coverage, company, agent and rate. Depending on the quality of the captive market and the return realized by the lender over and above his actual cost of providing insurance, the system offers a potential for abuses. The existence of these captive markets, coupled with the insurer's intense competition for business led to a phenomenon that has been called "reverse competition."

The term reverse competition refers to the tendency of the cost of the borrower of consumer credit insurance to increase or remain high because of the practice of the insurance company's bidding for the lenders business through payment to the lender to excessively higher commissions. Competition for business, instead of lessening the cost of the product, tended to increase that cost to the consumer (debtor).

The most controversial subject in relation to the cost of consumer credit insurance involved the amount paid to the creditor as compensation for his efforts. Competition among the insurers for creditor's business has always been keen, and commissions ranged from 40 per cent to 55 per cent of each premium dollar, and in some instances reached as high as 65, 75 or even 85 per cent of the premiums. Such commissions were obviously difficult to justify, and brought considerable criticism from the public and regulators. The NAIC subcommittee also found that some creditors had been compensated indirectly through interest free deposits and compensating balances. In order to write a bank's business for example, an insurance company would deposit a large amount of money in an interest free account in that bank. The bank had the use of the funds to increase its earnings without paying the insurance company for this additional capital. The use of interest free deposits as an inducement to creditors to place insurance with insurance companies large enough to provide these services was labeled as an abusive (unfair) practice by the NAIC subcommittee, and is also covered by Iowa law.

In addition, it was found that lenders sometimes overcharged borrowers—that is, charged the borrowers more for the insurance than the actual premiums paid by the creditor to the insurance company. Although this is contrary to the laws of most states which specify that only those rates filed with the commissioner may be charged, in most instances the borrower had no notion of what the filed and approved rates were. The net result of the excessive commission levels on individual credit life and disability policies and the overcharging in the case of group contracts was an unreasonably high cost to the consumer for a product which he was in many instances required to purchase.

Abuses Not Involving Rates. In addition to the abuses involving rates and pricing, the NAIC subcommittee also identified other abuses unrelated to rates: the sale of excessive amounts of credit insurance (including the sale of coverage for periods in excess of the period of indebtedness and the pyramiding of coverage) non-disclosure of insurance information, and non-payment of claims.

The first of the major abuses not related to rates was the sale of excessive amounts of insurance to the borrowers. The NAIC subcommittee found numerous instances in which the credit insurance that was sold to the borrower extended beyond the maturity of the loan, or exceeded the face amount of the loan. In this connection, the pyramiding of coverages was a typical practice. It was found that because many loans of all types are refinanced before maturity, lenders would issue new consumer credit policies without cancelling existing policies, causing pyramiding of coverage and insurance in excess of the amount of indebtedness.

Evidence uncovered by the NAIC Committee also indicated that some lender agents were failing to provide insured debtors with proof of the insurance in effect. Where evidence of insurance was not given to the insured, the survivors or the estate of the insured were in a position comparable to one in which the debtor had no insurance, since it could not be expected that the lender would know when the borrower died unless so notified, and the survivors would have no reason to notify the lender of the debtor's death unless they knew of the insurance. The net result was that survivors frequently did not know that the insurance existed, and not knowing, did not press the claim for payment, but instead continued to make payments to the creditor.

Another non-rate abuse involved the non-payment of claims. In some instances, lender agents were given the sole power to settle claims, and to deduct the amount of the claims from the premiums to be remitted to the companies. The fewer claims the creditor felt compelled to pay, the greater was his profit. Since the borrower often had no evidence of the insurance, the borrower was at a disadvantage in trying to prove that insurance coverage did exist.

Finally, there were allegations of coercion of debtors—requiring the purchase of credit insurance as a condition precedent to obtaining the loan, thereby depriving the consumer of his freedom of choice.

The NAIC Model Bill

The final result of the efforts of the NAIC Credit Life and Credit Accident and Health Insurance Subcommittee was the report of the subcommittee in 1954, which was subsequently adopted by the Association as a whole. The report contained certain recommended

"Rules and Regulations" related to consumer credit insurance, which represented proposals to the states for steps to eliminate the abuses that had been identified during the subcommittee's study. Shortly after receiving the report of the subcommitte, the NAIC proposed legislation to the states, in the form of the NAIC Model Credit Life and Credit Accident and Health Regulation Bill, which was first drafted in 1957, and which has been revised in 1960 and 1968. Virtually all of the abusive practices identified by the NAIC subcommittee and the various Congressional subcommittees are dealt with and can be eliminated or prevented through the adoption and enforcement of the NAIC Model Bill.

REGULATION OF CONSUMER CREDIT INSURANCE IN IOWA

Like many other states throughout the country, Iowa has taken steps to eliminate the abusive practices that formerly existed in the credit insurance field. The result has been a number of important rulings by the office of the commissioner and the enactment of legislation specifically regulating each of the areas in which the potential for abuse exists. Iowa laws pertinent to Credit Life Insurance and Credit Disability Insurance generally parallel the recommendations of the NAIC Model Bill. Those engaged in the sale of credit life insurance and credit accident and health insurance must be thoroughly familiar with the provisions of the insurance Code relating to consumer credit insurance. In addition to the provisions of the Iowa Code itself, the applicant for a license must also be familiar with the official regulations of the Iowa Department of Insurance pertaining to the Credit Life and Credit Accident and Health Insurance. The specific regulations pertaining to the credit life field with which you should be familiar are discussed below.

Regulation of Rates

Rates for Credit Life Insurance and Credit Accident and Health Insurance are strictly regulated in the State of Iowa. Regulations provide that rates must be filed with the Commissioner of Insurance, and that rates other than those filed may not be charged. Furthermore, the law provides that the rates must be reasonable, adequate, and not unfairly discriminatory. The law spells out in detail the precise meaning of each of the requirements, and specifies maximum rates that are presumed to meet the provisions of the law. A detailed examination of the legislation related to the rates should serve to illustrate the nature and extent of the regulation.

General Requirements of the Law. In 1973, the General Assembly of the State of Iowa enacted legislation empowering the commissioner of insurance to regulate premium rates for the Credit Life and Credit Accident and Health Insurance, and specifying the general requirements which the rates must meet. The law provides that:

> No individual policy of credit life or credit accident and health insurance or certificate under a policy of group credit life or credit accident and health insurance shall be issued for delivery, or delivered in this state unless the premium rates charged for the insurance are approved by the commissioner of insurance.

This means, very simply, that rates must be filed with the Commissioner for approval, and that only those rates actually approved may be charged. Insurance Department Regulations forbid either the creditor or its representative from charging a policy writing fee or other fee for writing the insurance. Department regulations also specify that considerations charged the debtor for credit insurance shall not be consolidated with other charges unless stated separately elsewhere in the credit contract. The law further specified that rates shall not be excessive, inadequate, or unfairly discriminatory, and that rates will be deemed reasonable if they may reasonably be expected to produce a loss ratio of 50 per cent by dividing claims incurred by premiums earned.

The Fifty Per Cent Loss Ratio. The 50 per cent loss ratio means that the losses incurred by the insurer should be equal to at least 50 per cent of the earned premiums. If the rate charged by the insurer produces a loss ratio in excess of 50 per cent, the company may file a request for permission to charge a higher rate. Conversely, if an insurer's loss ratio is less than 50 per cent, the Commissioner may order the insurer to either reduce the rates, or increase the benefits by an amount sufficient to produce a minimum loss ratio of 50 per cent. This 50 per cent loss ratio follows the proposal originally made by the NAIC in 1959. The requirement that premiums must generate a 50 per cent loss ratio serves to limit insurer profits and indirectly prevents excessive compensation to lender agents.

Maximum Rates. In addition to specifying that rates shall not be "excessive, inadequate, or unfairly discriminatory," for the guidance of insurers, the law also specifies maximum rates which are presumed to meet the requirements of the law.

The law deals separately with life insurance rates and credit accident and health rates. With respect to life insurance rates, the law provides that

> "A charge or premium of not more than seventy-five cents per annum per one hundred dollars of initial amount of decreasing term credit life insurance, or its actuarial equivalent for credit insurance written on other than the decreasing term basis, shall be conclusively presumed to meet the requirements of this section."

A Bulletin from the Department of Insurance specifically designates the "actuarial equivalent" for policies written on a basis other than decreasing term. A monthly premium payable at the rate of 11⅔ cents per $100 of outstanding unpaid insured indebtedness is the actuarial equivalent of the 75 cent rate for decreasing term. The equivalent level term life insurance rate is a single premium of $1.40 per annum per $100 of initial insured indebtedness.

Although the act did not specify maximum credit accident and health rates, it required the commissioner

to hold a public hearing for the purpose of approving a reasonable charge for accident and health insurance rates. After the public hearing, at which evidence and written comments by interested parties were submitted, the Commissioner of Insurance approved the following rates as appropriate:

No. of Months in which Indebtedness is Repayable	Non-Retroactive Benefits 14 Day Elimination	30 Day Elimination	Retroactive Benefits 14 Day Retroactive	30 Day Retroactive
12	$1.40	$ .80	$2.20	$1.70
24	2.20	1.60	3.00	2.50
36	3.00	2.40	3.80	3.30
48	3.50	2.90	4.30	3.80
60	3.90	3.30	4.70	4.20

Rates for periods of coverage less than 12 months are derived by multiplying the number of months for which coverage is provided by 1/12 of the 12-month rate and rounding to the nearest cent. Rates for periods over 12 months, but less than 60 months that are not listed above are derived by interpolation between the listed rates, with the results rounded to the nearest cent. Rates for durations exceeding 60 months are derived by adding 3 1/3 cents to the 60-month rate for each month in excess of 60 months and rounding to the nearest cent.

The premium rates specified are for policies which contain no exclusion for pre-existing conditions except for those conditions which required medical diagnosis or treatment (or would have caused a reasonably prudent person to have sought medical diagnosis or treatment) within six months preceding the application for insurance and which cause loss within the six months following the effective date of coverage.

Contracts to which the approved rates apply may contain provisions which require that a debtor be actively employed at the time the insurance is applied for. Contracts may also exclude or restrict coverage in the event of total disability resulting from pregnancy, intentionally self-inflicted injuries, foreign travel or residence, flight in non-scheduled aircraft, war, or military service. The policies may not contain age restrictions, or may contain only restrictions making persons 65 or over at the time the indebtedness is incurred ineligible for the coverage.

A credit disability insurance policy to which the specified rates apply must define disability, during the initial 12 months of disability, as the inability of the insured debtor to perform the occupation of the debtor at the time such disability occurred. Disability may be defined as the inability to perform any occupation for which the debtor is reasonably fitted by education, training or experience after the period of total disability has existed for 12 consecutive months. Disability may not be defined as the inability to perform any occupation. Finally, a credit disability policy may not restrict benefits to those periods of total disability when the insured is under the regular and continuing care of a physician.

A company may apply for approval of credit life or credit accident and health insurance rates which exceed those specified in the law or by the Insurance Department, or for policies containing limitations or restrictions other than those listed. However, any such rates which differ from those specified in the law (or the actuarial equivalent as defined by the Commissioner for other periods or forms) or which apply to coverages containing limitations or restrictions other than those listed, must be accompanied by appropriate experience data which demonstrates that they may reasonably be expected to produce at least a 50 per cent loss ratio.

Lender Compensation. In dealing with excessive compensation to lender-agency representatives, the Iowa code stipulates that the premiums should generate a 50 per cent loss ratio. Furthermore, premium rates to be charged for credit life and credit disability insurance must be filed with the forms to be used. If the rates are greater than the rates set forth in the law or determined at the public hearing, supporting statistical data must be filed justifying such rates.

The rate filings must be accompanied by an exhibit showing the portion of the premium allocated for

1. Losses
2. Loss adjustment expense
3. Commission and compensation to lenders
4. Other acquisition costs
5. Other expenses, contingencies, and profits

Policies issued must be issued at the filed and approved rates, which are on file with the Commissioner's office. Iowa law also forbids a company or its agent licensed to sell Credit Life Insurance or Credit Accident and Health Insurance from depositing or offering to deposit funds in a financial institution in exchange for the privilege of selling such credit insurance to or on behalf of the financial institution.

Regulation of Areas Other Than Rates

In addition to the regulations dealing with premiums, rates, expenses, and compensation to lender-agents, most of the other abusive practices identified by the NAIC Subcommittee are also dealt with specifically under Iowa laws, either in the provisions of the Iowa Code, or in Insurance Department Regulations. As the reader will recall, the major abuses to which the NAIC Subcommittee addressed itself included coercion of the borrower to purchase the insurance, failure to provide evidence of the insurance, non-payment of claims, and the sale of excessive amounts of credit life and disability insurance through pyramiding and sale of amounts in excess of the indebtedness. As the following discussion will indicate, each of these practices is specifically dealt with under Iowa law.

Coercion. Federal statutes and the Iowa Unfair Trade Practices Act make it illegal for a lender to require the purchase of insurance as a condition precedent to obtain a loan. In addition, Iowa Insurance Department Regulations also specifically forbid making

the purchase of credit life or credit disability a requirement for obtaining a loan:

> "No debtor shall be required to purchase such insurance as a condition percedent to a loan or credit transaction unless such insurance is required of all of the eligible debtors of the creditor in the same class, except any as to whom evidence of insurability is not satisfactory to the insurer. If such coverage is required as a condition precedent to the extension of credit to all such eligible members of the class of debtors, each such debtor shall have the option of furnishing such coverage under the terms of a policy issued by any insurer licensed in the State of Iowa."

In addition to this Department Ruling, Section 507B.5 of the Iowa Code provides in part:

1. No person may do any of the following:
   a. Require, as a condition precedent to the lending of money or the extension of credit, or any renewal thereof, that any person to whom such money or credit is extended or whose obligation the creditor is to acquire or finance, negotiate any policy or contract of insurance through a particular insurer or group of insurers or agent or broker or brokers.
   b. Unreasonably disapprove the insurance policy provided by a borrower for the protection of the property securing the credit or lien.

This section of the Code applies to any "individual, corporation, association, partnership or other legal entity."

Both the Insurance Department Ruling and the provision of the Code make it clear that it is permissible to require security for payment of a debt in the form of insurance. What is forbidden is requiring the borrower to purchase such insurance from a particular source, such as, for example, from the lender.

Evidence of Insurance. For the reasons previously outlined, it is considered essential that the individual insured under a credit life insurance or credit disability insurance policy be given evidence of the insurance, and Insurance Department Regulations require that such evidence be delivered to the insured borrower:

> "Upon being insured, there shall be delivered to the debtor within 30 days of the credit transaction evidence of insurance in the form of a policy, certificate, or statement of insurance, setting forth the name of the insured or his loan number, a description of the coverage, the amount and term thereof, all exceptions or limitations, and if an identifiable charge has been made for such insurance, the amount of the premium or the rate charged the debtor thereof."

Department regulations further provide that if the policy or certificate is not issued at the time the coverage becomes effective, there must be some written description of the coverage provided given to the insured, which will serve as a binder and as evidence of the coverage pending the issuance of the policy or certificate.

Payment of Claims. The NAIC Subcommittee found that most of the abuses involving non-payment of claims in the credit insurance field involved creditors selling credit life insurance that were permitted by the insurers to handle the settlement of claims. In order to reduce the possibility of such practices, the Iowa Insurance Department Regulations specifically forbid the creditor from becoming involved in claim adjustment:

> "Claims shall not be adjusted by the creditor or its representatives, nor shall the insurer make any special allowances to the creditor or its representatives in connection with the filing, investigation and payment of claims."

The prohibition against insurers making special allowances to the creditor for filing or investigation of claims serves to outlaw subterfuges that might be used to circumvent the limitations on credit compensation previously discussed.

Excessive Amounts of Insurance. In attempting to deal with the problem of the sale of excessive amounts of insurance, Iowa law treats a number of practices, setting forth specific regulations relative to the amount of insurance that may be written, the period for which the coverage may be written, and the procedures for cancellation of credit life policies when a debt has been discharged.

First of all, Insurance Department Regulations require that with respect to the term of the insurance, the insurance shall not extend beyond the maturity date of the entire indebtedness or extensions thereof. In addition, Department regulations also specify that the benefits under Credit Accident and Health Insurance shall not exceed the approximate amount of the payments provided for in the contract of indebtedness, and that the life benefits provided under the terms of a credit life coverage shall not exceed the approximate amount of the maximum indebtedness. Furthermore, as we have seen with respect to group credit life only, the Iowa Code sets a dollar maximum on the amount of coverage permitted, and limits the amount of group credit life insurance on the life of any one debtor to $35,000.

Finally, Insurance Regulations dealing with cancellation of Credit Life and Credit Accident and Health Insurance serve to prevent the sale of excessive amounts of credit insurance by permitting the insured to cancel his coverage in the event of prepayment or refinancing of the loan. In those instances in which the insured debtor has paid all or a part of the premium for the credit insurance protection, he is entitled to a refund of a part of that premium if the policy or certificate is cancelled before the end of the period for which he has paid. Such instances would arise, for example, in the event that the loan were paid off early, or if it were refinanced. Insurance Department Regulations provide that a debtor may cancel his insurance if the indebtedness is discharged, renewed, or refinanced prior to its scheduled maturity date. In such instances, the regulations provide that the return premium to

which the insured is entitled is to be calculated on the basis of the applicable Iowa short rate table or the Rule of 78.

When the policy is of the level term variety, cancellation is on a short rate basis. This means that a slightly less than proportional return of premium is made to the insured. For example, assuming an initial premium of say, $20 on a level term policy for one year, cancellation at the end of six months would yield a return premium to the insured borrower of $8. (Under the "short rate" cancellation basis, 40 per cent of the initial premium is returned for the six month unexpired portion of the policy.)

When an installment or declining balance loan is involved and decreasing term insurance has been provided, most insurers use the "Rule of 78" in computing the return premium to which the insured borrower is entitled. As the reader may no doubt be aware, the Rule of 78 has been accepted by the American Bankers Association and many lending institutions as the standard approach to calculating minimum refunds for installment loan charges when such charges have been paid in advance and the loan is repaid early. Because of its prevalence in the area of lending charge refunds, it has also become the more or less standard approach to calculating insurance premium refunds on decreasing term insurance in the case of prepayment, refinancing, and renewal. The Rule of 78, which is also called the "sum of the digits method," calculates the portion of the initial prepaid premium to be refunded in a manner so as to provide a proportional charge for the amount of coverage provided up until the time of cancellation. An illustration should serve to illustrate the operation of this method of calculating return premiums. For the purpose of illustration, we will assume a $1,200 loan which is scheduled for repayment over the period of one year at the rate of $100 per month.

	FACE AMOUNT OF LOAN AND AMOUNT OF PROTECTION PROVIDED	UNITS OF PROTECTION	PROPORTION OF INITIAL ADVANCE PREMIUM EARNED DURING MONTH (end of month)	CUMULATIVE PROPORTION OF INITIAL PREMIUM EARNED TO DATE (end of month)
1st month	$1,200	12	12/78	12/78
2nd month	1,100	11	11/78	23/78
3rd month	1,000	10	10/78	33/78
4th month	900	9	9/78	42/78
5th month	800	8	8/78	50/78
6th month	700	7	7/78	57/78
7th month	600	6	6/78	63/78
8th month	500	5	5/78	68/78
9th month	400	4	4/78	72/78
10th month	300	3	3/78	75/78
11th month	200	2	2/78	77/78
12th month	100	1	1/78	78/78
		78		

If the total amount of insurance provided under a decreasing term policy is viewed as a series of "units of protection" as indicated in the above illustration, the logic of the Rule of 78 becomes apparent. In the illustration above, the initial amount of protection is $1,200, and during the first month, there are 12 units of $100 in protection. In the second month, the number of units has decreased to 11, in the third month there are ten units and so on. During the one-year period, there are a total of 78 "units of protection." Since the initial premium represents the cost of the total 78 units, calculating the return premium in the event of cancellation requires calculation of the proportion of the total insurance paid for that protection that has been provided. This may be equitably done through the application of the above technique. Obviously, although the illustration above uses a one-year period for the purpose of illustration, the same principle may be applied to other time periods with the same result.

In those instances in which the borrower is insured under an individual policy, he may be given the option of retaining the insurance until its expiration date, even after the loan has been paid off. In such cases, the debtor must be furnished a form clearly explaining the two options (cancellation or permitting the coverage to run until expiration) and is required to sign the form indicating which of the options he has elected.

Licensing of Agents. In order to subject those who actually sell credit life insurance and credit disability insurance to the regulatory authority of the Commissioner of Insurance, the Iowa Code specifically requires that every person who acts "directly or indirectly . . . as agents or otherwise, in receiving or procurring applications for insurance . . ." be licensed as an insurance agent. Specifically, Section 522.1 of the Code states:

> **522.1 License Required.** No person shall directly or indirectly, act within this state as agent, or otherwise, in receiving or procurring applications for insurance, or in doing or transacting any kind of insurance business for any company or association . . . until he has procured from the commissioner of insurance a license authorizing

him to act for such company or association as agent.

In addition, Section 522.3 provides that the Commissioner shall require of each first time applicant reasonable proof of character and competency with respect to the type and kind of insurance the applicant proposes to sell. As pointed out in the General Section of the **Iowa Agents Study Manual,** because of the technical complications in the insurance product, it is especially important that those selling insurance understand the products which they propose to sell. Before licensing an individual as an agent, the Commissioner must be satisfied that the applicant understands the contracts that he proposes to sell, and in order to do this, the Insurance Department requires satisfactory performance on a written examination by all applicants.

[2] The Attorney General has given an opinion that a small loan licensee may, because of the specific provisions of Section 536.26 of the Iowa Code, issue certificates of insurance under a master policy of group credit life insurance without being licensed as an agent. In all other circumstances, every person must be licensed if he or she is receiving or procuring applications for any kind of insurance.

GLOSSARY

ABANDONMENT — the act of surrendering to the underwriters all interests in the thing insured. It is generally conceded that property cannot be voluntarily abandoned to the insurance company. One notable exception to this general rule occurs in Ocean Marine where abandonment is merely one step in proving a loss.

ACCEPTANCE — agreeing to terms or proposals by means of which a bargain is concluded and the parties are bound; the binding of an insurance contract by the insurer.

ACCIDENT — an event or occurrence which is unforeseen and unintended.

ACCIDENT INSURANCE — a form of health insurance against loss by accidental bodily injury.

ACCIDENTAL BODILY INJURY — injury to the body of the insured as the result of an accident.

ACCIDENTAL DEATH BENEFIT — a provision added to an insurance policy for payment of an additional benefit in case of death by accidental means. It is often referred to as "Double Indemnity."

ACCIDENTAL MEANS — appearing in some policies, the unexpected or undesigned cause of an accident. The "means" which caused the mishap must be accidental in order to claim policy benefits.

ACQUISITION COST — that portion of an insurance premium which represents the cost of producing the insurance business. It includes the agent's commission, the company field expense, and other related expenses.

ACTUAL CASH VALUE — the limit of indemnification under the Standard Fire Policy and other property contracts; in most cases it is replacement cost minus depreciation.

ACTUARY — a person professionally trained in the technical aspects of insurance and related fields, particularly in the mathematics of insurance such as the calculation of premiums, reserves, and other values.

ADDITIONAL INTEREST — one who may claim under or is protected by an insurance policy issued to another, as a mortgagee named in a Fire Policy.

ADDITIONAL LIVING EXPENSE — insurance paying the extra expense involved in living elsewhere during the period of time it is impossible to remain in a dwelling which has been damaged by fire or another insured peril.

ADJUSTER — one who settles insurance claims. May be a salaried employee or an independent operator.

ADMIRALTY — involving maritime law; concerning the high seas or navigable waters.

ADVERSE SELECTION — the tendency of poorer risks or less desirable insured to seek or continue insurance to a greater extent than do the better risks.

AGE LIMIT — the age below which or above which a company refuses to insure a risk. Usually Accident, Health, Life or Automobile insurance.

AGENT — in property and casualty insurance, an individual authorized by an insurance company to create, modify, and terminate contracts of insurance. In life insurance, a sales and service representative who is also called "a life underwriter".

AGGREGATE — the greatest amount recoverable on account of a single loss or during a policy period, or on a single project.

ALIEN COMPANY — an insurance company organized under the laws of a foreign country.

ALL RISK — a term commonly used by insurance people to describe broad forms of coverage. It is misleading because no property or liability insurance policy is truly an all risk coverage. These policies insure "all risks" of loss subject to the listed exclusions.

ALLIED LINES — a term that has been adopted to refer to the lines of insurance that are allied with property insurance. These coverages provide protection against perils traditionally written by fire companies, such as sprinkler leakage, water damage, and earthquake.

AMERICAN AGENCY SYSTEM — the term applied to the system of insurance marketing in which the agent is an independent businessman rather than an employee of the company.

ANNUITANT — the person during whose life an annuity is payable, usually the person to receive the annuity.

ANNUITY — a contract that provides an income for a specified period of time, such as a number of years or for life.

ANNUITY CERTAIN — A contract that provides an income for a specified number of years, regardless of life or death, to the insured if living or to his beneficiary if he has died.

APPLICATION — a statement of information made by a person applying for life insurance. It is used by the insurance company to determine the acceptability of the risk and the basis of the policy contract.

APPORTIONMENT — a division according to the interests of the various parties therein, as the Apportionment Clause in a Fire Policy.

APPRAISAL — an estimate of value, loss or damage; see Arbitration.

ARBITRATION — the submitting of a matter in dispute to the judgment of a specified number of disinterested persons called "arbitrators," whose decision, called an "award," is binding upon the parties; see Appraisal.

ASSESSMENT — a charge sometimes levied against policyholders by certain types of companies.

ASSURED — the insured; the one for whom insurance is written.

ASSIGNED RISK — an applicant for automobile or workmen's compensation insurance declined by one or more companies. Such a risk may be assigned to designated companies as directed by recognized authority. The operation is called an Assigned Risk Plan.

ASSIGNMENT — the legal transfer of one person's interest in an insurance policy to another person.

ASSOCIATION GROUPS — see Professional Association Groups and Trade Association Groups.

ATTACHMENT — a statutory legal remedy whereby one party may prevent removal of property belonging to another party, pending determination of a court action.

ATTORNEY-IN-FACT — one appointed to act for another; the chief administrative officer of a reciprocal insurance group, who uses his power of attorney to commit the members of the group as insurers of each other.
Also one who executes a Surety Bond on behalf of the company he represents.

AUDIT PREMIUM — the additional premium to which the company is entitled or the return premium to which the insured is entitled after an audit and refiguring of the base on which the original or deposit premium was charged.

AUTOMATIC PREMIUM LOAN — a provision in a life insurance policy authorizing the company to pay automatically by means of a policy loan any premium not paid by the end of the grace period.

AVERAGE CLAUSE — a coinsurance clause; a clause requiring an insured to purchase insurance for a stipulated portion of the entire value of the thing insured; see General Average; Particular Average.

BAIL — a deposit or assignment guaranteeing appearance of a defendant for a trial and which is forfeited if the defendant fails to appear at the stipulated time.

BAILMENT — a contract resulting from delivery of goods by one party, called the bailor, to another party, called the bailee on a promise from the latter to return them when the purpose for which they were delivered has been fulfilled.

BENEFICIARY — the person named in the policy to receive the insurance proceeds at the death of the insured.

BENEFICIARY, PRIMARY — the person or persons designated to receive the death benefit.

BENEFICIARY, CONTINGENT — the person or persons designated to receive the death benefit if the primary beneficiary dies prior to the death of the insured.

BETTERMENT — an improvement rendering property better than mere repairs would do.

BID — a proposal or offer.

BINDER — a written agreement (sometimes oral) whereby one party agrees to insure another party pending receipt of and final action upon the application. Agents may secure it only through written consent of management.

BLANKET — in property and liability, used to designate insurance which extends to more than one location, or one class of property or one employee.

BLANKET MEDICAL EXPENSE (Accident) — a provision for the payment of actual expense of hospital, nurse, surgical and medical care subject to an overall maximum for all such expense.

BLANKET POLICY — one which covers all individuals (thus the term blanket) in a given group against a specified category of hazards. It is used for such groups as athletic teams, campers, travel policies for employees, etc.

BLUE CROSS — an independent, nonprofit membership corporation providing protection against the costs of hospital care in a limited geographical area.

BLUE SHIELD — an independent, nonprofit membership corporation providing protection against the costs of surgery and other items of medical care in a limited geographical area.

BODILY INJURY — physical injury to a person.

BOILER AND MACHINERY INSURANCE — coverage for loss arising out of the operation of pressure, mechanical and electrical equipment. It may cover loss suffered by the boiler and machinery itself and may include damage done to other property, as well as business interruption losses.

BOND — a written agreement of obligation under seal. The person to whom the undertaking is given is called obligee; the person liable for the undertaking is called the obligor or principal, if a third party guarantees performance of the agreement, he is called the surety.

BREACH OF CONTRACT — failure to comply with the terms or conditions incorporated in an insurance policy, frequently resulting in a restriction of coverage or a voiding of a policy itself.

BROKER — an individual who arranges and services insurance policies on behalf of the insurance buyer. He is the representative of the insured, although he

receives his compensation in the form of a commission from the company.

BUREAU — a cooperative rate making body, which is supported by member companies. The member companies agree to abide by the rates published by the bureau.

BURGLARY — felonious abstraction of property from within premises by persons making felonious entry by force of which there are visible marks on the exterior.

BUSINESS INTERRUPTION — the name given to insurance covering the loss of earnings resulting from and occurring after destruction of property; also called Use and Occupancy Insurance.

BUSINESS LIFE INSURANCE — life insurance purchased by a business enterprize on the life of a member of the firm. It is often bought by partnerships to protect the surviving partners against loss caused by the death of a partner, or by a corporation to reimburse it for loss caused by the death of a key employee.

CAPITAL SUM — a lump sum payable for dismemberment and sight losses.

CASH SURRENDER VALUE — the amount available in cash upon voluntary termination of a policy before it becomes payable by death or maturity.

CATASTROPHE LOSS — a loss of unusual size; a shock loss; a very large loss.

CESSION — the amount of a risk which the insurance company reinsures. The amount passed on to the reinsurer.

CLAIM — notification to an insurance company that payment of an amount is due under the terms of a policy.

COINSURANCE — in property and casualty insurance, a clause or provision in an insurance policy requiring a specified amount of insurance based on the value of the property insured. Normally there is a premium reduction for purchasing insurance to some percentage of the value of the property. If the insured fails to comply with the clause, he will suffer a penalty in the event of partial loss.
In health insurance a policy provision requiring the insured to share a given percentage of the loss.

COLLUSION — a compact between persons usually to the detriment of other persons or for some improper purpose.

COMMERCIAL — the opposite of personal; of a business nature, usually mercantile or manufacturing.

COMMISSION — the fee paid by insurance companies to agents for the sale of policies.

COMMON CARRIER — a transportation company such as a railroad or bus line.

COMPENSATION — wages, salaries, awards, fees, commissions, financial returns of any kind.

COMPREHENSIVE — a loosely used term signifying broad or extensive insurange coverage.

COMPREHENSIVE MAJOR MEDICAL INSURANCE — a policy designed to give the protection offered by both a basic and major medical health insurance policy. It is characterized by a low "deductible" amount, coinsurance feature, and high maximum benefits—usually $5,000 to $10,000 or higher.

COMPREHENSIVE PERSONAL LIABILITY INSURANCE — a type of insurance that reimburses the policyholder if he becomes liable to pay money for damage or injury he has caused to others. This form does not include automobile liability, but does include almost every activity of the policyholder except his business operations.

CONCEALMENT — deliberate failure to reveal material facts, which would affect the validity of a policy of insurance.

CONCURRENT — covering the same kind of property at the same location under the same terms and conditions, with the same types of coverage, as two or more insurance policies.

CONDITIONAL SALE — a transfer of property without transfer of title; installment selling, as buying a radio "on time".

CONFINING SICKNESS — that which confines an individual to his home or a hospital. (Visits to physicians and hospitals are generally considered as not terminating confinement).

CONSEQUENTIAL LOSS — loss occurring after and as a result of some other loss, as loss of profits resulting from a fire or a loss of frozen foods resulting from electrical failure.

CONSIDERATION — price, token or other matter used as an inducement for the completion of a contract, as an insurance premium.

CONSTRUCTIVE TOTAL LOSS — a loss of sufficient amount to make the cost of salvaging or repairing the property equal to or greater than the value of the property when repaired.

CONTINGENT — conditional; depending upon another happening. A contingent beneficiary is one next in line after the first named.

CONTRIBUTION — a participation, as two insurance policies in the same loss.

COVERAGE — the insurance afforded by the policy.

CONVERSION — wrongful appropriation to one's own use, as an automobile.

CONVERTIBLE TERM INSURANCE — term insurance which can be exchanged, at the option of the policy-

holder and without evidence of insurability, for another plan of insurance.

COUNTER-SIGNATURE — an additional signature required in most states to comply with residence agency laws. Applies when a producer in one state controls business located in or operating in another state.

CO-SURETY — a personal or corporate guarantor of a surety obligation on which one or more of the sureties are directly responsible for the same obligation.

CREDIT LIFE INSURANCE — term life insurance issued through a lendor or lending agency to cover repayment of a specific loan, installment purchase or other obligation, in case of the debtor's death.

CRIME — a wrong against public laws or customs punishable by fine, imprisonment, or death, after trial in a criminal court.

CROP-HAIL INSURANCE — protection for monetary loss resulting from hail damage to growing crops. Although hail is the basic peril named in crop-hail policies, a number of other perils are covered as well, depending on the crop and area. Crop-hail policies cover fire, lightning, windstorm, aircraft, smoke and other miscellaneous perils.

DAILY REPORT — a copy of that portion of an insurance contract dealing with the description of the risk and the amount of insurance, which is sent to the home office of the insurance company and retained in the agent's files.

DAMAGES — the amount claimed or allowed as compensation for injuries sustained or property damaged through the wrongful acts or the negligence of another; an award.

DECLARATIONS — that part of an insurance policy containing the representations of the applicant.

DECLINATION — the rejection by a life insurance company of an application for life insurance, usually for reasons of the health or occupation of the applicant.

DEDUCTIBLE — a provision whereby an insured may be required to pay part of a loss, the insurance being excess over the amount of the deductible.

DEFERRED ANNUITY — an annuity providing for the income payments to begin at some future date, such as in a specified number of years or at a specified age.

DEFERRED GROUP ANNUITY — a type of group annuity providing for the purchase each year of a paid-up deferred annuity for each member of the group, the total amount received by the member at retirement being the sum of these deferred annuities.

DEPOSIT ADMINISTRATION — a type of group annuity providing for the accumulation of contributions in an undivided fund out of which annuities are purchased as the individual members of the group retire.

DEPOSIT PREMIUM — an original premium paid by the insured at the inception date of the policy; estimated premium, subject to later adjustment; see Audit Premium.

DEPRECIATION — the lessening of value through age, deterioration and obsolescence.

DEVIATION — use of a premium rate other than the standard rate filed with the state insurance department.

DIRECT LOSS — loss resulting directly and immediately from the hazard insured against.

DIRECT WRITER — an insurance carrier that deals directly with the insured through a salaried representative, as opposed to those carriers which use agents. (Also used to refer to carriers which operate through exclusive agents.)

In reinsurance, the company that originally writes the business.

DISABILITY — inability to perform all or part of one's occupational duties because of an accident or illness. (See, Total Disability and Partial Disability).

DISABILITY BENEFIT — a provision added to a life insurance policy for waiver of premium, and sometimes payment of monthly income, if the insured becomes totally and permanently disabled.

DISCOVERY PERIOD — the period after termination of an insurance policy or bond, or after the occurrence of a loss, within which the loss must be discovered to be covered.

DISMEMBERMENT — accidental loss of limb or sight. (Capital Sum)

DISTRESS CARRIER — an insurance company specializing in substandard risks, usually in the field of automobile insurance.

DIVIDEND ADDITION — an amount of paid-up insurance purchased with a policy dividend and added to the face amount of the policy.

DOMESTIC COMPANY — a name given to a company in the state of its incorporation, as an Iowa company is domestic in the State of Iowa, foreign as to all other states and alien as to all other countries.

DOUBLE INDEMNITY — a provision under which certain benefits are doubled when accident is due to specified circumstances, such as public conveyance accidents. In a life insurance policy, a provision that the face amount payable on death will be doubled if the death is a result of an accident.

EARNED INCOME — employment income derived from salary, wages, commissions, or fees.

EFFECTIVE DATE — the date upon which the policy is put in force; the inception date.

ELECTIVE BENEFIT — a benefit payable in lieu of another. e.g., A lump sum benefit may be allowed for specified fractures or dislocations in lieu of weekly indemnity.

ELMINIATION PERIOD (See Waiting Period).

ENDORSEMENT — a written amendment affecting the declarations, insuring agreements, exclusions or conditions of an insurance policy; a rider.

ENDOWMENT INSURANCE — insurance payable to the insured if he is living on the maturity date stated in the policy, or to a beneficiary if the insured dies prior to that date.

ESTATE — possessions of a deceased person; possessions of a minor or incompetent person; possessions of a bankrupt person or corporation; worldly goods of anyone.

ESTOPPEL — an admission or declaration by which a person is prevented from proving the contrary.

EXCESS — that which goes beyond, as excess insurance, over and above a primary amount.

EXCLUSION — that which is expressly eliminated from the coverage of an insurance policy.

EXPECTATION OF LIFE — (Life Expectance). The average number of years of life remaining for persons of a given age according to a particular mortality table.

EXPERIENCE RATING — the act of computing a premium based on the loss experience of the risk itself; a step beyond class rating.

EXPIRATION — the date upon which an insurance policy terminates unless continued or renewed by an additional premium.

EXTENDED COVERAGE INSURANCE — protection for the insured against loss or damage of his property caused by windstorm, hail, smoke, explosion, riot, riot attending a strike, civil commotion, vehicle and aircraft. This is provided in conjunction with the fire insurance policy.

EXTENDED TERM INSURANCE — a form of insurance available as a nonforfeiture option. It provides the original amount of insurance for a limited period of time.

FACE AMOUNT — the amount stated on the face of the policy that will be paid in case of death or at the maturity of the contract. It does not include dividend additions, or additional amounts payable under accidental death or other special provisions.

FAMILY INCOME POLICY — a life insurance policy, combining whole life and decreasing term insurance, under which the beneficiary receives income payments to the end of a specified period if the insured dies prior to the end of the period, and the face amount of the policy either at the end of the period or at the death of the insured.

FAMILY MAINTENANCE POLICY — life insurance which pays, in addition to the face of the policy, a monthly income for a period commencing with the insured's death and continuing for the number of years specified. The period is most often 10, 15, or 20 years.

FAMILY POLICY — a life insurance policy providing insurance on all or several family members in one contract, generally whole life insurance on the husband and smaller amounts of term insurance on the wife and children, including those born after the policy is issued.

FIDELITY BOND — a form of protection which reimburses an employer for losses caused by dishonest or fraudulent acts of his employees.

FIELD SUPERVISOR — a salaried employee of an insurance company, whose responsibilities are:

A. Production of new business through existing agents.

B. The appointment of new agents.

C. General supervision of the company's affairs in his territory.

FINANCIAL RESPONSIBILITY LAW — a statute which requires motorists to show evidence of financial responsibility following an accident which involves bodily injury or property damage in excess of some amount. Normally, proof of financial responsibility is given through a valid policy of insurance.

FIRE INSURANCE — coverage for losses caused by fire and lightning, as well as the resultant damage caused by smoke and water.

FLEET — a group, as of automobiles.

FLOATER — a Marine or Fire Policy, the coverage of which follows the movement of the property insured.

GENERAL AVERAGE — In marine insurance, a loss that must be borne partly by someone other than the owner of the goods that were lost or destroyed. For example, if it is necessary to jettison cargo in order to save a ship, the owners of the ship and the rest of the cargo which is saved will share in the loss of the goods that were intentionally sacrificed.

GRADED COMMISSION — a reduced commission justified by the size of the premium.

GRADED EXPENSE — a reduced expense item for the insurance company justified by the size of the premiums.

GRATUITOUS — made without a consideration, as a gift, requiring nothing in return.

GROUP ANNUNITY — a pension plan providing annuities at retirement to a group of persons under a

single master contract, with the individual members of the group holding certificates stating their coverage. It is usually issued to an employer for the benefit of employees. The two basic types are deferred and deposit administration group annuities.

GROUP INSURANCE — any insurance plan under which a number of employees and their dependents are insured under a single policy, issued to their employer, with individual certificates given to each insured employee. The most commonly written lines are life and accident and health.

GUARANTEED RENEWABLE POLICY — a policy which the insured has the right to continue in force by the timely payment of premiums to a specified age, (usually age 50) during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force, but may make changes in premium rates by policyholder class.

HAZARD — a condition that creates or increases the probability of a loss.

HAZARD MORAL — the chance that a loss may be caused by or due to a lack of character or integrity on the part of the insured.

HOLD HARMLESS AGREEMENT — a contract usually written whereby one party assumes legal liability on behalf of another party.

HOSTILE FIRE — a fire burning where none is intended.

HEALTH INSURANCE — a generic term applying to all types of insurance indemnifying or reimbursing for expenses or losses caused by bodily accident or sickness or for expenses of medical treatment necessitated by sickness or accidental bodily injury.

HEALTH INSURANCE ASSOCIATION OF AMERICA — a voluntary, non-profit association of companies organized for the purpose of promoting "the development of voluntary health insurance providing sound protection against loss of income and other financial burdens resulting from sickness or accidental bodily injury."

INCONTESTABLE CLAUSE — a provision that prevents the carrier from challenging the coverage because of alleged misstatements by the insured after a stipulated period has passed, usually two or three years.

INDEPENDENT CONTRACTOR —one who performs work for another in his own manner and method, and who is not subject to the control or direction of the party for whom the work is performed. He is not an employee of the party for whom the work is performed.

INDIVIDUAL POLICY PENSION TRUST — a type of pension plan, frequently used for small groups, administered by trustees who are authorized to purchase individual level premium policies or annuity contracts for each member of the plan. The policies usually provide both life insurance and retirement benefits.

INDUSTRIAL LIFE INSURANCE — life insurance issued in small amounts, usually less than $1000 on a single life exclusive of additional benefits, with premiums payable on a monthly or more frequent basis, and generally collected at insured's home by an agent of the company.

INSURABLE — able to meet the company's underwriting standards for coverage.

INSURANCE EXAMINER — the representative of a state insurance department assigned to participate in the official audit and examination of the affairs of and insurance company.

INSURED — the person on whose life an insurance policy is issued.

IMPROVEMENTS AND BETTERMENTS INSURANCE — insurance that protects a tenant against loss to improvements made by him to property in which he is a tenant.

INDIRECT — contingent; that which happens only after something else has occurred.

INHERENT VICE — a characteristic depreciation such as the fading of ink, a cracking of parchment, the graying of hair.

INLAND MARINE INSURANCE — a broad type of insurance, generally covering articles that may be transported from one place to another. The essential condition is that the insured property be moveable, though bridges, tunnels and similar instrumentalities of transportation are also considered inland marine. This form of insurance was developed originally by marine underwriters to cover goods while in transit by other than ocean vessels. It now includes any goods in transit (generally excepting trans-ocean) as well as numerous "floater" policies such as personal effects, personal property, jewelry, furs, fine arts and others.

INSPECTION — an examination by those having authority; right usually reserved by an insurance company with respect to any property it insures.

INSURABLE INTEREST — an interest which might be damaged if the peril insured against occurs. The possibility of a financial loss to an individual which can be protected against through insurance.

INSURANCE — a device by which an individual substitutes a small certain cost (the premium) for a large uncertain loss (the contingency insured against) which would exist in the absence of the contract. The device operates through the combination of a sufficiently large number of homogeneous exposure units so as to make losses predictable for the group as a whole.

Also used to describe the business of assuming risk in consideration of a premium.

INSURED — see assured.

INTESTATE — leaving no will at death.

INVITEE — a person having an express or implied invitation to enter a given location.

JOINT INSURED — one of two or more persons whose names or interests are insured under the same or identical contracts.

JUDGMENT — the decision of a court or the reason for such decision.

JUMBO RISK — a risk requiring exceptionally high benefit limits.

KEY-MAN INSURANCE — a program designed to cover the key employees of an employer. It may be written on a group or individual policy basis.

LAPSE — termination of a policy due to failure by the insured to pay the premium as required.

LAPSED POLICY — a policy discontinued for non-payment of premiums. The term is technically limited to a termination occurring before the policy has a cash or other non-forfeiture value.

LEGAL RESERVE LIFE INSURANCE COMPANY — a life insurance company operating under state insurance laws specifying the minimum basis for the reserves the company must maintain on its policies.

LEVEL PREMIUM INSURANCE — insurance for which the cost is distributed evenly over the premium-paying period. The premium remains constant from year to year, and is more than the actual cost of protection in the earlier years of the policy and less than the actual cost in the later years. The excess paid in the early years accumulates the reserve.

LIABILITY — a debt or responsibility; an obligation which may arise by a contract made or by a tort committed.

LICENSE — an official authority to do something; a permit issued by a political sub-division.

LIFE ANNUITY — a contract that provides an income for the life of the annuitant.

LIFETIME DISABILITY BENEFIT — a benefit for loss of time payable as long as the insured is totally disabled, even for lifetime.

LIMITED PAYMENT LIFE INSURANCE — a form of Whole Life Insurance on which premiums are payable for a specified number of years less than the period of protection, or until death if death occurs before the end of the specified period.

LIMITED POLICIES — those which cover specified accidents or sickness.

LIMITS — the value or amount of a policy; the greatest amount which can be collected under the policy.

LIVERY — delivery; transfer; in Automobile Insurance, the carrying of passengers for hire.

LOCAL AGENT — a producer of insurance whose activities are purely of local extent.

LOCATION — the place at which insurance coverage attaches; the situs of a risk.

LLOYDS — a voluntary unincorporated association of individuals organized for the purpose of writing insurance. Normally refers to LLOYDS of London, a group of individual underwriters and syndicates that underwrite insurance risks severally, using facilities maintained by the Lloyd's of London Corporation.

LONG-TERM DISABILITY — a generally accepted period of time for more than two years. Can vary according to company standards.

LOSS — the unintentional decline in or disappearance of value due to a contingency.

LOSS FREQUENCY — the number of claims on a policy during a premium period.

LOSS RATIO — the relationship between premiums collected and losses paid; losses (net) divided by premiums (net).

MAJOR MEDICAL EXPENSE INSURANCE — policies especially designed to help offset the heavy medical expenses resulting from catastrophic or prolonged illness or injury. They provide benefit payments for 75-80% of all types of medical treatment by a physician above a certain amount first paid by the insured person and up to the maximum amount provided by the policy — usually $5,000 or $10,000 or higher.

MANUAL — a book of rates, rules and coverages usually available for each kind of insurance.

MARINE — pertaining to the sea or to transportation; usually divided as to "ocean marine" and "inland marine"; the insurance covering transportation risks.

MISCELLANEOUS HOSPITAL EXPENSE — a provision for the payment on a blanket basis or schedule basis of hospital services (other than room and board, special nursing care, and doctors fees) up to a stipulated maximum amount.

MISREPRESENTATION — a misstatement; if done with intent to mislead, it may void the policy of insurance.

MORBIDITY TABLES — actuarial statistics showing the incidence and duration of disability.

MORTALITY TABLE — a statistical table showing the probable rate of death at each age, usually expressed as so many per thousand.

MORTGAGE — a deposit or conditional transfer to secure the performance of some act. The person who makes the transfer is called the mortgagor, the other

party, the mortgagee. Sometimes an intermediary called a trustee is appointed.

MULTIPLE LINE INSURANCE — policies that combine many perils previously covered by individual policies of fire and liability companies. The homeowner's policy is one example. Other examples are the commercial property policy, the farmowner's policy and the special multiperil policy for motels and apartments.

MUTUAL INSURANCE COMPANY — a nonprofit insurance carrier, without capital stock, which is owned by the policy holders. It may be incorporated or unincorporated.

MUTUAL LIFE INSURANCE COMPANY — a life insurance company whose legal ownership and control is vested in policyholders whose management is directed by a board elected by the policyholders. Mutual companies, in general, issue participating insurance only.

NAMED INSURED — the one named in the policy; see additional interest.

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS — a national organization of state officials who are charged with the regulation of insurance. Although the organization has no official power, it exerts a powerful influence through its recommendations.

NEGOTIATE — to dicker for; to make an offer; to deal as to negotiate an insurance policy.

NET RETENTION — the final amount of insurance retained by the company after reinsuring such amounts as it did not wish to retain.

NON ADMITTED CARRIER — an insurer that has not been licensed to write insurance in a given jurisdiction.

NON-CANCELLABLE OR NON-CANCELLABLE AND GUARANTEED RENEWABLE POLICY — a policy which the insured has the right to continue in force by the timely payment of premiums set forth in the policy to a specified age, (usually age 50) during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force.

NON-CONFINING SICKNESS — a sickness that does not confine the insured to his home or a hospital.

NON-DISABLING INJURY — an injury which does not cause total or partial disability.

NON-FORFEITURE OPTION — privilege available to the policyholder based upon his interest in the contract or once cash value has been created.

NON-OCCUPATIONAL POLICY — one which does not cover loss resulting from accidents or sickness arising out of or in the course of employment or covered under any Workmen's Compensation Law.

NON-PARTICIPATING INSURANCE — policy insurance on which the premium is calculated to cover as closely as possible the anticipated cost of the insurance protection and on which no dividends are payable to the insured.

NOTARY — commonly, a political appointee invested with the right to swear in a person making a statement under oath and to certify his signature.

NOT TAKEN — insurance policy issued and delivered to an insured but returned for flat concellation; see lapse.

OBLIGEE — the person or organization protected by a bond; see Principal.

OCEAN MARINE INSURANCE — coverage on all types of vessels, including liabilities connected with them, and on their cargoes. The cargo coverage has been expanded to protect the owners from warehouse to warehouse, inclusive of all intermediate transit by rail, truck or otherwise.

OCCUPATIONAL DISEASE — a disease or condition of health resulting from performance of an occupation as psittacosis, mercury poisoning, dust collection in the lungs, and the like. In most states occupational disease is now covered as part of the workmen's compensation exposure.

OCCURRENCE — a happening which occupies some length of time, as an individual catching cold after sitting in a draft in a theatre all evening; sometimes a series of accidents; see Accident.

OPEN FORM — a continuous policy written on a reporting basis.

ORDINARY LIFE INSURANCE — a form of whole life insurance usually issued in amounts of $1,000 or more with premiums payable on an annual, semi-annual, quarterly, or monthly basis to the death of the insured or to the end of the mortality table employed, whichever occurs first and at which time (benefits) proceeds are due. The term is also used to mean straight life insurance.

OVER-AGE OR SENIOR CITIZEN INSURANCE — policy forms that are issued beyond the normal age limits of 60 to 65.

PAID-UP INSURANCE — insurance on which all required premiums have been paid. The term is frequently used to mean the reduced paid-up insurance available as one of the non-forfeiture options.

PARTIAL DISABILITY — a provision generally found in accident and occasionally in sickness policies designed to offer some weekly or monthly indemnity benefit if the insured cannot perform all the important daily duties of his occupation.

PARTICIPATING INSURANCE — Policies which entitle the policyholder to receive dividends reflecting the difference between the premium charged and the actual operating expenses and mortality experience

of the company. If expenses and mortality are better than anticipated so that an excess of premium has been collected, a portion of the excess then so available is returned to the insured in the form of dividends. The premium is calculated to provide some margin over the anticipated cost of the insurance protection.

PARTICULAR AVERAGE — a term meaning an accidental and usually a partial loss suffered by one interest and not chargeable against others; see General Average.

PERIL — the event insured against; the cause of possible loss.

PERMANENT LIFE INSURANCE — a phrase used to cover any form of life insurance except term; generally insurance, such as whole life or endowment, that accrues cash value.

PERMISSIBLE LOSS RATIO — the maximum percentage of premium income which can be expended by the company to pay claims without loss of profit.

PLAINTIFF — a party to a law suit who brings charges against another party called the defendant.

POLICY — the written contract of insurance which is issued to the policyholder insured by the company insurer.

POLICY FEE — an additional charge placed on the initial premium designed to offset a portion of the expense of policy issuance.

POLICY DIVIDEND — a refund of part of the premium on a participating life insurance policy reflecting the difference between the premium charged and actual experience.

POLICY LOAN — a loan made by an insurance company to a policyholder on the security of the cash value of his policy.

POLICY PERIOD — the term for which insurance remains in force, sometimes definite, sometimes not.

POLICY RESERVES — the amounts that an insurance company allocates specifically for the fulfillment of its policy obligations. Reserves are so calculated that, together with future premiums and interest earnings, they will enable the company to pay all future claims.

POOL — a group of companies, the purpose of which is to undertake something the membership itself could not or would not do individually.

PRE-EXISTING CONDITION — a physical condition that existed prior to the effective date of the policy.

PREAUTHORIZED CHECK PLAN — a plan by which a policyholder arranges with his bank and insurance company to have his premium payments drawn, usually monthly, from his checking account.

PREMIUM — the payment, or one of the periodical payments, a policyholder agrees to make for an insurance policy.

PREMIUM LOAN — a policy loan needed for the purpose of paying premiums.

PREMIUM PERIOD — the length of time covered by the premium, usually identical with the policy period but frequently not.

PRIMARY — basic, fundamental; an insurance policy which pays first with respect to other outstanding policies.

PRINCIPAL — the applicant for or subject of insurance; the one from whom an agent derives his authority.

PRINCIPAL SUM — a term used to refer to the lump sum amount payable for accidental death, dismemberment, or loss of sight.

PROBATIONARY PERIOD (Also sometimes called Waiting Period) — a period of time from the policy date to a specified date, usually 15 to 30 days, during which no sickness coverage is effective. It is designed to eliminate a sickness actually contracted before the policy went into effect. Occurs only at the inception of a policy.

PRODUCER — an agent for an insurance company.

PRODUCTION COST — acquisition cost plus field expense.

PROFESSIONAL ASSOCIATION GROUP PLANS — those designed for associations of lawyers, doctors, dentists and other professions which offer two of the major advantages of group insurance — no individual cancellation and lower cost.

PROHIBITED RISKS — those not written by a company because of an unusual occupational exposure or uninsurable physical or moral conditions.

PROOF — the act of substantiating another act, such as a claim for insurance payment.

PROPOSAL — an application for insurance or the facts contained in it; a recommendation.

PRORATE CLAUSE — an optional policy provision designed to protect the company when an insured changes to a more hazardous occupation and does not have his policy amended accordingly. The company may pay only such portion of the indemnities provided as the premium paid would have purchased at the higher classification, subject to the maximum limits fixed by the company for such more hazardous occupation. It also protects the insured when he changes to a less hazardous occupation by providing for a return premium.

PRO-RATA CANCELLATION — cancellation with a return of premium charged for the period of time the policy was in force equal to the ratio of the total premium to the total policy period.

PRO-RATA DISTRIBUTION CLAUSE — a clause that provides that the face amount of the insurance will be divided between the objects insured in the pro-

portion that the value of each bears to the value of all.

PROXIMATE CAUSE — the immediate or actual cause of loss under an insurance policy.

PROVISIONS — the terms or conditions of an insurance policy.

RATE — the cost of a unit of insurance.

RATED POLICY — an insurance policy issued at a higher than standard premium rate to cover the extra-risk involved in certain instances where the insured does not meet the standard underwriting requirements. For example, impaired health or a particularly hazardous occupation.

REALTY — real property; real estate.

REBATE — the improper return of part or all of a premium to the policyholder.

RECURRING CLAUSE — a period of time during which a recurrence of a condition is considered as being a continuation of a prior period of disability or hospital confinement.

REIMBURSEMENT BENEFITS — those for which the insured is reimbursed on an actual expense incurred basis.

RECIPROCAL EXCHANGE — an association of individuals who agree to exchange insurance risks. Each member of the association insures each of the other members and in turn is insured by each of the other members; see Attorney in fact.

REDUCED PAID-UP INSURANCE — a form of insurance available as a nonforfeiture option. It provides for continuation of the original insurance plan, but for a reduced amount.

REGIONAL AGENT — a district agent; the grade between local and general agent.

REINSTATEMENT — the restoration of a lapsed policy.

REINSURANCE — insurance placed by an underwriter in another company to cut down the amount of the risk he has assumed under the original insurance.

RELEASE — a discharge, as from further liability under an insurance policy.

RENEW — to continue; to replace, as with new policy.

RENEWABLE TERM INSURANCE — term insurance which can be renewed at the end of the term, at the option of the policyholder and without evidence of insurability, for a limited number of successive terms. The rates increase at each renewal as the age of the insured increases.

RENTAL VALUE INSURANCE — insurance arranging to pay the reasonable rental value of property which has been rendered untenable by fire or some other peril insured against, for the period of time which would be required to restore the property to tenable condition.

REPORTING FORM — insurance which depends upon regular reports from the insured to determine the amount of insurance or the premium or both.

REPRESENTATIONS — statements made by an applicant in the application which he represents as being substantially true to the best of his knowledge and belief, but which are not warranted as exact in every detail.

RESERVE — funds set aside by the company to fulfill future liabilities.

RESIDUARY — the balance remaining, as in an estate after specific bequests and debts have been paid.

RESTORATION — reinstatement, as the amount of coverage after a loss.

RETROCESSION — the amount of risk which a reinsurance company reinsures. The amount of a cession which the reinsurer passes on.

RETURN PREMIUM — an amount due the insured upon cancellation of a policy.

REVIVAL — the reinstatement of a lapsed policy by the company upon receipt of evidence of insurability and payment of past due premiums with interest.

RIDER — a document which amends the policy. It may increase or decrease benefits, waive a condition or coverage, or in any other way amend the original contract. The terms rider and endorsement are oftentimes used interchangeably.

RISK — in the abstract, used to indicate a condition of the real world in which there is a possibility of loss. Also used by insurance practitioners to indicate the property insured or the peril insured against.

ROBBERY — the unlawful taking of property by violence or threat of violence.

SALVAGE — that which is recovered by an insurance company after paying a loss (not insurance itself); see Subrogation.

SCHEDULE — a list of coverages or amounts concerning things or persons insured.

SETTLEMENT OPTION — one of the ways, other than immediate payment in a lump-sum, in which the policyholder or beneficiary may choose to have the policy proceeds paid.

SHORT RATE CANCELLATION — cancellation with a less than proportionate return of premium.

SHORT-TERM DISABILITY — A generally accepted period of time for two years or less. Can vary according to company standards.

SICKNESS INSURANCE — a form of health insurance against loss by illness or disease.

SPRINKLER LEAKAGE INSURANCE — insurance against loss from accidental leakage or discharge from a sprinkler system due to some cause other than a hostile fire or certain other specified causes.

STANDARD — a form of policy whose terms or conditions are determined by law or agreement.

STANDARD PROVISIONS (Health Insurance) — a set of policy provisions prescribed by law setting forth certain rights and obligations of both the insured and company. These were originally introduced in 1912 and have now been replaced by the Uniform Provisions.

STOCK INSURANCE COMPANY — an insurance company owned by stock holders, usually for the purpose of making a profit.

STRAIGHT LIFE INSURANCE — whole life insurance on which premiums are payable for life.

SUBROGATION — an assignment or substituting of one person for another by which the rights of one are acquired by another in collecting a debt or a claim, as an insurance company stepping into the rights of a policyholder indemnified by the company.

SUBSTANDARD (Impaired Risk) — risks that have some physical impairment requiring the use of a waiver, a special policy form, or a higher premium charge.

SUPPLEMENTARY CONTRACT — an agreement between a life insurance company and a policyholder or beneficiary by which the company retains the proceeds payable under an insurance policy and makes payments in accordance with the settlement option chosen.

SURETY — a guarantor of a duty or obligation assumed by another.

SURETY BOND — an agreement providing for monetary compensation should there be a failure to perform certain specified acts within a stated period. The surety company, for example, becomes responsible for fulfillment of a contract if the contractor defaults.

SURPLUS LINES LAW — a provision in the Insurance Code of certain jurisdictions which permits an agent to place coverage with a nonadmitted carrier if he has exhausted the admitted market and cannot obtain coverage.

TERM — the length of time covered by a policy or a premium.

TERM INSURANCE — insurance payable to a beneficiary at the death of the insured provided death occurs within a specified period, such as five or ten years, or before a specified age.

THEFT — the unlawful taking of property of another. The term includes such crimes as burglary, larceny, and robbery.

THIRD PARTY — someone other than the insured and insuring company.

TORT — an injury or wrong committed against an individual.

TOTAL DISABILITY — disability which prevents the insured from performing all the duties of his occupation or any occupation. The exact definition varies among policies.

TRADE ASSOCIATION GROUPS — those made up of many employers of a common trade. Group policies may be issued to a trade association to cover these members and their employees and dependents.

TRAVEL ACCIDENT POLICIES — those that are limited to paying for loss arising out of accidents occurring while traveling.

TRUST — transfer of property right to one person called a trustee for the benefit of another called a beneficiary.

TWISTING — the act of switching insurance policies from one company to another, to the detriment of the insured.

UNDERWRITING — the process by which an insurance company determines whether or not and on what basis it will accept an application for insurance.

UNEARNED PREMIUM — that portion of an insurance premium covering the unexpired term of the policy or the unexpired period of the period.

UNIFORM PROVISIONS — statutory policy provisions which specify the rights and obligations of the insured and company.

VALUED POLICY — an insurance contract in which the value of the thing insured and the amout to be paid in case of total loss is settled at the time of making the policy.

VOID — of no force or effect; null.

WAITING PERIOD (Also sometimes called Elimination Period or Probation Period) — a provision designed to eliminate disability claims for the first number of days specified for each period of disability. The waiting period may run from 7 days to as long as one year. This term is also sometimes used to refer to a period of time after policy issuance during which specified conditions are not covered.

WAIVER — an agreement attached to the policy and accepted by the insured which eliminates a specified pre-existing physical condition from the policy.

WAIVER OF PREMIUM — a provision which waives payment of the premium which becomes due during a period of covered total disability which has lasted for a specified period of time, usually, three to six months.

WARRANTY — a statement concerning the condition of the item to be insured which is made for the purpose of permitting the underwriter to evaluate the risk. If found to be false, it provides the basis for voidance of the policy.

WHOLE LIFE INSURANCE — insurance payable to a beneficiary at the death of the insured whenever that occurs. Premiums may be payable for a specified number of years (limited payment life) or for life (straight life).

WORKMEN'S COMPENSATION INSURANCE — a method of providing for the cost of medical care and weekly payments to injured employees or to dependents of those killed in industry, regardless of blame for the accidents.

BIBLIOGRAPHY

The sources listed in this bibliography should be helpful to the agent in his further study of the subject of insurance. No attempt has been made to include every possible source. As a matter of fact, an attempt has been made to limit the listing to those sources which represent current sources, and which are most likely to be available to the agent.

In general, the list does not include a rather wide range of college text books on the subject of insurance, because such books are usually a poor reference for the practitioner. The rapid changes in the industry make books unreliable with respect to the current terminology of policy provisions. The best source in connection with the terms of contracts is, of course, the contracts themselves. As an aid to the interpretation of the meaning and intent of the policy provisions, one of the loose leaf services available from the insurance publishing houses is ideal. If one of these is not available, the other sources listed in this bibliography provide a reasonable substitute.

The bibliography is segregated by topic, listing the sources which are applicable to each area as these areas appear in the study guide.

GENERAL SECTION

The Insurance Device

The operation of the insurance mechanism is an interesting subject, and the agent should spend some additional time in study of the manner in which insurance operates to spread the risks of society. The two books listed below are traditional college texts, and although they are subject to the same criticism leveled previously at text books in general, the nature of the subject matter (insurance in general) under discussions makes them suitable.

Bickelhaupt, David L., and John H. Magee, **General Insurance.** Homewood, Illinois: Richard D. Irwin and Company, 1970. This book is almost an encyclopedia of insurance. It provides a detailed treatment of the history of insurance, the manner in which insurance operates, the structure and operations of the insurance business, the regulation of insurance, and a very good treatment of the fields of property, liability, health, and life insurance.

Emmet J. Vaughan and Curtis M. Elliott, **Fundamentals of Risk and Insurance.** New York: John Wiley and Sons, Second Edition, 1978. This book follows the same general format as the book described above, but is less comprehensive and detailed. For this reason it is perhaps a better introduction to the subject for a beginner.

The Insurance Industry

In addition to the two works cited above, important information about the insurance industry and its operations, and the extent of various insurance coverages is available in the publications of the public information services of the various fields of insurance:

Life Insurance Fact Book, published annually by the Institute of Life Insurance, 277 Park Avenue, New York, New York.

Source Book of Health Insurance Data, published annually by the Health Insurance Institute, 277 Park Avenue, New York, New York.

Insurance Facts, Property · Liability · · Inland Marine · Surety, published annually by the Insurance Information Institute, 110 William Street, New York, New York.

The agent should read at least one of the industry trade journals regularly. There are approximately 60 insurance publications, and at least one of these is probably available to the agent. As the "newspapers" of the insurance industry, they assist the agent in staying current with respect to developments in the industry. The following are recommended:

The National Underwriter, Life and Health Edition (weekly)

The National Underwriter, Property and Casualty Edition (weekly)

Life Association News (monthly)

The Local Agent (monthly)

The Independent Agent (monthly)

The Bulletin of the National Association of Mutual Insurance Agents (monthly)

Best's Review (monthly)

In addition to the sources already listed, there are two recent works of importance, one dealing with the field of Life and Health Insurance, and one dealing with the field of Property and Liability insurance:

Gregg, Davis W., **Life and Health Insurance Handbook** (Homewood, Illinois, Richard D. Irwin, 1959). This is a comprehensive reference source on all major phases of life and health insurance. It was written by 109 outstanding authorities; it is a valuable and practical tool to the insurance practitioner.

Long, John D., and Davis W. Gregg, **Property and Liability Insurance Handbook** (Homewood, Illinois: Richard D. Irwin, 1965). Like the Life Insurance handbook described above, this work was written by 132 experts, each treating his own particular area of competence. It is an invaluable source, not only on the property and casualty industry, but on the various coverages as well.

Regulation of the Insurance Industry

Insurance Laws of Iowa, published by the State of Iowa. Since the laws on insurance vary from state to state, it is important that the agent understand fully the laws of his own state. The only available source that fully serves as an adequate reference in this sense are the laws themselves.

Patterson, Edwin W., **Essentials of Insurance Law** (New York: McGraw Hill Book Company, 1957) 558 pp. Primarily a text on the legal framework within which the insurance industry operates. Chapter 1 provides a good explanation of the reasons for insurance regulation and a general description of insurance regulation today.

The Legal Framework

Patterson, Edwin W., **Essential of Insurance Law** (New York: McGraw Hill Book Company, 1957) 558 pp. Provides a good treatment, in layman's language of the various legal principles applicable to insurance, including the law of contracts, agency, and special legal principles relating to insurance.

PERSONAL LINES

There are several major sources which are recommended in connection with all of the personal lines coverages:

The Fire, Casualty, and Surety Bulletins, published by the National Underwriter Company. This is a monthly bulletin service which treats virtually all property and casualty coverages in detail. A monthly supplement is sent to subscribers, in which recent changes in policy coverage, court interpretations, and so on, are discussed. All of the personal lines coverages discussed in this study guide are treated in much greater detail in these bulletins. The service is commonly referred to as The F. C. & S. Bulletins.

The Policy, Form, and Manual Analysis Service, published by the Rough Notes Company. This is a monthly bulletin service which also treats virtually all of the property and casualty coverages in detail. It includes a monthly supplement with information about changes in policy coverage and court decisions. All of the personal lines coverages discussed in this study guide are treated in these bulletins. This service is commonly referred to as the P. F. & M. Manual.

Gordis, Philip, **Property and Casualty Insurance** (Indianapolis, Indiana: The Rough Notes Company, current date). 613 pp. This book is intended as a guide for agents. It contains a clear and concise analysis of various property and casualty coverages. It is revised and republished annually, so it is generally current. In addition, it contains an exhaustive bibliography of additional sources.

Personal Insurance Survey, a 72-page paperback book, published by the Rough Notes Company, is written by the editors of the P. F. & M. Manual. If a monthly service such as the P. F. & M. Manual for the F. C. & S. Bulletins is not available, this book is a good substitute with respect to the personal lines coverages. It is revised periodically, so the current edition should be obtained.

Broadened Protection for Personal and Business Risks, published by the National Underwriter Company, is written by the editors of the F. C. & S. Bulletins. It provides a detailed analysis of various personal lines coverages, based on the treatment in the F. C. & S. bulletins. It is published annually.

In addition to these references, which apply to all of the personal lines coverages, there are certain other works which may be helpful with respect to certain specific areas:

Long and Gregg, **Property and Liability Handbook**

Magee and Bickelhaupt, **General Insurance**

Mehr and Hedges, **Principles of Insurance**

Fire Rule Book, Dwelling Schedule

Homeowners Manual

Auto Rate Manual

Comprehensive Personal Liability section of Liability Manual

Iowa Automobile Insurance Plan section of Auto Manual

COMMERCIAL SECTION

The best sources for the commercial coverages are the monthly bulletin services described in the bibliography for the personal lines coverages. In addition, the other books listed below should be considered as secondary sources for all of the commercial line coverages. In addition to these, there are certain specialized publications which are useful in connection with the specific commercial line areas. These are listed below by topic.

General Sources For All Commercial Coverages

F. C. & S. Bulletins, The National Underwriter Company

P. F. & M. Manual, The Rough Notes Company

Broadened Protection for Personal and Business Risks, The National Underwriter Company.

Gordis, Philip, **Property and Casualty Insurance,** The Rough Notes Company.

Long and Gregg, **Property and Liability Handbook,** Richard D. Irwin

Magee and Bickelhaupt, **General Insurance,** Richard D. Irwin

Mehr and Hedges, **Principles of Insurance,** Richard D. Irwin

Fire and Consequential Loss Coverages

Gwertzman, Max J., The Standard Fire Policy (New York: Roberts Publishing Corporation, 1963). This 64-page paperback includes a detailed discussion of the doctrines of insurable interest, actual cash value, subrogation, and other principles as they apply to the standard fire policy.

Iowa Fire Rule Book. The rule book is an important source of information, not only with respect to rates and eligibility, but also with respect to the intent of various fire endorsements.

Boiler and Plate Glass Coverage

Stephens, W. L., **A Producers Boiler and Machinery Notebook,** The National Underwriter Company. A discussion of the details of policy coverage and endorsements to the boiler and machinery policy, including indirect loss coverages. 1963. Paperbound, 134 pp.

Inland Marine Insurance

Rodda, William H., **Inland Marine and Transportation Insurance** (Englewood Cliffs, N.J.: Prentice Hall, 1958). Although it is somewhat outdated, this book remains the standard reference on the field of inland marine insurance. Provides a good overall discussion of the history and development of the field, and a discussion of the forms of coverage.

Bonds

Crist, G. W. Jr., **Corporate Suretyship** (New York: McGraw Hill, Inc., 1950). Although slightly outdated, most of the material is nevertheless applicable. The book is intended for newcomers to the field, and provides a broad survey of the field of suretyship. 441 pp.

Gee, Harold, **Agents Bonding Guide,** The Rough Notes Company, 235 pp. A more practical approach to the field of bonding, including a discussion of the coverages, and a reference chart with various types of bonds listed.

Fundamentals of Bonding: A Manual on Fidelity and Surety, The Rough Notes Company, 1966. A paperbound introduction to the field. 127 pp.

Crime Coverages

Gee, Harold, **Broad Form Crime Insurance Primer,** Rough Notes Company, 1963. Discussed the Comprehensive 3-D policy, the Blanket Crime Policy and the Broadform Storekeepers Policy. 94 pp.

General Liability

Liability Insurance Guide, The Rough Notes Company, 1966. A paperbound discussion of the changes in liability forms introduced in October 1966. Essentially an extraction from the P. F. & M. Manual. A handy and useful source, with a discussion of the various policy provisions of the various coverage parts designed for use under the General Liability form.

Commercial Auto

Gee, Harold, **The Agents Automobile Guide,** The Rough Notes Company. A discussion in question and answer form, basically intended as an introduction to the field. A good reference.

Brainard, Calvin, **Automobile Insurance** (Homewood, Illinois: Richard D. Irwin, Inc., 1961). The most exhaustive treatment of the field of automobile insurance available. Some of the material is outdated, but the general discussion of automobile coverages and rates is the best available.

Employers Liability and Workmen's Compensation

The Iowa Law of Workmen's Compensation. The importance of the law in the operation of insurance dictates that the law itself should be the primary source in the field of Workmen's Compensation insurance. A copy of the current law, including amendments, may be obtained from the Office of the Iowa Industrial Commissioner, Iowa State House, Des Moines, Iowa.

Davis, Clifford, **et. al. The Iowa Law of Workmen's Compensation** (Iowa City: The Center for

Labor and Management, University of Iowa, 1967). This monograph discussed the Iowa law in detail, with additional information on the administration of the law; in general the best source available.

Gentile, Willard J., **Workmen's Compensation and Employer's Liability Insurance** (New York: Roberts Publishing Corporation, 1963). Paperback, 40 pp. A brief but detailed discussion of the Workmen's Compensation and Employer's Liability policy, including insuring agreements, conditions, and exclusions.

Special Multi-Peril Policy Program

The New Special Multi-Peril Guide, 1966 Program. Published by the Rough Notes Company. A clear and simple discussion of the SMP program, with a comparison of the 1966 program with the previous SMP program. Paperback, 60 pp.

Life and Health Insurance

Agent's Service, Section E, **Diamond Life Bulletin.**

The Economics of Life Insurance, Third Edition, by S. S. Huebner.

Volumes I, II, III, First Year Course, Life Underwriters Training Council.

The Annual Life Insurance Fact Book, published by Institute of Life Insurance Association of America, 1962.

List of Suggested Reference Materials On Classifications of Life Insurance

R & R Service: **"Introduce Yourself to Life Insurance"; "Introduction to Life Insurance"**

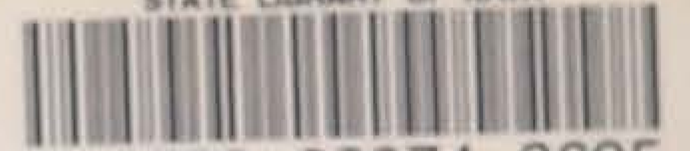
Life Insurance — Heubner, S. S., and Black, Kenneth

Life Insurance — Maclean, J. B.

Life Insurance — McGill, D. M.

Modern Life Insurance — Mehr, R.I., and Osler, R.W.

Life and Health Insurance Handbooks — Gregg, D. W., Editor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