Agents E&O Standard of Care Project

Survey Kansas

To gain a deeper understanding of the differing agent duties and standard of care by state, the Big "I" Professional Liability Program and Swiss Re Corporate Solutions surveyed their panel counsel attorneys. Each attorney was asked to draft a brief synopsis outlining the agents' standard of care in their state. They were also asked to identify and include a short summary of the landmark cases. In addition, many of the summaries include sample case studies emphasizing how legal duties and issues with standard of care effected the outcome. Finally, recent trends in errors in the state may also be included.

This risk management information is a value-added service of the Big "I" Professional Liability Program and Swiss Re Corporate Solutions. For more risk management information and tools visit www.iiaba.net/EOHappens. On the specific topic of agents' standard of care check out this article from the Hassett Law firm, our E&O seminar module, and this risk management webinar.

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1. **Summary of Standard of Care in Kansas.** The standard of care for an agent in Kansas is to exercise the skill, care and diligence that would be exercised by a reasonably prudent and competent insurance agent or broker acting under the same circumstances. It is referred to as the "exercise care duty". *Marker v. Preferred Fire Ins. Co.*, 211 Kan. 427, 506 P.2d 1163 (1973); *Casas v. Farmers Ins. Exchange*, 35 Kan.App.2d 223, 130 P.3d 1201 (2005); *Marshal Investments, Inc., v. Cohen*, 6 Kan.App.2d 672, 634 P.2d 133 (1981). A claim may be contract based or tort based, either viewed as an implied contractual term of the agent's undertaking or as a part of the duty owed to the client by reason of the principal-agent relationship the agent/broker has with the insured. Kansas courts have held that generally the duty is the same, regardless of whether it is contract or tort based, and the issue of which it may be is only relevant typically when there is an issue over the statute of limitations; because the tort based statute is two years and a contract claim is either three years if oral, or five years if written. Absent a specific agreement to do so, an insurance agent does not have a continuing duty to advise, guide or direct an insured's coverage after the agent has complied with his obligation to obtain insurance coverage on behalf of the insured. *Marshall v. Donnelli*, 14 Kan.App.2d 150, 783 P.2d 1321 (1989).

2. **First Case Study:**

A. Line of coverage involved. Business coverage

B. Position of person in the agency involved. Agent/owner

C. Commercial or personal lines. Commercial

D. Type of coverage involved. Theft coverage

E. Procedural or knowledge-based error. Alleged procedural error

F. Claimant allegation. The plaintiff claimed she asked her agent to obtain theft coverage for her small business. She alleged the agent failed to obtain the requested coverage when she renewed her policy.

G. Settlement or trial. The case was voluntarily dismissed by the plaintiff.

H. Description of alleged error. The agent purportedly failed to obtain theft coverage in a policy of insurance for the plaintiff's small business. The policy issued excluded coverage for theft. The agent discussed such coverage with the insured, but did not document in his file the insured's decision to not obtain the coverage, and when the insured first received a denial from the insurance company after submitting a theft claim, she contacted the agent who, after a cursory review of

his file, stated he thought she had such coverage and he would contact the company. After a more thorough review of his file, the agent recalled that he had discussed theft coverage with the insured, but she had declined it.

I. Tip to avoid claim. It is helpful to document the insured's file when specific or significant coverages are discussed and declined. Also, it is advisable to review the file carefully and completely before making any representations or statements to the insured about the existence of coverage after a claim is denied.

J. Summary of Case. The insured ran a small business. She had used the agent in years prior for the procurement of insurance covering her business. When the policy came up for renewal, she met with the agent and inquired about theft coverage for her business. After a discussion with the agent, she declined the coverage because she had a security system and thought the deductible would likely exceed any loss. The policy was issued and subsequently a break in at her business occurred and considerable property stolen. Plaintiff on her own filed a claim with the insurer and it was denied because theft was excluded. She then contacted the agent and asked why the claim had been denied, contending she had asked for theft coverage. Upon only a very cursory review of his file, the agent initially thought there was coverage for theft, and made statements to that effect to the insured. Subsequently, he reviewed his file in more detail, and realized that, in fact, theft coverage had been discussed but declined. The agent did not document the declination in his file, however. Ultimately, plaintiff voluntarily dismissed the case and did not pursue it after initial discovery was conducted. The lesson to be learned is that it is best to document any declination of coverages specifically discussed or otherwise significant coverages, and to make no statements about coverages or a denial of a claim without a thorough and complete review of the file. The agent's initial statement to the insured about coverage existing only served to cause the insured to pursue the claim in the first place, and raised an issue of credibility, since the file did not document that theft coverage had been discussed, but declined.

3. **Second Case Study.**

A. Line of coverage involved. Business coverage

B. Position of the person in the agency involved. Agent

C. Commercial or personal lines. Commercial

D. Type of coverage involved. Coverage for fire loss

E. Procedural or knowledge-based error. Alleged procedural error

F. Claimant Allegation. The insured operated a business at multiple locations. The insured had replacement cost coverage for its principal place of business, and also

for a satellite location. The plaintiff alleged that when a fire destroyed the satellite location, the insurer refused to pay more than the total coverage limit requested of slightly over $300,000. That limit had been based upon a mistaken belief that the satellite location was only 1,300 square feet, when in fact it was over 14,000 square feet. The plaintiff alleged the agent knew or should have known that the satellite location was much larger than what was put on the insurance application and what was described in the policy, and the agent was therefore allegedly negligent in failing to procure the appropriate coverage.

G. Settlement or trial. The case was settled.

H. Description of Alleged Error. On the application for insurance, the satellite location was described as approximately 1,300 square feet, when in fact it was almost 14,000 square feet. The square footage was placed on the application by the agent, but the agent's testimony was that the information had been obtained from the insured. The agent, however, did not have copies of that information, did not have any record of how or when he got it, and the insured denied ever providing it to the agent.

I. Tip to Avoid Claim. An agent should be familiar with the insured's business operations such that a mistake of this magnitude, even if in the agent's viewpoint caused by the insured, would have been discovered.

J. Summary of Case. The insured's business operated a satellite location which was described on the application for insurance as a 1,300 square foot building, when in fact it was 14,000 square feet. The insurance had been previously placed with another carrier. When the insured approached the agent about putting the insurance out for bid, an application prepared by the agent showed the satellite location to be 1,300 square feet. The agent's testimony was that he obtained the information from the insured, and would not have got it from any other source. The insured denied providing the information to the agent, and the agent's file did not reflect its source. The insured signed the application and signed a statement of value, both of which included the wrong square footage. The insured's testimony was that they never looked at the application that closely and trusted their insurance agent would make sure it was accurate. After the fire, the insurer would only pay the limit of insurance of slightly over $300,000, even though the cost to replace the building was actually $1.8 million. The insured did not specifically plead a special relationship between the insured and the agent, though the insured testified they expected the agent to make sure they had adequate coverage. The insured's expert contended that the agent had a duty to be familiar enough with the insured's business and property, to have realized that the 1,300 square feet description was grossly inadequate and thus the building was grossly underinsured. The agent was located in a city over 200 miles from the satellite location, and thus the agent did not have any personal knowledge regarding the actual building or its size. In defending the case, we were of the opinion that the agent had not done anything wrong, and that it was the insured that had provided inaccurate information to the agent and repeatedly reaffirmed that inaccurate

information in the application and statement of value. The main risk to the agent was the argument that the agent had a duty to be familiar enough with the insured's business operations such that the agent would have recognized the grossly underinsured building, even if the mistake was not his. The claim could have been avoided had the agent been more familiar with the insured's business. That is not to say it was negligence not to have had such knowledge, but the claim could likely have been avoided if such knowledge had existed, or if the agent had gone over the application with the insured in more detail.

4. **Third Case Study.**

A. Line of coverage involved. Homeowner's policy

B. Position of person in the agency involved. Agent

C. Personal or commercial lines. Personal lines

D. Type of coverage involved. Fire loss

E. Procedure or knowledge-based error. Alleged procedural and knowledge error

F. Claimant Allegation. The insured alleged she bought a home for her granddaughter and grandson-in-law to live in in an adjoining state. The insured owned her own home and bought the second home with no intention of living in it, but bought it for her granddaughter and grandson-in-law. When insurance was obtained on the home, it was not disclosed in the application that someone other than the owner would live in the house, and the policy excluded fire coverage for the property of others unless they were living with the named insured. After a fire destroyed the property of the granddaughter and her husband who were living in the home, they and the insured brought an action against the agent for failing to procure the insurance purportedly requested.

G. Settlement or trial. The case was settled.

H. Description of alleged error. The application for insurance did not disclose that the owner of the home would not be living in it and that someone else would be living there. The application stated the owner would be living in the property, when that was clearly not the case. The agent believed the owner intended to spend a "substantial" amount of time at the property, though the agent realized the insured also owned another home in another state.

I. Tip to avoid claim. An agent needs to be sure whether the insured intends to live in the home or if anyone other than the insured intends to live there, to clearly document that information in the file, and make sure, if the owner is not to live there, adequate coverage is obtained for those who will live there, or the lack of coverage is fully explained and documented.

J. Summary of case. The insured agreed to buy a home for her granddaughter and grandson-in-law to live in in another state. She bought the home and obtained a mortgage on it. The grandson-in-law and granddaughter agreed to pay the mortgage payments, taxes and maintenance on the property, but the deed was in the grandmother's name. The lender providing the loan to the insured contacted the agent about getting coverage on the property. The lender advised the agent initially assigned the file that she was "treating it as a primary residence", even though the owner also owned another home in another state, and that the lender did not want the insurance application to make any reference to a secondary home or a tenant-occupied home. It was not entirely clear why the lender took that position, but it's presumed it had something to do with obtaining more favorable financing if the home was owner-occupied. The agent who initially handled the insurance procurement made a note in the file that she had talked to the lender and she understood the actual owner would not be living in the home, and that the granddaughter and grandson-in-law would be the ones living there. Subsequently, the insurance application was assigned to a different agent who concluded the process, and had available to her the file notes made by the earlier agent. The new agent talked on more than one occasion with the grandmother, and the agent's testimony was that she understood the grandmother intended to live at the home a "substantial" amount of time, even though the agent understood the grandmother owned another home in another state. The new agent did not recall seeing the notes from the earlier agent, but testified that at the time of her handling of the application, it seemed clear the grandmother/insured intended to live a substantial amount of time in the home. None of that, however, was included in the application, and the insured and grandchildren told a completely different story. They claimed they specifically described the planned arrangement to the agent and made it clear to her that the property would be owned by the grandmother, but she lived in another state and at most would, on occasion, visit for short periods of time, but the granddaughter and grandson-in-law would be the ones living in the property, and they wanted to make sure their property was insured. After a fire occurred, a claim was made by the grandchildren and denied. Litigation ensued. The case was ultimately settled because the initial agent who had handled the file had made notes in the file that at least raised a red flag that the named insured might not be living in the home, and that while the insured signed applications that clearly were false because the applications indicated the home would be her primary residence, the claim was that she didn't pay that close attention to what she was signing and trusted the agent completed it accurately. The lesson to be learned is that there were sufficient red flags in the file to have put the agent on notice that the people actually living in the home were not the owner or named insured, and further inquiry should have been made and the file more closely documented as to what was being planned. The problem was complicated by the fact the file was transferred from one agent to another, and when that happens, it's important the two agents talk and the new agent is fully aware of any problem areas or concerns.